Department of Developmental Disabilities

MUI RULE OAC 5123-17-02
INTERPRETIVE GUIDELINES

Major Unusual Incident (MUI) means the alleged, suspected or actual occurrence of an incident when there is reason to believe the incident occurred.

For individuals served by the developmental disabilities (DD) system or that will be served as a result of the incident, MUIs are filed in all cases of Death, Attempted Suicide, Missing Individual, Law Enforcement, Abuse, Neglect, Exploitation, Misappropriation, Prohibited Sexual Relations, Peer-to-Peer Acts and Failure to Report.

The following categories of MUIs are only filed when the incident occurs with a DD licensed or certified provider or in a county board operated program: Medical Emergency, Rights Code Violations, Significant Injury, Unapproved Behavioral Support, and Unanticipated Hospitalizations. Reports regarding all major unusual incidents involving an individual who resides in an intermediate care facility for individuals with intellectual disabilities or who receives round-the-clock waiver services will be filed and the requirements of this rule followed regardless of where the incident occurred.

Please note that examples are provided, but do not take into consideration every possible scenario. For questions, please contact your local county board or DODD at MUI.UNIT@dodd.ohio.gov or 614-995-3810.

Table of Contents

EMOTIONAL ABUSE

TYPE/DEFINITION

Emotional abuse means the use of actions, words, gestures, or other communicative means to purposefully threaten, coerce, intimidate, harass, or humiliate an individual or a pattern of behavior that creates a hostile environment.

PROMPTS

1. What specific words were used?
2. Were the words threatening, coercive, intimidating, harassing, or humiliating to the individual or did the pattern of behavior create a hostile environment?
3. What was the intent of the words, gestures or pattern of behaviors?
4. What was the individual's reaction to the words, gestures or pattern of behaviors?
5. Threatening words or pictures that are sent through communication means should be filed as a MUI.
6. There may be times when texting or sending messages through electronic means will rise to the level of menacing and law enforcement needs to be notified.

EXAMPLES

1. The individual alleges their father threatened to punch him if he did not do the dishes.
2. The Direct Support Professional (DSP) is upset with the individual and smacks the individual's hands down twice but there is not enough physical force to meet physical abuse criteria.
3. An individual is seen cleaning the stove repeatedly despite it already being clean. When asked, the individual says that the DSP said she must clean the stove every day for an hour, or she will be punished.
4. An employee who is on administrative leave due to an allegation made by an individual is now on Facebook stating, if she gets fired because of the lies the individual is saying, she is coming to the house and beating up the individual for lying. The individual is now reporting this DSP is texting and threatening her for telling on her.
5. Staff take an unflattering photo or video of an individual and posts it on social media (i.e. Facebook, Twitter, Instagram).
6. While being trained over several days, a new DSP observes a staff talking to and engaging with all of the individuals in the home, except one who attempts to talk to staff but is ignored. The training staff tells the new DSP in front of the individual that she can't stand the sound of the individual's voice, so she always ignores him and suggests the new DSP do the same.
7. The respite provider tells the individual, "If you don't go to bed right now, I'll kick your butt". The individual is agitated and is being verbally redirected. The individual starts spitting at provider. The respite provider is heard telling the individual if he spits at him one more time he will get knocked out.
8. The Home Manager sprays an individual in the face with water as a way to coerce them into getting out of bed and doing their chores.

EMOTIONAL ABUSE (continued)	9. While transporting individuals, a Non-medical transport (NMT) Driver constantly calls an individual the wrong name, laughing when the individual corrects him. When the individual becomes upset, the NMT Driver mimics the individual, and tells the other individuals to also call him the wrong name. 10. An individual is scared of the dark. The DSP turns the light off each night after the individual is in bed, causing them to cry. 11. The individual enjoys watching TV after dinner and reports that her partner turns the TV off and hides the remote from her every evening.
EXPLOITATION **TYPE/DEFINITION** The unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit, or gain.	**PROMPTS** 1. Is the individual or their resources used in some way for individual benefit, profit, or gain? 2. What are the resources? 3. Were the PPI's actions unlawful and/or improper? 4. How does exploitation differ from misappropriation in money related incidents? 5. Is the act in violation of Personal Funds rule or the agency's financial policies/procedures? 6. Was the individual a willing participant? 7. DSP allows an individual to purchase food or gas for their vehicle and the DSP borrows money on a regular basis, even if they pay the individual back a MUI would be filed as exploitation. 8. If the individual is believed to be a victim of Human Trafficking, and the PPI is a DD provider, please file as abuse and contact your Regional Manager. **EXAMPLES** 1. DSP on duty takes the individual to their home to watch the DSP's kids while the DSP sleeps with no compensation or agreement by the individual. 2. An unknown person misrepresents themselves on social media with promises of an intimate relationship to gain the individual's trust enough that the individual posts nude photos. 3. A family member takes an individual with them to a casino and uses the individual's money to gamble. 4. A neighbor purchases a new I-Pad from an individual for $25. A DD teacher's aide contacts parents who are served by the county board and mis-represents himself by informing them of his skills as a behavior support professional and respite provider. The aide uses persuasion to convince the parents to allow him to take their 12-year-old daughter to his home on multiple occasions, with no one else present. The child informs her parents of the aide's sexual behavior toward her.

EXPLOITATION (continued)	5. DSP is always talking about how poor she is and how she cannot afford to buy holiday presents for her grandchildren. The individual is very nice and gives the DSP $500 so she can buy presents for the kids. 6. A "friend" that the individual met online has him co-sign for a loan even though the individual doesn't understand what he is signing for. 7. A job coach takes an individual to their home and has him move furniture all day. The individual does not receive fair compensation and states he didn't want to be there. 8. The pastor of the church where the individual attends, has the individual clean the church for 6 hours and gives the individual a bottle of water and $.50 cents. 9. Individuals are asked to purchase Avon from the Home Manager, who is a sales consultant. 10. An individual is in the Ricky Martin Fan Club and a person posing as Ricky Martin asked the individual to purchase Amazon gift cards. The individual believes that he is going to become her boyfriend and sends him pictures of the gift card numbers.
FAILURE TO REPORT **TYPE/DEFINITION** Failure to report. "Failure to report" means that a developmental disabilities employee does not immediately report the alleged, suspected, or actual occurrence of an individual suffering or facing a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate emotional abuse, exploitation, misappropriation, neglect, physical abuse, or sexual abuse to the agency provider, county board, or department.	**PROMPTS** 1. May also be a criminal act that needs reported to law enforcement. 2. Registry: DD employee unreasonably failed to report and knew or should have known not reporting would result in a substantial risk of harm for the individual because the individual was placed in the situation again. 3. Was there continued risk to the individual as a result of staff failing to report? Those individuals required to report: a. An employee of the department; b. A superintendent, board member, or employee of a county board; c. An administrator, board member, or employee of a residential facility licensed under section 5123.19 of the Revised Code; d. An administrator, board member, or employee of any other public or private provider of services to an individual with a developmental disability; or e. An independent provider.

FAILURE TO REPORT (Continued)	**EXAMPLES** 1. An individual reports to his work supervisor that home staff keeps hitting his legs with a broom handle. Discoloration and red marks are noted on his calves. The work supervisor does not report the incident and the individual goes home after work. 2. Individual reports to her home DSP that workshop DSP punched her on the back of the head 3 times prior to departing on the bus. Home DSP does not believe it occurred and tells no one. 3. Individual goes to day program and tells DSP her roommate hits her and tells her she is going to beat her up when no one is around. DSP failed to report, leaving the individual at continued risk of harm. 4. Individual tells his new second shift DSP that a peer has been coming into his room at night and raping him. Individual asks the DSP to keep this confidential because he is embarrassed and is afraid to report this. He asks the DSP to keep his promise. The DSP goes home when their shift is over without reporting. 5. A staff reported during a training that an individual told her a week earlier that staff, Pat, has been hitting him with a belt at night when he refuses to go to bed. 6. An individual is meeting with her Service and Support Administrator (SSA). The SSA asks her why she has a black eye. The individual tells the SSA that her live-in boyfriend has been hurting her when he comes home from the bar drunk. The SSA leaves the individual's apartment and takes no immediate action to ensure her health and welfare and does not make a report to law enforcement.
MISAPPROPRIATION **TYPE/DEFINITON** Depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the Revised Code, or the Administrative Code.	**PROMPTS** 1. Was there intent to deprive or defraud or obtain the money/property of the individual? 2. Value of the item does not matter. 3. Length of time, if replaced, does not matter. 4. Were items or money taken from the individual? 5. Does the property belong to the individual? 6. The individual did not willingly give the money or property. 7. Is there reason to believe the money or item was taken? 8. Identity theft is to be filed as Misappropriation regardless if the individual is out funds. (taxes, utilities, loans). 9. Is it believed the item or money was taken?

MISAPPROPRIATION (continued)

PROMPTS

10. Misappropriation should not be filed when a purchase can be verified, but the receipt is missing.
11. If an individual is missing an iPad, check to see where else it might be. A misappropriation would be filed once it is believed the item was stolen.
12. Misappropriation is not filed when fraudulent billing occurred.
13. Was funds monitoring being provided according to the service plan?

EXAMPLES

1. The individual's bank account shows several unauthorized withdrawals.
2. The individual's certificates of deposit (CD's) are withdrawn/cashed without individual's knowledge.
3. Applying for EBT benefits using the individual's identification information.
4. Cash App or other money App attached to an individual's personal bank account that the DSP then uses to transfer money to their own Cash App/money App.
5. Using individual's money/bank accounts for delivery services for food (Postmates, DoorDash, Grubhub, etc.) or purchases from any online store (Amazon, Walmart, et.) for the DSP's benefit.
6. A friend uses the individual's ATM card to make unauthorized cash withdrawals.
7. An individual's brother is using the individual's identity to get utilities in his name.
8. DSP is seen taking four (4) pairs of jeans out of the individual's closet and placing them in her car.
9. There is $300 unaccounted for when balancing the checkbook. Receipts are missing, and the individual denies making any purchases; misappropriation is alleged.
10. Staff borrowed money (with individual's permission) and doesn't pay back.
11. Individual had dental surgery two days ago and was prescribed pain medication as needed. When DSP opens the pill-container they find only 2 pills left and there should be 8-10 pills in the container.
12. DSP assists the individual with purchasing multiple gift cards, so the individual can give them out as holiday presents . The gift cards are placed in the lock box and are missing when the individual goes to get them.
13. It was discovered someone used the individual's name and Social Security number to open a credit card account without the individual's knowledge and $2,100 was charged to the account.

NEGLECT

TYPE/DEFINITION

When there is a duty to do so, failing to provide an individual with a medical care, personal care, or other support that consequently results in death or serious injury or places an individual or another individual at risk of serious injury. Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner

PROMPTS

1. Does the person involved with the individual(s) have a duty to provide care and/or support that was not provided that resulted in serious injury or placed an individual or another person at risk of serious injury?
2. Does the person have a duty to provide care and it was not provided?
3. Was the service plan reviewed to identify the risk?
4. If the neglect is criminal, then law enforcement (LE) and CSB (for an individual under the age of 21) should be contacted.
5. Allegations of teeth issues that involve infection, and poor podiatry care that results in a health and welfare concern.
6. Was there a delay in medical care with serious risk of harm?

EXAMPLES

1. An individual diagnosed with a seizure disorder and is placed in a warm bath and is left alone in the bathroom while staff assists another individual in the home.
2. The bus driver failed to secure an individual's wheelchair on the bus and when the bus stops, the individual tips over.
3. The individual's diet requires all food to be cut into dime-sized pieces and the teacher gives the individual a slice of pizza.
4. An individual with a history of eloping is left alone in a vehicle.
5. The regular 3rd-shift DSP calls off to the on-call manager. The on-call supervisor did not secure coverage, and the 2nd shift DSP left although no one came to replace him. This places the individual(s) at risk of serious injury.
6. An individual with constant supervision for aggression against others is left alone in the living room with other housemates while staff takes an extended break outside the home, resulting in a risk of serious injury.
7. The transportation driver drops an individual off at home without ensuring the home staff is there to receive them. Due to severe medical conditions, this individual requires supervision and support at all times and places the individual at risk of serious injury.
8. DSP is texting (not hands free) while driving and gets in a car accident and the individual gets a concussion.
9. An individual had a change in their diet plan due to a recent swallow evaluation and the SSA failed to update the service plan and communicate to all service providers.
10. Staff do not implement the service plan and the individual is arrested or placed at risk of serious injury.
11. A doctor's office contacts the county board to report that an individual has lost 20 pounds in 6 months and that the individual is at risk of being hospitalized due to malnutrition.

PHYSICAL ABUSE

TYPE/DEFINITION

Means the use of physical force that can be reasonably expected to result in physical harm to an individual. Such physical force may include, but is not limited to, hitting, slapping, pushing, or throwing objects at an individual.

PROMPTS

1. Could the level of force have resulted in physical harm?
2. Physical harm or injury occurred regardless of its gravity or duration.
3. Law enforcement (LE) or Children Services is contacted when the situation is an alleged crime.

EXAMPLES

1. The care provider allegedly slaps the individual in the face. The individual's cheek is red immediately after the incident, but the redness disappears quickly.
2. DSP pulls the individual's arm behind the individual's back, dislocating the individual's shoulder.
3. DSP throws a wooden handle brush at the individual hitting the individual's forehead.
4. A neighbor is seen kicking an individual repeatedly in the back.
5. A janitor roughly pushes the individual against a locker, causing the individual to hit his head on the locker.
6. Teacher noted what appears to be cigarette burns on a 7-year-old individual's shoulder blades.
7. Individual, who is 23 years old, comes to the day program and reports that his mom, hit him on his hand with a large metal spoon. The individual states, "it hurt really bad", and the individual has some red marks on his knuckles.
8. Individual is walking home after getting off the bus when he is beat up by 3 young men who he has never seen before.
9. An individual alleges the DSP placed their knee in his back.
10. DSP throws a punch at the individual, the individual ducks the punch.
11. During a 2-person escort the individual turns his head toward the DSP and spits in his face. The DSP then takes the individual's arm and twists it behind his back and puts pressure on the arm. The individual yells out that his arm hurts and he is sorry. The co- worker assisting with the escort tells the DSP he needs to stop before he hurts the individual.
12. There is an altercation between a 14-year-old unserved - student at South High and a 15-year-old served student in the hallway. The 14-year-old is overheard calling the 15-year-old names and seen punching him in the face. The 15-year-old was heard repeatedly asking him to stop hurting him.

PROHIBITED SEXUAL RELATIONS **TYPE/DEFINITION** Prohibited sexual relations. "Prohibited sexual relations" means a developmental disabilities employee engaging in consensual sexual conduct or having consensual sexual contact with an individual who is not the developmental disabilities employee's spouse, and for whom the developmental disabilities employee was employed or under contract to provide care or supervise the provision of care at the time of the incident.	**PROMPTS** Is the employee working with the individual with developmental disabilities under contract to provide direct care or in a supervisory role overseeing the individual? Is it alleged that a DD employee has had sexual conduct or contact with an individual served? **EXAMPLES** 1. DSP observed a coworker with an individual in a passionate kiss. DSP reports they observed a coworker with an individual in a passionate kiss. The Individual reports that he is a willing and consenting participant in a sexual relationship with DSP. 2. An individual reports that he is planning to move in with his girlfriend, with whom he has been in a consensual sexual relationship for the past six months. The team discovers the girlfriend is a DSP who has provided direct supports to the individual for the last 3 years and during their relationship. 3. Individual's mom sees text from the independent provider to her son that says that she was happy they finally slept together but not to let anyone know.
RIGHTS CODE VIOLATION **TYPE/DEFINITION** Any violation of the rights enumerated in section 5123.62 of the Revised Code that creates a likely risk of harm to the health or welfare of an individual.	**PROMPTS** 1. Did the act create a likely risk of harm to the health or welfare of the individual? 2. Rights restrictions implemented without the Human Rights Committee (HRC) approval would be an UI unless there is risk to health and welfare. 3. Did the act result in a UBS? **EXAMPLES** 1. Staff padlocks the refrigerator, and the individual sustains a laceration trying to break the lock. 2. Respite staff refuses to take the individual on a scheduled activity for their own convenience or preference. The scheduled activity is a reinforcer for positive behavior. The individual is upset due to this right violation and becomes aggressive. Law enforcement is contacted, and the individual is arrested. 3. Teacher prevented an individual from leaving the room. The individual became aggressive and broke items around the house. 4. The Home Manager prevented an individual from using their game controller at their scheduled time, the individual began to hit themselves. 5. DSP refuses to take the individual to see their friend as promised. The individual later attempts to sneak out to see their friend and was hurt.

SEXUAL ABUSE **TYPE/DEFINITION** Unlawful sexual conduct or sexual contact as those terms are defined in section 2907.01 of the Revised Code and the commission of any act prohibited by Chapter 2907. of the Revised Code (e.g., public indecency, importuning, and voyeurism) when the sexual conduct, sexual contact, or act involves an individual.	**PROMPTS** 1. Contact involves touching of any erogenous zone of another, including without limitation to the thigh, genitals, buttocks, pubic region, or if the purpose of sexually arousing or gratifying either individual. 2. Conduct includes oral sex and penetration including digital or with objects. 3. Law enforcement or CSB shall be contacted. **EXAMPLES** 1. The DSP sends a picture of his penis through a text message to an individual. 2. DSP is masturbating in front of an individual. 3. An individual alleges DSP made the individual touch the roommate's "private area". While the DSP watched and touched himself. 4. It was reported a bus driver was witnessed stroking the thigh of an individual served who is 12 years old. The witness believes this was done for sexual arousal of the driver. 5. A job coach is reported to be fondling an individual's breast. 6. Individual reports her husband is forcing her to have sex. The husband is not served by DODD. 7. A female individual is reporting her mom's new boyfriend that lives with them has been touching her private areas when her mom is at work. She does not like to be alone with him due to how he looks at her and touches her. 8. Individual alleged they were raped by their cab driver last month.
UNEXPLAINED OR UNANTICIPATED DEATH **TYPE/DEFINITION** "Unexplained or unanticipated death" means the death of an individual resulting from an accident or that was otherwise unexpected.	**PROMPTS** 1. Was the death an accident? 2. Was the death not anticipated? **EXAMPLES** 1. An individual is hit by a car and pronounced dead at the scene. 2. An individual falls into a pool and drowns. 3. An individual chokes on a donut and is unable to be revived.
ATTEMPTED SUICIDE **TYPE/DEFINITION** A physical attempt by an individual resulting in emergency room treatment, inpatient observation, or hospital admission.	**PROMPTS** 1. Did the individual make an actual physical attempt that resulted in: a. In-patient observation b. Hospital admission c. Receives treatment at the ER. No harm is required. 2. When an individual has the will and means to commit suicide, this should be a red flag for the team and preventive measures need to be in place with extensive training for the DSP.

ATTEMPTED SUICIDE (continued)	**EXAMPLES** 1. After the individual states she is going to kill herself, she stabs herself with scissors and is hospitalized for a puncture wound. 2. The individual tries to hang himself and is admitted to the psychiatric hospital. 3. The individual jumps off a fire escape onto the paved road below after threatening to kill himself and is admitted to the hospital with a broken leg. 4. The individual takes a handful of pills to end their life and receives treatment at the emergency room (ER). 5. Individual takes a razor and tries to cut their wrist. She is taken to the ER where her injuries are treated.
DEATH other than UNEXPLAINED or UNANTICIPATED DEATH **TYPE/DEFINITION** Death other than unexplained or unanticipated death means the death of an individual by natural cause.	**PROMPTS** **Status A** Individual's whose residence was with entities under the jurisdiction of the Ohio Department of Health (ODH) for at least a month – includes nursing homes, skilled nursing and nursing facilities. 1. Copy of the death certificate /Autopsy /Coroner Report/Supp. Med. Cert. (was the coroner notified). 2. Location of death (e.g., emergency room, hospital inpatient, home, nursing home). 3. Whether the death was expected or unexpected. (DNR, Type, Date issued) 4. What DD services were the individual receiving? (Provide reason death was reported to DODD). **EXAMPLE (Status A):** 1. Jane had been permanently discharged to Sunny Acres Nursing Facility from her I/O Waiver Home and passed away in her room. **PROMPTS** **Status B** Cases involving children and adults who live at home and have access to health care or live in the community with no waiver or have less than 20 hours of services weekly**.** (Access to health care is defined as having access to a primary care physician or advanced practice nurse on some recurring basis--at least annually.) Note there is a statutory requirement (ORC 307.621) for all children less than 18 years of age to be reviewed by local counties. 1. Copy of the death certificate/Autopsy/Coroner Report/Supp. Med. Cert. (was the coroner notified) 2. Location of death (e.g. emergency room, hospital inpatient, home, nursing home).

DEATH other than UNEXPLAINED or UNANTICIPATED DEATH (continued)

3. Whether the death was expected or unexpected. (DNR, Type, Date issued)
4. What DD services was individual receiving?
5. Description of 72 hours prior to death or the hospitalization proceeding death (e.g. events, activities, behaviors).

EXAMPLES (Status B)

1. An infant that was medically fragile passed away and it was ruled a natural death.
2. An adult living with his sister passed away at home with family. He died from natural causes.

PROMPTS

Status C

Individual(s) who died of cancer or were in a hospice program at the time of death;

1. Copy of the death certificate/Autopsy/Coroner Report/Support Med. Cert (was the coroner notified).
2. Location of death (e.g. emergency room, hospital inpatient, home, nursing home).
3. Whether the death was expected or unexpected (DNR, Type, Date issued).
4. What DD services was the individual receiving?
5. Description of 72 hours prior to death or the hospitalization proceeding death (e.g. events, activities, behaviors).
6. If individual died while under the care of Hospice or died of cancer, please include pertinent past medical treatment, health care screenings, dates conducted and results, type of cancer, treatments or refusals and medical diagnosis for which they were placed in hospice care.

EXAMPLES (Status C)

Hospice Cases

1. An individual died under the care of hospice while living with his shared living provider.
2. An individual diagnosed with renal failure, died at home with his family while receiving palliative care.

Cancer Cases

1. An individual diagnosed with lung cancer passed away.
2. An individual diagnosed with metastatic breast cancer passed away.

DEATH OTHER THAN UNEXPLAINED or UNANTICIPATED DEATH (continued)	**PROMPTS** **Status D** 12 death questions (All other deaths not covered in the above categories): 1. Copy of the death certificate/Autopsy/Coroner Report/Supp. Med. Cert. (Was the coroner notified?). 2. Location of death (e.g. emergency room, hospital inpatient, home, nursing home). 3. Whether the death was expected or unexpected. (DNR, Type, Date issued). 4. What DD services was the individual receiving? 5. Description of 72 hours prior to death or the hospitalization proceeding death (e.g. events, activities, behaviors). 6. If the individual died while under the care of Hospice or died of cancer, please include pertinent past medical treatment, health care screenings, dates conducted and results, type of cancer, treatments or refusals and medical diagnosis for which they were placed in hospice care. 7. Law enforcement investigations. 8. Med/Psych Diagnosis prior to Death. Please list all diagnosis. 9. Medications (name, dosage, and how it was received) the individual was taking prior to Death or hospitalization if the death occurred during hospitalization. 10. Past Medical History. List previous illnesses, chronic medical problems, surgeries, medical treatments, most recent pneumonia and influenza vaccines and most recent height and weight 11. Name of Primary Physician 12. All Aspiration, Pneumonia, or Respiratory Failure Cases: Include the individual's diet texture, if it was followed, date of most recent swallow study and how the individual received their medications. **EXAMPLES (Status D)** 1. When the staff at the ICF went to wake the individual up for work, they noted that she had passed away in her sleep of what appeared to be natural causes. 2. An individual living in a group home, diagnosed with COPD died while being treated for influenza.
MEDICAL EMERGENCY **TYPE/DEFINITION** Medical emergency means an incident where emergency medical intervention by a developmental disabilities employee is required to save an individual's life (e.g.,	**PROMPTS** 1. Was the medical condition one of a sudden onset? 2. Were any emergency medical interventions given, such as abdominal thrusts, back blows, CPR, AED and/or Narcan administered by DD staff? 3. Was the emergency medical intervention a lifesaving technique that was necessary to prevent the likelihood of death?

MEDICAL EMERGENCY (continued) choking relief techniques, or cardiopulmonary resuscitation, use of an automated external defibrillator (AED), or administration of overdose reversal medication such as "Narcan").	4. Was the emergency medical intervention performed by a DD employee? **EXAMPLES** 1. The individual is on the bus traveling from the workshop to the residence and suffers an apparent heart attack; CPR is performed by the bus aide. 2. The individual chokes on a hotdog and the DSP performs abdominal thrusts to clear the airway. 3. The individual has overdosed, and Naloxone (Narcan) is required and administered by a DD staff. 4. An individual is eating potato chips and begins to choke. Staff administer back blows, and the food bolus is dislodged. 5. An individual went into cardiac arrest and the DSP administered the AED while the other DSP called 911.
MISSING INDIVIDUAL **TYPE/DEFINITION** Missing individual means law enforcement has been contacted because an individual's whereabouts are unknown and the individual is believed to be at or pose an imminent risk of harm to self or others.	**PROMPTS** 1. Was the individual receiving the required supervision at the time of the incident? 2. What is the imminent risk of harm to the individual or others? 3. Imminent risk examples for the individual and others could be a documented history of inappropriate sexual behavior, medication dependent, fragile health, Dementia, MH/Dual Diagnosis, History of Aggression, and/or poor pedestrian skills. 4. Are there other circumstances not included in the OISP that make immediate discovery of whereabouts of the individual critical to the health/safety of the individual? 5. Are there other risk factors including the location (i.e. proximity to a busy highway or large body of water, rural surroundings, etc.) and the weather. **EXAMPLES** 1. The individual is in the backyard sitting in a lawn chair. DSP is to check on him every 15 minutes, but he is now missing when he is checked on. Due to his lack of pedestrian skills, the individual is at imminent risk and the police are called to assist. 2. The individual is overdue for time sensitive medication administration critical to cardiac health problems. Staff call 911 for assistance. 3. During a winter storm, an individual leaves his home heading to work, despite a weather emergency having been issued. He does not arrive at his worksite after several hours and is not responding to cell phone calls. Police are contacted.

PEER-TO-PEER ACTS **TYPE/DEFINITION** One of the following incidents involving two individuals served.	**PROMPTS** 1. Was supervision being provided according to the service plan? 2. Any past, similar incidents with preventative measures?
PEER-TO-PEER EXPLOITATION **TYPE/DEFINITION** The unlawful or improper act of using another individual or individual's resources for monetary or personal benefit, profit, or gain.	**PROMPTS** 1. When one served individual takes advantage of a peer for their own personal benefit, profit or gain. 2. Was supervision being provided according to the service plan? 3. Was this a criminal act? 4. Did the individual understand the consequences of their actions? **EXAMPLES** 1. A peer knows his roommate always says, "yes" whenever he asks him a question. So, he asked if he could buy his handheld electronic game for a quarter and the roommate agrees. 2. A peer asks his housemate to complete his chores and he'll pay him $20. Once the chores are completed the peer refuses to pay him. 3. Individual asking a peer to send nude photos of themself to the individual's cell phone.
PEER-TO-PEER THEFT **TYPE/DEFINITION** Intentionally depriving another individual of real or personal property in the amount of valued at twenty dollars or more or property of significant personal value to the individual.	**PROMPTS** 1. Is the misappropriation amount $20.00 or more or is item considered of significant value to the individual? 2. Did the individual have intent to deprive and defraud? 3. Should the individual's history, actions, and knowledge of consequences result in notification to Law Enforcement? 4. Were supervision levels in place according to OISP? **EXAMPLES** 1. Individual knows the peer has $25 in their top right-hand dresser drawer. Individual takes the cash and hides it or spends it when they have alone time in the community. 2. Individual knows his roommate (peer) loves his LA Dodger baseball cap. Individual steals the hat and refuses to tell anyone where the hat is. This upsets the peer because they love that hat, and they wear it every day. This would be an allegation of theft, due to the hat having significant value for the owner and the peer is depriving the individual of the item. 3. Peer steals housemate's debit card and uses it to make online purchases in the amount of $50.

PEER-TO-PEER PHYSICAL ACT

TYPE/DEFINITION

Physical act which means a physical altercation that:

a. Results in examination or treatment by a physician, physician assistant, or nurse practitioner; or
b. Involves strangulation, a bloody nose, a bloody lip, a black eye, a concussion, or biting which causes breaking of the skin; or
c. Results in an individual being arrested, incarcerated, or the subject of criminal charges.

PROMPTS

1. Strangulation: pressure around front of neck to restrict air flow.
2. Please note an individual has the right to notify law enforcement and to file charges against a peer even when the county board does not feel it is criminal.
3. Peer-to-Peer Act does not have a PPI or a victim. It is an act that occurs between two individuals served. Immediate action, cause and contributing factors and a prevention plan should be the result of the MUI investigation.
4. Does the county board feel that this is an alleged crime? Alleged Crimes must be reported to law enforcement.
5. Was supervision being provided according to the service plan?
6. Was there intent to harm? Does the individual understand their actions and consequences?
7. What, if any, was the precursor to the incident?

EXAMPLES

1. The individual is asked to leave his bedroom due to the fire drill. He is very upset and hits 3 peers while exiting and one of the peers gets a bloody lip.
2. An individual is teasing a peer. The peer tells the individual to stop it, or he will be sorry. Teasing continues, the peer gets up and starts strangling the individual.
3. An individual is taken to the emergency room to be checked out based a peer-to-peer physical act (i.e. hit to head-possible concussion) and concerns for the Individual's health.
4. Two male individuals get into an argument at the workshop. Individual A pushes Individual B. Individual B punches Individual A in the nose causing it to bleed.
5. Individual is agitated and is running through the workshop; an individual is in his path, so he pushes her to the floor. The female individual is taken to the hospital and diagnosed with a broken hip.
6. Individual has been telling peers that he plans to beat up a male peer because he has seen him talking to his girlfriend. The individual has a known history of being aggressive towards others. A few days later the peer is found in the bathroom with a black eye and claims that a peer did this to him. This could be filed as a peer-to-peer act and reviewed as a possible crime that law enforcement notification would be needed.
7. Individual strangled his roommate.
8. Individual reaches in front of a peer who bites him on the arm, causing an open wound.
9. Individual is pushed down by a peer and hits his head extremely hard. There are no visible injuries noted but the individual is taken to the doctor to get checked out.

PEER-TO-PEER SEXUAL ACT **TYPE/DEFINITION** Sexual conduct and/or contact for sexual gratification without the consent of the other individual.	**PROMPTS** 1. Was the supervision an issue related to the incident. 2. Is the sexual act consensual? 3. Is the sexual conduct or contact for sexual gratification? **EXAMPLES** 1. Individual touches a female peer on the breast more than once even though the peer is asking him not to. The individual tells her he likes her, and she is pretty. 2. DSP walks in on two individuals in the workshop restroom in the same stall. One of the individuals does not communicate verbally and appears to be very upset while the other individual has his hand down his pants. Both are to be supervised in the restroom [Neglect may also be filed]. 3. There is a married couple who are both receiving waiver services. The wife reports that her husband forced her to have sex yesterday. 4. While an individual is sleeping a peer rubs the individual's feet while he masturbates. 5. While riding to their community jobs, one peer leans over and kisses the other on the mouth. The other individual tells him to stop, but he does not and forcefully kisses her again which makes the individual cry.
SIGNIFICANT INJURY **TYPE/DEFINITION** Significant injury means an injury to an individual of known cause or unknown cause that results in a dental injury that requires treatment by a dentist, concussion, broken bone, dislocation, or second or third degree burns or that requires immobilization, casting, or five or more sutures. A significant injury will be designated in the Ohio incident tracking and monitoring system as either known cause or unknown cause.	**PROMPTS** 1. Results in injuries requiring a total of 5 or more sutures or staples. Broken bones, regardless of treatment, dislocation, serious burns, concussion from an injury or any other serious injury. 2. Injury that requires immobilization or casting. 3. Dental Injury (chipped or fractured teeth, knocked out tooth caused by fall and/or possible abuse) that results from a fall that requires treatment from a dentist. 4. Was the individual receiving DD supports/services at the time of the incident? **EXAMPLES** 1. The individual sustains a laceration on the left arm that requires 5 stitches and the cause of the laceration is unknown. 2. The individual states he fell down the basement stairs and broke his toe. 3. The individual sustains a large 2nd degree burn on her neck from using a curling iron. The burn is treated by a physician. 4. The individual sustains a laceration to the head requiring 5 stiches for closure and resulted from a fall observed by DSP.

SIGNIFICANT INJURY (continued)	5. The individual sprains her ankle while playing basketball; a soft cast is put on for immobilization and individual is ordered by the doctor to stay off foot for 5-7 days. 6. An individual walks fast to get into the swimming pool and slips on the wet surface. The individual falls to the ground and hits his face on the pavement. The individual has his two front teeth knocked out. The DSP puts the teeth in milk and transports the individual to the dentist for medical treatment.
LAW ENFORCEMENT **TYPE/DEFINITION** Any incident means any incident that results in an individual being tased, arrested, charged, or incarcerated.	**PROMPTS** Appendix C Administrative Review 1. Was the individual, charged, incarcerated or arrested? [CIA] 2. Needs to be filed whether individual is with a provider or not. 3. Probation violations are Unusual Incidents. **EXAMPLES** 1. Individual is arrested for shoplifting when he stole sunglasses while grocery shopping. 2. DSP learns that an individual was arrested for dealing drugs in his neighborhood while DSP was not present. 3. Individual receiving limited services tells his SSA he was charged with public intoxication and needs to see the Judge next Tuesday. 4. Police show up to an individual's home and while there, tase the individual. The police never charge, incarcerate or arrest the individual and then leave. This should be filed as a law enforcement MUI based on the seriousness of the incident, risk to individual and involvement by law enforcement. 5. An SSA discovers that a juvenile served was transported to a juvenile detention center over the weekend. The child's mother reports that the child was charged with Domestic Violence after hitting and kicking her. Law Enforcement came to the home which led to the child's arrest.
UNANTICIPATED HOSPITALIZATION **TYPE/DEFINITION** Unanticipated hospitalization means; A. A hospital admission lasting forty-eight hours or longer that: i. Is not associated with planned evaluations, scheduled procedures, or routine diagnostic tests that are part of ongoing medical care, including the diagnosis of conditions; and	**PROMPTS** Appendix D Administrative Review 1. Was the individual admitted to the hospital for 48 hours or more and was admitted for one or more of the following diagnoses: (A) Aspiration pneumonia; (B) Bowel obstruction; (C) Dehydration; (D) Medication error; (E) Seizures; or (F) Sepsis

UNANTICIPATED HOSPITALIZATION
(continued)

ii. following diagnoses:
   a. Aspiration pneumonia;
   b. Bowel obstruction;
   c. Dehydration;
   d. Medication error;
   e. Seizure; or
   f. Sepsis

B. Hospital re-admission lasting forty-eight hours or longer that:
   i. Is not associated with planned evaluations, scheduled procedures, or routine diagnostic tests that are part of ongoing medical care, including the diagnosis of conditions; and
   ii. Is due to any diagnosis that is the same diagnosis as a prior hospital admission lasting forty-eight hours or longer within the past thirty calendar days.

2. Was the admission associated with planned evaluations, scheduled procedures, or routine diagnostic tests that are part of ongoing medical care, including the diagnosis of conditions?
3. Was the individual re-admitted for 48 hours or longer due to ANY diagnosis that is the same diagnosis as a prior hospital admission lasting forty-eight hours or longer within the past thirty calendar days.

EXAMPLES

1. An individual is re-admitted to the hospital with a diagnosis of bacterial pneumonia and it's the second hospital admittance with the same diagnosis, lasting over 48 hours that occurred within 30 calendar days.
2. An individual is admitted for a psychiatric hospitalization for suicidal ideation after being discharged 2 weeks before with the same admitting diagnosis.
3. An individual is hospitalized for 48 hours for difficulty breathing and was diagnosed with COPD. Within 30 calendar days she was re-admitted to the hospital for the treatment of COPD.
4. Janet is hospitalized for over 48 hours due to seizures. Her OhioISP describes that she has epilepsy and is regularly seen by a neurologist.
5. Jim was hospitalized for 3 days due to hallucinations and threatening to harm himself. After being discharged, he was readmitted two weeks later for another week due to a recurrence of self-harm and ongoing hallucinations.
6. Jose is admitted to the hospital for 4 days due to a bowel obstruction.

UNAPPROVED BEHAVIORAL SUPPORT

TYPE/DEFINITION

Unapproved behavioral support" means the use by a developmental disabilities employee of a prohibited measure as defined in rule 5123:2-2-06 of the Administrative Code or the use of a restrictive measure implemented without approval of the human rights committee or without informed consent of the individual or the individual's guardian in accordance with rule 5123:2-2-06 of the Administrative Code, when use of the prohibited measure or restrictive measure results in risk to the individual's health or

PROMPTS

Appendix E Administrative Review

1. Physical restraint without HRC approval.
2. The restrictive measure was implemented by a developmental disabilities employee.
3. If a crisis restraint is used, the investigation should have documentation to show the DSP was trained on the crisis restraint used.
4. Any restraint in a prone (face down) position is considered an Unapproved Behavioral Support (UBS).
5. If the individual is in a supine restraint that is not an HRC approved restraint and rolls to their stomach and the staff immediately stop holding the individual, this would not be considered a prone restraint but is a UBS.
6. Medication given at the request of the physician for a medical appointment is not considered a MUI.

UNAPPROVED BEHAVIORAL SUPPORT
(continued)

TYPE/DEFINITION

welfare. When use of the prohibited measure or restrictive measure does not result in risk to the individual's health or welfare, the incident will be investigated as an unusual incident.

7. If the seatbelt is worn for protection or to provide support for upper body control/movement, etc., a MUI is not required to be filed. If the seatbelt is worn to keep the individual from getting up and moving around the bus during the trip, then a MUI is required to be filed (if it is not addressed in the plan and properly approved).
8. If the family member initiates the restraint when he/she is being paid to provide services, then the incident should be reported just as any other Unapproved Behavioral Support with a paid provider.
9. It is not a MUI if an Unapproved Behavioral Support is implemented by a family member; however, if the incident rises to the level of abuse or neglect, it is required to be reported.
10. Hand-over-hand assistance and guiding is considered prompting and would not be reported as a MUI; however, the prompting should be addressed in the individual's plan.

EXAMPLES

1. An individual is upset and aggressive but agrees to go to his bedroom. DSP stands in front of bedroom door and when the individual tries to leave his room, the DSP physically bumps into the individual, stands in front of or uses physical redirection back into the room would be filed as an Unapproved Behavior Support.
2. The individual's arms are strapped to a wheelchair on the bus to stop the individual from grabbing others' hair during a bus ride.
3. An individual is running toward the street when the DSP tackles him before he gets there in order to save his life.
4. An individual is trying to hit himself in the head with his fists and the DSP grabs his wrists to stop him.
5. An individual continuously leaves the home and walks down the street unattended. During one of the elopements the staff implements a physical restraint to guide the individual safely back into the home.
6. An individual is angry and physically attacking his housemate. Two staff respond with a seated assist. The individual lays and the ground as staff hold his arms and legs. The individual rolls to their stomach, in a prone restraint. Staff immediately release the hold.

UI EXAMPLES

1. Redirection can occur without a restraint occurring. Examples: Brief Hands Down without resistance, hair releases used without force, blocks, if the DSP briefly holds the hand of the individual with no resistance this can be investigated as a UI.

UNAPPROVED BEHAVIORAL SUPPORT (continued)	2. If an individual is afraid of needles and must get a shot and they ask the DSP to help them. It is an UI if the individual has chosen to have the DSP help hold them during a medical procedure.
SYSTEMS ISSUE **DEFINITION** Systems Issue means underlying circumstances (such as the physical environment, staffing levels, training provided to staff or supervisors, supervisory support for staff, previous awareness of a potential event, adequacy of processes and procedures, or availability of resources and equipment) beyond the action or inaction of the primary individual involved in a substantiated major unusual incident of neglect that contributed to the situation or outcome.	**PROMPTS** 1. What specific reason(s) is being used to determine a Systems finding of neglect instead of an identified PPI? 2. If the staff involved in the incident were replaced with new staff and no other changes were made, could the incident continue to occur, or the individual continue to be at risk? 3. Were there multiple factors involving training, oversight, monitoring, or service provision involved in the incident? **EXAMPLES** 1. An individual who is diagnosed with dysphasia and incidents of choking, choked on food and PPI/DSP was not trained on the individual's dietary restrictions/guidelines. 2. An individual left his home and was hit by a car. Assigned DSP had worked 14 consecutive hours providing one on one staff supervision, per individuals guidelines due to elopement, and had fallen asleep. 3. Non-ambulatory individual fell breaking his pelvis, while being assisted by a DSP from his wheelchair to the shower chair. Two months previous, based on the individual's deteriorating physical abilities, the PT had requested that a Hoyer lift be utilized for all transfers. The Hoyer lift was ordered but had not arrived yet. 4. For several days, multiple staff note in documentation that an individual was not eating well, was not engaged in daily activities, and charting on urination and bowel movement indicates he had little output. Nursing is not notified of these symptoms, and there is no requirement for anyone to review the daily documentation completed by staff.
UNUSUAL INCIDENTS **TYPE/DEFINITION** Unusual incidents mean an event or occurrence involving an individual that is not consistent with routine operations, policies and procedures, or the individual service plan, but is not a major unusual incident. "Unusual incident" includes but is not limited to the events and occurrences described in appendix F to this rule.	**PROMPT** 1. A Program Implementation incident involves minimal or no risk. **EXAMPLES (Appendix F)** 1. Dental injury that does not require treatment by a dentist. 2. Fall. 3. An injury that is not a significant injury. 4. Medication error without a likely risk to health and welfare. 5. Overnight relocation of an individual due to a fire, natural disaster, or mechanical failure.

UNUSUAL INCIDENTS (continued)

PROGRAM IMPLEMENTATION INCIDENT means an unusual incident involving the failure to carry out an individual-centered plan when such failure causes minimal risk or no risk.

Examples include, but are not limited to, failing to provide supervision for short periods of time, automobile accidents without harm, and self-reported incidents with minimal risk.

6. An incident involving two individuals served that is not a peer-to-peer act major unusual incident but does involve:
   a. A physical altercation; or
   b. The use of actions, words, gestures, or other communicative means to purposefully threaten, coerce, or intimidate when there is the opportunity and ability to carry out the threat.
7. Rights code violation or unapproved behavioral support without a likely risk to health and welfare.
8. Emergency room or urgent care treatment center visit.
9. An unplanned hospital admission or hospital stay that is not a major unusual incident as defined in paragraph (C)(16)(c)(ii) of this rule.
10. A situation where an individual's whereabouts is unknown for longer than the period of time specified in the individual service plan that does not result in imminent risk of harm to the individual or others and is not a major unusual incident as defined in paragraph (C)(16)(b)(iv) or (C)(16)(c)(i) of this rule.
11. Program implementation incident.

PROGRAM IMPLEMENTATION EXAMPLES

1. An individual with 20 minutes of alone time in the community demands his day program staff take him to McDonalds to purchase cheeseburgers. The staff cannot leave to take him, so he elopes and is gone more than 20 minutes. The staff call the police per his ISP. The individual is returned to the program by a transportation driver who spotted him walking when returning from dropping off first shift individuals. The individual is back at the program before police arrive.
2. An individual is riding in a car driven by staff. The individual tried to open the car door while the vehicle is moving. The staff engages the child safety locks to prevent the individual from opening the door.
3. An individual with severe intellectual disability has gone back into his bedroom and gone back to bed/sleep is left behind when staff transport housemates on an outing in the morning. The staff realize he is missing 5 minutes down the road and turn around to get him. The staff find him sound asleep. The individual has no alone time at home or in the community and cannot protect himself should there be an emergency situation in the home.
4. An individual is dropped off at home with no staff present. The individual uses his key and enters the home. The individual is home alone for an hour. There is no known risk to the individual.
5. An individual is angry and grabs the steering wheel while staff is driving in a parking lot. The staff hits a parked car. No one is injured. Staff is cited for hitting the car.

UNUSUAL INCIDENTS (continued)	6. An individual with eyes on supervision walks away from staff while they are paying for groceries. The individual makes it to the front door before staff catches up to them. 7. An individual with no history of skin breakdown is found to be in a soiled undergarment when the 1st shift staff arrive at the home. 8. An individual's staff is there to provide overnight support in case he has a seizure. The staff self-reported she fell asleep for 10 minutes. John was checked on and fine. He suffered no adverse effects. 9. An agency staff was involved in a minor car accident while transporting 2 individuals. Staff was cited for failing to assure clear distance. No one was harmed. 10. An individual was admitted to the hospital for an emergency appendectomy. 11. An individual was admitted to the hospital for one night for psychiatric stabilization.