Compliance Program

Investigations Policy & Incident Management Policy and Procedure

Unity House of Troy, Inc.

Purpose

To thoroughly respond to and investigate all potential compliance violations of federal, state, and local laws and regulations as well as policies and procedures as they apply to the operation of the agency, and develop the corresponding corrective action plans.

Applicability

The Compliance Program's Disciplinary Policy applies to Unity House's employees, managers, executives, board members, volunteers, interns, vendors, contractors, subcontractors, independent contractors, subrecipients and other agents who:

- Are required to participate in Unity House's Compliance Program,
- Furnish or otherwise authorize the furnishing of services funded through government programs,
- Perform billing and coding functions on behalf of Unity House,
- Voucher Unity House for services and goods that will be reimbursed through government programs, and/or
- Monitor such functions.

Individuals covered by this policy are hereafter referred to in short as "employees, interns, volunteers, contractors, independent contractors, subcontractors and other agents".

Policy

All employees, managers, executives, board members, volunteers, interns, vendors, contractors, subcontractors, independent contractors, subrecipients and other agents have a duty to report anything that a reasonable person might think is a violation of the Compliance Plan, the Standards of Conduct, other policies and procedures, or rules, regulations, or laws. The Compliance Officer will complete an initial screen of all reports received by the Compliance Program or discovered through other

monitoring mechanisms. If the initial assessment indicates the report is related to a potential act of intimidation or retaliation or if there is a basis for believing the conduct may constitute other non-compliance with applicable law, the Compliance Plan, the Standards of Conduct, or other agency policies and procedures, the matter will be fully investigated. Upon the completion of the investigation, appropriate and timely corrective action will be taken. Employees, contractors, and other agents have an obligation to, in good faith, fully participate and cooperate with investigations and any remedial action(s) taken.

Persons, including Medicaid service recipients, who report compliance issues should have a reasonable expectation that their communication will be kept confidential, whether requested or not. Individuals who raise questions or report concerns (in good faith) are protected under the Unity House non-intimidation and non-retaliation policy.

Exceptions to confidentiality include, subject to a disciplinary proceeding, referral to, or under investigation by, Medicaid Fraud Control Unit (MFCU), New York State Office of Medicaid Inspector General (OMIG), law enforcement or disclosure of investigation details is required during a legal proceeding.

The Compliance Officer will make regular reports to the Chief Executive Officer and Board of Directors with regard to investigations and any remedial action(s) taken. Efforts will be taken to maintain the confidentiality of employees, contractors, and other agents involved in investigations. Unity House will report violations of federal, state, or local law to the appropriate governmental authorities.

Procedure

Investigation

1. Upon identification of a potential compliance issue, the Compliance Officer will identify an appropriate investigator or team of investigators. Special consideration will be given to the nature and scope of the investigation in determining who will investigate. The Compliance Officer will ensure there are no conflicts of interest and that the investigation will be conducted in a manner that is neutral, not biased and purposed only to determine whether or not a compliance problem exists.

   The Compliance Officer or his/her designee will investigate all potential compliance issues. In the event that the Compliance Officer is not directly involved in the investigation, the designee will coordinate with and report to the Compliance Officer the results of the investigation and

any corrective action.

2. If the alleged violation is suspected to be a felony or if criminal conduct may have occurred, outside counsel will be retained to conduct the investigation and attorney-client privilege will apply. Outside Counsel will meet with the Compliance Officer and General Counsel, who will share information with the CEO and Board of Directors if there is a verification of a felony.

3. The investigation will be conducted in a timely manner, with a goal of completing the investigation within 5 – 10 business days following the receipt of the report, information, or compliant. Unforeseen challenges or complications may cause the investigation to take extended time to complete, but every effort will be made to fully investigate and resolve compliance issues efficiently and effectively. Should circumstances result in the determination extending beyond 10 business days, the investigation file must contain the detail to justify the extension. If the identified conduct is found to be a violation of law, the Compliance Plan, the Standards of Conduct, or agency policy, the Compliance Officer will notify the CEO and Board of Directors as soon as reasonably possible.

4. The destruction of documents or other evidence related to an investigation is strictly prohibited. The Compliance Officer or designated investigator will attempt to proactively prevent the destruction of evidence.

5. Persons involved in or having knowledge of the potential non-compliance matter will be interviewed. Employees, managers, executives, board members, contractors and other agents are required to, in good faith, participate in compliance investigations. Failure to participate may result in disciplinary action up to and including termination.

6. During an active investigation, a person may be temporarily relieved of his/her duties and/or responsibilities related to the alleged violation. In accordance with Unity House policy, this may occur through reassignment or through paid or unpaid suspension. Following the conclusion of the investigation, the person will either be returned to their work or terminated in accordance with the results of the investigation.

7. Individuals or entities named in a report of potential non-compliance will be reviewed for their status in the Medicaid exclusion database.

8. Investigations' records will include, but may not be limited to:

- documentation of the alleged violation
- a description of the investigative process
- a log of witnesses interviewed
- copies of interview notes
- a log of documents reviewed
- copies of key documents
- the results of the investigation
- disciplinary action taken
- corrective action plan.

Employees, managers, executives, board members, volunteers, interns, vendors, contractors, subcontractors, independent contractors, subrecipients and other agents who have violated the Compliance Program will be subject to disciplinary action for failure to comply with ethical standards or legal requirements. Any violation of law, the Compliance Plan, Standards of Conduct, or agency policy will result in appropriate sanctions as outlined in the Disciplinary Policy. Disciplinary action taken as a result of non-compliance is firmly enforced and fairly applied to employees, interns, volunteers, contractors, independent contractors, subcontractors, managers, executives, board members, and other agents. No group receives preferential treatment based on their status within the agency.

9. A summary report of non-compliant conduct will be provided to the CEO, Corporate Compliance Committee and Board of Directors. The Compliance Officer will prepare the report, which will include:

- the initial report or complaint, including specific details
- the results of the investigation
- recommended corrective, remedial, or preventative actions that were implemented

- reports made to governmental agencies
- any disciplinary action that was taken.

The Board of Directors will be provided with the summary report as a part of their regular Compliance Report.

10. At three months and 12 months following the completion of the investigation, the Compliance Officer will review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered and that remedial action(s) have been implemented. If similar problems are discovered, another investigation will be initiated.

Corrective Action

1. Corrective action will be appropriate to the level commensurate with the problem. Corrective action may include: referral to criminal and/or civil law enforcement authorities having jurisdiction over such matter, report to the government, submission of any overpayments (if applicable), revised policies and procedures, appropriate education or training, and/or appropriate disciplinary action. If an investigation determines that an overpayment has been made to agency, obligatory overpayment will be repaid within sixty (60) days of identification. The Compliance Officer will follow guidance established by the New York State Office of Medicaid Inspector General (OMIG) to complete the required self-disclosure process, as per the Medicaid Overpayment & Self-Disclosure Policy & Procedure.

Reporting

1. Prior to giving a report to governmental authorities, outside counsel will review the records of the investigation and the report.
2. A report that a violation of federal, state, or local law has occurred may be made to the appropriate governmental authorities if the conduct (1) is a clear violation of criminal or civil law; (2) has a significant adverse effect on the quality of care provided to program beneficiaries; or (3) indicates evidence of a systemic failure to comply with applicable laws, an existing corporate integrity agreement, or other standards of conduct, regardless of the financial impact on federal health care programs. In order to qualify for the “not less than double damages” provision of the False Claims Act, the agency may provide a report to the Government within 30 days after the date when agency first identifies the potential violation. The report will be made within 60 days after the end of any

investigation that determines that there is: (1) credible evidence of a violation of criminal, civil, or administrative law or (2) discovery of verifiable fraud (as confirmed by legal counsel).

3. After the investigation is complete, the Compliance Officer, with outside counsel representation, will make a report to the appropriate governmental authority if there has been a violation of law. This report may include: all evidence relevant to the alleged violation of applicable federal or state law, the outcome of the investigation, the potential cost impact, and a description of the impact of the alleged violation on the operation of the applicable health care programs or their beneficiaries. Appropriate Federal and State authorities include the Criminal and Civil Divisions of the Department of Justice, the District U.S. Attorney, and the investigative arms for the agencies administering the affected Federal or State health care programs, such as the Office of the Medicaid Inspector General, the Office of the Attorney General, and the Office of the Inspector General of the Department of Health and Human Services.
4. The agency may decide to voluntarily disclose matters that, in reasonable assessment, potentially violate federal criminal, civil, or administrative laws. The self-disclosure will follow the Update OIG's Provider Self-Disclosure Protocol issued on March 28, 2023. According to the Protocol, disclosure must be made prior to investigation and self-assessment. After disclosure is made, a review will be conducted in accordance with the OIG Internal Investigation Guidelines and the Self- Assessment Guidelines.

Incident Management Policy & Procedure for PROS, ACT, and Transitional Housing and Support Services

It is the policy of Unity House to have in place an Incident Management Program that includes effective abuse prevention and protection; the classification of the incident; the reporting, tracking and trending of incidents; and the implementation of effective actions to protect individuals served from harm with a commitment to incorporating the principles of clinical risk management, emphasizing system and process improvement.

DEFINITIONS (please note that the definitions presented in this policy are based on the NYS Justice Center OMH Incident Management Regulations)

Vulnerable Person - In the case of Unity House, a "Vulnerable Person" is an individual who is receiving care in a facility, provider agency, or program that is:

- Operated, certified, or licensed by the Office of Mental Health (OMH)

Custodian - A director, operator, employee or volunteer of Unity House or a consultant employee or volunteer of a corporation, partnership, organization or governmental entity that provides goods or services to Unity House pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services.

Mandated Reporter - All employees, interns, volunteers, and directors of Unity House who are required to report allegations of Reportable Incidents to the Justice Center's Vulnerable Person's Central Register (VPCR).

Justice Center-New York State Justice Center for the Protection of People with Special Needs.

Certified and Licensed Programs-those Unity House programs that are required to report to the Justice Center's Central Registry:

REPORTABLE INCIDENTS

Allegations of Abuse and Neglect and Significant Incidents that occur under the auspices of a certified or licensed program that must be reported to the Statewide Vulnerable Person's Central Register (1-855-373-2122).

ALLEGATIONS OF ABUSE AND NEGLECT

PHYSICAL ABUSE-Any non-accidental physical conduct by a custodian with an individual receiving services which causes or has the potential to cause physical harm. The conduct must intentionally or recklessly cause, by physical contact, physical injury or serious protracted impairment of the physical, mental, or emotional condition of an individual receiving services or cause the likelihood of such injury or impairment. Such conduct may Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any party.

PSYCHOLOGICAL ABUSE - Includes any verbal or non-verbal conduct that may cause significant emotional distress to an individual receiving services. Examples include, but are not limited to, teasing, taunting, name calling, derogatory comments or ridicule, intimidation, threats, or the display of a weapon or other object that could reasonably be perceived by the individual as a means for infliction of pain or injury, in a manner that

constitutes a threat of physical pain or injury, violation of an individual's rights or misuse of authority. In order for a case of psychological abuse to be substantiated after it has been reported to the Justice Center, the conduct must be shown to intentionally or recklessly cause, or be likely to cause, a substantial diminution of the emotional, social, or behavioral development or condition of the individual receiving services. Evidence of such an effect must be supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor.

SEXUAL ABUSE – Includes any sexual contact involving a custodian and an individual receiving services, or any sexual contact involving an individual receiving services that is encouraged or allowed by a custodian including, but not limited to, conduct that subjects the individual to any offense defined in Article 130 (sex offense) or Section 255.25 (incest, 3rd degree), 255.26 (incest, 2nd degree), or 255.27 (incest, 1st degree) of the Penal Law, or any conduct or communication that allows, permits, uses or encourages a patient to engage in any act described in Articles 230 (prostitution offenses) or 263 (sexual performance by a child) of the Penal Law. Examples include, but are not limited to rape, sexual assault, inappropriate touching and fondling, indecent exposure, penetration (or attempted penetration) of vagina, anus or mouth by penis, fingers or other objects and when an individual receiving services is encouraged to send sexually explicit materials through electronic means, voyeurism or sexual exploitation.

DELIBERATE INAPPROPRIATE USE OF RESTRAINT – Use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is deliberately inappropriate, deliberately inconsistent with an individual's plan of service (e.g. individualized service plan (ISP) or habilitation plan), or behavior support plan, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other party. For purposes of this paragraph, a restraint shall include the use of any manual, pharmacological, or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

USE OF AVERSIVE CONDITIONING – Application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services. Aversive conditioning may include, but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, and the withholding of meals and the provision of substitute foods in an unpalatable form.

OBSTRUCTION OF REPORTS OF REPORTABLE INCIDENTS – Conduct by a custodian that impedes the discovery, reporting, or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment, or supervision of an individual receiving services; actively persuading a custodian or other mandated reporter from making a report of a reportable incident to the statewide Vulnerable Persons'

Central Register (VPCR) or OMH with the intent to suppress the reporting of the investigation of such incident; intentionally making a false statement, or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report or, for a custodian /mandated reporter failing to report a reportable incident upon discovery.

UNLAWFUL USE OR ADMINISTRATION OF A CONTROLLED SUBSTANCE – Administration by a custodian to a service recipient of a controlled substance as defined by Article 33 of the public health law, without lawful prescription, or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by Article 33 of the Public Health Law, at the workplace or while on duty.

NEGLECT – Action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient. Neglect shall include, but is not limited to:

- For OMH - failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that constitutes a reportable incident;
- For OMH - failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulation of OPWDD and OMH provided that the agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; and
- Failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of Part One Article 65 of the Education Law and/or the individual's individualized education program.

TRAFFIC VIOLATIONS REPORTABLE TO THE JUSTICE CENTER:

- speeding
- reckless Driving
- failed to stop for a school bus
- inadequate brakes
- improper cell phone use
- following too closely
- passing improperly, changing lanes unsafely, driving to the left of center, driving in the wrong direction
- failing to obey a traffic signal, a stop sign, or a yield sign

- railroad crossing violations
- includes property damage or the injury of a domestic animal
  other moving violations
- use of portable electronic device ("texting") includes cell phones and handheld GPS
- failed to yield the right-of-way
- passenger safety violation, including seat belt and child safety seat violations for passengers under the age of 16
- left the scene of an accident that includes property damage or the injury of a domestic animal
- DUI/DWI

Vehicle and Traffic Infraction Reporting and Classification Guidance reference available here: Vehicle and Traffic Infraction (nysed.gov).

SIGNIFICANT INCIDENTS

A Significant Incident shall mean a Reportable Incident, other than an incident of abuse or neglect that, because of its severity or the sensitivity of the situation, may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of an individual receiving services. Incidents under the classification of "Significant" are also reportable to the Justice Center.

Significant incidents shall include but shall not be limited to the following OMH and OPWDD defined Significant Incidents:

OMH defined Significant Incidents

The following are OMH Significant Incidents when they occur on program premises or when the patient was under the actual or intended supervision of a custodian when the event occurred:

Assault: A violent or forceful physical attack by a person other than a custodian, in which a patient is either the victim or aggressor, and which results in serious injury or harm.

Crime: An event which is or appears to be a crime under New York State or Federal law, which occurs on program premises or when a patient is under the intended supervision of staff, and which involves a patient as the victim, or which affects or has the potential to affect the health or safety of one or more patients of the program or has the potential to have a significant adverse impact on the property or operation of the program. For the purposes of this Part, crimes shall include acts committed by persons less than 16 years of age which, if committed by an adult, would constitute a crime.

Falls by patient: Events where patient's trip, slip, or otherwise fall while in an inpatient or residential setting, resulting in serious injury or harm.

Fights: A physical altercation between two or more patients, in which there is no clear aggressor and no clear victim, resulting in serious injury or harm.

Fire setting: Action by a patient of a mental health provider, either deliberate or accidental, that results in fire on program premises and which causes serious injury, or a risk of serious injury, to patients and/or staff of the provider.

Injury of unknown origin: An injury to a patient for which a cause cannot be immediately determined because:

1. The source of the injury was not observed by any person or source of the injury could not be explained by the patient or other person; and
2. The injury is suspicious because of the extent of the injury, the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the frequency of the incidence of injuries over time.

Medication error: An error in prescribing, dispensing, or administering a drug which results in, or creates a risk of, serious injury or harm.

Missing patient:

1. A patient of an inpatient or residential program who has not been accounted for four hours, when expected to be present and who has not been found on the facility grounds or other expected location, or which is known to have left the facility grounds without the permission of an employee, when such permission is otherwise required; **or**
2. A patient of an outpatient mental health program who is under the age of 18, and whose whereabouts are not accounted for when expected to be present or under the supervision of an employee.

Mistreatment:

1. Use of restraint that is inappropriate because it was implemented without a valid physician's order in a manner that was otherwise not compliant with applicable state or federal regulations; but which does not rise to the level of physical abuse, as defined in this section;
2. Use of seclusion that was unauthorized because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable state or federal regulations;

3. Use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming;

4. Any intentional administration to a patient a prescription drug, or over the counter medication which is not in substantial compliance with a physician's, dentist's, physician's assistant's, specialist's assistant's, or nurse practitioner's prescription;

5. Use, appropriation, misappropriation, by a custodian of a patient's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources. Examples included the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a patient's belongings or money.

Self-abuse: Self-inflicted injury not intended to result in death that results in serious injury or harm.

Adverse drug reaction: An unintended, unexpected, or excessive response of a patient to a medication that occurs at doses normally used in patients for prophylaxis, diagnosis or therapy of disease, or for the modification of physiologic function and which:

1. Results in transfer to an emergency room, admission to a medical facility, or a longer hospital stay;
2. Requires intervention to prevent permanent impairment;
3. Results in permanent disability;
4. Results in congenital anomaly (birth defect);
5. Is life threatening; or
6. Results in death.

Sexual assault: A sexual attack including but not limited to those that result in vaginal, anal, or oral penetration, i.e., rape or attempted rape and sodomy or attempted sodomy; and/or any sexual contact between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years of age or older and a person who is less than 17 years old, or which involves a patient who is deemed incapable of consent, and which occurs on program premises or when a patient involved in the event is under the actual or intended supervision of staff.

Sexual contact between children: Vaginal, anal, or oral penetration by patients under age 18 that occurs in a setting where the patient receives around-the clock care or on the premises of an outpatient program.

Suicide attempt: An act committed by a patient of a mental health provider in an effort to cause his or her

own death that occurs on program premises or when the patient was under the actual or intended supervision of a custodian.

Verbal aggression by patients: A sustained, repetitive action or pattern by a patient or patients of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another patient or patients, which causes serious injury or harm.

Wrongful conduct: Actions or inactions on the part of the custodian that are contrary to sound judgment or training and which are related to the provision of services, the safeguarding of patient health, safety or welfare, or patient rights, but which do not meet the definition of abuse or neglect.

Other incident: An event, not otherwise identified as an OMH Significant Incident, which has or creates a risk of, a serious adverse effect on the life, health, or safety of a patient.

OMH ONLY REPORTABLE INCIDENT DEFINITIONS **(not reportable to the Justice Center)**

The following are reportable only to OMH and not the Justice Center when they occur **off** the premises of the Licensed Certified program or when the individual was not under the intended actual supervision of a custodian

Crimes in the Community – an event which is, or appears to be a crime under New York State or Federal law, which is perceived to be a significant danger to the community or which involves a patient whose behavior poses an imminent concern to the community.

Missing Subject of AOT Order – a person subject to an Assisted Outpatient Treatment (AOT) order who fails to keep a scheduled appointment and/or cannot be located within a 24- hour period.

Suicide Attempt, Off Site – an act committed by a patient of a mental health provider in an effort to cause his or her death that occurs off program premises, when the patient was not under the actual or intended supervision of a custodian.

OMH DEATH REPORT

OMH Licensed or Operated Inpatient Units, Residential Programs, or Comprehensive Psychiatric Emergency Programs (CPEP) – Client deaths occurring in OMH licensed or operated Inpatient Units, residential Programs, or CPEP, must be reported to the Justice Center Death Reporting line at 1-855-373-2124. (See the Reporting of Deaths in OMH and OPWDD Certified Settings section in this policy for additional requirements.)

OMH Licensed or Operated Outpatient Programs – Client deaths occurring in an OMH licensed or operated outpatient program must be reported to OMH via NIMRS.

UNITY HOUSE INCIDENT DEFINITIONS:

Major Incidents

Hospitalizations **–** either medical or psychiatric admittances, not overnight admits for observation.

Police involvement – arrests whether as the perpetrator or the victim that do not fit under the reportable categories.

Motor vehicle accidents – based on level of severity/not covered in any other category.

Sensitive situations – situations that the agency may deem to be reviewable by the Incident Review Committee due to the potential for; aggressive behavior escalation; media involvement or community response that do not fall into any other category.

Minor Incidents

Emergency Room visits**-** (no admittance)

Police contact- (no arrests)

Medication error**-** (either by staff or individual that does not fall under the definition of a Significant Incident or Abuse/Neglect)

Medication refusal – each event should be documented. Exception: when a service recipient regularly refuses their prescribed medications and they will not schedule a doctor's appointment to have the medications discontinued or the physician will not discontinue the medication, the program Director, at their discretion, with permission from the department head, can attach a tracking log to a single Incident Report and report the refusals on a weekly basis until resolved.

Behaviors (Unusual / uncontrolled behavior of individual that does not meet the definition of a Major Non-Reportable Incident or an OMH or OPWDD Reportable Incident)

Injury – (does not require beyond first aid and incident does not come under the definitions of OPWDD or OMH reportable incidents)

Slip, trip, fall – (does not require beyond first aid)

Vehicle incidents/accidents – (Vehicle accidents that do not result in an injury to a service recipient or staff member are reported on in Unity House's Incident Review Committee)

Planned surgeries with/without planned hospitalization

OMH Only

- The Office of Mental Health shall be notified immediately, via the NIMRS system, of the death of a patient who was enrolled in or receiving services from an Outpatient OMH certified program at the time of the death, or whose death occurred within 30 days of discharge from the OMH certified program of the following.

- The following shall be reported to the coroner/medical examiner:

  a) the death of an OMH Participant from an apparent homicide, suicide or unexplained or accidental cause;

  or

  b) the death of an OMH Participant which is unrelated to the natural course of illness or disease;

  or

  c) the death of an OMH Participant which is related to the lack of treatment provided in accordance with generally accepted medical standards.

Reporting

1. Only Reportable Incidents (as defined in this policy) that occur in the agency's OMH Certified or Licensed Programs (as listed in this policy) are to be reported to the Justice Center's Vulnerable Person's Central Register (VPCR).
2. Reportable Incidents that occur in an OMH certified or licensed program are to be reported to the Justice Center's VPCR immediately upon occurrence or discovery at 1-855-373-2122.
3. Reports to the Justice Center's VPCR are made by the applicable Mandated Reporter (s). All Mandated Reporters who have knowledge of an incident must report an incident to the Justice Center. Exception: A Mandated Reporter may make a conscious decision not to report the incident when: (1) they have actual knowledge that a Mandated Reporter has already called the incident in to the Justice Center's VPCR; and (2) they have actual knowledge that the Mandated Reporter has named them in the Justice Center report. The individual may be asked to sign a Mandated Reporter Statement and the document will be maintained in the Incident working file.
4. The New York State (NYS) Office of Mental Health (OMH) is to be notified within 24 hours of Unity House being notified by the Justice Center of a certified program's Reportable Incident, via the New York State Incident Management System) NIMRS, the OMH electronic incident reporting

system. A report that has been accepted by the NYS Justice Center will appear in the NIMRS queue and must be imported into NIMRS.

INCIDENT REVIEW COMMITTEE

Unity Houses' Incident Review Committee (IRC), meets approximately every 45-days, no less than quarterly. The Compliance Officer is designated as the Chair of the Incident Review Committee, as appointed by the CEO, unless otherwise appointed. The Chair is responsible for ensuring that all Reportable Incidents, Significant Incidents, Deaths, and Major Incidents which occurred within the preceding month are recorded in the agenda and reviewed by the Committee. The Chair will ensure all Reportable, Significant and Serious Notable Incidents are reviewed by the Committee within one month of the incident date.

The IRC is tasked with reviewing Reportable Incidents, Significant Incidents; Reportable Incidents, Significant Incidents, and OMH Incidents as defined by OMH regulations, and Major incidents as defined by the agency in this policy. The committee is charged with ensuring that the necessary and appropriate corrective, preventative, remedial and/or disciplinary action has been taken to protect persons receiving services from further harm, to safeguard against the recurrence of similar Reportable Incidents and Notable Occurrences, and make written recommendations to the CEO to correct, improve, or remediate inconsistencies.

Additionally, in the review of incidents presented to the committee, the members are responsible for:

- determining if further investigation or additional recommendations are necessary.
- identifying trends in reportable incidents and making additional recommendations for corrective, preventative, remediation, or disciplinary actions.
- determining the adequacy of the agency 's implementation of appropriate recommendations for corrective, preventative, and remediation actions.

Findings and recommendations made by the committee will be reviewed during the next Incident Review Committee meeting date.

Corrective Action Plans (CAPs)

- Upon review of each incident, the Committee will make recommendations as to whether any proposed corrective actions are deemed appropriate or whether additional corrective actions are warranted.
- Any recommendations made by the committee for a corrective action must be documented in a CAP, the responsible party identified, the due date, and, where applicable, uploaded/entered into NIMRS.

- Any corrective actions indicated in a Justice Center investigative report must be reviewed by the Committee and either accepted or revised if the Committee disagrees with the actions and the reason must be indicated on the CAP.
- CAPS for Allegations of Abuse and Neglect must be completed and uploaded into NIMRS within 60 days of the date of the Letter of Determination.

Closing Incidents

Prior to closing an incident

- The incident must be fully resolved.
- An Allegation of Abuse or Neglect incident cannot be closed until the Justice Center Letter of Determination has been received and reviewed by the Committee. Additionally, in the case where the Justice Center has investigated the Allegation, the investigative report and findings must be reviewed by the Committee before it can be closed.
- Corrective Action Plans (CAPs) must be fully implemented.

Incident Review Committee Meeting Minutes

- Meeting minutes shall provide a thorough summary of the situation that caused the report to be generated, including date, time and location of occurrence, incident report numbers, incident findings, recommendations, if any, and actions taken on the part of the agency as a result of the recommendations.
- Meeting minutes shall be entered into the regulatory agency's NIMRS within 3 weeks of the IRC meeting date.
- Meeting minutes shall be kept electronically in a designated folder on the agency's server. Only committee members and the agency's CEO have access to meeting minutes. In the event that Incident Review meeting minutes need to be provided to a third party for informational purposes, all names and any other identifying information shall be redacted to ensure confidentiality.

Incident Review Committee Members

Unity Houses' Incident Review Committee members shall be approved by the agency's CEO. The makeup of the committee must include at least one member of the board governing body, at least two professional staff (licensed clinician, social worker, physician, psychologist, nurse, Behavioral Intervention Specialist) and others with a primary responsibility for developing and/or monitoring individuals' plan of care. At least one member must be a licensed healthcare practitioner (physician, Physician's Assistant, Nurse Practitioner,

Registered Nurse), at least one Direct Support Professional, at least one individual receiving services, at least one representative of advocacy organizations or family members of service recipients

There must be representation by someone with knowledge of the program or service within the agency where the incident under discussion occurred or someone familiar with the person(s) involved.

Any committee member who recognizes a potential conflict of interest with an incident under discussion, must report this to the committee and recuse themselves from participation in a review of the incident.

Members of the Committee must be trained in confidentiality laws and regulations.

Regulation Reference: 14 NYCRR Part 624, 14 NYCRR Part 625, 14 NYCRR Part 524, Chapter 501 of the Laws of 2012 ("Protection of People with Special Needs Act.")