



## **Saratoga Bridges Policy and Procedure Manual**

### **Topic: Incident Management**

**Relevant to Dept(s): All**

**Original Effective Date: 2013**

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#### **Policy:**

It is the intent of SARATOGA BRIDGES to ensure that all individuals who receive services do so in an environment that is as safe as possible and are protected to the extent possible from any potential danger or abuse.

Incident management is the formal system established to do so.

Therefore, the process of reporting and reviewing of incidents must work to ensure that necessary and prompt steps are taken to protect these individuals and others. It must initiate a response to dangerous or abusive situations, as well as attempt to eliminate the potential for future recurrences. We are committed to the enhancement of quality of support.

This policy was written primarily for those individuals who receive services in the system for people with developmental disabilities, but the policy pertains to all people who receive services at Saratoga Bridges; however, the policy is based on those regulations set forth by OPWDD, and all regulations by OPWDD are to be followed for those in that service delivery system.

#### **Procedure:**

It is the intent of this policy to require an incident management system, including the reporting, investigation, review, correction, and monitoring of certain events or situations, to protect individuals receiving OPWDD services (to the extent possible)

from harm; ensure that individuals are free from abuse and neglect; and to enhance the quality of the services and care they receive.

This policy is based on regulations as outlined in 14 NYCRR Part 624 and Part 625.

### **Immediate Protections:**

Intervene! The first thing staff must do when an incident is occurring is to INTERVENE and keep the person safe from any further hurt or harm. Once the person is safe this policy and procedure must be followed.

Depending on the circumstances of the incident or allegation, protections may need to be put in place immediately upon discovery of an incident or situation. SARATOGA BRIDGES will act immediately upon discovery when individuals are at risk or when their well-being has been jeopardized. It is everyone's responsibility to take action to stop any abuse or further harm to an individual. Any employee acting on behalf of SARATOGA BRIDGES shall take whatever measures reasonable and prudent to ensure the protection of the individual from further harm, injury, abuse and to provide prompt treatment or care. Protections are accomplished many ways depending on the circumstances of the situation. Examples of this could include but are not limited to seeking medical treatment or calling 911, contacting SARATOGA BRIDGES's emergency number, increasing staff supervision, staff retraining, or administrative leave.

When applicable, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected an individual shall be removed from direct contact with, or responsibility for, all persons receiving services from the agency. In the event a staff is placed on administrative leave, that staff member is placed on leave from all individuals he/she works with at SARATOGA BRIDGES pending the outcome of the investigation, unless otherwise indicated. In other cases, referrals for other supports or advocacy may be appropriate.

### **2 Agency Internal Reporting and Communications:**

- ❖ All mandated reporters for programs certified or operated by OPWDD must report to the NYS Justice Center and OPWDD Incident Management Unit (IMU) whenever there is a reasonable cause to suspect that a reportable incident has occurred.
- ❖ This means that if you witness or become aware of an incident that is reportable to the Justice Center under this policy and procedure, you are required to call the Justice Center to report what you know, regardless of your direct involvement in the incident. Examples would include professional staff such as behaviorists, nurses or therapists hearing about an alleged incident and co-workers that tell you about an incident. You must make a phone call to the Justice Center once you are aware of an alleged reportable incident.

When an incident is alleged to have occurred, it is SARATOGA BRIDGES's expectation that the staff with the immediate knowledge of the situation contact the administrator on duty and if out of normal business days and hours reaching the administrator on call via the emergency number. This process is to occur as soon as possible, after any necessary emergency medical treatment or other form of protection is sought for the individual. If the incident should fall under the authority of the NYS Justice Center, it is expected that all custodians will make the report to the JC either by telephone or by web form. The Justice Center Hotline Telephone # is 1-855-373-2122. Our Agency Administrator on call number is 518-423-9185. Staff should call their Manager on Duty (MOC) after hours prior to calling the Administrator on Call (AOC).

The SARATOGA BRIDGES administrator or administrator on call who takes the call will take lead in making sure that all immediate protections have been taken in consultation with Quality Assurance when appropriate. The administrator on call will discuss as needed with QA and the CEO/designee as to what the next steps should be. SARATOGA BRIDGES's CEO/designee or QA will assign an investigator and depending on the classification of the incident, additional contacts may need to be made to CPS or law enforcement. Law enforcement must be contacted for any alleged crimes committed against an individual by a staff, intern, or volunteer, or if an emergency response by law enforcement is needed.

### **Incident Classification:**

The following incident classifications are required to be managed within the process of this policy and procedure. Staff should be familiar with what constitutes an incident and when an incident must be reported to administration and the Justice Center. Once reported to the Justice Center they will classify the incident according to the report. It is not the expectation that staff classify the incident, staff must know what and when to report an incident.

**REPORTABLE INCIDENTS:** Applies only to incidents that occur under the auspices of an agency. Reportable Incidents include both categories of "Abuse" and "Significant Incidents."

### **(I) ABUSE/NEGLECT:**

1. Physical Abuse shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the individual receiving services, or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not

include reasonable emergency interventions necessary to protect the safety of any person.

2. Sexual Abuse shall mean: any conduct by a custodian that subjects a person receiving services to any offense defined in article 130 or section 255.25, 255.26 or 255.27 of the penal law, or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles 230 or 263 of the penal law; and/or (ii) any sexual contact between an individual receiving services and a custodian of the program or facility which provides services to that individual whether or not the sexual contact would constitute a crime (see especially section 130.05(i) of the penal law). However, if the individual receiving services is married to the custodian the sexual contact shall not be considered sexual abuse. Further, for purposes of this subparagraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of an agency shall not be considered a custodian if he or she has sexual contact with another individual receiving services who is a consenting adult who has consented to such contact.

- ❖ **For any allegation of sexual abuse where sexual intercourse is reported, or any form of sexual abuse is being reported, hospital emergency room personnel should examine the victim as soon as possible. Examinations (Sexual assault forensic exam - SAFE) may show evidence up to 72 hours after the sexual assault. In the case of an individual that has a legal guardian, the guardian needs to be contacted to be able to provide consent for the examination. This usually occurs while in the emergency room.**
- ❖ **Staff that become aware of any event that is of a sexual abuse/assault should immediately intervene, contact nursing and management as well as the Justice Center and take direction on next steps to have the person evaluated at the emergency room accompanied by a police report.**

3. Psychological abuse includes any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services. (i) Examples include, but are not limited to, taunts, derogatory comments or ridicule, intimidation, threats, or the display of a weapon or other object that could be perceived by an individual receiving services as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury. (ii) In order for a case of psychological abuse to be substantiated after it has been reported, the conduct must be shown to cause intentionally or recklessly, or be likely to cause, a substantial diminution of the emotional, social, or behavioral development or condition of the individual receiving services. Evidence of such an effect must be supported by a clinical assessment

performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor.

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

**5. Use of aversive conditioning** shall mean the application of a physical stimulus that is intended to induce pain or discomfort to modify or change the behavior of a person receiving services. Aversive conditioning may include, but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form. *The use of aversive conditioning is prohibited by OPWDD.*

**6. Obstruction of reports of reportable incidents** shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of an individual receiving services; actively persuading a custodian or other mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register (VPCR) or OPWDD with the intent to suppress the reporting of the investigation of such incident; intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with OPWDD regulations, policies or procedures; or, for a custodian failing to report a reportable incident upon discovery.

**7. Unlawful use or administration of a controlled substance**, which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article 33 of the public health law, at the workplace or while on duty.

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

- (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) above if committed by a custodian.
- (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric, or surgical care, consistent with Parts 633, 635, and 686 of this Title (and 42 CFR Part 483, applicable to Intermediate Care Facilities), and provided that the agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate parties; or
- (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article 65 of the education law and/or the individual's individualized education program

## (II) SIGNIFICANT INCIDENTS:

**Significant incident** shall mean an incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the foreseeable potential to result in, harm to the health, safety or welfare of a person receiving services and shall include but shall not be limited to:

(i) **conduct between persons receiving services that would constitute abuse as described in numbers (1) through (7) above if committed by a custodian, except sexual activity involving adults who are capable of consenting and consent to the activity; *If the persons are non-consenting or are complaining of being sexually assaulted or abused, including touching of the intimate body parts, then you should consider this sexual assault under this category and follow the directions above for notifications and evaluation at an ER for a SAFE examination and a police report.***

(ii) **conduct on the part of a custodian that is inconsistent with the individual's plan of services, accepted treatment practices**, and/or applicable federal or state laws, regulations, or policies and which impairs or creates a Foreseeable potential to impair the health, safety, or welfare of a person receiving services, including but not limited to:

- a) **seclusion**, which shall mean the placement of a person receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will. OPWDD prohibits the use of seclusion.
- b) **unauthorized use of time-out**, which (for the purposes of this clause only) shall mean the use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming.
- c) **the administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order** issued for a service recipient by a licensed, qualified health care practitioner, and which has an adverse effect on a service recipient. For purposes of this clause, "adverse effect" shall mean the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the well-being of a person receiving services; and
- d) **inappropriate use of restraints**, which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is inconsistent with an individual's plan of services (including a behavior support plan), generally accepted treatment practices and/or applicable federal or state laws, regulations, or policies. For the purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs, or body
- e) **missing person** which shall mean the unexpected absence of an individual receiving services that is based on the person's history and current condition exposes him or her to risk of injury
- f) **choking, with known risk** which shall mean partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe, involving an individual with a known risk for choking and a written directive addressing that risk.
- g) **choking, with no known risk** which shall mean partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe, involving an individual with a no prior known risk for choking and a no written directive addressing that risk.
- h) **self-abusive behavior, with injury**, which shall mean a self-inflicted injury to an individual receiving services that requires medical care beyond first aid.

**Please note: any injury due to self-injurious behavior that requires medical care beyond first aid is a "Reportable Incident per regulation."**

### **(III) SERIOUS NOTABLE OCCURRENCES:**

Applies only to events and situations that occur under the auspices of an agency. These include:

## 1. Death

The death of any person services, regardless of the cause of death. This includes all deaths of individuals who live in residential facilities operated or certified by OPWDD and other deaths that occur under the auspices of an agency.

## 2. Sensitive Situation

Those situations involving a person receiving services that do not meet the definitions of other incidents in section 624.3 of this Part or in this subdivision, but that may be of a delicate nature to the agency and are reported to ensure awareness of the circumstances. Sensitive situations must be defined in agency policies and procedures, and include, but not be limited to, possible criminal acts committed by an individual receiving services.

## (IV) **MINOR NOTABLE OCCURANCES:**

### 1. Theft/Financial exploitation (more than \$15/less than or equal to \$100)

Any suspected theft of a service recipient's private property (including personal funds or belongings) or financial exploitation, involving values of more than \$15.00 and less than or equal to \$100.00, that does not involve a credit, debit, or public benefit card, and that is an isolated event; and

### 2. Injury, minor notable occurrence

Any suspected or confirmed harm, hurt, or damage to an individual receiving services, caused by an act of that individual or another, whether by accident, and whether or not the cause can be identified, that results in an individual requiring medical or dental treatment (see glossary, section 624.20) by a physician, dentist, physician's assistant, or nurse practitioner, and such treatment is more than first aid

## (V) **EVENTS/SITUATIONS (PART 625):**

Applies only to events and situations that occur *outside* of the auspices of an agency. This category only applies to programs under OPWDD. These include:

1. Physical Abuse
2. Sexual Abuse
3. Emotional Abuse
4. Active Neglect
5. Passive Neglect
6. Self-Neglect
7. Financial Exploitation
8. Death



**INTERNAL INCIDENTS:** Incidents that should be reported and tracked but do not reach the severity of a Reportable Incident, Notable Occurrence, or Event/Situation. Internal incidents can occur within, or outside of the auspices of SARATOGA BRIDGES, in which staff intervention and follow-up is important to document.

## **Reporting:**

SARATOGA BRIDGES administrator/designee who takes the emergency call will ensure that the CEO/Designee/QA is advised of all incidents as well as events/situations immediately upon occurrence or discovery. The investigator/designee shall notify via phone, all incidents immediately upon occurrence or discovery to the Incident Management Coordinator at OPWDD (518-388-1942 during business hours, 518-. This notification must include a description of the immediate protections. The investigator/designee must report to law enforcement if an emergency response by law enforcement is needed, and/or when a crime may have been committed against an individual receiving services by a staff/intern/volunteer/contractor. The investigator/designee shall notify the Care Manager of all incidents within 24 hours of entry of the incident into IRMA. The notification must include a description of the immediate protections. The investigator/designee will notify the chairperson of the Incident Review Committee (IRC) that an incident has occurred including the category to ensure the committee is scheduled to meet within the designated time frames.

## **Documentation:**

Incident information will be entered into the OPWDD Incident Report and Management Application (IRMA). The investigator/designee has responsibility for IRMA data entry within 24 hours of occurrence or discovery or by the close of the next working day, whichever is later. Information entered to IRMA will generate the OPWDD Form 147. Events/situations information will be entered into the OPWDD Incident Report and Management Application (IRMA). The Investigator/designee has responsibility for IRMA data entry within 24 hours of occurrence or discovery or by the close of the next working day, whichever is later. Information entered to IRMA will generate the OPWDD Form 150.

Incidents that should be reported and tracked but do not reach the severity of a Reportable Incident, Notable Occurrence, or Event/Situation shall be documented using Saratoga Bridges yellow Occurrence Form. This form may be completed by the employee involved, or after discussion, by a supervisor. This form should be completed within 24 hours of an occurrence.

**Jonathan's Law:** Incidents that are classified as Reportable, Serious Notable and Minor Notable incidents require additional notification by the investigator/designee to inform 'qualified' persons of their right to access information under Jonathan's Law. Jonathan's Law notifications are required for all reportable incidents and notable occurrences. This notification must occur as soon as possible but no later than 24

hours after the completion of the initial incident report in IRMA. A 'qualified' person is defined as:

- Parent of the individual receiving services • Spouse of the individual • Adult child of the individual
- Adult Sibling of the individual
- Legal guardian of the individual
- The individual - if a capable adult

The investigator/designee must attempt to make telephone contact to one of the above individuals unless the person has objected to this notification in writing, the adult individual objects, or if the contact person is the alleged abuser. Under Jonathan's Law, the 'qualified' person to whom notification is made is informed:

- Of a description of the situation and initial actions taken to protect the individual
- That he/she will receive a redacted Report on Actions Taken (OPWDD 148 indicating immediate steps taken in response of the incident to safeguards the person). This report must be sent out within 10 days of the completion of the initial written incident report or initial entry into IRMA.
- An offer to meet with the CEO/designee to further discuss the incident/occurrence.
- For **allegations of abuse/neglect**, an offer to provide information regarding the status or finding. The 'qualified' person can request any or all the following:
  - A meeting with the CEO/designee
  - A copy of the redacted initial incident report
  - Information on the status and/or resolution for allegations of abuse or neglect.

Quality Assurance is responsible for responding to further requests made by qualified persons.

### **Investigation Process:**

Any report of a reportable incident or notable occurrence must be thoroughly investigated by the CEO/designee, or an investigator designated by the CEO/designee, unless OPWDD or the Justice Center advises SARATOGA BRIDGES that the incident or occurrence will be investigated by OPWDD and specifically relieves the agency of the obligation to investigate. The assigned investigator will initiate the investigation immediately.

All employees, interns, volunteers, consultants, or contractors are expected to cooperate in the investigation process in a timely manner. A thorough investigation must be conducted into any incident, or notable occurrence. The Investigator is

expected to complete the investigation within 7 days. The investigator is expected to follow the investigatory process put forth in OPWDD investigator training. Once the investigation is completed the investigator has 3 days to complete the report using OPWDD Form 149 and submit it with all supporting documentation to the Quality Assurance Director for review.

On occasion there may be extenuating circumstances that prohibit this from happening in the expected period. Examples of this would be in the event of Justice Center, OPWDD or law enforcement involvement who must complete their investigation prior to SARATOGA BRIDGES's. If the investigator discovers the report cannot be completed in the expected period, the investigator must notify the Director of Quality Assurance in writing with the reason. The Quality Assurance Director will review the report for its thoroughness and will follow up with the investigator regarding outstanding questions or concerns and update IRMA every thirty (30) days as required.

Within 14 days the full investigation including recommendations will be forwarded to the CEO, Chief Operating Officer, and the Program Director for review and response. It is expected that investigations will be uploaded into IRMA within 30 days unless extenuating circumstances prohibit the conclusion. Examples of this would be in the event of Justice Center, OPWDD or law enforcement involvement who must complete their investigation prior to SARATOGA BRIDGES's.

In the event an investigation is not completed in the expected period the reason must be documented in the IRMA application. Investigations are reviewed at the next Incident Review Committee meeting. The committee is mandated to meet within one month of the date that a reportable incident or serious notable occurrence is discovered and reported. At a minimum, this committee must meet on a quarterly basis. It is the responsibility of the committee chairperson to ensure IRC minutes reflect the committee is thoroughly reviewing investigations. The immediate supervisor(s) and parties in the chain of command of staff directly involved in reportable incidents or notable occurrences are prohibited from conducting investigations of these incidents. Furthermore, immediate supervisors must not be involved in reviewing such incidents as part of the Incident Review Committee.

If an employee leaves employment prior to the conclusion of a pending investigation, the investigation shall continue until it is completed and a finding of substantiated or unsubstantiated is reached.

#### **Incident Review Committee (IRC):**

The CEO has appointed an agency-wide Incident Review Committee. The IRC reviews and monitors investigatory procedures for reportable incidents or serious notable occurrences. It is the responsibility of the committee to assess whether appropriate investigatory procedures are being followed, to make recommendations to the CEO,

when necessary, ensure the agency investigator has conducted a thorough investigation, and ensure contributing factors have been identified so they can make recommendations to help prevent future incidents from occurring.

This committee has an identified chairperson. It is the responsibility of the committee chairperson to ensure the committee fulfills all its responsibilities, including but not limited to; meeting within the required time frames, ensuring the IRC minutes reflect that the committee is thoroughly reviewing investigations, and the IRC findings and recommendations are forwarded to the CEO within 2 weeks of the meeting.

Documentation of Incident Reviews The chairperson of the Committee will ensure that minutes are kept for all meetings that minimally include the following information:

- Name or names of subjects of the incident report
- Incident report number
- Date of incident. classification of incident
- Name of agency program reporting the incident
- Name of investigator. corrections, changes (including reclassification of an original report), updates to original report if any.
- Status (open for both investigation and corrective actions, no further investigation necessary but open for corrective actions and No further Investigation needed, corrective actions implemented can be fully closed), and until closure, a brief review of status of the investigation.
- Upon closure of an alleged abuse case, the resolution (substantiated or unsubstantiated).
- Corrective and/or preventive actions taken
- The meeting minutes will be held in a confidential file and stored in such a way that they are not accessible to unauthorized persons.

It is the responsibility of the Director of Quality Assurance to communicate these findings and recommendations to the Administrator/Program Director.

The CEO ensures that committee recommendations are positively received and considered in the interest of preventing future occurrences on incidents. This committee determines whether incidents are fully investigated, formally 'closed' or whether additional information is needed, or further action must take place to safeguard the individual. They advise the CEO if they recommend additional safeguards.

The Committee meets on a biweekly basis unless an emergency meeting is required.

At a minimum, the committee is comprised of a member of the Board of Directors, two professional staff, an individual with a disability, a family member, and a DSP.

The Director of QA serves as chairperson of this committee and may offer information on regulatory compliance and answer questions that may arise regarding the investigation itself.

It is the responsibility of the Quality Assurance Department to ensure the individual's Care Manager receives an update within 10 days from when the Incident Review Committee closes the incident.

This written update must include identifying investigative conclusions and recommendations pertaining to the individual's care, protection, and treatment.

Incidents may result in written recommendations to the appropriate Department Director and members of leadership as appropriate, to eliminate or minimize similar incidents in the future.

Changes in policy/procedure may also be recommended to minimize recurrence.

Analysis of incidents occur on an annual basis. The completed annual trend analysis report is presented yearly to the Board of Directors to inform members on incident statistics.

#### **Notification of this Policy and Procedure:**

Upon commencement of service provision, and as changes occur.

SARATOGA BRIDGES provides written instruction to individuals and advocates on how to access SARATOGA BRIDGES's Incident Management Policy and Procedures as well as OPWDD's "Learning about Incidents" brochure in electronic format via our website. In addition, individuals and advocates are notified that upon written request SARATOGA BRIDGES will provide paper copies of such information. These notifications occur unless the individual has objected to this notification.

#### **Training:**

All staff, volunteers and contractors shall be trained in Abuse Identification, Prevention, and Incident Reporting upon hire and annually thereafter. The Board of Directors shall receive this training on an annual basis. The SRC committee shall receive training upon joining the committee and annually thereafter as to this policy and their duties. The QA Director shall ensure that training is conducted as specified in this policy and procedure.

#### **Incident Management System Monitoring:**

The CEO has designated the Quality Assurance Department responsible for the monitoring of the incident management system to ensure all procedures are being followed as required. Through information gathered from data collection, review of incidents, input in IRMA, and participation in the IRC the Quality Improvement

Director is responsible for reporting any concerns directly to the CEO. More information on 624 regulations can be found on OPWDD's website at:

[http://www.opwdd.ny.gov/opwdd\\_resources/incident\\_management/home](http://www.opwdd.ny.gov/opwdd_resources/incident_management/home)