OMH Incident ManagementGuide

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OMH Bureau of Quality Improvement

NYS Office of Mental Health
Incident Management Guide

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I. General Background

a. Purpose

The Protection of People with Special Needs Act, or PPSNA (Chapter 501 of the Laws of 2012) created the Justice Center for the Protection of People with Special Needs ("Justice Center"). The Justice Center is a State agency charged with the responsibility to track and prevent, as well as investigate and prosecute, reports of abuse and neglect of persons with disabilities or special needs (i.e., "vulnerable persons"). The PPSNA created a set of consistent safeguards for vulnerable persons served by systems under the jurisdiction of 6 State agencies, including the Office of Mental Health (OMH), to protect them against abuse, neglect, and other dangerous conduct, to aggressively investigate and address instances of neglect and abuse, and to provide fair treatment to employees upon whom vulnerable persons depend for their care.

In accordance with PPSNA requirements, OMH has promulgated regulations outlining incident management requirements for State operated and licensed providers under its jurisdiction. The purpose of this document is to provide guidance with respect to implementing these requirements. It includes definitions for reportable incidents and describes the steps for reporting to the Justice Center and OMH through the Vulnerable Persons Central Register (VPCR) hotline and the New York State Incident Management & Reporting System (NIMRS). This guidance is based on recent amendments to the 14 NYCRR Part 524 regulations which aim to clarify incident reporting requirements for OMH and the Justice Center. Some important highlights to note include:

- The list of "Significant Incidents" reportable to both OMH and the Justice Center has been updated to include only incidents that ***occur on program premises*** or ***when a vulnerable person is under the actual or intended supervision of the program***. As a result of this change, some incidents that previously had to be reported are no longer reportable to OMH and the Justice Center ***if they occur in the community when a vulnerable person is not under the actual or intended supervision of the program*** (e.g. fights, choking, injuries etc.).

- The list of incidents that are reportable **ONLY** to OMH pursuant to New York State Mental Hygiene Law Section 29.29 was refined and now includes Serious Crimes in the Community; Missing Subject of AOT Order; and Off-Premises Suicide Attempts.

b. What mental health providers must comply with 14 NYCRR Part 524 incident reporting requirements?

Providers of mental health services that are directly operated by OMH and providers of mental health services that have been licensed pursuant to Article 31 of the Mental Hygiene Law (including Article 31 licensed wards, wings or ambulatory services that are part of an Article 28 general hospital) are required to comply with the incident reporting requirements of the PPSNA and 14 NYCRR Part 524 with two exceptions: (1) State operated Sex Offender Treatment Programs; and (2) OMH operated programs located within correctional institutions. These latter programs are not required to report to the Justice Center; however, they must continue to report incidents to OMH in accordance with OMH Official Policy directive QA-510.

Although unlicensed, funded providers are not subject to most of the provisions of 14 NYCRR Part 524 as they are not subject to the Justice Center's jurisdiction, there are two important aspects for such providers to note:

1. Staff of unlicensed, funded providers that are licensed human service professionals are likely "mandated reporters" who are required to report Reportable Incidents involving vulnerable persons if they discover or learn of such events. For example, if a Health Home Case Manager is told by a patient on his caseload that she was physically abused by a staff member of an Article 31 outpatient clinic, that incident must be reported to the Justice Center and OMH.
2. HCBS Waiver services must report adverse events to OMH under Mental Hygiene Law Section 29.29 and federal requirements.

The process for reporting depends on incident type. The steps for reporting are described in Section 3 of this guidance document. Providers remain responsible for notifying other agencies (such as any accrediting or regulatory agencies) as required by all governing rules or statutes, including federal requirements.

c. What is an incident?

Section 29.29 of the New York State Mental Hygiene Law directs OMH to establish uniform policies and procedures for the submission of incident reports by providers under its jurisdiction. "Incident reports," as referenced in this law, means reports of accidents, injuries, and other events affecting patient health and welfare.

However, in Section 488 of the New York State Social Service Law, the PPSNA established a category of incidents called "Reportable Incidents" which must be reported by those required to report under the law ("mandated reporters") to the Justice Center and investigated. Under the Social Services Law, "Reportable Incidents" include allegations of abuse and neglect, and significant incidents. A "significant incident" is an event that, because of its severity or the sensitivity of the situation, may result in harm to the health, safety or welfare of a vulnerable person.

Given these two statutory approaches, for purposes of this guidance document, the term "incidents" includes:

- Reportable Incidents (i.e., allegations of abuse and neglect and significant incidents), which must be reported both to the Justice Center and OMH, pursuant to the PPSNA
- Patient Deaths
- Other adverse events that, while not required to be reported to the Justice Center, must be reported ONLY to OMH, pursuant to Mental Hygiene Law Section 29.29.

d. Who is responsible for reporting incidents?

"Custodians" of providers, as well as a number of human services professionals, are considered to be "mandated reporters" under the PPSNA and 14 NYCRR Part 524 and must report incidents that occur to persons receiving services from these programs. A "custodian" is a director, operator, employee or volunteer of a State operated or licensed provider or a consultant or contractor with such a provider that has regular and substantial contact with persons served by the provider. The list of human services professionals that are considered to be "mandated reporters" is broad and is included in 14 NYCRR Part 524 in Section 524.4(i)(2).

e. Confidentiality

All incident reports and incident investigation documents are confidential quality assurance documents, protected by New York State Education Law Section 6527. Incident reports are not considered part of an individual's clinical record and should not be filed in such record. A number of statutes govern disclosure of confidential quality assurance documents, depending on the circumstances of the requested disclosure, including New York State Mental Hygiene Law §§33.23 and 33.25 ("Jonathan's Law"), New York State Public Health Law §2805-m, New York State Social Services Law §496, and 45 CFR Parts 160 and 164 (HIPAA).

f. Key Incident-Related Terms

- "**Custodian**." as used in the PPSNA, refers to those who have a legal obligation to protect vulnerable persons from harm while they are under their care (of the care of the provider they work for). In the OMH regulated system, the following would be "custodians" – a director, employee, or volunteer of a provider operated or licensed by OMH, or a consultant or contractor with an OMH operated or licensed provider who has regular and substantial contact with persons served by the provider.
- **"Mandated reporter"** means someone who is required by the PPSNA to report suspected abuse and neglect of vulnerable persons, as well as "significant incidents," to the VPCR immediately upon discovery. All custodians are mandated reporters, as well as a specific list of human service professionals, included in 14 NYCRR §524.4(i).
- **"NIMRS"** refers to the New York State Incident Management and Reporting System, developed and maintained by OMH.
- "**Likely to result in injury or harm**" means that the injury or harm is a probable or the expected result of the particular conduct.
- "**Reasonably foreseeable potential to result in injury or harm (RFP)"** means that a reasonable person would be able to predict or anticipate that his or her conduct would result in harm or injury to a vulnerable person. It does not mean that such harm or injury is absolutely certain to occur, but instead means that given the circumstances involved, it is reasonable or realistic to expect that it would.

- **"Serious or protracted impairment of the physical, mental, or emotional condition"** means a state of substantially diminished physical, psychological, or intellectual functioning in relation to, but not limited to, such factors as failure to thrive, control of aggressive or self-destructive impulses, or ability to think and reason.
- "**Vulnerable person (VP)**" is an individual who is receiving care in a facility, provider agency or program that is operated or licensed by OMH (excluding the Sex Offender Treatment Program or programs located within correctional institutions).
- **"VPCR"** refers to the "Vulnerable Persons' Central Register," a statewide database maintained by the Justice Center to perform necessary functions related to the receipt and acceptance of reportable incidents involving vulnerable persons and the investigation of these incidents

II. Incident Categories

a. Reportable Incidents: Incidents that must be reported to the Justice Center & OMH

Pursuant to the PPSNA, Reportable Incidents (i.e. allegations of abuse and neglect, significant incidents and patient deaths) must be reported to the Justice Center and the Office of Mental Health.

1. Allegations of Abuse and Neglect: An allegation of abuse or neglect must involve an act (or failure to act) by a "custodian" that causes or was likely to result in, injury or harm to a person receiving services. All allegations of abuse or neglect must be reported to the Justice Center and OMH. This category includes:

Allegations of Abuse & Neglect – Reportable to Justice Center & OMH	
Incident Type	**Definition**
Physical Abuse	Non-accidental physical contact with a VP which causes or has the RFP to cause physical pain or harm
Psychological Abuse	Any verbal or nonverbal conduct that is intended to cause a VP emotional distress
Sexual Abuse	Any sexual contact involving a custodian and a VP, or any sexual contact

Allegations of Abuse & Neglect – Reportable to Justice Center & OMH	
Incident Type	**Definition**
	involving a VP that is encouraged or allowed by a custodian
Neglect	Any action, failure to act, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a VP
Deliberate Inappropriate Use of Restraint	Restraint that is done for the purpose of punishment or convenience, or which is done with deliberate cruelty
Obstruction of Reports of Reportable Incidents	Conduct by a custodian intended to impede the reporting or investigation of a reportable incident
Unlawful Use or Administration of a Controlled Substance	Any illegal administration, use, or distribution by a custodian of a controlled substance (e.g. codeine, Oxycontin, Ambien, cocaine)

2. ***Significant Incidents:*** The PPSNA and 14 NYCRR Part 524 define a "Significant Incident" as a Reportable Incident, (other than an incident of abuse or neglect) that because of its severity or the sensitivity of the situation results in, or has the RFP to result in, harm to the health, safety, or welfare of a vulnerable person.

   In order for an event to be considered a Significant Incident, it must occur on program premises or when the VP is under the actual or intended supervision of an OMH licensed or operated program.

   Please be aware that some incident types (e.g. suicide attempts and missing patients) are considered Significant Incidents regardless of whether or not they result in injury or harm. Other incident types are considered Significant Incidents only when they ***result in***, or ***create a reasonably foreseeable risk of***, **Serious Injury or Harm,** defined in 14

NYCRR Part 524 as **"Injury or harm that requires medical intervention or treatment *beyond* First Aid."**

First Aid is defined in 14 NYCRR Part 524 as "One-time treatment, and any follow up, of minor scratches, cuts, burns, splinters, or other minor injuries which do not ordinarily require medical care." Some examples include:

- Using a non-prescription medication (e.g. Tylenol) at recommended dosage
- Cleaning, flushing, or soaking wounds on the surface of the skin
- Applying wound coverings, such as Band-Aids, gauze pads, butterfly bandages
- Using hot or cold therapy
- Removing foreign bodies from the eye using only irrigation or a cotton swab;
- Using non-rigid means of support, such as elastic bandages
- Removing splinters or foreign materials from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
- Drinking fluids for relief of heat stress

*Note: A visit to an emergency room is not, in and of itself, considered an incident. Incident reports are **not necessary** for visits to a hospital or emergency room if the person received no treatment. An X-Ray, CAT scan, drawing of blood, or any other diagnostic assessment is not considered treatment. Example: A VP thinks his arm is broken and is taken to the E.R. An X-ray is performed, and his arm is not broken. He is advised to take ibuprofen at non-prescription strength and use hot or cold therapy. This is not an incident. If the X-ray showed his arm was broken and a doctor applied a cast (a rigid means of support), the application of the cast is treatment beyond first aid. Other examples of treatment beyond first aid include stitching a wound, dispensing prescription medication, or administering a tetanus shot.*

The following incidents are **Significant Incidents** when they **occur on program premises** or when the VP was under the **actual or intended supervision of an OMH licensed or operated program.** These incidents must be reported to the Justice Center and OMH.

Significant Incidents – Reportable to Justice Center & OMH	
Incident Type	**Definition**
Adverse Drug Reaction	An unintended, unexpected or excessive response to a medication given at

Significant Incidents – Reportable to Justice Center & OMH	
Incident Type	**Definition**
	normal doses, which results in serious injury or harm
Assault	A violent or forceful physical attack by a person other than a custodian, in which a VP is either the victim or aggressor, which results in serious injury or harm
Child Missing from Staff Supervision	A patient of an outpatient program who is under the age of 18, and whose whereabouts are not accounted for when expected to be present or under the supervision of a custodian
Choking	A choking event experienced by a VP as a result of ingestion of food or other foreign object, resulting in life threatening harm or admission to a hospital, **and** there is a written directive for such VP concerning risk of choking in place at the time of the event
Crime	An event which is or appears to be a crime under NYS or Federal law, which (1) Involves a VP as the victim or aggressor; or (2) Does or could affect the health or safety of one or more VPs; or (3) Could have a significant adverse impact on the property or operation of the program
Falls by VPs	Events where VPs trip, slip, or otherwise fall **(Inpatient & Residential only)**, resulting in serious injury or harm
Fights	A physical altercation between two or more VPs in which there is no clear victim and no clear aggressor, resulting in serious injury or harm
Fire Setting	Action by a VP, either deliberate or accidental, that results in fire and which causes serious injury or harm to any person
Injury of Unknown Origin	an injury to a patient for which a cause cannot be immediately determined because 1) the source of the injury could not be explained by the patient or other person; and (2) the injury is suspicious because of the extent or location of the injury, or the number of injuries observed at one point in time, or the frequency of the incidence of injuries over time.
Medication Error	An error in prescribing, dispensing, or administering a drug that results in

Significant Incidents – Reportable to Justice Center & OMH	
Incident Type	**Definition**
	serious injury or harm
Missing Patient	A patient who has not been accounted for when expected to be present (in accordance with facility or program practice or policies) and who has not been found on the facility grounds or other expected location, or who is known to have left the facility grounds without the permission of an employee when such permission is otherwise required, or any absence that requires law enforcement contact. **(Inpatient & Residential Only)** (Minors missing from outpatient programs should be reported using the "Child missing from Staff Supervision" incident type in NIMRS)
Mistreatment: • Inappropriate (unauthorized) Restraint or Seclusion	Unauthorized use of restraint or seclusion that is inappropriate because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable state or federal regulations, but which does not rise to the level of abuse (i.e., physical abuse or deliberate inappropriate use of restraint)
Mistreatment: • Intentional Improper Administration of Medication	Intentional administration to a VP of a prescription drug or over-the counter medication which is not in substantial compliance with a prescription
Mistreatment: • Inappropriate use of time out	Use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming
Mistreatment: • Misappropriation of Patient Resources	Misappropriation of a VP's resources, (including but not limited to funds, assets, or property) by deception, intimidation, or similar means, with the intent to deprive (either permanently or temporarily) the VP of those resources
Self-Abuse	Self-inflicted injury not intended to result in death that results in serious injury or harm
Sexual Assault	A sexual attack including but not limited to those that result in vaginal, anal, or oral penetration (i.e., rape or attempted rape and sodomy or

Significant Incidents – Reportable to Justice Center & OMH	
Incident Type	**Definition**
	attempted sodomy, and/or any sexual contact between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years old or older and a person who is less than 17 years old, or which involves a VP who is deemed incapable of consent.)
Sexual Contact Between Children	Vaginal, anal, or oral penetration by patients under age 18 that occurs in a setting where the patient receives around-the-clock care or on the premises of an outpatient program.
Suicide Attempt	An act committed by a VP in an effort to cause his or her own death
Verbal Aggression by Patients	A sustained, repetitive pattern by a VP or VPs of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another VP or VPs, which causes serious injury or harm
Other	An event, other than those identified above, which has or creates a risk of, a serious adverse effect on the life, health, or safety of a patient

3. ***Patient Death:*** The Death of a patient of an OMH operated or licensed mental health provider who was enrolled in or receiving services at the time of the death, including any patient death occurring within 30 days after the admission to or discharge from an OMH operated or licensed mental health program, must be reported both to the Justice Center and OMH.

b. Incidents reportable only to OMH (MHL 29.29)

Pursuant to Mental Hygiene Law Section 29.29, the following incidents must be reported to OMH when they **occur off the premises of the facility or program** or when the VP was **NOT under the actual or intended supervision of an OMH licensed or operated program**. ***These incidents should be reported directly in NIMRS and NOT called in to the VPCR.***

Reportable only to OMH	
Incident Type	**Definition**
Crimes in the Community	An event which is or appears to be a crime under NYS or Federal law, which is perceived to be a *significant danger* to the community or involves a VP whose behavior poses an *imminent concern to the community*
Missing Subject of AOT Order	A person subject to an AOT order who fails to keep a scheduled appointment and/or who cannot be located within a 24 hour period (outpatient programs only).
Suicide Attempt, Off Site	An act committed by a VP in an attempt to cause his or her own death.

III. How to Report

a. How to Report Allegations of Abuse & Neglect and Significant Incidents

Allegations of Abuse and Neglect and Significant Incidents must first be reported to the Justice Center, and then to OMH, using the following steps:

1. **Report to the Justice Center:**

   Call the Vulnerable Persons Center Register (VPCR) at (855) 373-2122 or submit the report via web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WI/ when reporting incidents to the VPCR, the 4-digit OMH Facility Code should be included to facilitate timeliness and accuracy of assignment. For most programs, the OMH Facility Code is the first 4 digits of the Operating Certificate Number; it is also the facility identifier used when completing the OMH Patient Characteristic Survey.

   Mandated reporters who become aware of incidents that allegedly occurred at another OMH licensed or operated facility need to immediately notify the Justice Center. If the incident is accepted by the Justice Center, the provider where the incident allegedly occurred will receive electronic notification which will allow them to create a NIMRS report and investigate the incident.

2. **Report to OMH:**

   When the report is made to the VPCR, the information will be transferred to NIMRS. The provider's authorized NIMRS users should review the report on the ***Justice Center Import Queue*** and create a NIMRS incident report for submission to OMH. A web-based video demonstrating this process can be viewed at the NIMRS ***Learning Center*** web page at http://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/videos.html

3. **Document the investigation and "Close" the report in NIMRS:**

   - **Allegations of Abuse or Neglect:** After reporting the incident to OMH and conducting the investigation, the NIMRS "Follow Up Details" screens must be completed and the report "closed" within 45 days. This signals that corrective action has been assessed for this allegation and allows OMH Central Office to review any recommendations made.
   - **Significant Incidents:** After reporting the incident to OMH, the investigative findings and the NIMRS "Follow Up Details" screens must be completed and the report closed within in 50 days. Once the report is "Closed" OMH will review and transfer the information to the VPCR where the final disposition will be recorded

   A web-based video demonstrating how to "Close" incidents in NIMRS can be viewed at the NIMRS ***Learning Center*** web page at http://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/videos.html

b. How to Report Patient Deaths

Patient Deaths must be reported to the Justice Center and OMH using the following steps:

1. **Make Initial Report to the Justice Center**

   Upon discovery of a patient death, call the VPCR Death Reporting Line at 1-855-373-2124 and provide initial report.

2. **Report to OMH using NIMRS**

After the initial report is made to the VPCR, the information will be transferred to NIMRS. The provider's authorized NIMRS users should review the report on the ***Justice Center Import Queue*** and create a NIMRS incident report for submission to OMH.

3. **Submit *Report of Death to the Justice Center* using NIMRS**

   Within 5 days of the initial report to the VPCR, the ***Report of Death to the Justice Center*** must be completed and submitted to the Justice Center using NIMRS. A web-based video demonstrating this process can be viewed at the NIMRS ***Learning Center*** web page at http://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/videos.html

c. How to Report MHL 29.29 incidents directly to OMH:

These incidents must be reported to OMH using the following steps:

1. An authorized NIMRS user logs into NIMRS and selects "New Incident" from the home screen menu.
2. The NIMRS incident screen opens and a pop-up message describing the process for reporting incidents to the Justice Center will appear. User should click "X" to bypass the pop-up.
3. Enter required information on each NIMRS screen (Incident, Client, Initial Findings etc.) and click "Email OMH."

If the report is mistakenly called into the VPCR, it will be classified as a "Non-NYJC Incident" and transferred to the NIMRS Justice Center Import queue. Incidents classified as "Non-NYJC Incidents" may or may not meet the definition of an OMH reportable incident so providers must review these reports as they are assigned to the queue and follow up as needed. "Non- NYJC Incidents" that are reportable to OMH should be imported as NIMRS incidents and reported to OMH. "Non- NYJC Incidents" that do not meet the definition of an OMH reportable incident can be imported into NIMRS for internal tracking or designated as "Non-Incidents" which require no further action.

IV. Incident Review Committees (IRC)

1. *Composition:* Per the PPSNA, IRC membership must **exclude** a provider's director, but must **include** at least:
   - Members of the governing body of the mental health provider; and
   - Persons identified by the director of such provider, including some members of direct support staff, licensed health care practitioners, service recipients, and representatives of family, consumer, and other advocacy organizations.

   OMH has interpreted these provisions to mean that a provider's IRC must be comprised of at least some members of the current governing board and "other" persons identified by the provider's Executive Director. Of that group, the IRC would need at least one direct support staff person, one licensed health care practitioner, a service recipient, and a single family/consumer/advocacy organization representative. However, not all representatives need to be from a formal "organization;" they may merely include individuals identified as "family" or "consumer" representatives without necessarily being formally affiliated with a bona fide family or consumer "organization." The "direct support staff" representative must be someone involved in the provision of direct care services, as opposed to an administrative staff person, and the "service recipient" may either be a current or past recipient of such services.

2. *Confidentiality*. Providers may wish to go outside of their own organization to identify appropriate representatives of family, consumer, and other advocacy organizations. This necessarily raises concerns about how to protect the confidentiality of the protected health information (PHI) discussed in the course of these meetings. Providers of mental health services that are operated or licensed by OMH must continue to comply with HIPAA and the New York State Mental Hygiene Law with respect to disclosures of PHI to persons or entities that are not part of the workforce of the mental health provider.

   It is important to note that nothing in the PPSNA requires that these representatives be external to the provider. Therefore, if a provider currently has employees that could serve as representatives of family, consumer, or other advocacy organizations (e.g., peer advocates), those persons could be used to meet the composition requirements.

However, if persons external to the provider are to participate on the IRC, the provisions of HIPAA can be satisfied in either of two ways:

- First, the provider could consider the person to be a member of the provider's workforce for purposes of HIPAA, provided: (1) that the person is under the supervision and control of the provider while the person is accessing PHI; and (2) the person receives the same HIPAA training other members of the provider's workforce receive; or
- The person could be considered a "business associate" of the provider for purposes of IRC participation. In this case, a HIPAA compliant Business Associate Agreement should be executed with the external member.

The analysis does not end there, however. It is also necessary to consider the New York State Mental Hygiene Law Section 33.13 to identify an applicable exception that would permit disclosure of patient information to external members of the IRC without patient consent. For State Operated providers, disclosures are permitted if there is a confidentiality agreement between the external member and the State Operated facility.

Because this exception is limited to State Operated providers, if licensed providers wish to use external members, they may obtain patient consent before disclosing PHI to external IRC members, or only use de-identified information in meetings involving external members. Licensed providers should consult with their own legal advisors as they consider appropriate solutions for their own circumstance.

3. Definition of "Director:"

The PPSNA covers providers regulated by multiple State agencies and each defines its hierarchical directors differently. Section 490 of the New York State Social Services Law provides that the "director of the facility or provider agency" cannot be a member of the IRC. For entities under OMH jurisdiction, OMH recommends interpreting "the director" to mean the Chief Executive Officer of the agency. This would be the individual (or his or her successor) who signed the Part A (Acknowledgment) of the PAR application (or its predecessor form).

V. OMH Customer Relations Line

OMH maintains a toll-free Customer Relations Line that is responsible for handling questions and complaints from the public, including persons receiving care from mental health providers that are under OMH's jurisdiction. Providers are encouraged to post information about OMH's Customer Relations Line prominently, so that persons who are experiencing clinical symptoms or who have complaints about their care know that they can call OMH for assistance.

The OMH Customer Relations Line toll-free number is: 1-800-597-8481

VI. Jonathan's Law (Mental Hygiene Law Sections 33.23 and 33.25)

Jonathan's Law established procedures that facilities must follow to notify and inform parents and legal guardians of children and adults receiving certain services (including mental health services provided by providers under the jurisdiction of OMH) of incidents involving their loved ones. It also allows qualified persons to access certain documents pertaining to such incidents. Under the law, qualified persons include:

- Parents or other legal guardians of minor patients;
- Parents, legal guardians, spouses, or adult children of adult patients who are legally authorized to make health care decisions on behalf of the adult patient; or
- Adult patients who have not been determined by a court to be legally incompetent.

A facility will inform the qualified person(s) by telephone of accidents or injuries that affect the health or safety of an individual receiving services within 24 hours of the initial report of the incident. **If requested** by a qualified person, the facility must promptly provide a copy of the written incident report. The facility must also offer to meet with the qualified person to further discuss the incident. The director of the facility must provide the qualified person(s) with a written report on the immediate actions taken to address the incident (e.g., steps taken to protect the involved individual) within 10 days of the initial report of the incident.

If requested by the qualified person in writing, Jonathan's Law requires facilities to provide records and documents pertaining to allegations and investigations into abuse, neglect, and significant incidents (reportable incidents) to the qualified person(s). These documents must be provided within 21 days after the investigation

is concluded. The names or information that identifies other persons receiving services and employees will be redacted unless these individuals authorize disclosure. Federal laws or regulations may pose additional restrictions on the release of records or information contained in those records.