NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Developmental Disabilities Section

POLICY ISSUANCE # 18-04
October 2025

TO: Licensed DD Service Providers
Regional DD Program Administrators
ND Protection and Advocacy Project (P&A)
ND Department of Health and Human Services, Health Facilities Unit
Children and Family Services, Child Protection Services

FROM: Tina Bay, Director, Developmental Disabilities Section

DATE: 10/1/2025

SUBJECT: Incident Reporting: Abuse, Neglect, Exploitation & Quality Assurance Response System

EFFECTIVE DATE OF POLICY:

PI-18-04 has been revised. Please discard all former versions of this policy, as well as any accompanying attachments.

Effective **immediately**, the following Abuse, Neglect, and Exploitation (A/N/E) policy is in effect for any person receiving DD licensed services and supports authorized by the Department of Health and Human Services – Developmental Disabilities Section (DD Section), which includes participants of Medicaid Home and Community-Based (HCBS) waivers for people with an intellectual or developmental disabilities and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) state plan services.

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BACKGROUND

The State of North Dakota has an overriding obligation to ensure that people receiving publicly financed intellectual or developmental disabilities services are treated with dignity and respect, receive services and supports designed to meet their individualized needs, and can live safe and secure lives in their respective communities.

North Dakota Century Code (NDCC) 25-01.3 identifies definitions and mandatory reporting of abuse, neglect, or exploitation of persons with a developmental disability and/or a mental illness. This statute authorized the Department of Health and Human Services to develop rules for implementation.

Administrative Code Chapters 75-04-01, Code of Federal Regulations 483.420 (conditions for participation of ICFs/IID for Federal Financial Participation – Medicaid), 42 Code of Federal Regulations 441.302 (a) (Home and Community Based Services: Waiver Requirements) to abuse neglect or exploitation are incorporated in this policy.

Refer to North Dakota Century Code (NDCC 25-01.3-01) for the definitions of abuse, neglect, and exploitation.

Background: Investigations of Abuse, Neglect and Exploitation

Elements of effective state quality assurance and monitoring include the following:

Proactive risk management strategies for people receiving services and supports.
A fundamental element is the systematic identification of health and safety risks facing each person receiving community services and supports, and as part of the person-centered planning process, the development of specific safeguards, on a person-by-person basis, to minimize such risks. The resulting safeguard will balance individual safety and security against the risks inherent in being a fully participating member of the community.

A workable risk management strategy also entails that Providers have the capabilities, and/or external quality management supports necessary to safeguard the health and safety of people receiving services.

Administrative policies and procedures for recording, reporting, and investigating suspected incidents of abuse, neglect and exploitation involving people receiving services.
These policies/procedures specify the reporting/investigative time frames as well as the steps that must be taken to protect people receiving services from possible further harm or retribution while the investigation is being conducted. Within such policies/procedures, the entity(ies) responsible for conducting investigations and following up to ensure that any necessary corrective actions are completed in a prompt and effective manner must be identified.

Corrective actions a state may impose in confirmed cases of abuse, neglect, and exploitation.
These actions, including penalties and sanctions, must encompass both individual perpetrators of the abuse, neglect or exploitation as well as the Provider that employs them (where negligence on the part of the Provider has been established during the investigation).

Provider agreements that obligate all agencies and individuals furnishing community DD services to report Serious Events and suspected incidents of abuse, neglect, and exploitation in accordance with state policies.
These policies delineate clearly the parties (including direct support professionals) who are required to report, the procedures for doing so, and the time frames such reports must be filed and required follow-up actions completed.

- A description of the steps that will be taken to ensure that all responsible staff members of the licensed/certified Provider agencies are notified in writing, of their obligation to report Serious Events and incidents of suspected abuse, neglect, and exploitation. Steps will also be taken to ensure that all such employees receive training in identifying, recording, and properly reporting Serious Events and incidents of suspected abuse, neglect and exploitation upon hire and at least annually thereafter, as per DD Training Policy.
- A description of the steps that will be taken to ensure that all Serious Events and suspected abuse**,** neglect and exploitation reports are promptly and effectively investigated, including the plan for ensuring that responsible Provider and Provider personnel are trained to conduct thorough investigations and summarize their findings in writing.
- A requirement that each person receiving services (and his/her legal guardian, where appropriate) is notified, in a manner understandable to the person involved, of how to report Serious Events and suspected incidents of abuse, neglect and exploitation.

Background: Service Review Oversight

- Completion of periodic, in-depth reviews of the services and support provided to persons with developmental or intellectual disabilities and related disabilities. These reviews will include on-site observations to determine the appropriateness of the services and supports being provided to people with disabilities and families. Reports summarizing the findings will identify any follow-up corrective actions that need to be pursued, the responsible parties, and the required timelines for completing such actions.
- All reports and findings for serious events and all other incidents of suspected abuse, neglect and exploitation are entered into an incident management database required by the DD Section.
- Policies and procedures in soliciting, investigating, and resolving complaints from people receiving services and others concerning the appropriateness and quality of the services provided (including reports of suspected mistreatment).

Confirming that all stakeholders within the state's service delivery system acknowledge the importance the state places on protecting vulnerable people from harm as well as their respective responsibilities

for ensuring that this goal is achieved. A quality assurance system ensures that the services and supports provided to people are appropriate and effective, and identifying and swiftly rectifying Serious Events and incidents of suspected abuse, neglect, exploitation, and care that does not align with the expectations of service delivery when they occur.

Incidents that have the capacity to cause harm or injury to a person receiving services, or cause actual injury or death, must be reported. Reporting Serious Events and reports of suspected abuse, neglect, and exploitation; and implementing changes to minimize the recurrence is an integral part of the larger function of quality assurance and improvement. The system should not be disciplined for finding deficiencies, but for failing to correct them.

QUALITY ASSURANCE RESPONSE SYSTEM (QARS)

Quality Assurance Response System are the identified Responses to an incident that meets the Serious Event or Reporting Determination Guidelines (RDG) criteria. The responses can indicate a need for further intervention based upon the response levels and outlined expectations.

The Provider, along with P&A Centralized Intake, will assess each report and determine what the response will be. The responses are:

1. No Probable Cause
2. Investigative Action (IA) Response (Appendix 5-A)
3. Agency Action (AA) Response (Appendix 5 – B)
4. Corrective Action (CA) Response (Appendix 5 – C)

If the Serious Events and RDGs are not met - No A/N/E suspected, level using the General Event Reports Reference Guide - North Dakota

If P&A indicates that they will complete the primary investigation, P&A staff has access, by statute, to providers, facilities, and staff, the person's records and other people deemed to be relevant to an investigation. Pursuant to ND Administrative Code, "Providers are required to make reasonable accommodation to the P&A Project so as to permit them to promptly complete their investigation."

QARS: Provider Responsibilities

The QARS process is mandatory for all licensed DD Providers. Providers must comply with state law, regulations, and policies for reporting and investigating suspected reports of abuse, neglect, and exploitation.

If the DD Provider currently provides services state-wide or in multiple locations across the state, all pertinent personnel will be required to complete the QARS Monitoring and Training.

The Provider will need to ensure that staff responsible for completing investigations has received the following approved training: Abuse, Neglect, Exploitation, Conducting Investigations, Risk Management, Serious Event Criteria, Using and Applying the RDGs, and Agency Responses (AA, CA, IA). If the Provider does not have anyone that has completed the identified trainings, the Provider needs to identify who will conduct the investigations in the interim while they swiftly arrange for the staff to receive the identified training. The identified person must have the training(s) completed within one year. The Provider can also work with P&A during regarding incidents that have been identified as Investigative Action for Technical Assistance until staff have been trained.

If services are being expanded by the DD Provider, the Provider must notify the DD Section and P&A so that additional training can be conducted to review the new services and/or locations.

QARS: Notification to the Human Rights Committee (HRC):

All incidents involving rights violations and/or unauthorized restrictions MUST be reported to HRC. If the incident does not involve a rights violation or restriction, the Provider is not required to report the incident to the HRC. However, there may be times when the Provider, P&A, and/or DDPM may ask the HRC to review a report. The quality assurance team will be responsible for reviewing the incident and reporting according to the requirements of this policy.

Providers must document whether the incident was reported to HRC. The date of notification must be documented in the Investigative Action Checklist, GER, and the internal investigation report. The Provider will need to ensure compliance with PI 21-23 Behavior Support and Human Rights Committees.

The HRC may, upon request, have access to Provider reports, investigations, and/or findings related to incidents of suspected abuse, neglect, or exploitation. If during their review they have reason to believe there may be a pattern of rights violations, or systemic issues that need to be examined and analyzed, the HRC will contact the Provider who is responsible for notifying the team to mitigate the review.

If necessary, emergency approval for the implementation of rights restrictions and restraints may be obtained when the HRC is not scheduled to meet. This step would need to be completed if it is essential that the plan must be updated to ensure the person's health and safety. Plans cannot be implemented until all parties have approved of it (Individual/guardian, team, Behavior Intervention Review Committee/BIRC and HRC) and staff have been trained.

QARS: Guardian Notification

The Provider must notify the guardian regarding the Provider's completion of the investigation stating whether it happened. The name(s) of other people receiving services and/or staff involved in the incident, and/or other confidential information, must NOT be included in contacts or correspondence with the guardian. If the individual is their own decision maker, the information related to the investigation will be communicated directly to the individual.

QARS: DDPM/DD Section Responsibilities

- The DDPM and DD Section staff will review all Serious Events and suspected Abuse, Neglect or Exploitation reports. The DDPMs follow-up activities must be documented in the GER. Their follow-up will be to address any needs for the person's plan, health and safety, as well as to ensure risk management steps are being addressed. If the DDPM places a check mark in the box in the GER without a comment, the system will automatically generate a response that says, "I have approved this report." If this occurs, it is assumed that the reviewer agrees with the action plan contained in the GER that the Provider has completed.

- The DDPM will follow up on any suspected incidents of Abuse, Neglect or Exploitation throughout the quality enhancement review (QER) process, to determine if the Provider's recommendations and plan to prevent recurrence were implemented as stated in the Letter of Findings issued by P&A. During the QER process, the DDPM will review the incident and findings with the person receiving services and guardian to address any additional areas of concern. The DDPMs follow-up will focus on health, safety, the person's plan, and the quality of life for the person.
- DDPM or DD Section staff may review low and medium GERs. During this review, they may place comments, ask questions, or provide follow-up documentation within the GER as there may be questions on determination of the GER was leveled correctly. DDPMs must alert the Provider if they add a comment to the GER via Scomm. The Provider will ensure that communication/response occurs timely. If the Provider does return communication and there are lingering questions on the reportability of the GER, the DDPM or DD Section staff will be responsible for calling P&A to report the incident.
- Repeated incidents or outstanding issues of a systemic nature may be identified by DDPM/DDPA, P&A or the DD Section. When these occur, collaboration between the DDPM/DDPA, DD Section, P&A and the Provider CEO or designee will address the issues as it relates to Quality Assurance.
- After completion of the Provider's response (IA, CA, AA), DDPM/DDPA and/or DD Section staff may offer additional recommendations or ask for further follow-up to resolve identified problems and implement changes to prevent future incidences.

QARS Monitoring and Training is mandatory for all licensed Providers and coordinated with the DD Section Staff to assure that Providers comply with the requirements of PI 18-04.

Should concerns arise at any point in time, the Provider may receive notification that monitoring of the agency's compliance will be completed. Indicators that may trigger a review of the Providers' compliance includes, but are not limited to:

- Title XIX or HCBS surveys where immediate jeopardy concerns are cited
- Patterns of investigations or allegations where the Provider fails to implement corrective actions steps
- Demonstrated pattern of not implementing DD Policies
- Issues are identified as a result of monitoring

REPORTING REQUIREMENTS

Reporting Requirements: Mandatory Reporting

All Provider staff are considered Mandatory Reporters and are required to report Serious Events, incidents that meet the Reporting Determination Guidelines (RDGs) and/or meet the definitions of Abuse, Neglect Exploitation. Mandatory reporting occurs when a person has knowledge or reasonable cause to suspect Abuse, Neglect or Exploitation of a person supported.

Provider policies and procedures must ensure that State Law and this Policy are complied with regarding Mandatory Reporting. Information on Mandatory reporting/Mandatory reporters can be found in NDCC 25-01.3-04.

Reporting Requirements: Good Faith Reports

Any reporter/witness providing information pertaining to a good faith report (reports given accurately, describing only what the reporter/witness saw/heard, an honest portrayal of what occurred) are provided immunity from civil or criminal liability which may otherwise arise from making the report.

Reporting Requirements: Employer Retaliation

Employers may not retaliate against employees or people with disabilities, due to the reporting of suspected abuse, neglect, or exploitation. Employers who do so are guilty of a Class B Misdemeanor. Employees who believe their employer is retaliating against them for reporting can contact their States Attorney's office for investigation of the employee's allegation of retaliation.

Reporting Requirements: Provider Responsibilities

Staff working directly with the people supported must receive training on Reporting Requirements, Serious Events, Reporting Determination Guidelines, and NDCC definitions of Abuse, Neglect, and Exploitation.

All Serious Events or incidents meeting the Reporting Determination Guidelines (RDGs) must be **recorded and reported in the state web-based program management system, further referred to as General Event Records (GERs) in Therap.**

It is the Provider's responsibility to:

1. Implement risk management steps; and
   If the incident appears to have criminal intent or criminal in nature, the Provider must contact law enforcement immediately and follow directives for preserving evidence. The person receiving services and guardian must be informed of their right to file a complaint with law

enforcement as well. Law enforcement may take the lead in further investigation of the incident.

2. Assess the environment to determine if changes are needed; and
3. Take immediate action to minimize the probability of the incident re-occurring; and
4. Report the allegation to P&A, Institutional Child Protection Services /Child Protective Services (ICPS/CPS) (if the person is under the age of 18), Regional DD Program Management (DDPM), the DD Section, the person's guardian (if appropriate), the Chief Executive Officer or designee, and the Human Rights Committee (if appropriate).
5. The Provider is responsible for recording and approving a General Event Report (GER) for all incident types and levels. This includes anonymous reports or reports received from entities outside of the Provider (P&A, community based, etc.).

Providers who fail to record and report any suspected incidents of abuse, neglect, or exploitation may result in a formal review by the DD Section, Regional Program Management (DDPM), P&A, or ICPS/CPS, if it applies. Applicable corrective action may include, but is not limited to, notification of the Health Facilities Unit for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs); notification of any accrediting or licensing bodies; licensure sanctions; and/or revocation of the Provider's license per NDAC 75-04-01.

The intent of reporting and recording is to identify and rectify the causes. Failure to report is a violation of state law and licensure.

Reporting Requirements: Where/How to Report Incidents

1. Protection and Advocacy (P&A): All reports, regardless of the person's age, need to be made to P&A, including those that are reported to CPS/ICPS.

   Phone: 701-328-2950 – Toll Free: 1-800-472-2670 – ND Relay TTY: 711 – Fax 701-328-3934
   Central Intake Email: panda_intake@nd.gov
   On-line Incident Reporting: Report of Serious Events; or Abuse, Neglect or Exploitation
   Address: Protection & Advocacy, 400 East Broadway, Suite 409 – Bismarck, ND 58501

Providers must contact P&A Centralized intake within 24 hours of the incident occurring. This can be done during P&As business hours (Monday-Friday 8am-12pm & 1pm-5pm CST). To meet the timeline for reporting requirements on weekends and holidays, a report can occur using P&As website and their online incident reporting (see above).

2. Institutional Child Protection Services /Child Protective Services (ICPS/CPS) (if the person is under the age of 18)

   Anyone who suspects a child is being abused or neglected in North Dakota shall immediately call 1-833-958-3500 during ICPS/CPS business hours (Monday-Friday 8am-5pm CST). If a child is in immediate danger, 911 can be called.

The form used to report to ICPS/CPS is SFN 960.

RISK MANAGEMENT

Risk management is the process to ensure the safety and well-being of the person supported after an incident occurs. This is the first step a Provider completes after an incident occurs, and it must be documented in the GER.

Risk Management: Immediate Steps

Immediate risk management occurs instantly after the incident occurs. These steps must be documented in the GER. The Provider staff must ensure the following occurs for each incident to prevent recurrence or ensure the safety of everyone involved:

- Ensuring all people supported that are involved are safe, both physically and emotionally
- Seek medical treatment, if needed
- Provide emotional reassurance
- Monitor those involved to ensure there is no residual harm that was not evident initially (upon incident occurring)
- Preserve any evidence that may be relevant/needed
- Assess the environment to determine if any changes are needed
- Contact law enforcement, if needed
- Others (this is not an all-inclusive list, each type of risk management will vary by the incident)

Risk Management: Future Steps

Future risk management steps are developed to promote long-term safety and reduce the likelihood of recurrence. These may be identified immediately after an incident or later, once more information is obtained. The Provider may also determine additional future risk management steps during their Responses or P&A Investigation. Any identified future risk management steps must be documented in the GER and/or in the Investigative Action Response (IA), Corrective Action Response (CA), or Agency Action Response (AA). Completion dates for each step must also be present in the GER. Some examples of things to address through development of future risk management are:

- Safety
- Health
- Quality Assurance
    - Looking at repeat issues and tracking and trending incidents
- Re-Training
- Plan Updates
- Environmental changes
- Changes in staffing
- Others (this is not an all-inclusive list, each type of risk management will vary by the incident)

Providers may need to gather information to assess the situation so that appropriate risk management (including any necessary personnel action) can be taken. Additionally, P&A Central Intake will ask what risk management steps are in place when the Provider is reporting the incident.

There may be times when determining Risk Management steps, that a Provider needs to clarify information related to the incident. Providers are asked to gather adequate information to assess the situation **WITHOUT** beginning an investigation, until instructed to do so.

Risk Management: Risk Levels and Responsive Actions:

After an incident occurs, Providers must immediately assess the risk levels as outlined below. Based on the risk level, the Provider must develop the appropriate responsive actions as outlined below.

Risk Levels:

- Emergency: there is a current and immediate threat to the safety of the person receiving services (ex. The alleged victim is currently being threatened, there is a medical emergency)
- Immediate Danger: there is reason to believe there is an impending risk of harm to the alleged victim (ex. Alleged victim is receiving services/care from the alleged perpetrator, the alleged perpetrator has access to the alleged victim)
- Non-Emergency: the alleged victim is not in need of emergency services and imminent danger is not present

Responsive Actions:

- Emergency intervention: priority focus is on the life/safety of the alleged victim; involve necessary services to accomplish this, such as law enforcement, medical/mental health, case management, person's guardian, ICPS/CPS, Protection & Advocacy, etc. (Provider may remove alleged perpetrator from direct client care; access medical/emergency room services; rape/crisis intervention).
- Imminent danger: priority focus is on the protection of the victim, and other potential victims, through the involvement of services such as those mentioned above, as well as through the implementation of protections within the Providers authority (e.g., removal of the alleged perpetrator from direct client care, increase staff to client ratio, increase supervision, etc.).
- Non-emergency: priority is to focus on remedying any abuse/neglect/exploitation and to prevent any further occurrences. Once emergency and imminent danger situations have been resolved, those cases may then be re-assessed under this level. Determine responsibilities and cooperative efforts between P&A and the Provider (and any other entities) in conducting the investigation.

In determining Responsive Actions, one must consider the alleged victim's ability to consent, their right to self-determination, their right to refuse services and their right to risk.

Regardless of the QARS, immediate and ongoing risk management steps must be implemented promptly and documented in the GER to help prevent future incidents from occurring. The Provider should not wait to implement risk management and/or recommendations relative to the incident.

SERIOUS EVENTS - High Level GERs

Serious Events are critical events (per CMS) that are severe in nature and need to be reported immediately. These incidents would all be entered in a GER at a **HIGH** Level. There are 5 categories of Serious Events that DD Providers are required to report in the State of North Dakota.

Types of Serious Events

Serious Event #1:

Serious injuries and/or diagnoses that result in medical treatment beyond first aid (for physical and/or mental health) and not diagnostic in nature.

Examples: *Not an all-inclusive list

Fractures	Sutures, staples or glue	Dislocation
Burns (including sunburn if medical care is needed)	Heat exhaustion or heat stroke	Frostbite
Ingestion of harmful substances	Internal bleeding	Puncture wound
Dental emergencies	Bites that break the skin	Cardiac arrest
Renal Failure	CPR	IVs
Abdominal Thrusts	Heat Stroke	Heat Exhaustion
Unplanned hospitalizations, including psychiatric hospitalizations	Self-Injuries behaviors/suicide attempts	Concussion

There may be times where a diagnosis is given, however, due to the diagnosis alone or the type/location of the diagnosis medical treatment beyond first aid may not be applicable (ex. Fractured toe, heat exhaustion, concussion). Due to the diagnosis the person received, the incident would still meet the Serious Event Criteria.

Diagnostic procedures that meet the criteria of medical treatment beyond first aid would not meet the criteria for Serious Event if they were performed solely to determine a diagnosis (ex. CT scan with/without contrast, catheterization). However, depending on the results of those diagnostic testing and diagnosis the incident may be elevated to a Serious Event.

Exception Guidelines

In certain cases, exceptions may permit an incident that meets the above Serious Event Criteria to bypass some steps of the standard process. These exceptions would allow the incident that meets Serious Event Criteria to be classified as a **Medium GER** rather than a High GER, therefore being non-reportable. However, the exception must be **clearly** documented in the individual's service plan and documented in a Medical Plan of Care attached to the service plan.

The Exception Guidelines only pertain to this section of the Serious Event Criteria (Serious Injury or Medical treatment beyond first aid).

The incident must still be reviewed against other Serious Event Criteria and RDGs to determine if it is reportable and documentation of the review must be present in the GER.

The following criteria/documentation must be present for the Exception Guidelines to be considered:

- The person supported must have documented treatments and/or hospitalizations showing repeat incidents/trends where a Medical Plan of Care would allow for continued oversight into the documenting process and historical incidents have been non-life threatening.
- The Medical Plan of Care must be agreed upon by the team and the final version submitted to the DD Section.
- The Medical Plan of Care must only outline specific treatments/hospitalizations that would meet the exception guidelines and not just a blanket statement indicating any treatment for a specific condition.
- The chronic condition must be specifically identified in the Risk Management Assessment Plan and OSP.
- If the Medical Plan of Care applies to the reported incident and a Medium GER is used to record the incident, the following documentation components must be documented by Provider staff within the GER (in addition to the required documentation):
    - Incident follows criteria outlined in the Person's Medical Plan of Care
    - Incident was screened for Serious Event Criteria (met yes/no)
    - If incident did not meet Serious Event Criteria, Incident was screened for RDGs (met yes/no)

Examples of Exceptions Guidelines – but not limited to:

- Individuals with chronic medical conditions resulting in treatment or hospitalizations that are consistent with an individual's medical plan of care
- Planned psychiatric hospitalization for medication adjustments
- Chronic UTI with specific treatments outlined
- G-tube placement with specific treatments outlined

Serious Event #2: Unauthorized restraints or physical interventions (chemical, mechanical or physical), including the use of an intervention on an emergency basis.

Unauthorized use of intervention/restraint occurs when the intervention/restraint is used and is not written into the person's plan and has not been approved by the Human Rights Committee or Behavior Support Committee. The intervention/restraint would be **authorized** once approvals have been obtained, the plan is updated, and staff are properly trained.
Examples:

- The use of intervention/restraint that is outside of what is approved in person's plan. Finger release is the only authorized technique in a person's plan and hair pull release was used.
- The use of intervention/restraint that is not in compliance with the techniques the staff are taught. Finger release is the only authorized technique in a person's plan and staff did not implement the release correctly.

There may be times where emergency use of restraint/interventions are used.

- Even though the Provider may identify the urgent need for the technique to be used, these incidents would still meet the definition of Serious Event if the techniques were unauthorized.
- Interventions/restraints implemented by Provider staff during a medical/dental procedure or exam (even if ordered by a physician) would need to be reported as a serious event if unauthorized.

Serious Event #3: Prohibited Procedures

There are certain restrictive interventions that are prohibited for any individual receiving services and supports authorized by DHHS, DD Section. Further information can be found in DD Policy: PI-09-23 Restraint and Seclusion Policy and NDCC 25-01.2-09.

Serious Event #4: Alleged sexual abuse or inappropriate sexual contact involving a person with a disability

Any alleged sexual abuse or sexual contact involving a non-consenting person who has a disability must be reported as a serious event. This includes "sexting", snapchat videos, Facebook or use of other electronic communication modes that one may be using. If the person with the disability is not able to consent, their plans (OSP, RMAP etc.) need to identify any concerns that may have come up and ensure their health and safety.

When an incident of alleged sexual abuse or inappropriate sexual contact occurs involving two individuals who receive services, the serious event definitions apply to the alleged victim. Reporting Determination Guidelines (RDGs) must be applied to the alleged perpetrator.

Serious Event #5: Death

All deaths, even if expected, must be reported as a serious event.

Further information about specific reporting requirements related to this Serious Event can be found later in this Policy.

Serious Event: Other Information

If a Serious Event occurs at a time when the Provider is not providing services (Independent Habilitation, Family Support Services, substitute caregiver, etc.) reporting and recording must still occur. Timelines start when the Provider becomes aware of the incident. The date the Provider became aware should be clearly documented in the GER. This process ensures that there is continuity of care across individuals caring for the person supported. Furthermore, there is still a responsibility as a mandated reporter to report suspected abuse, neglect or exploitation.

If it is not clear if an incident meets the definition of a Serious Event, contact P&A Centralized Intake for technical assistance.

Serious Event Table

<table>
<tr><th colspan="3">HIGH GER / SERIOUS EVENTS</th></tr>
<tr><th>Serious Events</th><th>Verbal Report Timeline</th><th>GER Timelines</th></tr>
<tr><td>Category #1: Events or Diagnosis that result in medical treatment or care BEYOND first aid for physical or mental health

Examples (not an all-inclusive list): Fractures, Sutures, Staples, glue, dislocation, burns, sunburns, heat exhaustion, heat stroke, frostbite, ingestion of harmful substances, internal bleeding, puncture wound, dental emergencies, bites that break skin, cardiac arrest, renal failure, CPR, IVs, concussion, abdominal thrusts, self-injurious behaviors/suicide attempts, unplanned hospitalizations (including psychiatric).

*Some events may not require treatment beyond first aid, but the diagnosis would meet the serious event</td><td rowspan="5">Within 24 hours of the Serious Event (or upon discovery) P&A must be contacted. CPS must also be notified of events when the individual is under the age of 18.

Within ONE working day of the verbal report to P&A (or sooner if necessary or requested) Guardian and DDPM must be notified.

*Documentation of notifications must be present in the GER.</td><td rowspan="5">GER must be approved within 1 working day of the report to P&A.</td></tr>
<tr><td>Category #2: Unauthorized restraints or physical interventions (chemical, physical or mechanical) including the use of a restraint on an emergency basis.</td></tr>
<tr><td>Category #3: Prohibited Procedures per DD Policy</td></tr>
<tr><td>Category #4: Alleged Sexual abuse or inappropriate sexual contact of a person with a disability</td></tr>
<tr><td>Category #5: Death</td></tr>
</table>

Serious Events Reporting and Recording Process:

If the Serious Event Criteria is met – the following steps must be completed:

- The Provider MUST ensure that **immediate** risk managements steps have been taken to ensure the health and safety of the person(s) involved. P&A staff are available to provide technical assistance with risk management if necessary.
    - Providers need to gather adequate information to assess the situation so that appropriate risk management steps can be taken. This could be potential personnel actions. The provider must address risk Management steps and document them in the GER. The following Risk areas must be addressed:
        - Ensure the person's safety
        - Ensure the safety of others
        - Provide necessary medical and emotional support
        - Notify law enforcement if incident is criminal in nature
- A report of the Serious Event must be made to P&A within **TWENTY-FOUR (24) HOURS** of the incident occurring or upon Provider knowledge of the event occurring. The notification date/time to P&A must be documented in the GER.
- The guardian/legal decision maker (if applicable) and DDPM/DDPA must be notified within **one (1) working day** of the event, or sooner as outlined in the person's plan. The notification dates must be documented in the General Event Report (GER).
- Within **one (1) working day** of the report to P&A, a written report of the incident (GER) must be **approved** in Therap at a **HIGH** level. By approving the report, it allows the GER to be accessed by:
    - P&A
    - Regional DD Program Management
    - DD Section
- For children under 18 years of age:
    - Reports of Serious Events will be made to ICPS/CPS and P&A if child abuse or neglect is suspected (See Appendix 3 & 4). If it meets the definitions of Child Abuse and Neglect (CAN), the reporter will call ICPS/CPS and complete and submit the SFN 960.
    - If the Provider has not contacted ICPS/CPS before talking with P&A, P&A will ask that the incident be reported to ICPS/CPS.
    - P&A will follow up with ICPS/CPS to determine which entity (if any) will be investigating. ICPS/CPS has primary jurisdiction in cases where the individual is under 18. If they decline involvement, P&A will then screen the report and determine if it meets criteria for an investigation. P&A Central Intake staff will document this in the comment section of the GER.
- P&A Central Intake will screen all Serious Event and will comment in the GER. P&A has internal policies and procedures for timelines of when the screening comment will be added to the GER.
    - The Provider can reach out to P&A Central Intake staff if there is a delay in documentation of the screening comment to the GER.

    - **The investigation is NOT to be initiated by the Provider until P&A has commented in the GER.** The comment from P&A Central Intake will indicate if an investigation is required and who is responsible for the investigation.
- For incidents where the Serious Event Criteria is met, the Reporting Determination Guidelines do not need to be used as the report has already been identified as reportable.

Serious Event: Investigation Activities

P&A will screen the report to determine if there is a need for an investigation and will comment on the GER who will complete the investigation, if applicable.

If P&A determines there is a need for an investigation the following screenings are possible:

- **ICPS/CPS will investigate** *(only for incidents where person supported is under 18)*
    - ICPS/CPS will conduct an assessment regarding the incident and the Provider may be issued a letter which includes recommendations as it pertains to the person supported.
    - The Provider is responsible for completing these recommendations and documenting these steps within the GER.
- **P&A will conduct a primary investigation**
    - P&A will complete the investigation. They will work collaboratively with the identified Provider to access the necessary records and interview the necessary parties.
    - When P&A has completed their investigation, the identified contact with the Provider will be issued a Letter of Findings (LOF). This letter will also go to any other applicable entities.
- **P&A will conduct a collaborative/joint investigation with the Provider**
    - If P&A and the Provider are working on the investigation together, the two entities will determine action steps and will work to complete the investigation together.
- **P&A will direct the Provider to complete an Investigative Action with P&A completing follow-up.**
    - The Provider must complete and submit an Investigative Action within **10 working days** of the screening of the incident by P&A Central Intake staff.
    - The Provider's investigation will be attached to the GER or sent via Scomm/Secure mail if the Provider is not able to attach it to the GER. If the Investigation is not attached to the GER, the Provider must document in the GER comment section the date the Investigation was sent to P&A.
    - The Provider must communicate to the DDPM, P&A, and DD Section that the report is complete and available for review.

If police determine they will complete an investigation, P&A will not complete their investigation until police involvement has ended/concluded. P&A has processes identified to ensure they are aware of the completion of the police investigation. If the Provider has questions on the pending police investigation, they can work with the individual's team to determine who should be the contact person and/or work with P&A to get an update on the status of the police investigation.

Serious Event: P&A Timelines

P&A has policies and procedures regarding timelines for the completion of their investigations. If an extension is needed, P&A will notify the Provider of the extension. The following will occur if P&A requires an extension:

- P&A will notify the Provider of the extension details
- Provider will document in the GER comment section the extension details to ensure DD Section, DDPM, DDPA are aware of the timeline changes.

When P&A has completed their investigation, a Letter of Findings (LOF) is issued to the Provider and any applicable entities.

Serious Event: Provider Timeline Exceptions

If the Provider is unable to complete their investigation within the **10 working days** from the date of the P&A screening, the Provider can request an extension from the DD Section. In this request, the Provider must state indicate the following (unless detailed in the GER):

- What risk management steps have been implemented
- What risk managements steps will remain throughout the investigation
- Reasonable date for the investigation to be completed.
    - Careful consideration will be given to each request to determine the approved extension date.
- If the extension is approved, DD Section staff will place a comment in the GER noting the approval and the date on which the investigation needs to be completed.
- The Provider is responsible for notifications of the DDPA/DDPM and P&A (if applicable) of the extension request and approval.

Serious Event: Follow-up on Investigative Activities

- When the Provider is completing the Investigative Action, the Provider must offer recommendations relative to their findings with the goal of preventing future incidents from occurring (long term risk management).
- These internal recommendations must have dates of completion documented in the GER. This will be done by attaching documentation to the GER or placing comments with completion dates in the GER comment section. Notification of these completion steps will be made to DDPM, DDPA and DD Section Staff. If P&A has determined that they will be conducting follow-up regarding the recommendations, they should then be included in the notification process. The Provider would be made aware of P&A's involvement in this process in the LOF.
- When P&A is completing follow-up on Investigative Action, a Letter of Findings (LOF) will be issued at the conclusion of their investigation. The LOF will indicate:

    - If P&A found a preponderance of evidence to indicate that abuse, neglect, and/or exploitation occurred citing which applicable definition.
    - May indicate if P&A agrees or disagrees with the recommendations the Provider has made.
    - P&A may offer additional recommendations for consideration. These recommendations must have documentation from the Provider on intentions to complete and/or completion dates of the recommendations. This is done by attaching documentation to the GER or comments in the GER specifically outlining the dates of completion of the recommendations.
    - P&A's LOF will also include a statement regarding who will monitor the follow-up for each incident. If the LOF indicates P&A will be completing additional follow-up, documentation regarding recommendations should be provided to P&A.
- If any recommendations are made related to the person's plans, the Provider will follow-up with the DDPM, the person receiving services and/or legal decision maker, and the person's team to determine if it is necessary to modify the person's current plan, supports, and services.
- If there were recommendations that were suggested of the secondary or tertiary Providers, the team will also review those related to the person, setting and continuity of care across settings.
- The DDPM will ensure and verify that all recommendations and action steps developed to minimize the chance of recurrence have been implemented. This will be documented in the GER and addressed and reviewed during the Quality Enhancement Review (QER) process.
- The DD Section will determine if follow-up is needed relative to the licensing standards.

Serious Event: Death Reporting Requirements

A Death of a person in services is considered a Serious Event. When reporting a death, the Provider will need to be prepared to provide the following information to P&A during the initial report (within 24 hours):

1. Name and date of birth of the deceased.
2. Date and estimated time of death
3. Whether the person had a legal decision maker (ex. Guardian)
4. Where the person was when the death occurred
5. Whether the death was expected and the cause, if known
6. Who, if anyone, was present at the time of death
7. Others who have been notified (family, law enforcement, etc.)

- A person's death must also be **verbally** reported to the guardian/legal decision maker and the DDPA/DDPM within **one working day** and documented in the GER.
- The GER must be approved within **one working day** of the initial report to P&A.
- The written, **approved GER** will be the notification to the DD Section.
- The ND P&A Death Report (SFN 62162) form must be completed and attached to the GER in the incident management system within **ten (10) working days**.

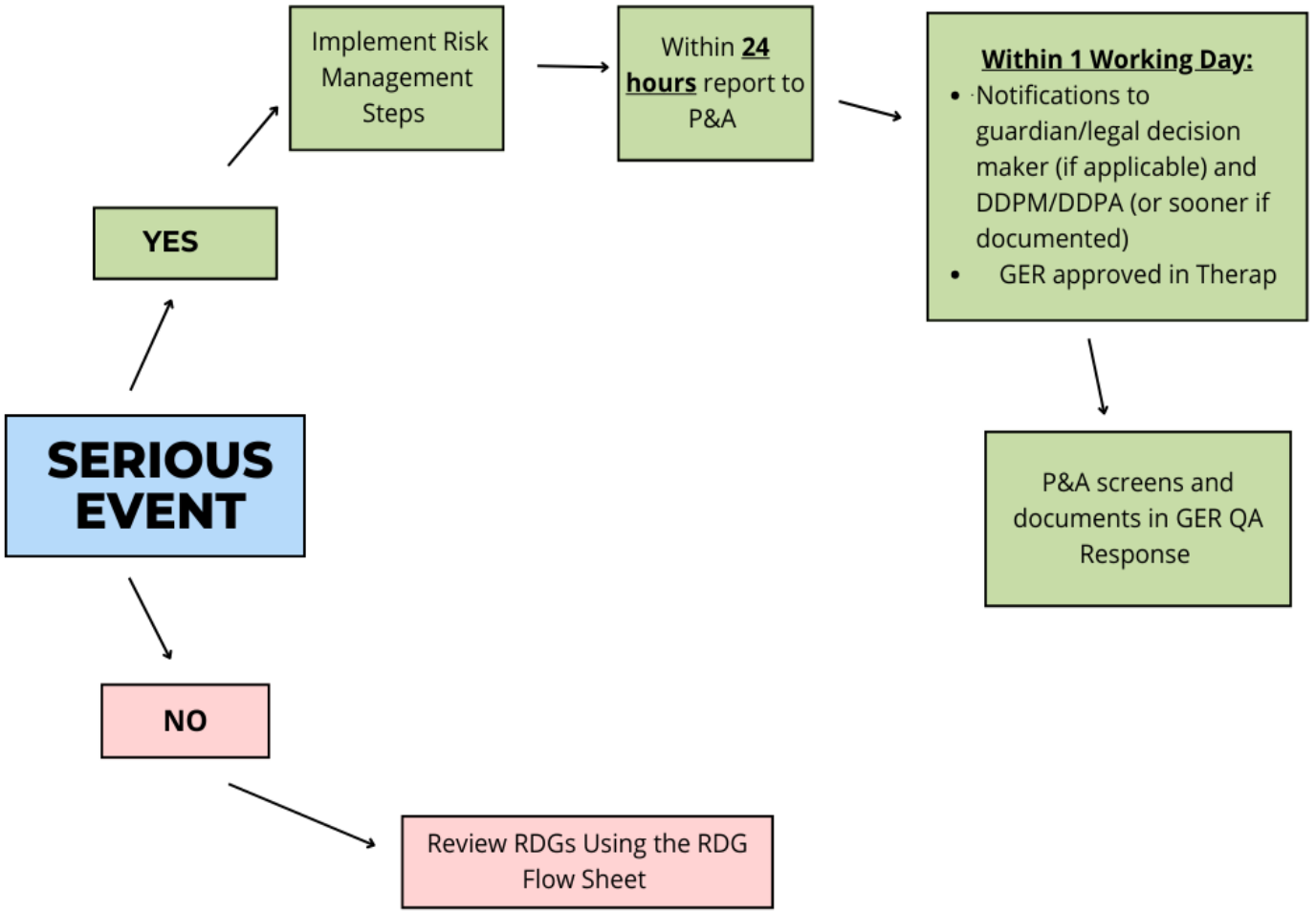
Follow-up for death reports will occur after P&A receives the following from the Provider or Department of Health and Human Services:

- ND P&A Death Report
- Death Certificate
- Autopsy, if one was completed

Once the above information is received, P&A's internal review committee will review the death report. P&A will complete the screening review and will notify the Provider when this is available. P&A's process to screen the individual death may take time depending on the nature of the death, waiting on documentation, and/or other formal review processes that may be required.

If a person is not currently admitted to any DD licensed Providers or is not receiving any DD authorized services, the DDPM/DDPA is responsible for notifying P&A of the death and completing the ND P&A Death Report form. This document must be submitted to the DD Section and P&A by email or Scomm.

Serious Event Flow Chart



REPORTING DETERMINATION GUIDELINES (RDGs) - High Level GERs

Reporting Determination Guidelines (RDGs) will only be used if an incident does not meet the Serious Event Criteria. RDGs are applied to each incident to determine if there is suspected abuse, neglect or exploitation. If an incident meets any criteria for the RDGs, a **High GER** must be generated. In the comment section of the GER, the Provider must identify which RDG applies and which definition of Abuse, Neglect, Exploitation may apply according to NDCC 25-01.3-01.

RDGs: How to Screen

There are four categories of RDGs:

A. Bruise/Injury
B. Person to Person
C. Medical or Medication Error
D. General Review

When reviewing the RDGs, **refer to the Reporting Determination Guideline Flow Chart** in the following section of this document. Determine which categories (A-D) applies to the incident based upon the identified criteria. Utilize the General Review section only when the incident under review does not fall into one of the other categories (A through C).

Provider staff must start with the top of the RDG screening document with number 1 and work their way to the bottom to determine if an incident/situation meets the RDGs. If the incident meets the criteria of any section, the Provider must verify that section "E" of the RDGs applies. **Refer to the Reporting Determination Guideline Flow Chart** in the following section of this document.

When reviewing the RDGs, staff must ensure they are being objective in the screening process. Specifically, when reviewing the components of Professional Judgement.

Each RDG section identifies a Provider's requirement to assess an incident as a repeat (more than 1) in the last six months. Providers must have mechanisms and/or systems in place to track and trend to identify where repeat incidents meet the criteria defined in the RDGs to ensure proper recording and reporting.

Timelines for reporting the incident will begin when a mandated reporter has knowledge of, or reasonable cause to suspect that an incident of suspected A/N/E may have occurred.

When the Provider has determined that an incident does not meet Serious Event Criteria or the RDGs, the Provider will use the GER Reference Guide to determine the level of the GER and proceed with implementing their policy regarding personnel action, quality assurance (including tracking and trending) and administrative steps for each incident. Documentation on these steps (as relevant) should be captured in the GER comment section of the GER.

RDGs: Reporting and Recording Process

<u>If the RDG criteria is met – the following steps must be completed:</u>

- The Provider MUST ensure that immediate risk management steps have been taken to ensure the health and safety of the person(s) involved. P&A staff are available to provide technical assistance with risk management.
    - Providers need to gather adequate information to assess the situation so that appropriate risk management steps can be taken. This could be potential personnel actions. The Provider must address risk management steps and document them in the GER. The following Risk areas must be addressed:
        - Ensure the person's safety
        - Ensure the safety of others
        - Provide necessary medical and emotional support
        - Notify law enforcement if the incident is criminal in nature
- A report of the incident that has met RDGs must be made to P&A within **<u>TWENTY-FOUR (24) HOURS</u>** of the incident occurring, or upon knowledge of the event occurring. Documentation of notification must be in the GER.
- The guardian/legal decision maker (if applicable) and DDPM/DDPA must be notified within **one (1) working day** of the event, or sooner if indicated in the person's plan. These notification dates must be documented in the GER.

    **If the report involves the parent, guardian, or another family member ICPS/CPS and/or P&A must be contacted and a determination made as to whether the parents/guardian would need to be notified. Guidance to not complete notification should be present in the GER.*
- Within **one (1) working day** of the report to P&A, a written report of the incident (GER) must be **approved** at a **HIGH** level in Therap. By approving the report, it allows the GER to be accessed by:
    - P&A
    - Regional DD Program Management
    - DD Section
- For children under 18 years of age:
    - Reports will be made to ICPS/CPS and P&A if child abuse or neglect is suspected (See Appendix 4 & 5). If it meets the definitions of Child Abuse and Neglect (CAN), the reporter will call ICPS/CPS and complete and submit the SFN 960.
    - If the Provider has not contacted ICPS/CPS before talking with P&A, P&A will ask that the incident be reported to ICPS/CPS.

- P&A will follow up with ICPS/CPS to determine which entity (if any) will be investigating. ICPS/CPS has primary jurisdiction in cases where the individual is under 18. If they decline involvement, P&A will then screen the report and determine if it meets criteria for an investigation according to DD policy. P&A will document this in the GER.
- **The investigation is NOT to be initiated by the Provider until P&A has commented in the GER.** The comment from P&A Central Intake will indicate if an investigation is required and who is responsible for the investigation.

RDGs: Investigation Action, Corrective Action Response, and Agency Action Response

P&A will screen the report to determine if there is a need for an investigation and who will be completing the investigation. If P&A determines there is a need for an investigation, the following responses are possible (risk management steps must remain in place during the duration of the investigation process).

RDGs: Possible Screenings and Determinations of Screenings

P&A will screen the report to determine if there is a need for an investigation and will comment in the GER who will be completing the investigation, if applicable.

If P&A determines there is a need for an investigation the following screenings are possible:

- **ICPS/CPS will investigate** *(only for incidents where person supported is under 18)*
  - ICPS/CPS will conduct an assessment regarding the incident and the Provider may be issued a letter which includes recommendations as it pertains to the person supported.
  - The Provider is responsible for completing these recommendations and documenting the completion of the recommendations within the GER as a part of the follow-up.
- **P&A will conduct a primary investigation**
  - P&A will complete the investigation. They will work collaboratively with the identified Provider to access the necessary records and interview the necessary parties.
  - When P&A has completed their investigation, the identified contact with the Provider will be issued a Letter of Findings (LOF). This letter will also go to any other applicable entities.
- **P&A will conduct a collaborative/joint investigation with the Provider**
  - If P&A and the Provider are working on the investigation together, the two entities will determine action steps and will work to complete the investigation together.
- **Other Screenings**
  - Investigative Action (IA) Response, Corrective Action (CA) Response, or Agency Action (AA) Response, No Probable Cause (NPC)
    - All of these responses are described in further details below on how they are determined and the Providers responsibilities.

If the incident has police involvement and an investigation is initiated by the police, P&A (nor the Provider) will complete their investigation until police involvement has ended/concluded. P&A has processes identified to ensure they are aware of the completion of the police investigation. If the Provider has questions on the pending police investigation they can work with the individual's team to determine who should be the contact person and/or work with P&A to get an update on the investigation status.

RDGs: Investigative Action (IA) Response

This response will be used when harm is evident or professional judgment indicates the need to elevate the response with P&A follow-up.

Investigative Action Response is also used when there is risk of harm, and an incident is a repeat occurrence and, in these instances, follow-up is completed by DDPM.

The Provider will be responsible for completing the following steps if the incident has been screened to Investigative Action (IA).

- **Provider will complete an Investigative Action (IA) with DDPM or P&A**
    - The Provider must complete and submit a full investigation report of their findings with statements and recommendations within **10 working days** of the screening of the incident by P&A Central Intake and send to the reviewing entity identified by P&A Centralized Intake.
    - The Provider's investigation report must indicate whether the incident occurred.
        - The Provider will NOT state in their investigation whether abuse, neglect, or exploitation occurred.
    - The Provider can use and attach the template **(Appendix 5-A)** to the GER, or they must ensure all the steps and components (of **Appendix 5-A**) are present in their IA Response.
    - When the Provider has their Investigative Action completed, they must communicate to the DDPM, DD Section staff, and P&A that the report is complete and available for review.
    - The Provider must also comment in the GER their completion of the IA if it is not attached to the GER.
    - If the DDPM is completing follow-up, the DDPM will document in the GER and communicate via Scomm any further recommendations or requests for further documentation from the Provider if needed. If the DDPM has no further information to relay to the Provider, they will acknowledge the report (at minimum) as the final step indicating completion of their review of the Provider's IA.
    - If P&A is completing the secondary review, P&A will review the Provider's IA and conduct any additional follow-up if needed to determine if abuse, neglect, or exploitation occurred. Once P&A has completed their secondary review, P&A will issue a Letter of Findings (LOF) to the Provider and any other applicable entities.

If the Chief Executive Officer (CEO) of the Provider is the subject of the investigation or a conflict of interest is identified, it is the responsibility of the Provider's board to fulfill the reporting and investigation/follow-up requirements of this policy. The Board has the option to complete the investigation and provide it to P&A, or request that P&A complete the investigation independently.

RDGs: Agency Action (AA) Response

This response is used when no harm is evident, when there is not a risk of harm, and the incident is not a repeat. This type of response does not require staff statements. The Provider is responsible for completing the following steps for Agency Action Responses:

- **Provider will complete an Agency Action Response (AA) with DDPM follow-up**
  - The Provider has **5 working days** to complete this report and communicate action steps to the DDPM.
  - The Provider can use and attach the template **(Appendix 5-B)** to the GER or ensure the required information from the template is documented in the GER comments.
  - Once the Agency Action is documented and recommendations are completed, the Provider must send an Scomm to the DDPM notifying them of the completion of their AA Response.
  - If the DDPM has further recommendations or requests further documentation from the Provider, they will document this in the GER and an Scomm will be sent by the DDPM to the Provider.
  - Follow-up and/or Completion of recommendations must be completed timely.

RDGs: Corrective Action (CA) Response

This response is used when no harm is evident, there is identified to be a risk of harm, or this incident is a repeat. This type of response does not require staff statements. The Provider is responsible for completing the following steps for Corrective Action Responses:

- **Provider will complete a Corrective Action Response (CA) with DDPM follow-up**
  - The Provider has **5 working days** to complete this report and communicate action steps to the DDPM.
  - The Provider can use and attach the template **(Appendix 5 – C)** to the GER or ensure **all** information and components from the template are documented in the GER comments section.
  - Once the Corrective Action Response is outlined and recommendations are completed, the Provider must send an Scomm to the DDPM notifying them of the completion of their response.
  - If the DDPM has further recommendations or requests further documentation from the Provider, they will document in the GER and an Scomm will be sent by the DDPM to the Provider.
  - Follow-up and/or Completion of recommendations must be completed timely.

RDGs: P&A Timelines

P&A has policies and procedures regarding timelines for the completion of their investigations. If an extension is needed, P&A will notify the Provider of the extension. The following will occur if P&A requires an extension:

- P&A will notify the Provider of the extension details
- Provider staff will document in the GER comment section the extension details to ensure DD Section, DDPM, DDPA are aware of the timeline changes.

When P&A has completed their investigation, a Letter of Findings (LOF) is issued to the Provider and any applicable entities.

RDGs: Provider Timeline Exceptions

If the Provider is unable to complete their investigation within the **10 working days** from the date of the P&A screening, the Provider can request an extension from the DD Section. In this request, the Provider must state indicate the following (unless detailed in the GER):

- What risk management steps have been implemented
- What risk managements steps will remain throughout the investigation
- Reasonable date for the investigation to be completed.
    - Careful consideration will be given to each request to determine the approved extension date.
- If the extension is approved, DD Section staff will place a comment in the GER noting the approval and the date on which the investigation needs to be completed.
- The Provider is responsible for notifications of the DDPA/DDPM and P&A (if applicable) of the extension request and approval.

RDGs: Follow-up on Investigative Activities

- When the Provider is involved in the investigative process, the Provider must offer recommendations relative to their findings to prevent future incidents from occurring (long term risk management).
- These internal recommendations must have dates of completion. This will be done by attaching documentation to the GER or placing comments with completion dates in the GER comment section. Notification of these completion steps will be made to DDPM, DDPA and DD Section Staff.
- When P&A is involved in the Investigation Activities, a Letter of Findings (LOF) will be issued at the conclusion of their investigation. The LOF will indicate:
    - If P&A found a preponderance of evidence to indicate that abuse, neglect, and/or exploitation occurred.
    - May indicate if P&A agrees or disagrees with the recommendations the Provider has made.
    - P&A may offer additional recommendations for consideration. These recommendations must have documentation from the Provider on intentions to complete and/or completion

dates of the recommendations. This is done by attaching documentation to the GER or comments in the GER specifically outlining the dates of completion of the recommendations.
    - Who P&A recommends will monitor the follow-up for each incident. If the LOF indicates P&A will be completing additional follow-up, documentation regarding recommendations will also need to be provided to P&A.
- If any recommendations are made related to the person's plans, the Provider will follow-up with the DDPM, the person receiving services and/or legal decision maker and the person's team to determine if it is necessary to modify the person's current plan, supports and services.
- If there were recommendations that were suggested of the secondary or tertiary Providers, the team will also review those relative to the person and continuity of care across settings.
- The Provider must ensure that completion of any/all recommendations are documented and completed timely.
- The DDPM will ensure and verify that all recommendations and action steps developed to minimize the chance of recurrence have been implemented. This will be documented in the GER and addressed and reviewed during the Quality Enhancement Review (QER) process.
- The DD Section will determine if follow-up is needed relative to the licensing standards.

RDGs: Other Information

If an incident occurs at a time when the Provider is not providing services (Independent Habilitation, Family Support Services, substitute caregiver, etc.) reporting and recording must still occur. Timelines start when the Provider becomes aware of the incident. The date the Provider became aware should be clearly documented in the GER. This process ensures that there is continuity of care across individuals caring for the person supported. Furthermore, there is still a responsibility as a mandated reporter to report suspected abuse, neglect or exploitation.

Reporting Determination Guideline Flow Chart

Reporting Determination Guidelines (RDGs)

Only used if incident does not meet Serious Event Criteria

Determine which categories below (A-D) applies to the incident answering each question under each section objectively. Utilize the General Review section (D) only when the incident under review does meet the criteria of the other categories.

Category A: Bruises/Injury Review

NOTE – All bruises/injuries will be documented and reviewed by the person's QDDP/Team/Nursing Services to ensure that possible causes are assessed, and the safety of the person is assured. If one of the following applies, **Go to E**.

1) ___ Adequate safety precautions are not in place to reduce the likelihood of bruises/injuries for a person with a documented history of similar bruises/injuries due to a medical condition, medications, or self-injurious tendencies.

2) ___ There is no documentation regarding how the bruise/injury occurred (i.e., restraint implemented, person returns from a substitute caregiver with a bruise/injury, person fell, etc.) **and** a reasonable person would suspect it is a result of possible abuse or neglect.

- Look at **the type of bruise** (i.e., finger/nail marks; nail scratches; teeth marks; imprint of possible weapon; bruise from a twisting motion, etc.)
- Look at **the location of the bruise** (i.e., face; neck; private parts; areas the person could not reach; etc.)

3) ___ There is a repeat occurrence of unknown bruises/injuries for this person, or in this setting, and it is not being addressed by the team/provider.

4) ___ Professional Judgment indicates a need for review (i.e., repeated bruises due to restraints; unauthorized restraint implemented, etc.)

Category B: Person to Person Review

NOTE – Focus is on the **Provider's** responsibility rather than holding a person accountable. If one of the following applies, **Go to E.**

1) ___ Incident occurred because staff failed to follow a person's program, provider policy, staffing levels, etc. The person whose program, etc., was not followed is the focus of the incident for reporting, review, and investigation.

2) ___ This is a repeat occurrence of a similar incident within **6 months,** and the team has not addressed the issue.

3) ___ This is the first occurrence of an incident, but staff could have foreseen and prevented the incident.

4) ___ Professional Judgment indicates a need for review (i.e., severity of the incident; response from consumers/staff; etc.)

Category C: Medical/Medication Error Review

NOTE – Harm and risk of harm are assessed by the consumer's physician, nurse, and/or pharmacist with knowledge of the consumer. If one of the following applies, **Go to E.**

1) ___ A medication was not administered according to doctor's orders, and the person was harmed or placed at risk of harm (including having to repeat medical treatment or medication).

2) ___ A medical procedure was not administered or completed according to doctor's orders, and the person was harmed or placed at risk of harm.

3) ___ A controlled substance is missing.

4) ___ Professional Judgment indicates a need for review
   a) ____ Procedural, or repeat procedural errors where there is harm or risk of harm
   b) ____ Repeat errors in a setting, by a staff, or for a person supported
   c) ____ Falsification of documentation/MAR
   d) ____ Non medication certified staff passing medications
   f) ____ Possible systems issues
   g) ____ Other

Category D: General Review

NOTE: Utilize the General Review section **only** when the incident under review does not fall into one of the other categories. If one of the following applies, **Go to E.**

1) ___ The person's plan, behavior support plan (etc.) was not implemented correctly resulting in a negative or potentially negative impact on the person.

2) ___ The issue related to the incident had been identified as a need/ concern but has not been addressed within the person's plan.

3) ___ Staff failed to follow agency policies, regulations, or standards, resulting in a negative or potentially negative impact on the person.

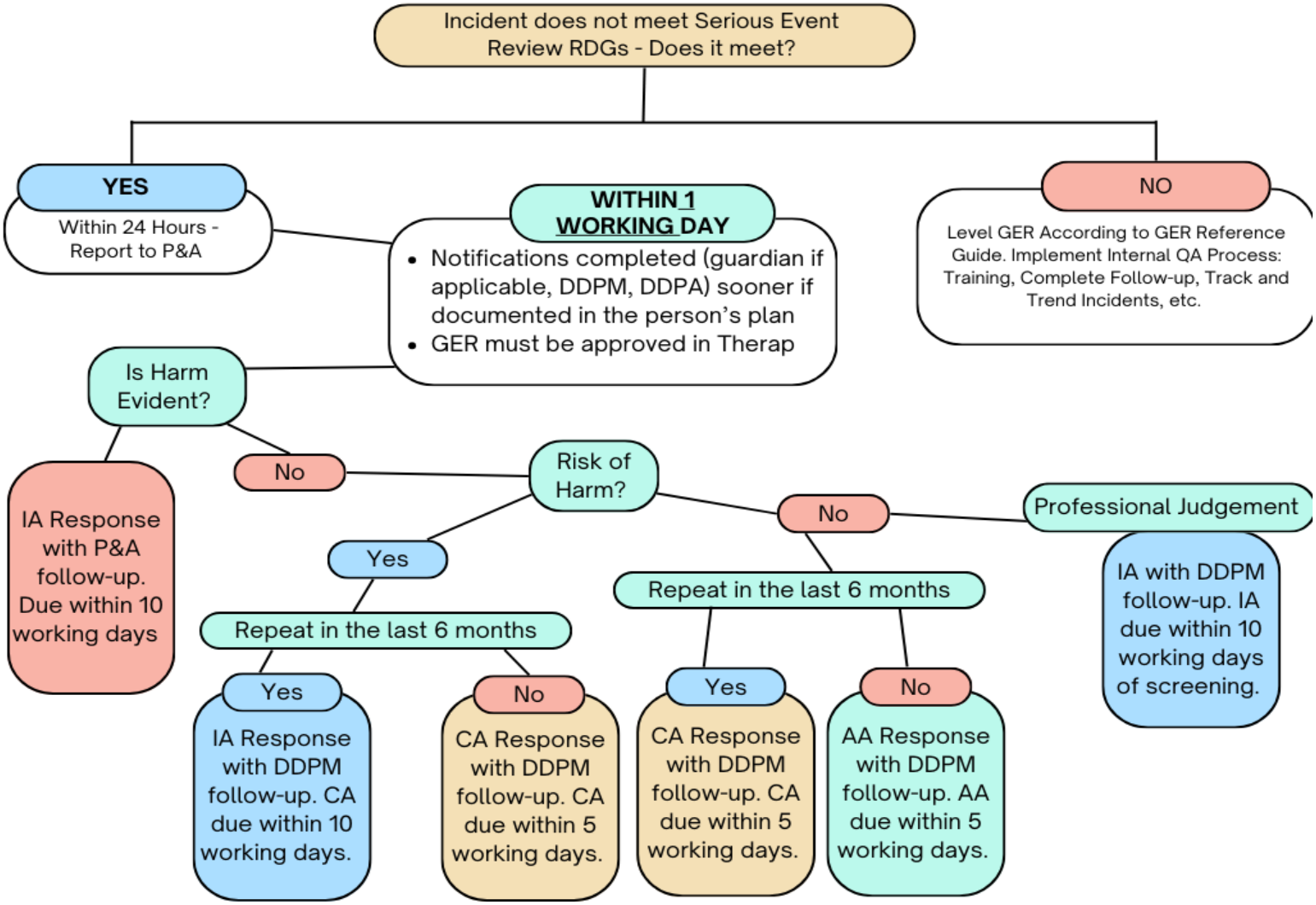
4) ___ Staff failed to provide appropriate intervention, resulting in a negative or potentially negative impact on the person.

5) ___ Professional Judgment indicates a need for review (i.e., - multiple concerns; serious nature of the report; person report; common sense, etc.)

Section E – Applies to all categories: Verify the Following

1) ___ The incident could have occurred as reported (must apply)
2) ___ If the consumer is under the age of 18, contact ICPS/CPS **and** P&A
3) ___ The incident may fall within the parameters of one or more of the statutory definitions of Abuse, Neglect, and Exploitation according to NDCC 25-01.3 (must apply if the person is over the age of 18 years of age)

RDG FLOW CHART



MEDIUM AND LOW LEVEL GERS

All incidents must be screened (and documented in the GER as being screened) against Serious Event Criteria and RDGs. If an incident does not meet these criteria, the GER Reference Guide will then be used to determine if an incident meets the levels outlined in the GER Reference Guide (Medium/Low).

The GER Reference Guide indicates levels of GERs for certain incidents which is an expectation for Providers to follow.

GERs that meet the Medium or Low category must be entered and approved in Therap within **7 days.**

MEDIUM GERs
Injuries • Falls • Sprains/strains • Minor bruises • Superficial scratches, scrapes, cuts • Reddened areas on the skin / Rashes
All Medication errors (6 r's), unless meets serious events or RDG's, including refusals.
Seizure – No diagnosis or present history (break through seizure), unless there is treatment beyond First Aid.
Illness • Fever • Refusing to eat/vomiting • Complaint of pain
Choking – unless hospitalization occurs or the plan is not followed (apply serious events and then RDGs and elevate to a high)
Elopement (if RDGs are not met) • Missing person/police involvement • Missing person/found right away
Property Destruction • Destroying belongings of self or others without history • Documented history of property destruction • Setting fires (with/without history)

Restraint • Initiated by medical/dental professional in a clinic/hospital setting • Physical restraint that is IN THE PERSON'S PLAN (if not in a BSP/ISP program that will track this) • Chemical restraint (PRN) – is in the plan and is approved by HRC/BRC
Behaviors, including self-Injurious behaviors • Cutting, hitting, biting, pulling hair, banging without history • Suicidal talk and suicide attempt (if the attempt has been ruled out diagnostically or there is no probable cause) • Medication overdose • Alcohol/drug abuse • Aggression/altercation
PLANNED hospitalizations and surgeries (treatment that is part of the plan of care – chemo, bypass that is planned etc.)
Other: i.e. police involvement, motor vehicle accident

*If any of the above criteria is an identified target behavior for a person supported and the target behavior is tracked somewhere in Therap, a Medium GER is not required. The person's plan must state where this is being tracked.

LOW GERs
Injury • Accident with no apparent or lasting injury • Injury reported to have occurred when not in Provider's care
Medications (other): dropped med, non-facility error (family/pharmacist)
Seizure – routine occurrence with diagnosis present
Illness • Cold symptoms • Minor indigestion
Confidentiality/HIPAA violation (screen to determine if it should be leveled higher)
Behavior – other atypical reports (something abnormal/out of routine) • Out of character behavior • Mild anxiety

• Mild or fleeting sadness • Major change in mood (happy or sad) • Minor paranoia
Miscellaneous – events not fitting another event type

GENERAL EVENTS REPORT (GER) DOCUMENTATION REQUIREMENTS

A GER required to be used to document all incidents for Providers. Every GER, no matter what the level, must have documentation present indicating the Provider has first screened for Serious Event criteria and then reviewed the RDG's identifying if the incident met either criterion.

The Provider must ensure the GER is comprehensive includes the following:

- Timely notifications to appropriate entities are completed and documented
- Event Summary: documentation of the incident looking back up to 24 hours prior to the incident occurring (if applicable)
- Risk Management steps (immediate and future)
- Review and Follow-Up Occurs on all incidents:
    - Documentation will not conclude on a GER until all issues/follow-up related to the incident have been addressed. Each incident follow-up will be unique to the incident.
        - Examples:
            - If there is a hospitalization, the discharge date should be present and documentation if/when the individual has returned to baseline.
            - If there is an injury, documentation should be present when the injury has healed.
    - If two incidents occur that are similar in nature and/or related and the timelines between the incidents are close, follow-up documentation can be completed on the most recent GER. The oldest dated GER will have documentation in the comments indicating that all future documentation will occur on the most recent GER and the GER form ID must be listed in the comment section.
    - Provider staff can also determine when/if using the MIE (Multi-Incident-Event) option in Therap is appropriate to link GERs together if they are similar or related.

There are times when the Provider may approve the level of a GER at what is identified to be the correct level. However, after further review, more information obtained, and/or clarification, the Provider determines the level of the GER should be a HIGH level, the Provider must reach out to DD Section Staff to request the GER to be re-leveled. If the Provider finds that a GER level should be changed to any other level (high to medium or low, low to medium) the Provider should document in the GER comment section the documented error in the level.

The Provider is responsible to ensure they have a process to track and trend GERs looking for repeat issues (more than one), and systemic issues (e.g. medication errors, specific incident types, settings, staff, person involved, etc.) This process is important as it assists the Provider when leveling the GERs and determining if an RDG has been met so that proper reporting can occur.

A GER is required for any incident no matter who the report generates from. If the Provider becomes aware of the incident from an external source (P&A, community, another Provider, etc.) a GER must be written. The Provider should add as much details as possible to the GER from the report that they received.

GER Documentation: Reporting of Incidents Involving Another Provider(s)

It is critical that Provider's communicate incidents that meet the Serious Event criteria, RDGS, and GER reference guidelines to a person supported tertiary Provider. This allows both Providers (and at times the team) an opportunity to discuss the incident and implement risk management. If the incident occurs or affects both Providers, a GER should be entered for both entities and the required documentation should be completed as outlined above.

If there is an incident where one Provider (Provider A) has knowledge of or reasonable cause to suspect that a person with a disability may have been abused, neglected, and/or exploited by another Provider (Provider B) or the incident meets Serious Event criteria or RDGs the following steps are to be taken:

1. Provider A will contact Provider B regarding the incident. Provider A will also make a report to P&A's Centralized Intake. If Provider A is not able/willing to follow this procedure, Provider A must notify P&A Central intake and explain why they are not reporting to Provider B. P&A will then follow up with Provider B to ensure risk management is in place and follow-up on the report. P&A will ask that a GER be generated by the appropriate Provider. Provider A will generate a High GER (submit and approve it) that contains the following information:
    a. Supporting documentation as attachments
    b. Notifications to appropriate entities
        i. Identify which staff from Provider B was notified and what information was provided to Provider B (photos, documentation, etc.)
2. Provider B will also generate a High GER (submit and approve it).
3. P&A will document in both GERs who will be responsible for an investigation, if one is needed.
4. If there is a need to investigate activities involving more than one of the agencies, P&A will conduct the primary investigation (next steps found under RDGs: Investigation Activities).
5. In the case of multiple Provider involvement and Provider A does not know who the other involved Agencies are, Provider A will make the initial report to P&A Centralized Intake. Provider A will generate and approve a GER with as much information as possible to notify P&A and the DDPM. The Provider is expected to generate a GER for anything meeting reporting level and as directed by P&A. P&A will initiate appropriate follow-up.

There may be times that issues arise during an investigation which could affect a person (or could affect the person) across more than one environment/Providers. The Provider(s) will notify other team members from other involved agencies so that the team can address the issues timely.

Any respective P&A LOF (Letter of Findings) will be sent to the Provider who is the subject of the investigation. Any recommendations the Provider receives from the LOF must be reviewed by the Provider and DDPM. However, there may be times the recommendations must be reviewed across all settings/services. In those cases, having a team meeting is best practice so that all Providers implementing the person's plan are aware of any discussion/changes. If P&A determines that recommendations will be given to the Provider who was not the focus of the investigation, separate correspondence will be sent to that Provider with copies to the DDPM and DD Section Staff. Follow-up on these recommendations must be documented in the GER.

GER Documentation: Reports Not Involving Provider Staff

If a Provider has knowledge of, or reasonable cause to suspect a person with a developmental disability may be or may have been abused, neglected and/or exploited by a person other than Provider staff (ex. Family members or members of the community), the Provider will implement risk management steps that are within their control. The Provider must notify P&A Centralized Intake within **24 hours** of the incident. P&A is responsible for taking the lead in conducting follow-up. Provider staff may be asked to assist in gathering information, interviewing the person receiving services, etc. at the request of P&A. The Provider should ensure a GER is entered for this incident. An LOF may be issued for these incidents and in those cases, follow-up would occur as outlined above.

If the incident falls under the following two risk levels, the Provider must notify P&A Centralized Intake:

1) Emergency - there is a current and immediate threat to the safety of the person receiving services, e.g., the alleged victim is currently being threatened; there is a medical emergency.
2) Imminent danger - there is reason to believe there is impending risk of harm to the alleged victim, e.g., alleged victim is receiving services/care from the alleged person; the alleged person has access to the alleged victim.

If the confidentiality of the reporting source could be compromised, a GER may not be generated. If a GER is not generated, P&A will notify the DDPM/DDPA and the DD Section that a report was made, and they will complete the investigation, and a letter of findings may follow.

Process for dispute of P&A LOF

If the Provider plans to complete either step of this dispute process, documentation must be present in the GER, so DDPM and/or DD Section staff are aware of any delay in completing recommendations from the LOF.

If the Provider does not concur with P&A's Letter of Findings, informal or formal steps can be taken.

- If the Provider would like to have the findings formally reviewed, P&A's public inquiry process may be used as outlined in ND Administrative Code 65.5-01-06.
- P&A is unable to document in the GER, therefore, the Provider must ensure steps of this process are documented in the GER.

If the Provider would like to have the findings informally reviewed, the following steps must be taken:

- Documentation about receiving the LOF from P&A and next steps regarding a discussion/meeting must be present in the GER.
- Provider will discuss concerns with the P&A advocate and/or P&A Program Director
    - The Provider may request to have staff from Regional DD Program Management and/or DD Section participate.

- If the agreement has not been reached through this process, the final determination will be made by P&A. The Provider will document the determination from the informal review process in the GER.
- If a revised Letter of Findings is determined to be necessary through the informal review process, it will be sent to the Provider's CEO with copies to all involved entities. The Provider will document the determination from the informal review process in the GER.
    - P&A has internal policies and procedures that outline timelines for Letter of Findings.
- Approval and acceptance of Provider plans to address recommendations and steps to prevent future incidents rests with the DD section as the licensing entity in consultation with Regional DD Program Management.

APPENDIX 1: Responses / Timelines / Requirements

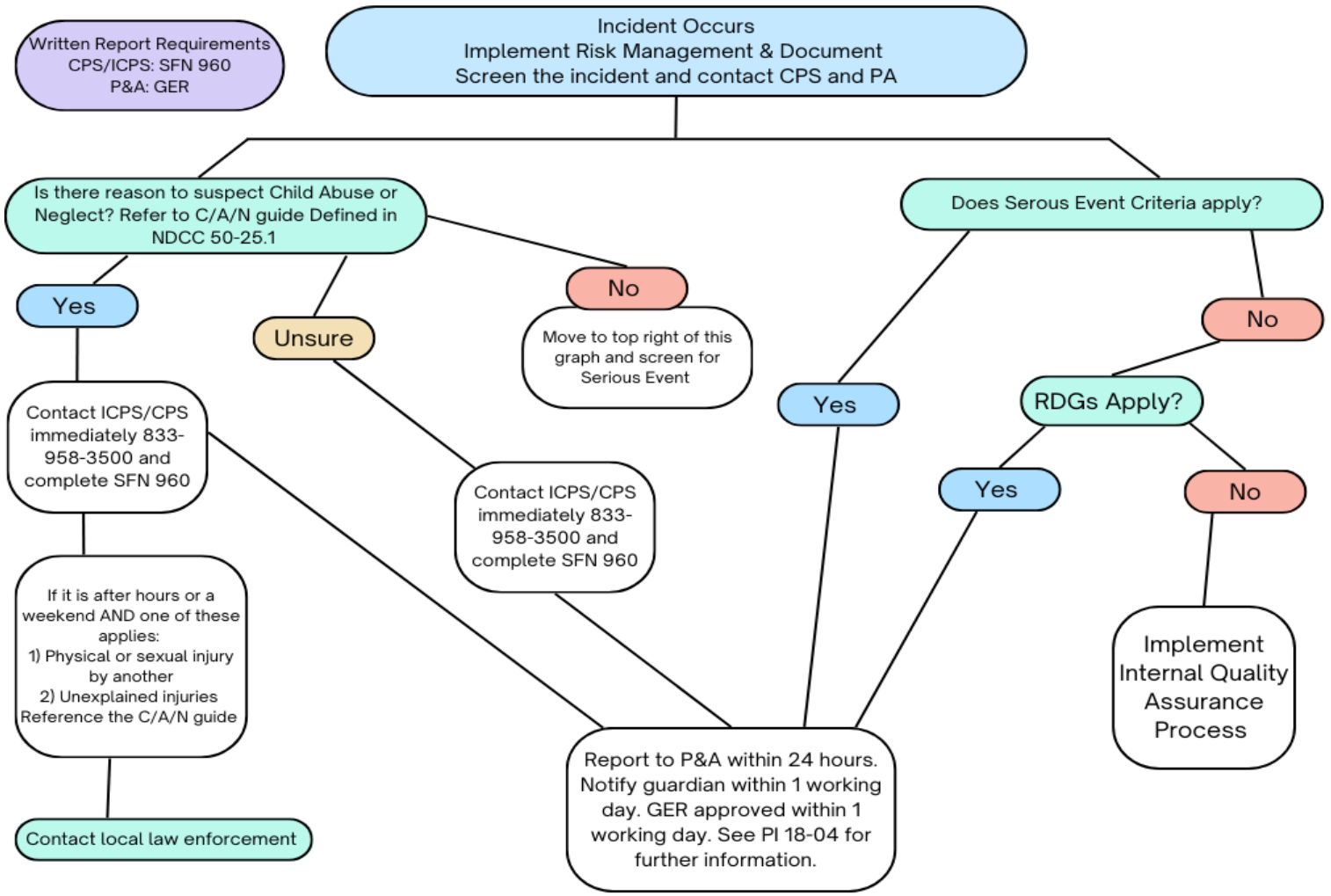
Level	Criteria	Provider	P&A	DDPA/DDPM
No Probable Cause	Not reportable as determined by reviewing Serious Events and RDGs	May review with P&A Create and approve GER within 7 days using GER reference guide to level Handle incident internally tracking & trending incidents and ensure follow-up	Provide TA to Provider Document in GER	Review – may have comments/questions for Provider which will be sent via Scomm
Agency Action	Suspected ANE And no harm or risk of harm to person is evident; and Not a repeat incident or similar incident within 6 months.	- Assess immediate risk management - Report to P&A within **24 hours** - Notify guardian, and DDPA/DDPM within **1 working day** - Complete high GER and approve within **1 working day of report to P&A** - Attach/Document AA response in GER within **5 working days** - Notify DDPM/DDPA of completion of the response & recommendations – Notify Guardian of any findings and follow-up	Assess initial risk management Provide TA to Provider	Review documentation DDPM follow-up in GER and in the QER process Provide TA as requested DD Section-review and provide TA, as needed
Corrective Action	Suspected ANE; & No harm is evident (risk of harm may be present); & repeat incident w/in 6 months Or not a repeat & risk of harm Or insufficient response to Agency Action (determined by DD or P&A)	- Assess immediate risk management - Report to P&A within **24 hours** - Notify guardian, and DDPA/DDPM within **1 working day** - Complete the high GER and approve within **1 working day of report to P&A** - Attach/Document CA response in GER within **5 working days** - Notify DDPM/DDPA of the completion of the response & recommendations – Notify Guardian of any findings and follow-up	Assess initial risk management. Provide TA to the Provider. Option to request investigative action	Review GER and documentation to assure that risk management steps are in place long term Respond if needed DDPM follow-up in the QER process DD Section-review and provide TA, as needed
Investigative Action	Suspected ANE and Harm is evident Or this is a repeat occurrence of a similar incident within 6 months, & placed at risk of harm, Or insufficient response to corrective action (determined by DD or P&A) Or Professional judgment	- Assess immediate risk management - Report to P&A within **24 hours** - Notify guardian and DDPA/DDPM within **one working day** (or sooner if requested by guardian) - Comply with all the protocols for investigative action.	Assess initial risk management. Provide TA to Provider Follow-up in GER. Review the findings and recommendations if P&A is responsible.	Review report with completed findings and recommendations. Follow-up with person and guardian as appropriate. Follow-up through the QER process, depending on the incident. DD Section-review report and documentation. Follow-up after the LOF is received, if appropriate

APPENDIX 2: Reporting Timelines Grid

	Initial notification to:		Written, approved GER	Timelines for Quality Assurance Response System for DD Provider
	ICPS/CPS and P&A*	**DDPM/DDPA, & OTHERS AS APPLICABLE (GUARDIAN)**	**P&A, DD Section, DDPA, & OTHERS AS APPLICABLE (GUARDIAN, ICPS/CPS)**	**P&A, DD Section, DDPA, & OTHERS AS APPLICABLE**
Serious Events	***ICPS–ASAP (If Child abuse/neglect suspected) Report to P&A within 24 hours	1 working day	1 working day from the initial report to P&A	IA: 10 working days from screening completed by P&A CA: 5 working days from screening completed by P&A AA: 5 working days from screening completed by P&A
Deaths	***ICPS–ASAP (If Child abuse/neglect suspected) Report to P&A within 24 hours	1 working day	1 working day from the initial report to P&A. (ND P&A form attached within 10 working days)	
RDG's (ANE)	***ICPS/CPS–ASAP (If child abuse/neglect suspected) Report to P&A within 24 hours	1 working day	1 working day from the initial report to P&A	

Providers must notify P&A Centralized intake within 24 hours, during P&As business hours (Monday-Friday 8am-12pm & 1pm-5pm CST). To meet the reporting requirements on weekends and holidays, a report can occur using P&A's website.

APPENDIX 3: ID/DD & CPS Incident Report Flow (for individuals under 18 years old)



APPENDIX 4: Child Abuse and Neglect Reference Guide

Types of Maltreatment	Report Timelines
Physical Abuse: Injury by another (staff or Resident), Unexplained bruise/injury (reference RDG), Injury as a result of a restraint (regardless of plan), Forced ingestion of a noxious substance (soap, tabasco)	1.) Contact Regional Office Immediately at 1-833-958-3500 2.) Submit SFN-960 3.) Report to P&A within 24 hours *If there is a physical injury, a sexual assault/injury, or an unexplained injury to a youth and the Regional Office is not available due to it being after hours/or weekend leave a detailed message of the suspected maltreatment and plan for immediate youth safety. Then contact local law enforcement for immediate response. Follow-up with Regional Office on the next business day.*
Sexual Abuse: Youth is forced or encouraged to engage in sexual activity with another youth or staff, Staff exposing their genitals or to youth, Staff allowing a youth to touch staff genitals, Engaging in inappropriate physical boundaries, Youth is encouraged or allowed to act, model, view, or in any other way participate in, or be photographed for, the production, presentation, dissemination, or advertisement of any material or performance that is obscene or involves exploitation.	
Neglect - Psychological Maltreatment: Staff ridicules and/or degrades a child or their family, Staff criticizes, threatens or ignores a child, Staff demonstrates favoritism for one child over another, Staff initiates inappropriate consequences or punishments such as not limited to denying the youth a meal, denying the youth bedding, taping the youth's mouth, locking the child in their room or out of the living unit	1.) Contact Regional Office Immediately at 1-833-958-3500 2.) Submit SFN 960 3.) Report to P&A within 24 hours
Neglect - Inadequate Supervision: Elopement, A youth is injured/assaulted by another child when they are left unattended or when there is inadequate staffing or impaired staff, Youth is placed in an isolation room and is not adequately monitored resulting in the child harming himself/herself	
Neglect - Medical: Medication errors resulting in physical or emotional impact on the youth, Suicide attempt or self-injurious behaviors that result in treatment beyond first aid.	
Death	1.) Contact Emergency Medical Services (911) 2.) Contact Regional Office 833-958-3500 3.) Contact P&A within 24 hours

APPENDIX 5-A: Investigative Action Response Checklist

P&A will comment in the GER when an Investigative Action Response is required and who will be completing the follow-up (DDPM/P&A). Providers will use this template/checklist when an Investigative Action is required.

Provider Responsibilities (List Completion Dates below):

_____Initial report made to ICPS/CPS (if applicable) and P&A prior to submitting a GER.

_____Within 1 working day, guardian/legal decision maker & DDPM must be notified, unless sooner as noted in the person's plan.

_____Within 1 working day of the report to P&A, a written and approved report (high level GER) must be completed so that the following entities have access to review the report:

- ND Protection and Advocacy Project
- Regional DD Program Management
- Developmental Disabilities Section

_____Within ten (10) working days from the P&A comment in the GER, the Provider must have the investigation completed. The Provider must document its completion in the GER and copies distributed to the following entities:

_____P&A (if applicable) Provider must also attach the IDF and Guardianship papers to the GER

_____Regional DD Program Management

_____Developmental Disabilities Section

***If you are attaching the results/investigation to the GER, you MUST notify the above parties that this is attached via Scomm or e-mail**

This internal report must include the following:

1. **The Provider's investigation report must include a thorough summary of the following and submitted to P&A (if applicable), DDPA/DDPM and DD Section**:

    a. Name of the alleged victim(s); date and time of alleged incident
    b. Summarize, in detail, the events that occurred, from beginning to end.
    c. What immediate risk management steps were taken to ensure the health and safety of the person receiving services, the safety of the environment and others?
    d. Why did the incident happen, i.e., consider, could the incident have been prevented? If so, how? Was the necessary training provided for staff? Were Provider policies and procedures followed? If not, why not? Was the person's plan followed?
    e. Provider's role, if any, in the incident occurring
    f. Steps taken **by the Provider to ensure the incident is not repeated**. **The response must indicate:**
        1. Who is responsible for implementing the plan or the recommendations; and
        2. When it will be completed; and
        3. Who is responsible for follow-up; and

4. Once the plan is implemented, the Provider must provide documentation that it was in fact completed and available to the DD Program Manager and/or P&A if follow-up is being conducted. This must be completed by placing a statement in the GER to alert them it is done.

g. **Date and document that the following parties were promptly <u>notified of the incident AND the findings:</u>**
   1. the governing body; and
   2. the chief executive officer or designee; and
   3. the chairperson of the Provider's Human Rights Committee if the incident is related to a person's rights; and
   4. the persons' guardian (if one has been appointed and the issue is within the guardian's area of authority.); and
   5. the person receiving services.

2. **The following will be attached to the investigation report and submitted to P&A:**

a. **Signed** and dated statement from the person receiving services (alleged victim(s). If the person cannot participate in an interview, or sign the statement, this must be documented within the report.
b. **Signed** and dated statements from each staff person of the organization involved in the incident as to what happened, when it happened, precipitating factors to the alleged incident, and the individual staff person's involvement.

3. **Supporting documents will include, but not limited to:**

a. Person's OSP, Behavior Plan, Risk Assessment, Psychological Evaluation, etc.
b. Progress notes or documentation regarding the implementation of the client's plan.
c. Medication Administration Records
d. T-logs
e. Relevant Provider policies and procedures
f. Training records for the staff who may have been involved in the incident.
g. Other relevant GER's if the incident is a repeated occurrence.

_____If applicable, indicate if an extension (additional time to complete the investigation report) was requested by the Provider and that the request was granted.

If applicable, note the date when HRC/BSC was notified:

_____ Human Rights (note date and person talked to)
Committee member(s): _____
Committee member(s): _____

_____ Behavior Management (note date and person talked to)
Committee member(s): _____
Committee member(s): _____

Document all follow-up and recommendations completed on ALL reports, substantiated or not:

_____ Recommendation # and date (note completion date and person completing the recommendation)
Person(s) Responsible: _____
(continue this process until all recommendations have been completed)

The Provider MUST maintain all documentation for verification (meeting minutes, training/retraining, staff sign-in sheets, etc.).

APPENDIX 5-B: Agency Action Response

QUALITY ASSURANCE RESPONSE SYSTEM

Agency Action Response

Date:
Person Name(s):
Person Address:

Incident/Summary of Event:

- Attach Incident Report and Consumer Face/Data Sheet

GER Form ID:

Risk Management Steps Taken:

What RDG was applied? _____
Incident could have occurred? Yes: _____ No: _____
Under the age of 18? Yes: _____ No: _____
Meets an ANE definition:

- Abuse: _____
- Neglect: _____
- Exploitation: _____

Verification of Level:
_____A. Suspected A/N/E
_____B. **AND** No Harm or Risk of Harm to Person is Evident
_____C. **AND** First Time Occurrence

Steps Taken to Assure Incident is Not Repeated:

APPENDIX 5-C: Corrective Action Response

QUALITY ASSURANCE RESPONSE SYSTEM

CORRECTIVE ACTION RESPONSE

Date:
Person Name(s):
Person Address:

Incident/Summary of Event:
- Attach Incident Report and Consumer Face/Data Sheet

GER Form ID:

Risk Management Steps Taken:

What RDG was applied? _____
Incident could have occurred? Yes: _____ No: _____
Under the age of 18? Yes: _____ No: _____
Meets an ANE definition:
- Abuse: _____
- Neglect: _____
- Exploitation: _____

Verification of Level:
_____A. Suspected A/N/E
_____B. **AND** No Harm to the Consumer is Evident
_____C. **AND** Repeat Occurrence/Consumer Not at Risk of Harm
_____D. **OR** First Time Occurrence/Consumer Placed at Risk of Harm
_____E. **OR** Inadequate Response to Agency Action

Steps Taken to Assure Incident is Not Repeated:
Each response must include:
WHO is responsible for implementation; and
WHEN it will be completed; and
WHO is responsible for the follow-up

Signature of Designee:

APPENDIX 6: Definitions

The following definitions apply to this policy

"Active Treatment" refers to the aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. Active treatment does not include services to maintain generally independent clients who can function with little supervision or in the absence of a continuous active treatment program.

"Agency Action Response" (AA) This response will be used when no harm is evident, when there is no risk of harm, and this is not a repeat occurrence. The Provider and corrective action follow-up do not need to include staff statements. Document the response within the GER.

"Alleged Perpetrator" is the person who allegedly abused, neglected and/or exploited the person with a developmental or mental illness.

"Alleged Victim" is the person(s) with a developmental disability who allegedly was or is being abused, neglected and/or exploited.

"Behavior Support Committee" (BSC) is the committee responsible for reviewing individual programs designed to eliminate maladaptive behavior and replace them with behaviors and skills that are adaptive and socially productive. Programs that call for any restrictive procedures must be submitted to the behavior support committee for review prior to implementation to ensure that the proposed intervention is likely to produce the desired effect, and that any risks to the person receiving services are outweighed by the risks of the behavior. Once approval from the BSC is obtained, the staff must receive training on the plan prior to implementation.

"Calming Area/Separation (non-restrictive)" A calming area or separation from an environment is the use of an area where a person may voluntarily go to calm, where they have the option of coming and going. This may include others who are voluntarily leaving an area to allow someone the time to calm in their present space. Staff may offer the person the opportunity to choose their own area to do this.

"Caretaker" is a person, organization, association, or facility who has assumed legal responsibility or a contractual obligation for the care of a person with a developmental disability or mental illness, or parent, spouse, sibling, other relative, or person who has voluntarily assumed responsibility for the person's care (NDCC 25-01.3-01).

"Child Abuse or Neglect (CAN)" see NDCC 50-25.1

"Collateral Contact" is a person who may have knowledge about the allegation and/or the person(s) receiving services involved.

"Consent" means an act of reason, accompanied by deliberation, the mind weighing as in a balance the good/bad, pros/cons, information obtained on each side. It means voluntary agreement by a person in possession and exercise of sufficient mental capacity to make an intelligent choice to do something proposed by another or by themselves. It supposes a physical power to act, a moral power of acting and a serious, determined, and free use of these powers. It is an act unclouded by fraud, duress, or sometimes even mistake.

> **Information** – all the information (i.e., facts, data, options, choice available, and the pros and cons of each) the person needs to decide, given in a way the person can comprehend.
>
> **Capacity** – the ability to understand the nature and consequences of a specified matter, to process the information received, to weigh out the information.
>
> **Voluntariness** – the ability to exercise free power of choice without force, duress, undue influence or external persuasion.
>
> Many times, we feel "forced" into doing something. There can still be consent if we know and understand and relay back the pressure that others may be applying.

"Corrective Action Response" (CA) This response will be used when no harm is event, there is identified to be a risk of harm, or this is a repeat occurrence. The Provider and corrective action response follow-up do not need to include staff statements. The CA response must be documented in the GER including all components outlined in the CA template (if not used).

"Developmental Disabilities Section (DD Section)" Developmental Disabilities provides support and training to individuals and families to maximize community and family inclusion, independence, and self-sufficiency; to prevent institutionalization; and to enable institutionalized individuals to return to the community. To achieve this goal, the Developmental Disabilities Section contracts with private, non-profit, and for-profit organizations to provide an array of residential services, day services, and family support services.

"Dignity of Risk" means expressing one's individuality by consenting to expose oneself to a possible or known risk connected with an activity. The dignity of risk is the right of every person, including those with a disability. To make informed choices, and to take reasonable risks to learn, grow, and have a better quality of life. To assist a person to exercise their right to risk, a Provider must: 1) Assess the person for their current knowledge or skills involved with the desired activity. 2) Provide information/training needed to engage in the activity. 3) Ensure the person understands the potential risks. 4). Ensure the person is voluntarily exposing themselves to the risk.

"Emergency" is any situation that could have an immediate and severe or substantially detrimental impact upon a person's physical or mental health and safety.

"**Emergency Procedures**" are to be used only when an individual's behavior becomes severely aggressive or so destructive that the behavior places the individual, or others, in imminent danger of physical harm or major property destruction is likely to occur, when those reasonably could not have been anticipated. The behavior is at a point where the team member is no longer able to respond effectively/safely to the situation. The situation is one in which: 1) the individual is endangering himself and/or others and not just a situation of individual non-compliance; or 2) significant property damage is occurring or in real danger of occurring.

"Essential Services" are those social, medical, psychiatric, psychological, or legal services necessary to safeguard the individual's rights and resources, and to maintain the physical and mental wellbeing of the person.

"Evidence" is any information collected during the investigation that has the potential to assist in establishing the truth or falsehood of the allegation.

> **Testimonial –** All information given orally or in an equivalent manner, such as sign language, communication device, Braille, etc.
>
> **Documentary –** Information gained from documents such as policy statements, correspondence, medication logs, program plans, and progress notes. Documentary evidence may exist on paper, cell phone, videotape, computer, or other such medium.
>
> **Demonstrative –**Items such as pictures, diagrams, or maps, which may be created or become relevant during an investigation.
>
> **Physical/Real-** any evidence that is tangible, such as a bruise, cut, injury, weapon etc.

"General Events Report (GER)" is the universal incident report form on the web-based incident management system found in Therap which constitutes a written report (incident report) of a Serious Event or report of suspected abuse, neglect, or exploitation. At minimum, information entered in a GER must include a thorough description of the incident, risk management steps taken (immediate and future), decision-making process that led to identification of type of report (i.e., What led the Provider to determine it was a serious event, or what RDG was used to determine an incident was a reportable ANE issue). The documentation used by the Provider to report and/or communicate issues which may include, but are not limited to, suspected abuse, neglect and/or exploitation; failure to implement programs; medication errors; critical events involving personal injury; unknown bruising; restraint; person to person mistreatment etc.

"General Events Report Resolution (GERR)" is a module in the web-based incident management system which is linked to the written report (GER) of a Serious Event or report of suspected abuse, neglect, or exploitation. The resolution is a way of documenting the investigation details, housing the

documents that the Provider used to complete their findings, summarizing the event, and placing recommendations and follow-up conducted in this response document.

"Guardian/Legal Decision Maker" – for the purposes of this policy, "Guardian" is used to describe the court-appointed decisionmakers who may have the responsibility to assist with and/or make decisions on behalf of a person. The types of decision-makers are:

Parent(s) – Parents, barring any circumstances such as certain divorce decrees or termination of parental rights, have broad authority to make decisions on behalf of their minor children until the children reach the age of 18.

Legal custodian – A juvenile court may appoint a legal custodian who, along with parental input can make decisions regarding the minor's care. Or a court may determine that a parent/parents will not be able to provide adequate parenting as needed by the child and terminate the rights of the parent/parents. In such a case, the legal custodian will make all the care decisions without input from a parent. Legal custodians are normally appointed for a period which does not exceed 18 months.

Guardian of a minor – A guardian may be appointed for a minor solely because of their age. Like parents, and legal custodians, guardians of minors do not have authority to continue their decision-making once the person becomes an adult.

Guardian of an Incapacitated Person – Minors or adults who lack the capacity to make their own decisions may have a court appoint a full or limited "guardian of an incapacitated person". A "limited guardian" is appointed to assist with and/or make decisions in one or more areas of the person's life if that person has some capacity, but not full capacity for making decisions. A "full guardian" (sometimes referred to as a "general guardian") is appointed to make decisions in most areas of a person's life when that person is considered to have no capacity for making decisions. Guardianships of incapacitated people do not expire on the person's 18th birthday. Currently, ND law requires that guardianship is formally reviewed by the court every five years.

Conservator – North Dakota law also provides for the possibility of conservatorship as a means of protecting the estate or finances of a person one who is unable to manage his or her finances. In this state, the term conservatorship only refers to assistance in the financial area. A person can have both a conservator and a guardian.

"Guidelines" are the Reporting Determination Guidelines that must be applied to an incident when it does not meet a Serious Event to assist in determining whether a particular incident is reportable as suspected abuse, neglect, or exploitation. These are merely "guidelines" – each situation will also be scrutinized with "professional judgement" utilizing the knowledge regarding the person, the staff, the facility, their mission, and the community.

"Harm" is the existence of a loss or detriment of any kind resulting from the incident:

Emotional – (i.e., that which affects negatively an individual's emotional well-being and state of mind).
Psychological – (i.e., humiliation, harassment, threats of punishment or deprivation, name-calling, sexual coercion, intimidation).
Physical – (i.e., any physical motion or action such as striking, pinching, kicking, punching, pushing, etc.)
Financial – (i.e., that which affects a person's state of financial affairs).

"Harm is Evident" – is a loss or detriment of any kind which is noticeable or apparent to observation:

Emotional – i.e., crying, unusual behaviors for that person, behaviors associated with a person when upset such as pacing, self-injury etc.
Psychological – i.e., person becomes passive, withdrawn, aggressive, fearful of people, places, objects etc.
Physical – i.e., bruise marks, injuries, individual displays defensive reaction to an imaginary threat, etc.
Financial – failing to complete required forms for assistance programs/benefits; failing to complete transactions as requested by the person/guardian; person's money not being used for their well-being; overdrafts, misuse of funds, etc.

"Title XIX Regulations" since many people reside in ICFs are unable to communicate feelings of fear, humiliation, etc., the assumption must be made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, is also viewed as abusive by the person residing in the ICF, regardless of that person's perceived ability to comprehend the nature of the incident. Regulations established by the Centers for Medicaid and Medicare Services which apply to Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IID). These regulations apply to any person who resides within a licensed ICF/IID facility.

"Health Facilities" is a Unit within the North Dakota Department of Health and Human Services that is responsible to complete annual Medicaid certification of Intermediate Care Facilities (ICF). The Health Facilities Unit may also be responsible for investigating complaints involving the ICF and service recipients.

"Human Rights Committee (HRC)" is the entity responsible for ensuring that individual rights are supported and protected. Each Provider may have its own HRC or may participate in a multi-Provider HRC. The committee includes people served and/or their representatives and at least one-third of the committee's members may not be affiliated with the Provider. All instances of suspected abuse, neglect, or exploitation of people served are reported to the Human Rights Committee in accordance with Provider policy, state law, and provisions of this policy.

"**Institutional Child Protective Services (ICPS)"** means situations of known or suspected child abuse or neglect in a public or private school, a residential facility or setting either licensed, certified, or

approved by the department, a residential facility, or a setting that receives funding from the department. Facilities excluded include correctional, medical, home-and community-based residential rehabilitation, early childcare facilities (daycares), foster homes, and educational boarding care settings.

"Individualized habilitation or education plan" Per North Dakota Century code NDCC 25-01.2-14, Any public or private Provider or organization that provides services to an individual with a developmental disability must have a written, individualized habilitation, person-centered service, or individual educational plan developed and put into effect for each individual for whom that public or private Provider or organization is primarily responsible for the delivery, or coordinating the delivery, of services

"Intent" is that which is designed, willful, aimed, and purposeful. The definitions of abuse, neglect, and exploitation must be reviewed carefully to determine if "intent" is a required element as it is **not** a required element of each definition.

"Investigation" is a systematic collection of information (facts) to describe and explain an event or series of events relative to the report. An investigation is required for all reports of suspected abuse, neglect, and exploitation that meet the level of Investigative Action.

"Investigative Action response (IA) with DDPM follow-up" This response is used when there is a risk of harm, and an incident is a repeat occurrence. DDPM will complete follow-up after the Provider has completed their IA response. No LOF is issued by the DDPM.

"Investigative Action response (IA) with P&A follow-up" This response is used when harm is evident or professional judgement indicates the need to elevate the response. In these situations, an LOF will be issued by P&A.

"Mandatory reporter" (defined by law NDCC 25-01.3-04) Every medical, mental health, or developmental disabilities professional, educational professional, police or law enforcement officer, or caretaker having knowledge of or reasonable cause to suspect that an adult with developmental disabilities or mental illness coming before the individual providing services in that individual's official or professional capacity is abused, neglected, or exploited shall report the circumstances of that abuse, neglect, or exploitation to the project.

"Medication Errors" are defined as staff not complying with the 6 R's (rights): giving the medication to the RIGHT person, giving the RIGHT medication, RIGHT dose, RIGHT documentation, RIGHT route, or the RIGHT time.

Wrong medication (i.e., – the wrong pill container is grabbed and given)
Wrong dose (i.e., – too much or too little of a medication given)
Wrong time (medication given at a time other than that identified in doctors' orders/on the MAR – error is outside the 1-hour window for giving the med)

Wrong route (i.e., – eye drops are given in the ear)
Wrong person (i.e., – another person's medications are grabbed and given)
Wrong documentation (i.e., no documentation or no follow-up on the medication outcome)

"Negative Impact" is a fact, situation or experience that is negative, unpleasant, or depressing applying the "reasonable person standard".

"Notification" – means the requirement of the Provider to notify the appropriate entities of the serious event report or report of suspected A/N/E within the required timelines. All notifications must be documented in the GER.

"Potentially Negative Impact" is a fact, situation, or experience that has the potential to be negative, unpleasant, or depressing, to include the application of the "reasonable person standard".

"Preponderance of Evidence" – means evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; evidence which shows that the fact sought to be proved is more probable than not. A preponderance of Evidence may be determined by the greater weight of all evidence, which does not necessarily mean the greater number of witnesses, but the opportunity for knowledge, information possessed, environmental factors, supporting documentation, and physical evidence.

"Professional Judgment" – is a decision reached through the application of specialized knowledge. Each situation/incident is reviewed and scrutinized utilizing the totality of knowledge regarding the person, the facility, their mission, and the community. Professional Judgment is one of the criteria applied in the Reporting Determination Guidelines and Quality Assurance Response System.

"Protective Services" with P&A are the actions to assist persons with a developmental disability or mental illness who are unable to manage their own resources or to protect themselves from abuse, neglect, exploitation, or other hazards (NDCC 25-01.3)

"Provider" is an entity licensed by the Department of Health and Human Services under North Dakota Administrative Code (NDAC) 75-04-01 to provide services to eligible people.

"Quality Assurance Response System (QARS)" is the process in which DD Providers can implement the various response levels as defined in DD Policy for possible allegations of A/N/E.

"Reasonable Person Standard" – Since many individuals with disabilities are unable to communicate feelings associated with actions that may be abusive or neglectful by a member of the public, it can be determined that the actions may also be viewed as abusive or neglect. This can be done regardless of the individual's perceived ability to comprehend the nature of the incident. (i.e., it can be assumed that if a reasonable person were harmed because of the incident, it can be determined that a person with a disability would react in the same manner).

"Record" means all records including those identifying specific clients, including staff notes and logs maintained by a Provider; all individual records of a person prepared by any staff rendering care or treatment; reports by an Provider investigating incidents of A/N/E and injury occurring at such facility; discharge planning records; hospital, psychiatric, psychological, medical care records; school or education records; and records otherwise maintained by facilities regarding general care of clients, including facility policies and regulations, staff ratios, staff training records, and employee records. North Dakota Administrative Code - Title 65.5 Article 1 Chapter 3

"Repeat Occurrence" is a term used to determine reportability of incidents when reviewing the RDGs. When using the word repeat to apply the RDGs, the Provider would apply the word when there are more than one incidents that are similar in nature in the past six months. Providers should be tracking and trending incidents as a part of the QA process to ensure systemic issues and incidents that meet RDGs are leveled appropriately. After the first incident, follow-up should occur relative to the incident through recommendations, instructions, reminders, etc. This is done as a part of risk management to ensure the incident does not occur again. Staff across programs within a Provider must be informed of any risk management steps that may pertain to their job or working with a particular person(s). If a Provider fails to do so, they could be neglectful.

> Example 1: Staff in Program A was involved in an incident, and it was addressed with Program A staff only, as they are only staff to work with the involved person, and the recommendations were all person specific. An incident of the same nature occurs in Program B, with a different person and different staff. This would not be a repeat occurrence.

> Example 2: Staff in Program A was involved in an incident, and it was addressed with Program B staff as well, as they also work with the person. If a similar incident occurred in Program B after they were informed of the recommendations, then it would be a repeat occurrence, even though this was the first time the incident occurred with Program B.

"Report" is a verbal or written communication, including anonymous communication, alleging abuse, neglect, or exploitation of a person with a developmental disability or mental illness.

"Reportable" – is an incident that has met the criteria to be reported as suspected abuse, neglect, and /or exploitation per the Reporting Determination Guidelines. An incident that is reportable is more than mere suspicion but not established fact. A reportable incident exists when facts, circumstances, and reasonably trustworthy information provides "knowledge of or reasonable cause to suspect" abuse, neglect and/or exploitation occurred.

"Reporter" is the person(s) (known or anonymous) who communicates or provides information about the report. The reporter's name is confidential information.

"Risk Management" is the process to ensure the safety and well-being of the person(s) with disabilities when there is a report of suspected abuse, neglect, or exploitation, mainly geared to ensure the person(s) is/are not at continued risk while the allegation is being reviewed/investigated. Risk Management should be addressed with immediate and future steps.

"Risk of Harm" means there is a likelihood that, if the action were allowed to continue, harm would be evident. There may be a potential of danger, or perception, for experiencing emotional, physical, or psychological harm, or a perceived negative impact on the person, (i.e., resulting in changes to the supervision, needing to monitor health status, watching for signs or symptoms, needing to monitor them in their environments, etc.).

> Example: Medication errors where risk of harm would be identified if the error has the potential to be harmful by possible side effects from the error (ex: lethargy, nausea, vomiting dizziness).

"Seclusion" is defined as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. (i.e.., locking a wheelchair and they are unable to move, or turn it on; turning someone around and making them face a wall etc.) This is prohibited per DD policy.

"Serious Events" are critical events or incidents that occur and are to be reported immediately and are severe in nature. The categories for serious events that DD Providers are required to report in the State of North Dakota are**:**

- Serious injuries and medical treatment sought for physical or mental health where **treatment is beyond first aid** (not diagnostic in nature).
- Unauthorized restraints or physical interventions (chemical, mechanical, or physical), including the use of interventions or restraint on an emergency basis.
- Prohibited procedures as defined in DD Policy.
- Alleged sexual abuse or inappropriate sexual contact involving a person with a disability.
- Death.

"Substantiated Report" is a report in which the resulting investigation produces a "preponderance of evidence" that abuse, neglect, or exploitation has occurred. A determination is only made under Investigative Action with P&A follow-up.

“Technical Assistance” is assistance provided to the Provider by Protection and Advocacy Project (P&A), regional DD Program Management, or the Developmental Disabilities Section, regarding questions or concerns related to abuse, neglect, and/or exploitation; the process of review/investigation; rights; or other issues.

“Therap” is a web-based data system utilized by all DD service Providers in North Dakota and is the designated means by which **all** incident reports, including written reports of Serious Events and alleged abuse, neglect, or exploitation, are entered and can be reviewed by P&A, the DD Section and DD Program Administrators.

“Time Out” is a technique in which a **child** is allowed to move away from an activity and may sit alone for a few minutes to calm. If any physical intervention is used to separate the child from the activity, this is restrictive in nature. A time-out is to be used solely for ages 3-12, age-appropriate and the time to be used during the time-out is 1 minute for every year the child is (if a child is 4, the timeout amount is 4 minutes). Time out will not be used as seclusion where a child is placed in an environment and is unable to leave on his/her own accord (i.e., taken to their bedroom and the door is shut and the child is unable to open this). This technique may **only** be used as part of an **approved** plan (i.e., not to be used on an emergency basis). All Federal Health Facilities for ICF/ID rules apply.

“Unsubstantiated Report” is a report in which the resulting investigation does not produce a “preponderance of evidence” that abuse, neglect, or exploitation has occurred.