

A young child with Down syndrome is shown from the chest up, wearing a brown jacket and a grey hoodie. The child is blowing a dandelion seed head, with several seeds floating in the air around their face. The background is a soft, out-of-focus green, suggesting an outdoor setting with foliage.

**MUI Rule Training
2014
for Administrators and
Management Personnel**

MUI Registry Unit



**Department of
Developmental Disabilities**

Purpose of Training

This training is intended for professionals who work in an administrative capacity and are responsible for the oversight of reporting and investigations. This training covers the following topics:

- ***MUI Rule Definitions***
- ***Reporting Requirements***
- ***Patterns and Trends***
- ***Access to Records***
- ***Training***



What is O.A.C. 5123:2-17-02?

The MUI Rule establishes the requirements for addressing major unusual incidents and unusual incidents and implements a continuous quality improvement process in order to prevent or reduce the risk of harm to individuals.



MUI Means...

The alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or welfare of an individual may be adversely affected or an individual may be placed at a likely risk of harm, if such individual is receiving services through the developmental disabilities service delivery system or will be receiving such services as a result of the incident. There are three categories of major unusual incidents that correspond to three administrative investigation procedures delineated in appendix A, appendix B, and appendix C to this rule.

Key Points:

- Alleged, suspected or actual occurrence***
- Reason to believe a person is at risk of harm based on facts present not opinion***
- Receiving services or will be as a result of incident***

Physical Abuse

- Physical force
- Reasonably be expected to result in harm

***Examples:** Hitting, slapping, pushing, dragging or throwing an object when the allegation indicates that it could reasonably result in harm.*

Physical Abuse Trends 2013

1567 Allegations were reported and 404 (26%) were substantiated. Break down by PPI Type is as follows:

- *Family- 84 (21%)*
- *Employees - 109 (27%)*
- *Others- 62 (15%)*
- *Unknown- 72 (18%)*
- *Friend- 68 (17%)*
- *Guardian- 8 (2%)*
- *Payee-1(less than 1%)*

Cause/Contributing Factors:

- Control, mean, unrealistic expectations, retaliation, intimidation for covering up theft

Verbal Abuse

Verbal abuse which means the use of words, gestures, or ***other communicative means*** to threaten, coerce, intimidate, harass or humiliate an individual.

Verbal Abuse Trends 2013

857 Allegations were reported and 343 (40%) were substantiated. Break down by PPI Type is as follows:

- Employees-172 (50%)
- Others-60 (18%)
- Family-42(12%)
- Friend-37 (11%)
- Unknown-21 (6%)
- Guardian-8 (2%)
- Payee-3 (1%)

Cause/Contributing Factors:

- Control; unrealistic expectations
- Staff are in challenging situation with little support
- Staff are scheduled an excessive amount of hours

Sexual Abuse

- Unlawful sexual contact
- Unlawful sexual conduct
- Public indecency, voyeurism, importuning, etc.

Sexual Abuse Trends 2013

339 Allegations were reported and 88 were substantiated (26%). Break down by PPI:

- Others-29 (33%)
- Family-32 (36%)
- Unknown-7 (8%)
- Friend-8 (9%)
- Employees-12 (14%)
- Guardian-0 (0%)
- Payee-0 (0%)

Misappropriation

- With intent
- Deprive, defraud, or otherwise obtain real or personal property
- As prohibited in Ohio Revised Code 2911 and 2913

Misappropriation Trends 2013

1528 Allegations were reported and 899 were substantiated (59%). Break down by PPI:

- Unknown-498 (55%)
- Employees-180 (20%)
- Guardian-3 (Less than 1%)
- Others-126 (14%)
- Family-79 (9%)
- Payee-13 (1%)

Neglect

- A duty
- Failing to provide treatment, care, goods, supervision or services
- Necessary to maintain the health or welfare of the individual
- What is Reasonable Risk? Harm more likely than not could occur

Neglect Trends 2013

2064 Allegations and 1217 Substantiated Cases (59%).

Break down by PPI:

- Employees-992 (82%)
- Others-71 (6%)
- Family-122 (10%)
- Guardian-29 (2%)
- Unknown-3 (less than 1%)

Neglect

- Failing to provide supervision made up 65% of all substantiated neglect cases.
- Failing to provide treatment was 35% of all substantiated 2013 cases.

What is Systems Neglect?

When a individual is neglected and the neglect is not the result of a particular person/people, a system neglect is identified. A systems issues is a process that involves multiple components playing a role in a the neglect.

Causes & Contributing Factors Supervision Neglects

- Supervision Levels are not met by:
 - Scheduling Problems; Impaired Staff
 - Employee-No Shows, Planned sleeping and/or leaving
- Not following supervision levels (i.e., community, mealtimes).
- No training or lack of training on supervision levels (1:1, 24-7 eyes on, etc.) Risk of Harm?

Causes & Contributing Factors Treatment Neglects

- Criminal activity – not feeding/medication
- Medical attention – will not call 911
- Dietary Texture, Pacing
- Failure to follow ISP
- Failure to follow Doctor's orders
- Lack of training on treatments (i.e., turning schedule, monitoring treatments).

Medical Emergency

Medical emergency. "Medical emergency" means an incident where emergency medical intervention is required to save an individual's life

Examples include: choking relief techniques such as back blows or cardiopulmonary resuscitation, epinephrine auto injector usage, or intravenous (for dehydration)

Medical Emergencies-2013

688 Medical Emergencies were filed in 2013 which is an increase from 667 in 2012.

- Heimlich and Back blows were used 295 and 88 times respectively accounting for 56% of all medical emergencies. These interventions were successful in all but 5 incidents when the individual died due to choking
- 79 were due to dehydration, which is the 2nd highest category

Attempted Suicide

Physical attempt that:

- Results in ER treatment or
- Inpatient observation or
- Hospital admission

In 2013, there were 73 attempted suicides reported and 2 individuals died as a result.

Take any suicidal talk very seriously. It's not just a warning sign that the person is thinking about suicide — it's a cry for help.

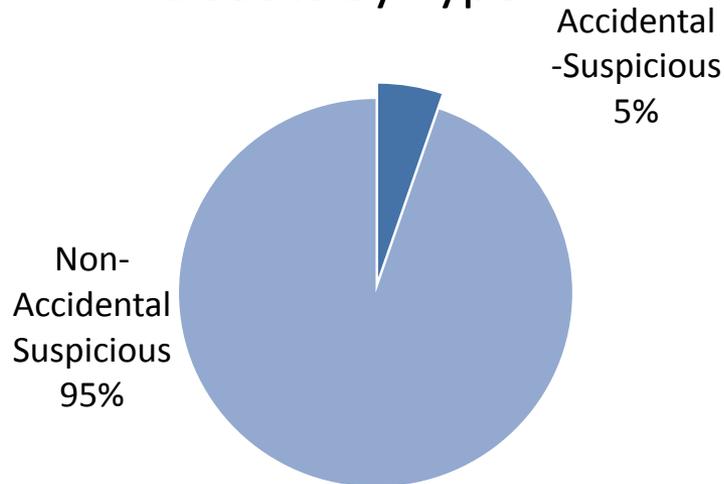
Death Definitions

- Accidental or suspicious death. "Accidental or suspicious death" means the death of an individual resulting from an accident or suspicious circumstances (Category A)
- Death other than accidental or suspicious death. "Death other than accidental or suspicious death" means the death of an individual by natural cause without suspicious circumstances (Category B)

Deaths Trends-2013

All deaths of individuals served

Deaths by Type



- Accidental -Suspicious
- Non-Accidental Suspicious

- There were 783 reported deaths in 2013.
- Of the 2013 deaths, 41 were considered Accidental or Suspicious while 742 were Non-Accidental/Non-Suspicious Deaths.
- Heart disease continues to be the leading cause of death for Ohioans with disabilities (14%) as well as the general population.
- Pneumonia and aspiration pneumonia continue to make up the next largest causes of death.

Every Healthy Person

The “*Every Healthy Person*” initiative is a joint effort between the Ohio Department of Developmental Disabilities (DODD) and the Ohio Department of Health (ODH) to focus attention on the importance of preventive healthcare, including periodic health care screenings, for people with developmental disabilities. The joint initiative complements [Healthy Ohioans](#)—a statewide health and wellness plan to replace unhealthy habits with healthy ones.

Exploitation

- Unlawful or improper act
- Using individual
- Individual's resources for personal benefit, profit, or gain

There were 119 allegations of exploitation and 57 substantiations in 2013.

Failure to Report (Registry)-2013

- Developmental Disabilities employee unreasonably failed to report Abuse or Neglect
- Knew or should have known
- Failure would result in a substantial risk of harm

In 2013, there were 176 allegations and 94 (53%) substantiated

Significant Injury

Significant injury means an injury of known or unknown cause that is not considered abuse or neglect and that results in concussion, broken bone, dislocation, second or third degree burns or that requires immobilization, casting, or five or more sutures. Significant injuries shall be designated in the incident tracking system as either known or unknown cause.

- *Replaces known and unknown injury MUIs*

2013 Significant Injury Stats

There were 1755 reported Significant Injuries.

The Break Down:

1341 were of known Injuries.

- Seizure – 58 (4%)
- Peer/Peer – 19 (2%)
- Medical – 25 (2%)
- Falls – 767(57%)
- Behavior – 133 (10%)
- Accident – 323 (24%)
- Other Not Listed- 16 (1%)

414 were of unknown origin

Law Enforcement

Individual is:

Charged (C)

Incarcerated (I)

Arrested (A)



In 2013, there were 614 MUIs filed for Law Enforcement events with individuals served.

Missing Individual

An incident that is not considered neglect and an individual whereabouts after immediate measures taken are unknown and the individual is believed to be at or pose an **imminent risk of harm to self or others.**

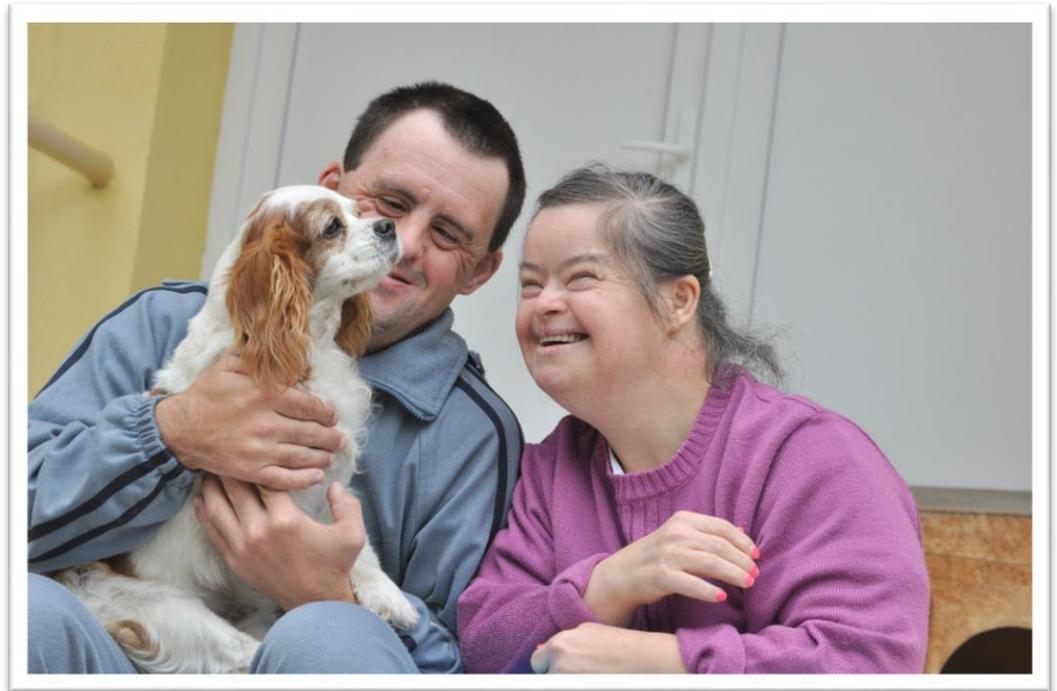
An incident when an individual's are unknown for longer than the period of time specified in the individual's service plan that does not result in imminent risk of harm to self or others shall be investigated as an unusual incident.

In 2013, there were 411 MUIs filed for Missing Individuals

Peer to Peer Acts

Peer-to-peer act. "Peer-to-peer act" means one of the following incidents involving two individuals served:

- *Physical Act*
- *Sexual Act*
- *Verbal Act*
- *Theft*
- *Exploitation*



In 2013, there were 2, 108 MUIs filed for Peer to Peer Acts. This is the second leading type of MUI filed behind unscheduled hospitalization.

Peer to Peer Act Definitions

Physical Act that occurs when an individual is targeting, or firmly fixed on another individual such that the act is not accidental or random and the act results in an injury that is treated by a physician, physician assistant, or nurse practitioner. Allegations of one individual choking another or any head or neck injuries such as a bloody nose, a bloody lip, a black eye, or other injury to the eye, shall be considered major unusual incidents.

Minor injuries such as scratches or reddened areas not involving the head or neck shall be considered unusual incidents and shall require immediate action, a review to uncover possible cause/contributing factors, and prevention measures.

Peer to Peer Act Definitions

Sexual Act which means sexual conduct and/or contact for the purposes of sexual gratification without the consent of the other individual.

Verbal Act which means the use of words, gestures, or other communicative means to purposefully threaten, coerce, or intimidate the other individual when there is the opportunity and ability to carry out the threat.

Peer to Peer Act Definitions

- Theft which means intentionally depriving another individual of real or personal property valued at *twenty dollars or more or property of significant personal* value to the individual.
- Exploitation which means the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit, or gain.

Prohibited Sexual Relations

- Developmental Disabilities employee
- Consensual sexual conduct or contact
- With an individual who is not their spouse
- Employed or under contract to provide care to the individual at the time of the incident
- Anyone in the Developmental Disabilities employee's supervisory chain of command

22 Allegations and 8 Substantiated Cases (36%) in 2013

Rights Code Violation

"Rights code violation" means any violation of the rights enumerated in section 5123.62 of the Revised Code that creates a likely risk of harm to the health or welfare of an Individual.

79 Allegations of Rights Code Violation and 43 Substantiated Cases (54%)

Unapproved Behavior Support

*Unapproved behavior support. "Unapproved behavior support" means the use of an aversive strategy or intervention prohibited by paragraph (J) of rule 5123:2-1-02 of the Administrative Code or an **aversive strategy** implemented without approval by the human rights committee or behavior support committee or without informed consent, that results in a likely risk to the individual's health and welfare. **An aversive strategy or intervention prohibited by paragraph (J) of rule 5123:2-1-02 of the Administrative Code that does not pose a likely risk to health and welfare shall be investigated as an unusual incident.***

Unapproved Behavior Support 2013



- There were 1,827 UBS reports made in 2013.
- This is 52 less UBS than were filed in 2012.
- Continue to emphasize Positive Culture.

Unscheduled Hospitalizations

Unscheduled hospitalization. "Unscheduled hospitalization" means any hospital admission that is not scheduled unless the hospital admission is due to a pre-existing condition that is specified in the individual service plan indicating the specific symptoms and criteria that require hospitalization.

Unscheduled Hospital-2013

- In 2013, there were 4,627 reports of unscheduled hospitalizations (leading reported MUI).
- **Unscheduled Hospitalizations make up 24% of all MUIs.**

Some Examples:

- The individual has labored breathing and rapid heartbeat and is admitted to the hospital with a diagnosis of pneumonia.
- The individual is lethargic and unsteady, goes to the ER and is hospitalized for a possible medication error.
- Individual goes to ER and is sent home after 25 hours.

2013 Top Ten Reported MUIs

Category	2013 Count	All MUIS 2013	% of MUIs
Unscheduled Hospitalization	4,627	19,637	23.56
Peer to Peer Acts	2,108	19,637	10.73
Alleged Neglect	2,064	19,637	10.51
Unapproved Behavior Support	1,827	19,637	9.3
Significant Injury	1,755	19,637	8.94
Alleged Abuse-Physical	1,567	19,637	7.98
Misappropriation	1,528	19,637	7.78
Alleged Abuse - VERBAL	857	19,637	4.36
Non-Accidental and Suspicious Deaths	742	19,637	3.78
Medical Emergency	688	19,637	3.5

(D) Reporting Requirements



**(D)(1)-All MUIs should be reported
for those living in ICFs or
receiving around the clock services**

(1) Reports all major usual incidents involving an individual who resides in an intermediate care facility or who receives round-the-clock waiver services shall be filed and the requirements of this rule followed regardless of where the incident occurred.

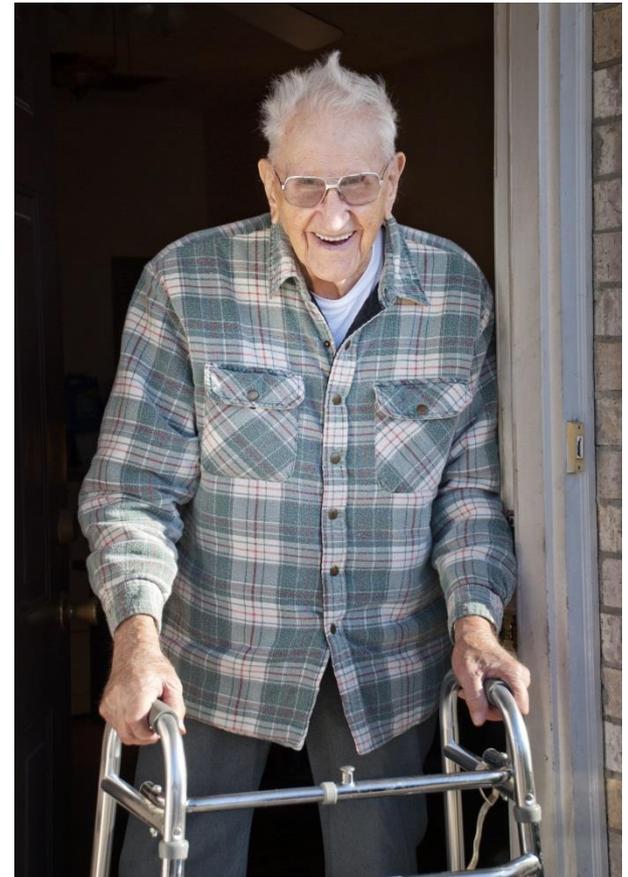
(D)(2)-These MUI Reports shall be filed regardless where the incident occurs:

(2) Reports regarding the following major unusual incidents shall be filed and the requirements of this rule followed regardless of where the incident occurred:

- (a) Accidental or suspicious death;
- (b) Attempted suicide;
- (c) Death other than accidental or suspicious death;
- (d) Exploitation;
- (e) Failure to report;
- (f) Law enforcement;

(D)(2)-These MUI Reports shall be filed regardless where the incident occurs

- (g) Misappropriation;
- (h) Missing individuals
- (i) Neglect;
- (j) Peer-to-peer act;
- (k) Physical abuse;
- (l) Prohibited sexual relations;
- (m) Sexual abuse; and
- (n) Verbal abuse.



(D)(3) Reports regarding the following MUIs shall be filed when with provider:

Shall be filed and the requirements of this rule followed only when the incident occurs in a program operated by a county board or when the individual is being served by a licensed or certified provider:

- (a) Medical emergency;
- (b) Rights code violation;
- (c) Significant injury;
- (d) Unapproved behavior support; and
- (e) Unscheduled hospitalization.

(D)(4) Upon Identification or Notification of MUI, Provider or County Board Shall:

Take immediate actions to protect all at risk individuals which shall include:

- a. Immediate or ongoing medical attention as appropriate
- b. Removal of an employee from direct contact with any at-risk individual when the employee is alleged to have been involved in abuse or neglect until such time as the provider has reasonably determined that such removal is no longer necessary;
- c. Other measures as necessary

The Department shall resolve any disagreements

(D)(5) County Board Upon Notification Shall:

- Ensure reasonable measures are appropriate
- Determine if additional measures are needed
- Notify the Department if circumstances in Paragraph (I)(1) of this rule are present requiring a Department directed investigation

(D)(6) Immediate to 4 Hour Reporting

Provider or county board as a provider, using county board identified system for MUIs, should report incidents or allegations of:

- (a) Accidental or suspicious death;
- (b) Exploitation;
- (c) Misappropriation;
- (d) Neglect;
- (e) Peer-to-peer act;
- (f) Physical abuse;
- (g) Sexual abuse;
- (h) Verbal abuse; and
- (i) When the provider has received an inquiry from the media regarding a major unusual incident.

(D)(7) Submit Written Incident Report by 3:00 p.m. the Next Working Day

- Agency providers and county boards as providers
- Department prescribed format
- Individual providers notify county board contact person
- Potential or determined MUI

(D)(8) County Board enter reports into Incident Tracking System by 3 p.m.

The county board shall enter preliminary information regarding the incident in the incident tracking system and in the manner prescribed by the department by three p.m. on the working day following notification by the provider or of becoming aware of the major unusual incident.

(D)(9) CB/Provider keep apprised of investigation and protective actions

When a provider has placed an employee on leave or otherwise taken protective action pending the outcome of the administrative investigation, the county board or department, as applicable, shall keep the provider apprised of the status of the administrative investigation so that the provider can resume normal operations as soon as possible consistent with the health and welfare of at-risk individuals.

The provider shall notify the county board or department, as applicable, of any changes regarding the protective action.

(D)(10) DC notifies the Department

If the provider is a developmental center, all reports required by this rule shall be made directly to the department.

(D)(11) CB shall have a system 24-hours for reporting

The county board shall have a system that is available twenty-four hours a day, seven days a week, to receive and respond to all reports required by this rule. The county board shall communicate this system in writing to all providers in the county and to the department.

24 Hour County Contact numbers are available on the Department's website at www.dodd.gov

(E) Alleged Criminal Acts

The provider shall immediately report to the law enforcement entity having jurisdiction of the location where the incident occurred, any allegation of exploitation, failure to report, misappropriation, neglect, peer-to-peer act, physical abuse, sexual abuse, or verbal abuse which may constitute a criminal act. The provider shall document the time, date, and name of person notified of the alleged criminal act. The county board shall ensure that the notification has been made.

(F) Abused or Neglected Children

Allegations of Abuse or Neglect per Ohio Revised Code 2151.03 and 2151.031

Under the age of 21

Report to local public children's agency

The county board shall ensure reports have been made

(G)(1) Notifications

The provider shall make the following notifications, as applicable, when the major unusual incident or discovery of the major unusual incident occurs when such provider has responsibility for the individual. The notification shall be made on the same day the major unusual incident or discovery of the major unusual incident occurs and include immediate actions taken.

- (a) Guardian or other person whom the individual has identified.
- (b) Service and support administrator serving the individual.
- (c) Licensed or certified residential provider.
- (d) Staff or family living at the individual's residence who have responsibility for the individual's care.
- (e) Support broker for an individual enrolled in the self-empowered life funding waiver.

(G)(2) All notifications shall be documented

All notifications or efforts to notify shall be documented. The county board shall ensure that all required notifications have been made.

(G)(3) Notification shall not be made to the PPI

Notification shall not be made if the person to be notified is the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved.

(G)(4) Notifications to Guardian

Notification shall be made to the individuals, individuals' guardians, and other persons whom the individuals have identified in a peer-to-peer act unless such notification could jeopardize the health and welfare of an individual involved.

(G)(5) Notifications are not required in deaths when family already aware

Notification to a person is not required when the report comes from such person or in the case of a death when the family is already aware of the death.

(G)(6)Secondary Notifications

In any case where law enforcement has been notified of an alleged crime, the department may provide notification of the incident to:

- Any other provider;
- Developmental center;
- County board for whom the primary person involved works, for the purpose of ensuring the health and welfare of any at-risk individual.

The notified provider or county board shall take such steps necessary to address the health and welfare needs of any at-risk individual and may consult the department in this regard. The department shall inform any notified entity as to whether the incident is substantiated. Providers, Developmental centers, or county boards employing a primary person involved shall notify the department when they are aware that the primary person involved works for another provider.

(H)(1) General Investigations

Each county board shall employ at least one investigative agent or contract with a person or governmental entity for the services of an investigative agent. An investigative agent shall be certified by the department in accordance with rule 5123:2-5-07 of the Administrative Code. Developmental center investigators are considered certified investigative agents for the purpose of this rule.

(H)(2)Appendix A, B and C

All major unusual incidents require an administrative investigation meeting that applicable administrative investigation procedure in appendix A, appendix B or appendix C to this rule unless it is not possible or relevant to the administrative investigation to meet a requirement under this rule, in which case the reason shall be documented. Administrative investigations shall be conducted and reviewed by investigative agents.

Appendix A

- Cases in which the police, CSB or IA may be involved in the investigation.
- Good communication and cooperation among investigative entities will be required for these investigations.
- Accidental or Suspicious Death, Exploitation, Failure To Report, Misappropriation, Neglect, Peer to Peer Act, Physical Abuse, Prohibited Sexual Activity, Rights Code, Sexual Abuse and Verbal Abuse

Appendix B

- Cases investigated by IA
- Attempted Suicide, Medical Emergency, Missing Individual, Death other than an accidental or suspicious, and Significant Injury

Appendix C

- Cases investigated by IA- Format Requirements
- Law Enforcement, Unapproved Behavior Supports and Unscheduled Hospitalizations.

(H)(2)(a) Elect to complete Category A

(a) The department or county board may elect to follow the administrative investigation procedure for category A major unusual incidents for any major unusual incident.

(H)(2)(b) Category could change

(b) Based on the facts discovered during administrative investigation of the major unusual incident, the category may change. If a major unusual incident changes category, the reason for the change shall be documented and the new applicable category administrative investigation procedure shall be followed to investigate the major unusual incident.

(H)(2)(c)-Closing of Criminal Cases

Major unusual incidents that involve an active criminal investigation may be closed as soon as the county board ensures that the major unusual incident is properly coded, the history of the primary person involved has been reviewed, cause and contributing factors are determined, a finding is made, and prevention measures implemented. Information needed for closure of the major unusual incident may be obtained from the criminal investigation.

(H)(3) Gathering Docs for Category C

County board staff may assist the investigative agent by gathering documents, entering information into the incident tracking system, fulfilling category C administrative investigation requirements, or performing other administrative or clerical duties that are not specific to the investigative agent role.

(H)(4)IA conducts interviews

Except when law enforcement or the public children's services agency is conducting the investigation, the investigative agent shall conduct all interviews for major unusual incidents unless the investigative agent determines the need for assistance with interviewing an individual.

(H)(5)County Board shall commence Category A within 24 hours; days for B,C

Except when law enforcement or the public children's services agency has been notified and is considering conducting an investigation, the county board shall commence an administrative investigation. If law enforcement or the public children's services agency notifies the county board that it has declined to investigate, the county board shall commence the administrative investigation within a reasonable amount of time based on the initial information received or obtained and consistent with the health and welfare of all at-risk individuals, but no later than twenty-four hours for a major unusual incident in category A or no later than three working days for a major unusual incident in category B or category C.

(H)(6) ICF shall conduct investigations in accordance with 42 C.F.R. 483.420

An intermediate care facility shall conduct an investigation that complies with applicable federal regulations, including 42 C.F.R. 483.420 (October 1, 2012), for any unusual incident or major unusual incident involving a resident of the intermediate care facility, regardless of where the unusual incident or major unusual incident occurs. The intermediate care facility shall provide a copy of its full report of an administrative investigation of a major unusual incident to the county board. The investigative agent may utilize information from the intermediate care facility's administrative investigation to meet the requirements of this rule or conduct a separate administrative investigation. The county board shall provide a copy of its full report of the administrative investigation to the intermediate care facility. The department shall resolve any conflicts that arise.

(H)(7) ICF's findings due to CB within 14 calendar days

When an agency provider, excluding an intermediate care facility, conducts an internal review of an incident for which a major unusual incident has been filed, the agency provider shall submit the results of its internal review of the incident, including statements and documents, to the county board within fourteen calendar days of the agency provider becoming aware of the incident.

(H)(8) All DD employees required to cooperate with investigation



All developmental disabilities employees shall cooperate with administrative investigations conducted by entities authorized to conduct investigations. Providers and county boards shall respond to requests for information within the time frame requested. The time frames identified shall be reasonable.

(H)(9)IA submits report into ITS within 30 working days

The investigative agent shall complete a report of the administrative investigation and submit it for closure in the incident tracking system within thirty working days unless the county board requests and the department grants an extension for good cause. If an extension is granted, the department may require submission of interim reports and may identify alternative actions to assist with the timely conclusion of the report.

(H)(10)Report Requirements

The report shall follow the format prescribed by the department. The investigative agent shall include the initial allegation, a list of persons interviewed and documents reviewed, a summary of each interview and document reviewed, and a findings and conclusions section which shall include the cause and contributing factors to the incident and the facts that support the findings and conclusions.

(I)(1) Department Directed Investigations

(1) The department shall conduct the administrative investigation when the major unusual incident includes an allegation against:

- (a) The superintendent of a county board or developmental center;
- (b) The executive director or equivalent of a regional council of governments;
- (c) A management employee who reports directly to the superintendent of the county board, the superintendent of a developmental center, or executive director or equivalent of a regional council of governments;
- (d) An investigative agent;
- (e) A service and support administrator;
- (f) A major unusual incident contact or designee employed by a county board;
- (g) A current member of a county board;
- (h) A person having any known relationship with any of the persons specified in paragraphs (I)(1)(a) to (I)(1)(g) of this rule when such relationship may present a conflict of interest or the appearance of a conflict of interest; or
- (i) An employee of a county board when it is alleged that the employee is responsible for an individual's death, has committed sexual abuse, engaged in prohibited sexual activity, or committed physical abuse or neglect resulting in emergency room treatment or hospitalization.

(1)(2)-(3) Department Directed Investigations

(2) A department-directed administrative investigation or administrative investigation review may be conducted following the receipt of a request from a county board, developmental center, provider, individual, or guardian if the department determines that there is a reasonable basis for the request.

(3) The department may conduct a review or administrative investigation of any major unusual incident or may request that a review or administrative investigation be conducted by another county board, a regional council of governments, or any other governmental entity authorized to conduct an investigation.

(J)(1) Written Summaries for A, B due within 5 days of recommended closure

No later than five working days following the county board's, developmental center's, or department's recommendation via the incident tracking system that the report be closed, the county board, developmental center, or department shall provide a written summary of the administrative investigation of each category A or category B major unusual incident, including the allegations, the facts and findings, including as applicable, whether the case was substantiated or unsubstantiated, and preventive measures implemented in response to the major unusual incident to the following unless the information in the written summary has already been communicated:

(J)(1) (a) Written Summaries to:

- (a) The individual, individual's guardian, or other person whom the individual has identified, as applicable; in the case of a peer-to-peer act, both individuals, individuals' guardians, or other persons whom the individuals have identified, as applicable, shall receive the written summary;
- (b) The licensed or certified provider and provider at the time of the major unusual incident; and
- (c) The individual's service and support administrator and support broker, as applicable.

(J)(2)-(4) Written Summaries

(2) In the case of an individual's death, the written summary shall be provided to the individual's family only upon request by the individual's family.

(3) The written summary shall not be provided to the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved. No later than five working days following the closure of a case, the county board shall make a reasonable attempt to notify the primary person involved as to whether the major unusual incident has been substantiated, unsubstantiated/insufficient evidence, or unsubstantiated/unfounded.

(4) If a service and support administrator is not assigned, a county board designee shall be responsible for ensuring the preventive measures are implemented based upon the written summary.

(J)(5) Disputing the Findings

An individual, individual's guardian, other person whom the individual has identified, or provider may dispute the findings by submitting a letter of dispute and supporting documentation to the county board superintendent, or to the director of the department if the department conducted the administrative investigation, within fifteen calendar days following receipt of the findings. An individual may receive assistance from any person selected by the individual to prepare a letter of dispute and provide supporting documentation.

(J)(6) CB reviews dispute within 30 calendar days

The county board superintendent or his or her designee or the director or his or her designee, as applicable, shall consider the letter of dispute, the supporting documentation, and any other relevant information and issue a determination within thirty calendar days of such submission and take action consistent with such determination, including confirming or modifying the findings or directing that more information be gathered and the findings be reconsidered.

(J)(7) Dispute to the Department

In cases where the letter of dispute has been filed with the county board, the disputant may dispute the final findings made by the county board by filing those findings and any documentation contesting such findings as are disputed with the director of the department within fifteen calendar days of the county board determination. The director shall issue a decision within thirty calendar days.

(K)(1) Review, Prevention, and Closure of MUIs

County boards and agency providers shall implement a written procedure for the internal review of all major unusual incidents and shall be responsible for taking all reasonable steps necessary to prevent the recurrence of major unusual incidents.

(K)(2) Preventative Measures

The individual's team, including the county board and provider, shall collaborate on the development of preventive measures to address the causes and contributing factors to the major unusual incident. The team members shall jointly determine what constitutes reasonable steps necessary to prevent the recurrence of major unusual incidents. If there is no service and support administrator, individual team, qualified intellectual disability professional, or agency provider involved with the individual, a county board designee shall ensure that preventive measures as are reasonably possible are fully implemented.

(K)(3)Department Review

The department may review reports submitted by a county board or developmental center. The department may obtain additional information necessary to consider the report, including copies of all administrative investigation reports that have been prepared. Such additional information shall be provided within the time period specified by the department

(K)(4) Dept. Closes the following MUIs

- (a) Accidental or suspicious death;
- (b) Exploitation;
- (c) Failure to report;
- (d) Misappropriation;
- (e) Missing individual;
- (f) Neglect;
- (g) Peer-to-peer act;
- (h) Physical abuse;
- (i) Prohibited sexual relations;
- (j) Rights code violation;
- (k) Sexual abuse;
- (l) Significant injury when cause is unknown;
- (m) Unapproved behavior support;
- (n) Verbal abuse;
- (o) Any major unusual incident that is the subject of a director's alert; and
- (p) Any major unusual incident investigated by the department.

(K)(5)The CB closes these MUIs

The county board shall review and close reports regarding the following major unusual incidents:

- (a) Attempted suicide;
- (b) Death other than accidental or suspicious death;
- (c) Law enforcement;
- (d) Medical emergency;
- (e) Significant injury when cause is known; and
- (f) Unscheduled hospitalization.

(K)(6) Dept. Review of CB Closures

The department may review any case to ensure it has been properly closed and shall conduct sample reviews to ensure proper closure by the county board. The department may reopen any administrative investigation that does not meet the requirements of this rule. The county board shall provide any information deemed necessary by the department to close the case.

(K)(7) Case Closures

The department and the county board shall consider the following criteria when determining whether to close a case:

- (a) Whether sufficient reasonable measures have been taken to ensure the health and welfare of any at-risk individual;
- (b) Whether a thorough administrative investigation has been conducted consistent with the standards set forth in this rule (based on review in ITS);
- (c) Whether the team, including the county board and provider, collaborated on developing preventive measures to address the causes and contributing factors;
- (d) Whether the county board has ensured that preventive measures have been implemented to prevent recurrence;
- (e) Whether the incident is part of a pattern or trend as flagged through the incident tracking system requiring some additional action; and
- (f) Whether all requirements set forth in statute or rule have been satisfied.

(L)(1)Analysis of MUIs

Providers shall produce a semi-annual and annual report regarding major unusual incident trends and patterns which shall be sent to the county board.

The county board shall semi-annually review providers' reports. The semi-annual review shall be cumulative for January first through June thirtieth of each year and include an in-depth analysis. The annual review shall be cumulative for January first through December thirty-first of each year and include an in-depth analysis.

(L)(2) Analysis Requirements

(2) All reviews and analyses shall be completed within thirty calendar days following the end of the review period. The semi-annual and annual reports shall contain the following elements:

- (a) Date of review;
- (b) Name of person completing review;
- (c) Time period of review;
- (d) Comparison of data for previous three years;
- (e) Explanation of data;
- (f) Data for review by major unusual incident category type;
- (g) Specific individuals involved in established trends and patterns (i.e., five major unusual incidents of any kind within six months, ten major unusual incidents of any kind within a year, or other pattern identified by the individual's team);
- (h) Specific trends by residence, region, or program;
- (i) Previously identified trends and patterns; and
- (j) Action plans and preventive measures to address noted trends and patterns.

(L)(3)Analysis of MUIs

County boards shall conduct the analysis and implement follow-up actions for all programs operated by county boards such as workshops, schools, and transportation. The county board shall send its analysis and follow-up actions to the department by August thirty-first of each year for the semi-annual review and by February twenty-eighth of each year for the annual review. The department shall review the analysis to ensure that all issues have been reasonably addressed to prevent recurrence.

(L)(4)Analysis of MUIs

- Providers shall conduct the analysis, implement follow-up actions, and send the analysis and follow-up actions to the county board for all programs operated in the county by August thirty-first of each year for the semi-annual review and by February twenty-eighth of each year for the annual review. The county board shall review the analysis to ensure that all issues have been reasonably addressed to prevent recurrence. The county board shall keep the analyses and follow-up actions on file and make them available to the department upon request.

(L)(5) Trends and Patterns

The county board shall ensure that trends and patterns of major unusual incidents are included and addressed in the individual service plan of each individual affected.



(L)(6)CB and COGs required to review for Trends and Patterns

Each county board or as applicable, each council of governments to which county boards belong, shall have a committee that reviews trends and patterns of major unusual incidents. The committee shall be made up of a reasonable representation of the county board(s), providers, individuals who receive services and their families, and other stakeholders deemed appropriate by the committee.

(L)(6)(a)Committee's Role

The role of the committee shall be to review and share the county or council of governments aggregate data prepared by the county board or council of governments to identify trends, patterns, or areas for improving the quality of life for individuals served in the county or counties.

(L)(6)(b)Committee meets each Sept

The committee shall meet each September to review and analyze data for the first six months of the calendar year and each March to review and analyze data for the preceding calendar year. The county board or council of governments shall send the aggregate data prepared for the meeting to all participants at least ten calendar days in advance of the meeting.

(L)(6)(c)-(d) Record of Meetings

(c) The county board or council of governments shall record and maintain minutes of each meeting, distribute the minutes to members of the committee, and make the minutes available to any person upon request.

(d) The county board shall ensure follow-up actions identified by the committee have been implemented.

(L)(7) Dept. shall prepare a report on patterns and trends of MUIs

The department shall prepare a report on trends and patterns identified through the process of reviewing major unusual incidents. The department shall:

- Periodically, but at least semi-annually, review this report with a committee
- Appointed by the director of the department which shall consist of at least six members who represent various stakeholder groups, including disability rights Ohio and the Ohio department of Medicaid.
- The committee shall make recommendations to the department regarding whether appropriate actions to
- Ensure the health and welfare of individuals served have been taken.
- The Committee may request that the department obtain additional information as may be necessary to make recommendations.

UI Definition

"Unusual incident" means an event or occurrence involving an individual that is not consistent with routine operations, policies and procedures, or the individual's care or service plan, but is not a major unusual incident.

Unusual incident includes, but is not limited to: dental injuries; falls; an injury that is not a significant injury; medication errors without a likely risk to health and welfare; overnight relocation of an individual due to a fire, natural disaster, or mechanical failure; an incident involving two individuals served that is not a peer-to-peer act major unusual incident; and rights code violations or unapproved behavior supports without a likely risk to health and welfare.

(M)(1)-(2) Reqs for Unusual Incidents

- (1) Unusual incidents shall be reported and investigated by the provider.
- (2) Each agency provider shall develop and implement a written unusual incident policy and procedure that:
 - (a) Identifies what is to be reported as an unusual incident which shall include unusual incidents as defined in this rule;
 - (b) Requires an employee who becomes aware of an unusual incident to report it to the person designated by the agency provider who can initiate proper action;

(M)(2)(c) Requires report be made no more than 24 hours after the UI

(c) Requires the report to be made no later than twenty-four hours after the occurrence of the unusual incident; and

(d) Requires the agency provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk individuals.

(M)(3) Staff shall be knowledgeable

The agency provider shall ensure that all staff are trained and knowledgeable regarding the unusual incident policy and procedure.



(M)(4)UI Notifications

If the unusual incident occurs at a site operated by the county board or at a site operated by an entity with which the county board contracts, the county board or contract entity shall notify the licensed provider or staff, guardian, or other person whom the individual has identified, as applicable, at the individual's residence. The notification shall be made on the same day the unusual incident is discovered.

(M)(5) Independent Provider Requirements

Independent providers shall complete an incident report, notify the individual's guardian or other person whom the individual has identified, as applicable, and forward the incident report to the service and support administrator or county board designee on the same day the unusual incident is discovered.

(M)(6) Monthly Review

Each agency provider and independent provider shall review all unusual incidents as necessary, but no less than monthly, to ensure appropriate preventive measures have been implemented and trends and patterns identified and addressed as appropriate.

(M)(7) Document Trends and Patterns

The unusual incident reports, documentation of identified trends and patterns, and corrective action shall be made available to the county board and department upon request.

(M)(8) UI Logs

Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to:

- Name of the individual
- A brief description of the unusual incident
- Any injuries
- Time and date
- Location
- Preventive measures
- Causes and Contributing Factors (best practice)

(M)(9) Trends addressed in Plan

The agency provider and the county board shall ensure that trends and patterns of unusual incidents are included and addressed in the individual service plan of each individual affected.

(N) (1) Oversight

The county board shall review, on at least a quarterly basis, a representative sample of provider logs, including logs where the county board is a provider, to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with this rule. The sample shall be made available to the department for review upon request.

(N)(2) CB Programs

When the county board is a provider, the department shall review, on a monthly basis, a representative sample of county board logs to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with this rule. The county board shall submit the specified logs to the department upon request.

(N)(3) Department review of logs

The department shall conduct reviews of county boards and providers as necessary to ensure the health and welfare of individuals and compliance with this rule. Failure to comply with this rule may be considered by the department in any regulatory capacity, including certification, licensure, and accreditation.

(O)(1) Access to Records

Reports made under section 5123.61 of the Revised Code and this rule are not public records as defined in section 149.43 of the Revised Code. Records may be provided to parties authorized to receive them in accordance with sections 5123.613 and 5126.044 of the Revised Code, to any governmental entity authorized to investigate the circumstances of the alleged abuse, neglect, misappropriation, or exploitation and to any party to the extent that release of a record is necessary for the health or welfare of an individual.

(O)(2) Access to Records

A county board or the department shall not review, copy, or include in any report required by this rule a provider's personnel records that are confidential under state or federal statutes or rules, including medical and insurance records, workers' compensation records, employment eligibility verification (I-9) forms, and social security numbers. The provider shall redact any confidential information contained in a record before copies are provided to the county board or the department. A provider shall make all other records available upon request by a county board or the department.

(O)(3) Waive report

Any party entitled to receive a report required by this rule may waive receipt of the report. Any waiver of receipt of a report shall be made in writing.

(P)(1) Training

Agency providers and county boards shall ensure staff employed in direct services positions are trained on the requirements of this rule prior to direct contact with any individual. Thereafter, staff employed in direct services positions shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

(P)(2) Training Requirements

Agency providers and county boards shall ensure staff employed in positions other than direct services positions are trained on the requirements of this rule no later than ninety days from date of hire. Thereafter, staff employed in positions other than direct services positions shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

(P)(3) Training on Alerts

Independent providers shall be trained on the requirements of this rule prior to application for initial certification in accordance with rule 5123:2-2-01 of the Administrative Code and shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

THANK YOU!

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Abuse/Neglect Hotline

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