SCOPE:

All individuals who receive supports and services authorized by a County Mental Retardation Program and/or who receive supports and services from licensed facilities are covered under this bulletin.

Anyone who receives funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from a County Mental Retardation Program and employees of facilities licensed by the Department of Public Welfare’s Office of Mental Retardation (OMR) are to report incidents as defined within this bulletin.

Following the processes outlined in this bulletin will satisfy the incident reporting requirements of Pennsylvania Code Title 55, Public Welfare for the following chapters:

- Chapter 20 – Licensure or Approval of Facilities and Agencies
- Chapter 2380 – Adult Training Facilities
- Chapter 2390 – Vocational Facilities
- Chapter 6400 – Community Homes for Individuals with Mental Retardation
- Chapter 6500 – Family Living Homes
- Chapter 6600 – Intermediate Care Facilities for Persons with Mental Retardation

PURPOSE:

This bulletin establishes processes that will protect the health and safety, enhance the dignity, and protect the rights of individuals receiving supports and services. The processes include uniform practices for:

- Timely and appropriate action in response to incidents.
- Reporting of incidents.
- Investigation of incidents.
- Corrective action in response to incidents.
- Analysis of individual and aggregate incident data.
- Making necessary changes to reduce risk of recurrence.
BACKGROUND:

All providers of mental retardation services and supports, including private and state-operated Intermediate Care Facilities for Persons with Mental Retardation (ICF’s/MR), County Mental Health and Mental Retardation Programs and OMR are partners in the effort to assure the health, safety and rights of persons receiving supports and services. Each reports certain incidents, collects information about those incidents and takes action based on those reports. The development and expansion of community-based supports and services and the increasing flexibility people enjoy to choose a wide variety of both traditional and non-traditional supports have increased the need to establish consistent statewide processes for reporting, investigating, analyzing trends to prevent the risk of recurrence and taking corrective action in response to incidents.

Services and supports provided through the mental retardation service system are designed to enable each individual to determine their own personal goals and to make decisions about the services and supports they receive. While respecting individual and family privacy concerns and the right to individual and family decision making in regard to services and supports, the public service system must ensure that safeguards are in place to protect the health, safety and rights of anyone receiving these services and supports.

DISCUSSION:

The incident management processes described in this bulletin are more than standardized reporting processes. The primary goal of an incident management system is to assure that when an incident occurs the response will be adequate to protect the health, safety and rights of the individual. This bulletin communicates clear and specific methodologies to assure appropriate responses at the provider, county and state levels. The standardization of reporting, the time frames for reporting, investigation and follow-up are key to conducting individual, provider, county-wide and state-wide analysis of incidents. The continuous review and analysis of reported incidents at the provider, county and state levels is aimed at uncovering trends and formulating action to prevent recurrence.

All reportable incidents are to be submitted electronically via a web-based system developed by OMR. The methodology for reporting incidents in the web-based system is documented in a user manual that will be available prior to the effective date of the bulletin.

The incident management processes described in this bulletin expect that investigations at the provider, county and state levels be conducted by certified investigators. This will assure that all incidents, which require investigation, receive a thorough investigation that meets established standards. A training program and certification process will be established by OMR.

This bulletin is applicable to individuals or families who are their own providers. Specific application is covered in Attachment I.

In addition to the OMR reporting processes described in this bulletin, reporting requirements of other laws, regulations and policies must also be followed. See Attachment II.
INCIDENT MANAGEMENT PROCESS

PROVIDERS ARE TO:

- Promote the health, safety, rights and dignity of individuals receiving services.
- Develop provider-specific policy/procedures for incident management.
- Ensure that staff and others associated with the individual have proper orientation and training to respond to, document and prevent incidents.
- Provide ongoing training to individuals and families on the recognition of abuse and neglect.
- Assure when incidents occur that affect a person’s health, safety or rights, that the people who are present:
  - Take prompt action to protect the person’s health, safety and rights. This includes separation of the target when the individual’s health and/or safety is jeopardized. This separation shall continue until an investigation is completed. In addition, the target shall not be permitted to work directly with any other service recipient during the investigation process. When the target is another individual receiving supports or services, and complete separation is not possible, the provider shall institute additional protections.
  - Notify the responsible person, designated in provider policy.
- Assign trained individual(s) “point person” to whom incidents are reported when they occur and who will make certain that all immediate steps to assure health and safety have been implemented and follow the incident through closure.
- Input data.
- Contact appropriate law enforcement agencies when there is suspicion that a crime has occurred.
- Comply with all applicable laws, regulations and policies.
- Conduct certified investigations.
- Analyze the quality of investigations.
- Respond to concerns from individuals/family about the reporting and investigation processes.
- Inform the family of the incident.
- Notify the family of the findings of any investigation.
- Maintain an investigation file within the agency.
- Create an incident management process which:
  - Designates an individual with overall responsibility for incident management.
  - Considers possible immediate and long-term effects to the individual resulting from an incident or multiple incidents.
  - Relies on trend analyses to identify systemic issues.
  - Analyzes and shares information with relevant staff, including direct care staff.
  - Analyzes the quality of investigations.
  - Periodically assesses the effectiveness of the incident management process.
  - Monitors quality and responsiveness of all ancillary services (such as health, therapies, etc.) and acts to change vendors or subcontractors, or assists the individual to file available grievances or appeals procedures to secure appropriate services.

1 Quality management policy/procedures (including incident management and risk management policies) must be submitted to OMR for approval in accordance with a forthcoming provider qualification process.
COUNTIES ARE TO:

- Promote the health, safety, rights and dignity of individuals receiving services.
- Develop county policies and procedures necessary to implement this bulletin and submit them to OMR for approval by the effective date of this bulletin.
- Have an administrative structure sufficient to meet mandates of this bulletin:
  - Designate an individual with overall responsibility for incident management.
  - Train staff in incident management procedures.
  - Assure that supports coordinators are notified of all incidents.
  - Assure that supports coordinators have proper orientation and training to respond to, document and prevent incidents.
  - Support providers with appropriate training and resources to meet the mandates of the bulletin.
- Provide ongoing training to individuals, families, guardians, and advocates regarding their rights, roles and responsibilities that are outlined in this bulletin.
- Provide training to individuals and families on the recognition of abuse and neglect.
- Have the Incident Management Processes in this bulletin referenced in county/provider contracts.
- Maintain an investigation file within the county.
- Create an incident management process which:
  - Assures accuracy of incident reports.
  - Reviews and closes all provider generated incidents.
  - Reviews and analyzes data.
  - Identifies and implements individual and systemic changes based on data analysis.
  - Analyzes and shares information with relevant staff.
  - Regularly reviews trend and occurrence data compiled by providers.
  - Assesses provider’s incident management and investigative processes.
  - Assures provider compliance with plans of correction resulting from incidents and investigations.
- Conduct certified investigations.
- Analyze the quality of investigations.
- Respond to concerns from individuals/family about the reporting and investigation processes.
- In collaboration with the individual’s planning team revise the individual’s plan as needed in response to issues surfaced through the incident management process.
- Comply with all applicable laws, regulations and policies.
- Coordinate with other agencies as necessary.
- Input data.
- In those instances where the county is the initial reporter of the incident the county will assume the responsibility of the point person.

THE OFFICE OF MENTAL RETARDATION IS TO:

- Promote the health, safety, rights and dignity of individuals receiving services.
- Develop a web-based electronic data management system.
- Create an incident management review process which:
  - Maintains the statewide data system.
  - Analyzes data for statewide trends and issues.
  - Identifies issues and initiates systemic changes and provides periodic feedback.
  - Evaluates county and provider reports and analysis of trends.
- Monitor implementation of this bulletin.
- Approve provider and county policies and procedures relative to incident management.
Support providers and counties with appropriate training to meet the mandate of the bulletin.
Certify investigators.
Provide support and technical assistance to counties to implement the incident reporting system.
Conduct certified investigations.
Analyze the quality of investigations.
Respond to concerns from individuals/families about the reporting and investigation processes.
Review and revise this bulletin as needed.
Assure compliance with all applicable laws, regulations and policies.
Coordinate with other agencies as necessary.

REPORTING:

Anyone who receives funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from the County Mental Retardation Program; and employees, subcontractors and volunteers of facilities licensed by the Department of Public Welfare, Office of Mental Retardation are to report incidents as defined within this bulletin to the county and OMR.

When providing services in the home of an individual or his/her family, providers, their employees or contracted agents are to report incidents that occur when they are present in the home. Additionally, providers, their employees or contracted agents are to report suspected or alleged abuse of which they become aware, regardless of whether they were providing services at the time the alleged abuse occurred. They also are to report the death of any individual to whom they are providing services. When an individual receives only case management services, the supports coordinator is to report incidents of suspected abuse and death whenever they learn of them.

All reportable incidents are to be submitted electronically via a web-based system approved by OMR. No contingencies have been made for submission of reportable incidents by any other means.
REPORTABLE INCIDENTS

- **Abuse** - The infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation.
- **Neglect** - The failure to obtain and/or provide the needed services and supports defined as necessary in the individual’s plan or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, attention and supervision, including leaving individuals unattended, personal hygiene, medical care, protection from health and safety hazards, and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.
- **Physical Abuse** – An intentional physical act by an individual, staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual. This also includes the improper or unauthorized use of restraint.
- **Psychological Abuse** – Acts, other than verbal, which may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual.
- **Sexual Abuse** – Acts or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Sexual contact between a staff person and an individual is abuse. Any sexual exposure of a staff person to an individual is also considered abusive.
- **Verbal Abuse** – Verbalizations which inflict or may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual.

- **Accident or injury requiring treatment beyond first aid** – Any accident or injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, etc. Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb, etc.

Treatment of an acute or chronic illness, or the assessment of a condition without treatment, by a medical or health professional is not reportable unless otherwise covered (i.e. the treatment is provided in an emergency room) except in those instances where the acute illness being treated is one of those contained on the list of reportable diseases published by the PA Department of Health. The Pennsylvania Department of Health List of Reportable Diseases is attached as Attachment III. An incident report is required only when the reportable disease is initially diagnosed. Incident reports are not required when an individual receives follow-up treatment of this illness unless the event is otherwise covered (i.e., the treatment is provided on an in-patient basis in a hospital). Evaluation/assessment of an injury by emergency personnel in response to a “911” call is reportable even if the individual is not transported to an Emergency Room.

- **Death** – All deaths are reportable.
• Emergency Closure – Any unplanned situation which forces the closure of a home or program facility for one or more days. This category does not apply to individuals who reside in the home of a family member.

• Emergency Room Visit – Any use of a hospital emergency room. This includes situations that are clearly “emergencies” as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP.

• Fire – Any fire or other situation that requires the active involvement of fire personnel, i.e., extinguishing a fire, clearing smoke from the premises, responding to a false alarm, etc. Situations which require the evacuation of a facility in response to suspected or actual gas leaks and/or carbon monoxide alarms are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable.

• Hospitalization – Any inpatient admission, excluding a psychiatric admission, to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.

• Law Enforcement Activity – The involvement of law enforcement personnel is reportable in the following situations:
  - an individual is charged with a crime or is the subject of a police investigation which may lead to criminal charges.
  - an individual is the victim of a crime, including crimes against the person or their property [vandalism, break-ins, harassment, etc].
  - an on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation.
  - a volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering.
  - crisis intervention involving police/law enforcement personnel.
  - agency staff cited for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle.

Minor traffic accidents that result in no injury are not reportable unless otherwise covered.

• Medication Error – Reportable medication errors include the following:
  • Wrong Medication - When an individual receives and takes medication that is not their medication. This includes medication intended for another person, discontinued medication, and inappropriately labeled medication.
  • Wrong Dose - When an individual receives the wrong dosage of medication.
  • Omission - When an individual does not receive a prescribed dose of medication. This includes medication that is not available because a prescription
has not been filled or if the medication is not available for any other reason. This does not include an individual refusing to take the medication.

- **Missing Person** – A person is considered missing when they are out of contact with staff for more than twenty-four (24) hours without prior arrangement or if they are in immediate jeopardy, when missing for any period of time. A person with good survival skills may be considered in “immediate jeopardy” based on his/her personal history and may be considered “missing” before twenty-four (24) hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual and/or the police independently find and return the individual, regardless of the amount of time he or she was missing.

- **Misuse of Funds** – Any intentional act or course of conduct, which results in the loss or misuse of an individual’s money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual’s plan of support is considered financial exploitation and is reportable. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.

- **Psychiatric Hospitalization** – Any inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation and/or treatment, whether voluntary or involuntary. This includes admissions for “23 – hour” observation and those for the review and/or adjustment of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors.

- **Restraints** – Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual’s body, including those that are approved as part of an individual’s plan or those used on an emergency basis. Note: improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category.
  - **Physical** – A physical, or manual restraint is a physical hands-on technique that last more than thirty (30) seconds, used to control acute, episodic behavior that restricts the movement or function of an individual’s body such as a basket hold and prone or supine containment.
  - **Mechanical** – A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual’s body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with fasteners, muffts and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices. A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as a wheelchair belt or helmet for prevention of injury during seizure activity are not considered mechanical restraints.
  - **Chemical** – A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual. A drug ordered by a
licensed physician as part of an on-going treatment program is not a chemical restraint. A drug ordered by a licensed physician for a specific, time-limited stressful event or situation to assist the individual to control the individual’s own behavior, is not a chemical restraint. A drug ordered by a licensed physician as pre-treatment prior to medical or dental examination or treatment is not a chemical restraint.

The documentation of restraint usage does not include the use of a protective device as defined within applicable regulations; use of a safety or support device designed to assure proper body positioning or balance, etc.; use of restraints authorized/ordered by a physician or dentist during the provision of medical/dental treatment by the medical practitioner, while an individual is hospitalized, or to prevent aggravation while an injury is healing.

- **Rights Violation** – Any act which is intended to improperly restrict or deny the human or civil rights of an individual, including those rights which are specifically mandated under applicable regulations. Examples would include the unauthorized removal of personal property, refusal of access to the telephone, privacy violations, breach of confidentiality, etc. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.

- **Suicide Attempt** – The intentional and voluntary attempt to take one’s own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats.

**SEQUENCE OF REPORTING**

Many real life occurrences may result in events that may be classified under multiple types of incidents. In an attempt to assist the point person in identifying an appropriate order for reporting incidents that may be classified under multiple categories, the following sequence is suggested. This sequence may not be appropriate in all situations but should be used as a guide in selecting the most appropriate category.

1. Death
2. Suicide Attempt
3. Hospitalization or Psychiatric Hospitalization
4. Emergency Room Visit
5. Neglect, Physical Abuse, Psychological Abuse, Sexual Abuse, or Verbal Abuse
6. Missing Person
7. Accident or Injury Requiring Treatment Beyond First Aid
8. Physical Restraint, Mechanical Restraint, or Chemical Restraint
9. Fire
10. Misuse of Funds
11. Rights Violation
12. Law Enforcement Activity
13. Medication Error
14. Emergency Closure
REPORTING PROCESS:

The following describes the method of reporting incidents by the provider, county and OMR.

INITIAL REPORTER

The initial reporter is the person on the scene who witnesses the incident or is the first to discover or be made aware of the signs of an incident. The initial reporter first responds to the situation by securing the safety of the individuals involved. As soon as the immediate needs of the persons have been met, the reporter notifies the provider point person of the incident, receives instructions on next steps to take and documents observations. In cases of alleged abuse or neglect, the initial reporter will comply with all applicable laws and regulations. Refer to Attachment 2: "Related Laws, Regulations, and Policies.”

POINT PERSON

A point person is a person authorized in policy to receive verbal reports of incidents, ensure that web-based reports are submitted, and communicate with others involved in the investigation, follow-up and review of the incident. This role is pivotal in the incident management process. When an incident is reported, the point person is to:

- First confirm that appropriate actions have been taken or order additional actions to secure the safety of the individual(s) involved in the incident.
- Assure notification requirements of the Older Adults Protective Services Act and Child Protective Services Law are met.
- Determine whether an investigation or other follow-up is needed.
- Secure the scene when an investigation is needed.
- Determine if an incident should be a site report or multiple individual reports.
- Assure that, when needed, an investigator is promptly assigned.
- Notify appropriate supervisory/management personnel within twenty-four (24) hours of the incident, as specified in provider or county internal policies.
- Initiate the web-based Initial Notification within twenty-four (24) hours.
- Notify the family within twenty-four (24) hours unless otherwise indicated by the individual.

\(^2\) As a general rule, the person who begins as point person should be the person who follows an incident through closure. However, there may be more than one point person identified by an agency.
STANDARDIZED INCIDENT REPORT

All Incident Reports are to be submitted electronically through a web-based system approved by OMR. This electronic system will conform to the three timeframes for submission specified in this bulletin. The three sections are:

- **Initial Notification:** Due within twenty-four (24) hours of the incident or within twenty-four (24) hours of when the provider learns of the incident.
- **Incident Report:** Due within five (5) days of the incident or of the date when the provider learns of the incident.
- **Final Report:** Due when the incident is finalized by the provider, with an outside limit of thirty days from the date of the incident or of the date the provider learns of the incident unless notification of an extension has been generated.

If the provider agency determines that he/she will not be able to meet the reporting timeframes of the Final Report, notification of the extension is to be made to the county and the Regional Office of OMR prior to the expiration of the thirty-day period.

INITIAL NOTIFICATION

The Initial Notification, which is due within twenty-four (24) hours of the incident or within twenty-four (24) hours of when the provider learns of the incident, is to include the following:

- Name of the individual involved/affected by the incident.
- Primary and secondary nature of the incident, based on the “Reportable Incidents” definition.
- Actions taken to address the incident.
- Current status of the individual.
- Date and time when the incident occurred or was recognized/discovered.
- Location where the incident occurred.
- Name and address of the provider agency or other person/entity submitting the initial notification.
- Name of the person making the initial report.
- Name of the point person who has assumed responsibility for follow-up of the incident.
- Determination of whether or not an investigation is needed.
- Home address of the individual.
- Individual’s date of birth.
- Individual’s Base Service Unit (BSU) number.
- Date and time of the initial notification.
- Description of the immediate and subsequent steps taken by the point person or other representatives of the provider to assure the individual’s health, safety and response to the incident, including date, time and by whom those steps were taken.

3 If the incident involves several individuals, all names and other identifying information may be submitted as part of a single “site” report.

4 If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.
Identification of all persons to whom the initial notification has been (or will be) submitted (i.e., family, law enforcement agency, etc.), the date and time and method (phone, fax, electronic, etc.) by which the notification has been made, and the person who has/will notify the necessary parties.

INCIDENT REPORT

The Incident Report, which is due within five (5) days of the incident or of the date when the provider learns of the incident will contain all of the information included on the Initial Notification and add:

- Indication if the Incident Report will be the Final Report.
- Current update on the individual’s status.
- Change of classification or additional information on the nature of the incident, if applicable.
- Narrative description of the incident completed by staff or other person(s) who were present when the incident occurred or who discovered that an incident had occurred.
- Identification of other persons who may have witnessed or been directly involved in the incident.
- Specific description of any injury received by the individual, including the cause, effect, and the body part involved.
- Specific signs and symptoms of any illness (acute or chronic), which may be contributory to the incident.
- If the incident involves an illness or injury, the name of the practitioner/facility by whom the individual was treated initially, the date and time of the initial contact with a health-care/medical practitioner, the nature/content of the initial treatment/evaluation, and the nature of, date of, time of, and practitioner involved in any subsequent treatments, evaluations, etc.
- If the individual has been hospitalized, the name and address of the hospital, the admitting diagnosis(es), the estimated (or actual) date of discharge and the discharge diagnosis(es).
- Background information on the individual, including level of mental retardation, pertinent medical history, diagnoses, etc.
- Name of the certified investigator assigned, if the incident requires investigation and the date on which the investigation began.
- If the incident involves an allegation of abuse, current status of the target of the investigation, if one has been identified.
- If the nature of the incident requires contact with local law enforcement, the name and department/office of the person(s) contacted, the date and time of the contact and the name of the person who initiated the contact and a description of any steps taken by law enforcement officials.

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5 The narrative description may be summarized by the provider but the written statements of the person(s) directly involved are to be available for review if needed.
The Final Report will be completed by the provider, within thirty days from the date of the incident or of the date the provider learns of the incident (unless notification of an extension has been generated). The Final Report will retain all of the preceding information from the Initial Notification and Incident Report and will add:

- Present status of the individual in reference to the incident.
- Summary of the investigator’s findings and conclusions.
- If the incident involves an allegation of some type of abuse/neglect, the conclusion reached on the basis of the investigation (i.e., the allegation is confirmed, not confirmed, inconclusive, etc.) and the status of the target.
- Description of the steps taken by the provider in response to the conclusions reached as a result of the investigation.
- Verification by the provider that all necessary corrective actions have been identified.
- If any corrective action cannot/has not been completed by the time the Final Report is submitted, the expected date of completion must be provided along with the identity of the person responsible for carrying the extended action through to completion.
- If the incident involves an injury of unknown origin, confirmation of the cause if one has been identified and steps taken to prevent recurrence.
- Description of any changes in the individual’s plan of support necessitated by or in response to the incident.
- If the individual was hospitalized, the Final Report must include an indication that the Hospital Discharge Summary was provided, a summary of its contents and a description of any plans for subsequent medical follow-up.
- If the individual is deceased, the Final Report is to be supplemented by a hard copy of the following:
  - Lifetime medical history (see Attachment II).
  - Copy of the Death Certificate.
  - Autopsy Report if one has been completed.
  - Discharge Summary from the final hospitalization if the individual died while hospitalized.
  - Results of the most recent physical examination.
  - Most recent Health and Medical assessments.
- Name and address of the family member notified of the results of the investigation.
- Date on which the incident was considered “finalized” by the provider and the name and title of the provider representative who made the finalization determination.

After final submission by the provider the county or OMR will perform a management review and close the incident.

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6 Documents, which are not immediately available, must be forwarded to the appropriate parties as they become available. If, after attempting to acquire the document it is determined to be unobtainable the expecting party will be notified.

7 An incident is “finalized” when the report is complete, investigation is complete, and all required follow-up has been identified. This should normally happen within thirty (30) days of the incident or first knowledge of the incident by the provider, unless an extension has been generated.
INVESTIGATION PROCESS:

Any reportable incident may be investigated by the provider, county and/or OMR. Certain designated incidents are to be investigated, either jointly or independently, by the provider, the county and/or OMR. All of these designated investigations are to be conducted by certified investigators. The involvement of the county and/or OMR shall not hinder the prompt investigation by the provider.

The following chart indicates which incidents are investigated by the provider, the county and/or OMR. This investigation process in no way precludes investigations by law enforcement agencies.

<table>
<thead>
<tr>
<th>INCIDENTS NEEDING INVESTIGATION</th>
<th>Provider</th>
<th>County or OMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental injury requiring hospitalization</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Unexplained injury requiring hospitalization or emergency room treatment</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Staff to individual injury requiring hospitalization or emergency room treatment or treatment beyond first aid</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Injury resulting from restraint requiring hospitalization or emergency room treatment or treatment beyond first aid</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Allegation or finding of abuse</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Allegation or finding of abuse involving improper or unauthorized use of restraint</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Rights Violation</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Misuse of funds</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Deaths of individuals who reside in provider-operated settings</td>
<td>Provider</td>
<td>County or OMR</td>
</tr>
<tr>
<td>Any reportable incident in which the CEO or Board of Directors of an organization is the target of the investigation, requires outside investigation.</td>
<td>County or OMR</td>
<td>County or OMR</td>
</tr>
</tbody>
</table>

Investigations are to be completed on a standardized investigation format and according to standard investigation procedures. Formats and procedures will be adopted by OMR for this purpose. Additionally, criteria will be developed by OMR regarding the scope and nature of death investigations.

The training and certification of personnel to conduct investigations will be provided for by OMR.

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8 When the family is the provider and is reimbursed for providing services, the county will assign a certified investigator to any incident requiring investigation. When the county is the provider, OMR will investigate those incidents that are designated to be investigated by the county. If the person is from out of state and has no county of registration, OMR will investigate those incidents that are designated to be investigated by the county. If the person resides in a state operated facility, OMR’s Bureau of State Operated Facilities will investigate those incidents that are designated to be investigated by the county.
When an incident requires investigation, the provider point person assures that a certified investigator is designated to conduct the investigation. The county/OMR may determine a need to conduct their own investigation following review of the provider investigation or based upon an analysis of incidents and trends.

CERTIFIED INVESTIGATORS

Certified investigators are people who have been trained according to OMR specifications and received a certificate in investigation from OMR. Providers, counties and OMR are to have certified investigators available to conduct investigations. To be a certified investigator a person must:

- Be a high school graduate.
- 21 years of age or older.
- Meet the criminal background requirements of the Older Adults Protective Services Act and the Child Protective Services Law.
- Successfully complete the training.

Training and testing will be required for certification as an investigator. Persons who have taken the course “Conducting Serious Incident Investigation” after October 1, 1998 offered by Labor Relations Alternatives, Inc. may apply to take a test to be certified without needing to retake the course. Only those who pass the test will be certified.

Certification is good for three years. At least once every three years certified investigators must participate in a refresher class to be recertified. Investigators must have conducted a minimum of three investigations since being certified. Certification may be withdrawn by OMR for cause.

INVESTIGATION PROTOCOL

OMR will establish a protocol for the conduct of investigations. At a minimum the investigation protocol will include a process for addressing conflict of interest, establishing the purpose of the investigation, interviewing, gathering evidence, weighing credibility and reporting findings and conclusions.

The investigation record includes the incident report, evidence, witness statements, and the certified investigator’s report. The investigation record is to be secured and separate from the individual’s record. A summary of the investigator’s report is to be entered into the standardized web-based incident report. Families and individuals are to be notified of the outcome of all investigations.
DATA AND INFORMATION ANALYSIS

PROVIDER ROLE

Trend analysis is one of the critical uses of the data which accumulate when incidents are reported and documented in a database. Trend analyses provide the agency, the county and OMR with insights into specific issues that cannot be gained from the review of individual reports. As part of an ongoing risk management/quality improvement process, the provider may choose to examine a different question and/or analyze a specific trend at regular intervals. Some suggested areas for trend analysis are listed below. This is not an all-inclusive list.

- The same things happening to the same individual(s) over a period of time.
- Different things happening to the same person over time.
- The same things happening across groups over time.
- Involvement of the same staff.
- Cluster of incidents that are outside the norm.
- Variations from the norm over time.
- Variables that impact on incidents.
- Impact of place, time, etc.
- Nature of injury.
- High occurrence by type (locked in vehicles, left at site unattended by para transit, etc.).
- Low or no reporting.
- Typical risk or atypical risk.
- Process analysis/time needed to bring closure.
- Causes of hospitalization (including psychiatric diagnoses).
- Causes of death (especially those that are sudden and unexpected).
- Positive findings after allegations.
- Impact of changes on subsequent rate of events.
- Comparison of staff vacancy rate with rate/type of incidents.
- Comparison of variables (turnover rate, use of overtime…).
- Average number of incidents per person supported (changes over time, locales…).
- Changes in rate of incidents as models of support change.
- Agency issues (increase in medication errors since… etc.).

The provider review process shall include review of all incident reports and investigation. Incident reports are to be reviewed individually to determine if provider action has been appropriate and sufficient. They are to be reviewed in aggregate to determine if trends may be developing that warrant further intervention for the individual or systemic intervention, beyond what may have been taken in response to the individual incident. The provider’s administrative responses may include, but not be limited to referral to the Health Care Quality Unit, revision of an individual plan or any other action necessary to promote the health, safety and rights of individuals served by the provider.

Using system generated data the provider completes and files quarterly reports with the county within thirty (30) days of the end of the calendar quarter that include:

- Incidents per month by individual and site.
- Summary comparisons to prior four quarters.
- Incidents requiring investigation by individual and site.
- Results of investigations (confirmed, unconfirmed and inconclusive).
- Actions to be taken in response to the conclusion/determination.
- Analysis of increases/decreases in numbers and types of incidents from previous quarter and previous year by individual, by location.
- Analysis of individuals with three or more incidents during the reporting period to detect patterns or connections.
- Analysis of significant factors that may influence the data.
- Qualitative analysis of investigations conducted.
- Analysis of the implementation of corrective actions during the reporting period.
- Discussion of special areas of concerns identified in the review process.

COUNTY ROLE

The county is to have procedures for the review and analysis of system generated data on all reported incidents. The procedures are to include at least quarterly reviews to determine what trends may be developing. The county is to report on incident data to OMR at least semi-annually on June 1st and December 1st of each year. The report to OMR includes at a minimum:

- Incidents by provider by quarter for the reporting period.
- Summary comparisons of provider data for the past four quarters.
- Incidents requiring investigation by provider.
- Incidents requiring investigation by the county.
- Analysis of increases/decreases in numbers and types of incidents from previous reporting period.
- Analysis of individuals with six or more incidents during the reporting period.
- Analysis of significant factors that may influence the data.
- Analysis of the implementation of corrective actions during the reporting period.
- Discussion of special areas of concerns identified in the review process.
- A mechanism to communicate the results of its analyses to the providers.
- Discussion of joint actions between the county and the provider to reduce incidents.
- Based on trend analysis, counties and HCQU’s jointly determine the need for technical assistance.

HEALTH CARE QUALITY UNIT RESPONSIBILITIES:

The HCQU shall have access to incident data from counties with whom they serve. The HCQU shall review data:

- Related to medication errors, emergency room visits, in-patient hospitalizations, suicide attempts deaths and other health related matters.
- To determine where trends suggest training, a change in procedures, or where medical supports are needed.
- Based on trend analysis, counties and HCQU’s jointly determine the need for technical assistance.
OMR RESPONSIBILITIES

OMR will review data on all reported incidents at least semi-annually to determine what trends may be developing statewide or by county and take appropriate administrative steps to intervene. OMR will issue an annual report reviewing statewide incident trends.

Obsolete Bulletin

Attachment I

FAMILIES

OMR joins families in concern about the health and safety of their relatives, who receive supports and services through its licensed and funded programs. This bulletin specifies the process for providers, counties and OMR to report and investigate incidents that jeopardize the health and safety of individuals receiving services. In addition to the requirements placed on those providing and overseeing services, OMR also relies on families to report incidents that may affect the family member’s health and safety.

This attachment to the bulletin provides an easy guide for families of individuals, who receive supports and services both out of home and in the family’s home.

Notification to Families

Family members of individuals, who receive services outside the family home, have a right to receive timely, accurate and complete information regarding their relative’s health and safety. Unless otherwise indicated by your family member receiving services outside the family home:

- You will be notified of any reportable incidents.
- You will be notified within twenty-four (24) hours of occurrence or when they are discovered.
- You will be notified of the outcome of any investigation when it is complete.

Notification of Incidents by Families

- If a family member observes or suspects abuse, neglect or any inappropriate conduct, whether services are provided out of the home or in the home, they should contact the county supports coordinator and may also contact OMR directly at 1-888-565-9435.
- In the event of a death the family is to notify the supports coordinator. The supports coordinator assumes the role of the point person as described in this bulletin.

When services are provided in the family’s home

An increasing number of individuals are supported in their own homes or the homes of their families. When services are provided in the home of an individual or his/her family:

- Provider employees or their contract agents are to report incidents involving the individual receiving services that occur when they are present in the home.
- Providers or their contract agents report possible abuse of which they become aware regardless of whether they are present at the time or whether it involves a paid caregiver.
- If the family observes inappropriate conduct, they should contact the supports coordinator to initiate an incident report or they may also contact OMR directly at 1-888-565-9435.

When a family reports questionable conduct that may constitute abuse, an investigation is to be conducted by a certified investigator. Families are encouraged to cooperate to assure fairness and accuracy of the report.
When the family is the provider of service

When a family member is the provider, i.e., is identified in the individual plan as the provider and is receiving remuneration, all incidents needing investigation by the provider (see page 14) are to be reported to the supports coordinator who will initiate an incident report.

In the event that the family provider is the target of an investigation, the family provider may request that the county assign a certified investigator, unrelated to the target, that is also a family member of a person with mental retardation.

When individuals and families purchase community services

Families and individuals may purchase services from community organizations and individual people who are not licensed or otherwise regulated by OMR, who have no contractual relationship with the county and who are therefore not covered by this bulletin. These include such entities as YM/WCAs, community recreational programs, adult education programs and clubs. If individuals or family members become aware of abuse or neglect involving such entities or organizations, a report of the incident is to be made to their supports coordinator or OMR at 1-888-565-9435.

Incidents involving children 18 and under

Any act of abuse or neglect which constitutes criminal conduct must be reported under the Child Protective Services Law, if applicable, and to local law enforcement. Families may contact their supports coordinator for assistance in making such reports.

Reporting Deaths

Death of a family member can be an emotionally trying time, and the sympathies of the people who are responsible to administer supports and services must be extended to family members at such times. Family members are to notify the Supports Coordinator of the death of an individual receiving services as soon as possible.
RELATED LAWS, REGULATIONS AND POLICIES

The requirements and expectations for incident management and reporting detailed in this bulletin are related to a variety of laws, regulations, and policies. The applicable licensing regulations (and facilities licensed under those regulations) include:

Related Laws:

- MH/MR Act of 1966
- Title XIX Social Security Act
- Neglect of Care – Dependent Persons [18 Pa. C.S.A. § 2713]
- The Child Protective Services Law [23 Pa. C.S.A. Chapter 63]
- The Older Adults Protective Services Act [35 Pa. C.S.A. § 10225]
- Early Intervention Services System Act [P.L. 1372, No. 212]

Pennsylvania Code Title 55. Public Welfare

- Chapter 20 – Licensure or Approval of Facilities and Agencies
- Chapter 2380 – Adult Training Facilities
- Chapter 2390 – Vocational Facilities
- Chapter 3490 – Protective Services
- Chapter 3800 – Child Residential & Day Treatment Facilities
- Chapter 6400 – Community Homes for Individuals with Mental Retardation
- Chapter 6500 – Family Living Homes
- Chapter 6600 – Intermediate Care Facilities for Persons with Mental Retardation

Related Policy Guidelines:

- Mental Retardation Bulletin 00 – 94 – 32 --- Assessments: Lifetime Medical History (effective December 6, 1994)

ADDITIONAL REPORTING:

In addition to the reporting methodologies described in this bulletin, the following is provided as a guide to assist in identifying additional reporting. This does not fully define, nor is it intended to substitute for, the applicable statutes and regulations.

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9 Chapter 20 applies only in so far as the licensed facility serves individuals covered within the scope of this bulletin.
Reportable incidents involving individuals who reside in facilities licensed as ICF/MRs (both state- and privately-operated) must be reported to the appropriate Regional Field Office of the PA Department of Health, Division of Intermediate Care Facilities.

Reportable incidents that occur in facilities licensed by OMR, involving individuals whose support needs are not funded through the Commonwealth or county mental retardation systems must be reported to whomever funds the individual’s support and to the Commonwealth/Regional Office of Mental Retardation. This includes individuals from other states, individuals who are funded by agencies not part of the mental retardation system and individuals whose support needs are privately funded.

**Neglect of Care – Dependent Persons [18 Pa. C.S.A. § 2713]**

The Neglect of Care – Dependent Persons Act (often referred to as **Acts 28 / 26**) covers individuals, 18 years of age or above, who, due to physical or cognitive disability or impairment, require assistance to meet their needs for food, shelter, clothing, personal care or health care. It extends to certain listed facilities and to home health services provided to care-dependent persons in their residence. The Act criminalizes intentional, knowing or reckless conduct by a caregiver which results in bodily injury or serious bodily injury to a care-dependent person by the failure to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person for whom the caregiver is responsible to provide care. A caregiver may also be prosecuted if he intentionally or knowingly uses a physical restraint or a chemical restraint or medication on a care-dependent person, or isolates that person, contrary to law or regulation with resulting bodily or serious bodily injury.

The only people **mandated** to report an alleged violation of the Act are personnel of the Pennsylvania Departments of Aging, Health and Public Welfare. However, as in any instance where a person has knowledge of a criminal act, any one aware of possible violations of the Act may make a report to the appropriate law enforcement authorities. The reporting requirements of this bulletin must be followed even if a report of a possible violation of this Act is made to law enforcement authorities. Copies of the Neglect of Care – Dependent Persons Acts were distributed via Mental Retardation Bulletin 00 – 95 – 25, effective December 26, 1995 and Mental Retardation Bulletin 00 – 97 – 06, effective August 29, 1997.

**The Child Protective Services Law [23 Pa. C.S.A. Chapter 63]**

The Child Protective Services Law establishes procedures for the reporting and investigation of alleged child abuse. Certain types of suspected child abuse must be reported to law enforcement officials for investigation of criminal offenses. Children under the age of 18 are covered by the Act, including those who receive supports and services from the mental retardation system. Providers covered within the scope of this bulletin are required to report alleged child abuse in accordance with the procedures established in the Child Protective Services Law (CPSL) and the Protective services Regulations. The CPSL defines child abuse as any of the following when committed upon a child under 18 years of age by a parent, household member, person responsible for a child's welfare or the significant other of a parent:
• Any act or failure to act occurring within the last two years that is a non-accidental serious physical injury.
• Any act or failure to act that causes serious mental injury or sexual abuse.
• Any act or failure to act occurring within the last two years that creates imminent risk of serious physical injury or sexual abuse.
• Serious physical neglect that endangers a child's life or development or impairs the child's functioning.

Reports of suspected abuse are received by the Department of Public Welfare's (DPW) ChildLine and Abuse Registry (800-932-0313), which is the central register for all investigated reports of abuse. Individuals who come into contact with children in the course of practicing their profession are required to report when they have reasonable cause to suspect that a child has been abused. Any person may report suspected abuse. The reporting, investigation and documentation requirements of this Mental Retardation Bulletin must also be followed when a report of suspected child abuse is made. It must be noted that the definition of abuse found in the CPSL differs greatly from the definition promulgated in this bulletin. Because of this difference it is possible that an allegation may be “unconfirmed” in terms of the CPSL but still substantiated with reference to these guidelines.

The Older Adults Protective Services Act [35 Pa. C.S.A. § 10225]

The Older Adults Protective Services Act (OAPSA) establishes specific requirements and procedures for the mandatory reporting of alleged abuse and the provision of protective services when needed for adults over age 60. Chapter 7 of the OAPSA (often referred to as Act 13) extends the mandatory reporting requirements of the Act to all care-dependent adults[10] (those over the age of 18) who reside or receive services in specified facilities, including home health agencies. Employees or administrators of a covered facility who have reasonable cause to suspect that an individual receiving care, services or treatment from the facility is a victim of abuse shall immediately make a report in compliance with the requirements detailed in the Act. All adults covered within the scope of this Mental Retardation Bulletin who are receiving care or services in a facility as defined in the OAPSA are also covered by the Act. Individuals and agencies who provide facility-based supports and services within the scope of this bulletin are required to follow the mandatory reporting requirements of the OAPSA when they have reasonable cause to suspect that a care-dependent adult is a victim of abuse or neglect as defined within the OAPSA. Compliance with the mandatory reporting requirements of the OAPSA is in addition to the reporting requirements established in this bulletin.

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10 Allegations of abuse or neglect involving children under 18 who reside in a facility that primarily serves adults must be reported to Child Line and Area Agency on Aging.
The following is provided as a guide to assist in identifying additional reporting. This does not fully define, nor is it intended to substitute for, the applicable statutes and regulations.

<table>
<thead>
<tr>
<th>Reportable Incident</th>
<th>Report to OMR</th>
<th>Report to County</th>
<th>Report to AAA</th>
<th>Report to ChildLine</th>
<th>PA Department of Aging</th>
<th>DOH</th>
<th>Local Law Enforcement</th>
<th>Acts 28/26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident or Injury requiring treatment beyond first aid</td>
<td>X</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Death</td>
<td>X</td>
<td>x</td>
<td>If suspicious</td>
<td>If suspicious</td>
<td>If suspicious</td>
<td></td>
<td></td>
<td>If the result of neglect</td>
</tr>
<tr>
<td>Emergency Closure</td>
<td>X</td>
<td>x</td>
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<tr>
<td>Emergency Room Visit</td>
<td>X</td>
<td>x</td>
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<tr>
<td>Fire</td>
<td>X</td>
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<tr>
<td>Hospitalization</td>
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<tr>
<td>Law Enforcement Activity</td>
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<tr>
<td>Medication Error</td>
<td>X</td>
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<tr>
<td>Missing Person</td>
<td>X</td>
<td>x</td>
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<td></td>
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<tr>
<td>Misuse of Funds</td>
<td>X</td>
<td>x</td>
<td>If exploitation of person over 60</td>
<td>If ICF/MR</td>
<td>If it appears that a crime has occurred</td>
<td>If ICF/MR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>X</td>
<td>x</td>
<td>If over 18</td>
<td>If under 18</td>
<td>If serious bodily injury or serious physical injury and over 18</td>
<td>If ICF/MR</td>
<td>If serious bodily injury or serious physical injury</td>
<td>If serious bodily injury</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>X</td>
<td>x</td>
<td>If over 18</td>
<td>If under 18</td>
<td>If serious bodily injury and over 18</td>
<td>If ICF/MR</td>
<td>If serious bodily injury or serious physical injury</td>
<td></td>
</tr>
<tr>
<td>Psychological Abuse</td>
<td>X</td>
<td>x</td>
<td>If over 18</td>
<td>If under 18</td>
<td>If ICF/MR</td>
<td></td>
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<tr>
<td>Restraints</td>
<td>X</td>
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<tr>
<td>Rights Violation</td>
<td>X</td>
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<tr>
<td>Sexual Abuse</td>
<td>X</td>
<td>x</td>
<td>If over 18</td>
<td>If under 18</td>
<td>If over 18</td>
<td>If ICF/MR</td>
<td></td>
<td>x</td>
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<tr>
<td>Suicide Attempt</td>
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<tr>
<td>Verbal Abuse</td>
<td>X</td>
<td>x</td>
<td>If over 18</td>
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</tr>
</tbody>
</table>

11 If an individual is not funded by OMR or by County MR services a report should be made to the funding agent.
12 Allegations of abuse or neglect involving children under 18 who reside in a facility that primarily serves adults must be reported to Child Line and Area Agency on Aging.
13 Allegations of abuse or neglect involving children under 18 who reside in a facility that primarily serves adults must be reported to Child Line and Area Agency on Aging.
14 Reporting under Acts 28/26 is only mandated for Commonwealth employees.
Pennsylvania Department of Health List of Reportable Diseases  
(PA Code, Title 28, Chapter 27)

1. AIDS (Acquired Immune Deficiency Syndrome).
2. Amebiasis.
3. Animal bite.
4. Anthrax.
5. Botulism.
7. Campylobacteriosis.
10. Cholera.
11. Diphtheria.
12. Encephalitis.
13. Food poisoning.
15. Gonococcal infections.
17. Haemophilus influenzae type b disease.
18. Hepatitis non-A non-B.
19. Hepatitis, viral, including Type A and B.
20. Histoplasmosis.
22. Legionnaires' disease.
23. Leptospirosis.
24. Lyme disease.
25. Lymphogranuloma venereum.
26. Malaria.
27. Measles.
28. Meningitis – all types.
29. Meningococcal disease.
30. Mumps.
31. Pertusis (whooping cough).
32. Plague.
33. Poliomyelitis.
34. Psittacosis (Ornithosis).
35. Rabies.
36. Reye’s syndrome.
37. Rickettsial diseases including Rocky Mountain Spotted Fever.
38. Rubella (German Measles) and congenital rubella syndrome.
40. Shigellosis.
41. Syphilis – all stages.
42. Tetanus.
43. Toxic shock syndrome.
44. Toxoplasmosis.
45. Trichinosis.
46. Tuberculosis – all forms.
47. Tularemia.
48. Typhoid.
49. Yellow Fever.

Please note that the list of legally reportable diseases in Pennsylvania is subject to change (work is in progress to modify the regulation to match more recent public health policy and science). Also, please note that certain broad categories such as #13 (“Food Poisoning”), and #28 (“Meningitis - all types”) should be construed to mean all such illnesses, even if the etiology is either not otherwise listed here, or a specific etiology cannot be determined. Similarly, acute Hepatitis C infections should be reported under the authority of #18 (“Hepatitis non-A non-B”), and Ehrlichiosis should be reported under the authority of #37 (“Rickettsial diseases”). Finally, note that local jurisdictions may require reports of additional conditions not listed here within their jurisdictions.

In addition to the diseases listed above, CDE requests the voluntary reporting of either laboratory identification of, or illness caused by the following pathological agents: (1) E. coli O157:H7 and other verotoxin-producing (enterohemorrhagic) E. coli, (2) Cryptosporidium, (3) Cyclospora, (4) Hantavirus, (5) Hemolytic uremic syndrome (a likely marker of infection with verotoxin-producing E. coli), (6) Invasive disease due to Group A Streptococcus (such as necrotizing fasciitis, but not pharyngitis) and (7) Listeria monocytogenes.
Victim’s Assistance Programs

When individuals are abused, neglected, injured or victims of crimes, there are resources to assist them physically, emotionally, financially and legally. Organizations have been developed based on the need to support victims through the criminal justice system, recognizing that victim’s needs are oftentimes overlooked. Individuals with disabilities who fall victim to crimes, especially physical violence and sexual assaults should be encouraged and assisted to access these resources. It is suggested that providers develop relationships with local entities and assist individuals in accessing such services when appropriate.

There are two main types of victim assistance programs: system and community-based organizations. System-based programs which generally operate out of a District Attorney’s office, provide notification to victims/witnesses of court proceedings. Community based programs are designed to provide support and assistance to victims. Usually, the programs fall under the categories of:

- Rape Crisis/Sexual Assault programs providing services to victims and their family/supporters. Domestic Violence programs provide counseling and temporary housing to victims, as needed.
- Crime Victim Services provide supports and assistance to victims of crimes excluding sexual assaults and domestic violence.

There are domestic violence centers, rape crisis centers and victim assistance offices throughout the Commonwealth. In order to locate the most appropriate resource for individuals, you may contact the following statewide organizations. Additional information regarding local resources are available through these organizations:

**PA Commission on Crime and Delinquency [PCCD]**
[717] 787-2040

**PA Coalition Against Rape [PCAR]**
[800] 692-7445
[717] 728-9740

**PA Coalition Against Domestic Violence [PCADV]**
[800] 932-4632

**Office of Victim Advocate [crime victim compensation]**
[717] 783-7501