INSTRUCTIONS FOR COMPLETING FORM OMR 147

Use of Form OMR 147: All agencies are to use Form OMR 147 to report reportable incidents, serious reportable incidents and abuse allegations to the DDSO and other parties designated to receive such information in Part 624.

Intent of the Form. Form OMR 147 is intended to be used specifically for the purpose of identifying and recording that an event which must be reported in conformance with Part 624 has occurred. It is the first documentation of that event. For serious reportable incidents and allegations of abuse Form OMR 147 must be completed within 24 hours of the event's occurrence/discovery. For reportable incidents Form OMR 147 must be completed within 48 hours of the event's occurrence/discovery. It is not intended to capture information collected subsequent to the identification of the event (e.g. investigation reports, medical reports or findings, notifications, standing committee review documentation, etc.). Any agency may design and use adjunct forms for the recording of information subsequent to the reporting of an incident or allegation of abuse (e.g. record of notifications made, medical reports, checklist of actions taken, etc.). It is permissible for an agency to print an adjunct form on the reverse side of Form OMR 147.

Obtaining Form OMR 147: As Part 624 requires the use of Form OMR 147, it is available to all facilities from OMRDD, Central Services, 44 Holland Ave., Albany, NY 12229. The new form is also available on the OMRDD website at www.omr.state.ny.us. Look under "Information for Providers." Near the bottom of the page, see "Forms, Manuals and Publications…." Click on "Forms." The incident reporting forms are at the bottom of the page. Use the password "provider" to access the forms.

General Instructions for Completing Form OMR 147:

- Type or print legibly, using a dark colored ink that will reproduce when photocopied.
- Enter the complete names of agencies and facilities, as appropriate.
- The staff who may complete Form OMR 147 are to be designated in agency policy.
- Full names of persons receiving services and staff are to be used in completing Form OMR 147.
- Complete each line or box; if the requested information is not applicable, enter "N/A."

Line-by-Line Instructions for Completing Form OMR 147

Form OMR 147 is completed by all agencies for reportable incidents, serious reportable incidents and allegations of abuse that happen to or involve people receiving services. For family care homes, the sponsoring agency completes the Form.

Item 1 - AGENCY COMPLETING THIS FORM
Enter the name of the agency that is initiating the report (this is the agency under whose auspices the event occurred or which is responsible for taking appropriate steps if the event was not under the auspices of any agency). For state operated programs, enter the appropriate DDSO name.

Item 2 - FACILITY
Enter the name of the facility where the event occurred or is alleged to have occurred. For family care homes, the sponsoring agency is to enter the name(s) of the certified provider(s). Enter N/A if the location is a non-certified one.

Item 3 - PROGRAM TYPE
Specify the type of facility identified in Item 2 by the following classifications (the initials may be used):

- Supervised Individualized Residential Alternative (IRA - Supervised)
- Supportive Individualized Residential Alternative (IRA - Supportive)
- Intermediate Care Facility (other than a DC) (ICF)
- Developmental Center (DC)
- Small Residential Unit (SRU)
- Family Care (FC)
- Supervised Community Residence (CR - Supervised)
- Supportive Community Residence (CR - Supportive)
- Free Standing Respite (FSR)
- Residential School (RS)
- Day Habilitation Site (DH)
- Day Treatment (DTX)
- Day Training (DT)
- Clinic (C)
- If none of the above, specify

If the facility identified in Item 2 is State operated, also enter "SO." If the facility identified in Item 2 is voluntary operated, also enter "VO." For family care homes sponsored by a DDSO, use "SO." For family care homes sponsored by a voluntary agency, use "VO."

If the site is a non-certified location, be as specific as possible. For example, if the person lives with his or her family, enter "family home;" if the person resides in his/her own apartment, enter "own apartment."

Item 4 - FACILITY ADDRESS
Enter the complete address of the facility or non-certified location identified in Item 2.

Item 5 - PHONE
Enter the telephone number, including the area code, of the facility or non-certified location identified in Item 2.

Item 6 - INCIDENT/ALLEGATION REFERENCE NUMBER
Each occurrence/event being reported should be assigned an incident or allegation reference number. It would be beneficial if the numbering system enabled the agency to distinguish between those incidents/allegations that occur in a facility and those that occur at a non-certified location. If there is more than one person receiving services involved in the reported event requiring the filing of more than one report, the same reference number is to be specified on each report. They should be coded to indicate that there is more than one report related to a particular occurrence/event (e.g. 1001-A and 1001-B; or 1001.1 and 1001.2; or 1001-1 of 2 and 1001-2 of 2) in accordance with the agency's numbering/identification system.

Item 7 - WAS AN OMR 147 PREVIOUSLY SUBMITTED?
If an event was initially reported as an incident and upon investigation the incident was upgraded to a possible case of abuse, a new OMR 147 must be filed to report the allegation of abuse. For example, an OMR 147 was filed when it was discovered that a person receiving services has an injury requiring medical treatment (incident). Subsequently, in the process of determining the cause of the injury it is discovered that the individual had been hit by a staff person causing the injury. A new OMR 147 would be completed at the time of discovery of the possible abuse. In Item 7, indicate if an OMR 147 was previously submitted regarding the event/occurrence.

Item 8 - NAME OF PERSON RECEIVING SERVICES (LAST, FIRST)
Enter the full name of the person receiving services to which the incident or alleged abuse occurred by entering the last name and then the first name (carefully check spelling). Do not use nicknames. If more than one person receiving services is involved in the same event, it is permissible to note, "see attached," and to attach a list of names with appropriate information. If the occurrence being reported is a "possible criminal act," it is the name of the individual suspected of committing the act that is entered here.

Item 9 - DATE OF BIRTH
Enter the date of birth of the person receiving services whose name appears in Item 8.

Item 10 - GENDER
Check "M" for male or "F" for female for the person receiving services whose name appears in Item 8.

Item 11 - I.D. NUMBER
Enter whatever identifying number is used for the person receiving services by the agency.

Item 12 - DATE AND TIME INCIDENT/ALLEGED ABUSE WAS OBSERVED/DISCOVERED:
Indicate whether the date and time entered in this section was that of observation or discovery by making an "x" in the appropriate box. If the report is made at the time the event took place (or immediately subsequent to it), mark the "observed" box. If the report is made at another time (hours, days, weeks later) because it was discovered due to physical evidence or reported at a later date, rather than when witnessed and reported immediately, mark the "discovered" box, even if the exact time the event took place is reported then. Complete the rest of the Item by filing in the month, day (date), year,

hour, and minutes using the boxes provided. One number only should be entered in each division. Make an "x" in the applicable box to indicate whether the time is between midnight and 11:59 (A.M.) or between noon and 11:59 (P.M.). The next item records the date and time the event occurred. If the report is made out immediately, based on observation, the dates and times in Items 12 and 13 would be the same.

Item 13 - DATE AND TIME INCIDENT/ALLEGED ABUSE OCCURRED, IF KNOWN
If the event was witnessed, this would be the same date and time as the previous entry. If the event was "discovered" (learned about later by physical evidence or reported at a later date, rather than when witnessed and reported immediately), and the person receiving services or staff can provide information as to the date and time the event was supposed to have happened, it would be entered here.

Item 14 - PRELIMINARY CLASSIFICATION
Check one box which most closely describes the situation. Do not add a category not listed. Make the decision based on the definitions in Part 624.

Item 15 - SPECIFIC LOCATION WHERE INCIDENT/ALLEGED ABUSE OCCURRED
Check only one box. If the situation could be classified in more than one category the most serious category should be checked. For example, if there is an allegation that a staff member yelled at and then punched a consumer, the classification would be physical abuse, not psychological. If the location where the event occurred is not listed, check "Other" and specify the location.

Item 16 - DESCRIPTION OF THE INCIDENT/ALLEGED ABUSE
A clear, concise description of those facts known at the time the report is being completed must be provided here without speculation or opinion. The description should cover the who, what, where, and when and how of the incident. The full names of all persons receiving services, staff, or others either involved in or witness to the incident are to be listed. If additional space is needed, continue the description on a separate sheet of paper. When providing the "who" information, be sure to include the names and title (or other appropriate descriptor) of those involved or who are witnesses.

Item 17 - IMMEDIATE CORRECTIVE/PROTECTIVE ACTIONS
List all the corrective/protective actions taken to ensure the health or safety of those receiving services is maintained. This should include, but is not limited to any initial medical/dental treatment (including first aid) or counseling provided. Other examples are: increased supervision, staff reassignment/removal, correction of hazardous conditions, training provided, etc. Include a brief description of these actions (attach another sheet of paper, if necessary). However, do not delay notifications and distribution until information is available or confirmed. It can be included in the file at a later date.

Item 18 - REFERRAL TO ADULT PROTECTIVE SERVICES (APS)
Indicate if a referral was made to APS by checking the appropriate box. If a referral was made, indicate if it was accepted, not accepted or if acceptance is unknown.

Item 18a - REFERRAL TO THE STATEWIDE CENTRAL REGISTER OF CHILD ABUSE AND MALTREATMENT
Indicate if a referral was made to the Statewide Central Register of Child Abuse and Maltreatment by checking the appropriate box. If a referral was made, indicate if it was accepted, not accepted or if acceptance is unknown.

Item 19 - PERMANENT RESIDENTIAL ADDRESS AND PHONE NUMBER
If the report is not initiated at the residence of the person receiving services (identified in Item 8), the name, address and phone number of the place of residence of the person receiving services must be entered in this Item. For individuals in family care, the family care provider's name must be included. If the place of residence is the same as the facility specified in Item 2, enter "same."

Item 20 - DDSO
Enter the name of the DDSO in whose area the facility is located. To decide which DDSO should be listed, determine the catchment area of the location of the facility where the event occurred. For non-certified services determine the catchment area of the administrative offices of the staff (or staff supervisor, if the staff does not have an office location).

Item 21 - TYPE OF RESIDENCE
Check the appropriate box that applies to the residence of the person receiving services (identified in Item 8):

1) SOIRA State Operated Individualized Residential Alternative
2) VOIRA Voluntary Operated Individualized Residential Alternative
3) SOICF State Operated Intermediate Care Facility
4) VOICF Voluntary Operated Intermediate Care Facility
5) FC Family Care
6) DC Developmental Center
7) CR Community Residence
8) Other

Item 22 - TEMPORARY RESIDENTAL ADDRESS AND PHONE NUMBER
If, because of the incident/alleged abuse or any other reason, the person (identified in Item 8) is no longer at the residential location specified in Items 2 or 19, enter the specific name, address and phone number of the individual's present location (e.g., hospital, respite, private family home, etc.).

Item 23 - NAME OF PARTY COMPLETING FORM, TITLE, SIGNATURE, DATE
The party completing this form is to print his or her name and title, to sign in the space designated, and to enter the date the form was completed.

Item 24 - NAME OF PARTY REVIEWING FORM, TITLE, SIGNATURE, DATE
The party completing the first review of the event and the form is to print his or her name and title, to sign in the space designated, and to enter the date of the review. The person signing this section is indicating that the form is as accurate and complete as can be immediately determined. Corrections or additions can be made at a future date in the file. However, distribution of this form is not to be delayed pending this entry.

Item 25 - DDSO DIRECTOR/AGENCY CHIEF EXECUTIVE OFFICER OR DESIGNEE NOTIFICATION
Indicate whether or not the DDSO Director/Agency Chief Executive Officer or designee has been notified of the event or situation. Include the date of notification. Distribution of this form is not to be delayed pending this entry.