Department of Developmental Disabilities

Hearing Summary Report

Hearing Date: 02/13/2025 **Today's Date:** 02/21/2025

Rule Numbers: 5123-17-02 (Rescind and Enact)

If no comments at hearing, please check the box. ☐

List organizations or individuals giving or submitting testimony before, during or after the public hearing and indicate the rule number(s) in question.

Dr. Jennifer R. Brumfield
Harris Capps, Parent and Guardian
Greg Carter aka Lauren's Dad/Guardian/Advocate
Jeannette Coleridge, X-Excel, Ltd.
Natalie Curd
Jennifer Dietsch
Desirae Dunbar
Kimberlee Forbes
Valerie Fuller
Theresa Grant
Alisa Hartlage
Alicia Hopkins
Sonya Horton
Constance Johnson
Bethany Joyal-Cousin, Parent, Guardian, Advocate, Owner of SafeHaven Care Services
Grace Liston
Adelle R. Madison
Rachelle Magaram
Charlene Matus-Singleton
Mark and Renee Orolin
Alan Potter, Data Specialist, Wood County Board of Developmental Disabilities
Cheryl Scott

Brittni Seskey
Jennifer Sloan
Justin Sodano
Lindsey Sodano, End Ohio's Parent Penalty
Theresa Sweeny, Lakewood
Jeffrey Szkody
Gwen F. Wise
Anna, Mother of a Son with a Complex Medical History

Consolidated Summary of Comments Received

Please review all comments received and complete a consolidated summary paragraph of the comments and indicate the rule number(s).

Paragraph (C)(10): One person requested adding data fields to the incident report regarding a person's type of residence and providers of services. The Department pointed out that Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID) provide a residence which includes all aspects of a resident's care. The type of residence signifies the provider of services (i.e., the ICFIID) and the person completing the incident report is an employee of the ICFIID. In contrast, persons completing incident reports for individuals who do not live in ICFIID would not necessarily have information about the individual's type of residence and how an individual's services are funded (i.e., via a Home and Community-Based Services waiver or specifically which one). Further, the Department does not believe the addition of the data fields would improve investigation of incidents or capture meaningful data for analysis.

Paragraph (C)(10)(b): One person asked that individuals who are part of the Ohio Secretary of State's address confidentiality program be allowed to simply note "Safe at Home participant" under address. The Department responded that the Safe at Home program does not apply because Ohio's incident review and management system is not a public-facing system; major unusual incidents and unusual incidents are not public records.

Paragraph (C)(10)(e): One person suggested that the meaning of "who" might need to be more explicit (e.g., alleged perpetrator). The Department explained that as used in this paragraph, "who" means anyone involved in an incident (e.g., the victim, the alleged perpetrator, the primary person involved, or witnesses).

Paragraph (C)(16)(a): One person suggested bullying be included under Category A major unusual incidents. The Department responded that bullying would be included under "emotional abuse" which is in Category A.

Paragraph (C)(16)(a)(v): One person suggested that "neglect" should include failure to provide an individual with appropriate nutrition supports. The Department responded that failure to provide appropriate nutrition is already covered under neglect when an individual is placed at risk of serious injury.

Paragraph (C)(16)(a)(x): Twenty-seven persons expressed opposition to changing the name of a major unusual incident from "suspicious death" to "unanticipated death." The Department responded that "suspicious death" is being replaced by "unexplained or unanticipated death," a term from the Code of Federal Regulations as advanced by the federal Centers for Medicare and Medicaid Services:

> An unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect;
> https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.302

If abuse or neglect is suspected, a major unusual incident would also be filed under that category. Paragraph (I)(3) of the rule sets forth that the major unusual incident category may change or additional categories may be added to the record and the applicable procedure will be followed. A suspicious death would be subject to review and investigation by entities beyond the developmental disabilities system. Paragraph (F) of the rule requires immediate reporting of criminal acts to law enforcement. Paragraph (G) of the rule requires immediate reporting of abuse or neglect of children to the public children services agency.

Paragraph (C)(16)(b)(v): One person observed that the sub-categories of peer-to-peer acts were not in alphabetical order. The Department refiled the rule to correct this oversight.

Paragraph (C)(20): One person suggested that use of drugs or alcohol on the job fall under a "program implementation incident." The Department responded that use of drugs or alcohol on the job would be evaluated based on the specific facts. Depending on the level of risk the situation created for the individual receiving services, the incident might be an unusual incident or might be reported as neglect.

Paragraph (D)(8)(a): One person suggested that submitting an incident report and an administrative review form at the same time seems redundant, especially when information is still developing. The Department responded that the incident report initiates the process and drives the investigation. As the investigator discovers more information, s/he will add details to the administrative review form. The Ohio Incident Tracking and Monitoring System will be modified to align the information on the incident report with the administrative review form. The Department will provide systemwide training prior to implementation of the new rule.

Paragraph (I)(11): One person said the individual with a developmental disability or family or guardian should be notified in the event a county board asks for an extension to complete the report. The Department pointed out that paragraph (I)(10) was modified to address this concern. When it is not possible for the investigator to reach a preliminary finding regarding the most serious allegations (i.e., physical abuse or sexual abuse) within 14 days, the investigator is required to notify the individual/guardian of the status of the investigation every 7 days thereafter.

Paragraph (M): One person suggested that county boards do not timely close major unusual incidents or report findings and suggested individuals need information to ensure due process. The Department responded by pointing to paragraphs (K) and (L) of the rule. An individual is always notified via the written summary when a major unusual incident in Category A or Category B is closed. Paragraph (L) sets forth a process for the individual/guardian to dispute the findings of the written summary.

Paragraph (R): One person suggested that agency workers do not know how to file a major unusual incident which often leads to failure to report. The Department responded that paragraph (D)(1) of the rule was added to explicitly state, early in the rule, that a developmental disabilities employee must immediately report a major unusual incident. All direct support professionals must be trained in reporting incidents prior to direct contact with an individual served and receive annual training thereafter. Any person who believes a major unusual incident has not been properly reported should contact the local county board of developmental disabilities or contact the Department by:

- Calling the Department's Abuse and Neglect Hotline (1-800-617-6733) during business hours, or
- Reporting abuse or neglect online.

Incorporated Comments into Rule(s)

Indicate how comments received during the hearing process were incorporated into the rule(s). If no comments were incorporated, explain why not.

The Department alphabetically reordered the sub-paragraphs of (C)(16)(b)(v) which describe specific peer-to-peer acts.