EMBERS TO BLOOM LLC INCIDENT REPORTING & EMERGENCY POLICY

Policy Name: 2.9 Incident Reporting & Emergency Policy
Policy Number: EB-INC-001
Original Effective Date: 09/01/2025
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Next Review Date: 09/03/2027

Policy Statement
This policy ensures all incidents, including injury, medical emergency, suspected abuse/neglect, client death, or threats of violence, are reported and managed promptly to protect client and staff safety and aligns with OAC 5122-26-13 regarding incident reporting and OAC 5122-26-16 regarding quality assurance.

Definitions

- Incident: Any event that is not consistent with the routine care of a client, the routine operations of the agency, or the routine operations of a facility.
- Critical Incident: A serious event that poses an immediate risk to the health, safety, or well-being of a client.

Scope
Applies to all staff, contractors, and volunteers at Embers to Bloom. This policy applies to incidents involving clients, staff, and visitors and governs incidents occurring at agency locations, during community-based service delivery, and during any agency-arranged transportation.

Reportable Incidents (per OAC 5122-26-13 Appendix)
The following incidents must be reported and documented:

1. Death of a client (any cause).
2. Suicide attempt (with or without injury) and any self-harm requiring medical evaluation.
3. Serious injury to a client, staff, or visitor requiring medical treatment (including ER or urgent care).
4. Unplanned hospitalization or emergency department visit related to an incident (injury, overdose, self-harm, severe reaction, etc.).
5. Alleged or suspected abuse, neglect, exploitation, or fraud of a client.
6. Sexual assault, sexual contact, or sexual harassment involving a client, staff, or visitor (alleged or confirmed).
7. Physical assault, fight, or threats of violence involving a client, staff, or visitor.

8. Medication error or adverse drug event resulting in permanent harm, hospitalization or death.
9. Law enforcement involvement related to a client or occurring during agency services (arrest, detainment, welfare check, or police response).
10. Unauthorized absence/elopement of a client while under agency responsibility.
11. Emergency medical intervention, such as 911 call, CPR, or use of naloxone, including any event requiring first aid or emergency/unplanned medical intervention as defined by OAC 5122-26-13 Appendix A.
12. Fire, natural disaster, power outage, or environmental hazard affecting client or staff safety.
13. Vehicle accident involving clients or staff during agency-arranged transport.
14. Weapons or other dangerous contraband discovered or used during service activity.
15. Rights or confidentiality breach (e.g., HIPAA or client rights violation).
16. Any other event that a reasonable person would judge to pose a significant risk to health, safety, or service integrity, or that requires external reporting.
17. Death by suicide, homicide, or accidental/unexpected death of a client while in care or during agency activity.
18. Involuntary termination of services without appropriate client involvement, notice, or referral.
19. Adverse drug reaction resulting in harm, hospitalization, or death.
20. Alleged or confirmed employee theft of medication.
21. Communicable disease exposure or other medical event significantly impacting agency operations (e.g., quarantine, outbreak, or health-department notification).
22. Inappropriate or unauthorized use of seclusion or restraint.
23. Injury or death related to seclusion or restraint.
24. Prohibited restraint techniques or other inappropriate use of force.
25. Six-month reportable data: aggregate seclusion and restraint incidents and related injuries will be tracked and reported every six (6) months per OAC 5122-26-13(G).

Procedures

1. Immediate Action
   Staff must respond to ensure safety and obtain medical or emergency assistance when necessary.
2. Reporting

- All incidents must be reported to the Compliance Director (Incident Officer), who serves as the Executive Director's designee for incident reporting.
- Critical incidents must be reported immediately to leadership and external authorities as required.
- All incident reports must be submitted in writing within 24 hours of discovery.

3. Documentation

- Staff must complete an Incident Report Form within 24 hours of the event.
- Reports must include: date/time, location, individuals involved, description of the incident, action taken, and follow-up required.

4. Review and Investigation

- The Compliance Director will review all incident reports, investigate as necessary, and document findings.
- Root cause analysis will be conducted for critical incidents.
- If an incident involves a potential violation of client rights, the matter will also be referred to the Client Rights Officer and processed according to the agency's Grievance Policy (EB-CR-002).

5. Tracking and Quality Assurance (QA)

- All incidents will be logged in the Incident Tracking System.
- The log will be reviewed quarterly as part of the Quality Assurance program in accordance with OAC 5122-26-16 to identify trends, corrective actions, and performance improvement opportunities.
- Summaries of incident data will be reviewed by leadership and incorporated into the agency's annual Quality Improvement Plan.
- Root-cause analyses and corrective actions will be documented and reviewed as part of the Performance Improvement process.

6. Notification

- Incidents will be reported to OhioMHAS and other external bodies as required by law.

- Clients and guardians will be informed of incidents as appropriate.
- All incident reports and logs will be retained for a minimum of six (6) years from the date of the occurrence or closure, whichever is later.

Non-Retaliation
No staff member or client will face retaliation for reporting an incident in good faith.