From: Linguard, Christie
Subject: Meeting Notice - The Commission of the SCDDSN - Policy Committee Meeting - June 14, 2022
Date: Friday, June 10, 2022 12:37:51 PM
Attachments: June 14 2022 Policy Committee Packet.pd

Everyone,

The South Carolina Commission on Disabilities and Special Needs will hold an in-person Policy Committee meeting on Tuesday, June 14, 2022, at 10:00 a.m. The Committee Meetings are held at the SC Department of Disabilities and Special Needs Central Administrative Office, 3440 Harden Street Extension, Columbia, SC. This meeting can also be viewed via a live audio stream at www.ddsn.sc.gov.

Please see the attached meeting agenda for the Policy Committee Meeting.

For further information or assistance, contact (803) 898-9769 or (803) 898-9600.

Thank you.

POLICY COMMITTEE AGENDA

DRAFT

Commission of the South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Columbia, South Carolina

June 14, 2022 **10:00 a.m.**

1. Call to Order **Committee Chair Barry Malphrus**

2. Statement of Announcement **Lori Manos on behalf of Chairman Malphrus**

3. Invocation **Committee Chair Barry Malphrus**

4. Adoption of Agenda

5. Approval of Summary Notes from May 11, 2022 Meeting (TAB 1, pg. 1-2)

6. New Business: (TAB 2)

A. 567-04-DD: DDSN approved Crisis Prevention Curricula List and Curriculum Approval Process (pg. 3-5)
B. 600-05-DD: Behavior Support, Psychotropic Medications and Prohibited Practices (pg. 6-21)
C. 100-30-DD: Eligibility Determination (pg. 22-34)
D. 535-09-DD: Research Involving DDSN Resources and/or Persons Receiving Services from or Staff Employed by DDSN – Review and Approval (pg. 35-39)
E. 535-11-DD: Appeal and Reconsideration of Decisions (pg. 40-46)

7. Old Business: (TAB 3)

A. 104-01-DD: Certification and Licensure of DDSN Residential and Day Facilities (pg.47-81)
B. 104-03-DD: DDSN Contract Compliance/Quality Assurance Reviews for Non-ICF/IID Programs (pg. 82-93)
C. 275-01-DD: Missing Property Reporting (pg. 94-104)
D. 535-02-DD: Human Rights Committee (pg. 105-119)
E. 603-02-DD: Employee Health Requirements (pg. 120-125)

8. Status Update on Directives Referred to Staff

9. Adjournment – Next Meeting July 12, 2022

DRAFT

MEETING SUMMARY OF THE POLICY COMMITTEE
Commission of the South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Columbia, South Carolina
May 11, 2022

IN ATTENDANCE: Chairman, Barry Malphrus; Commissioner Eddie Miller; Commissioner David Thomas
Dr. Michelle Fry, Lori Manos, Harley Davis, Tracey Hunt, Janet Priest, PJ Perea, Erin Oehler
Ann Dalton, Courtney Crosby and Colleen Honey

1. Adoption of Agenda

Chairman Malphrus requested committee members to adopt the agenda.

As there were no objections, agenda was adopted.

2. Approval of Summary Notes from the April 12, 2022 Meeting

Chairman Malphrus requested committee members to adopt the summary notes.

As there were no objections, summary notes from the April 12, 2022 meeting were adopted.

3. Old Business:

A. 413-03-DD: Code of Conduct

During a previous meeting staff were asked to research whether other state agencies have dollar limits on gifts between co-workers. Language was added to clarify the state ethics law regarding gifts which prevents inappropriate behavior or influence. As there were no objections, the directive will be presented to the full Commission for approval and signing.

4. **New Business:**

A. 275-01-DD: Missing Property Reporting

After discussion, the Committee agreed to leave the dollar amount on DDSN property at $100.00, but add language to section Procedures, I. DDSN Property, to state “up to and including termination.” As there were no objections, the directive will be sent for external review and will be brought to the Committee at the next meeting for discussion to forward the directive to the full Commission for approval and signing.

B. 535-02-DD: Human Rights Committee

After discussion, the Committee agreed to add to the section MEMBERSHIP wherein the reappointment was changed to two consecutive terms. As there were no objections, the directive will be sent for external review and will be brought to the Committee at the next meeting for discussion to forward the directive to the full Commission for approval and signing.

C. 104-01-DD: Certification and Licensure of DDSN residential and Day Facilities

After discussion, the Committee agreed to accept staff recommended changes. As there were no objections, the directive will be sent for external review and will be brought to the Committee at the next meeting for discussion to forward the directive to the full Commission for approval and signing.

D. 104-03-DD: DDSN Contract Compliance/Quality Assurance Reviews for Non-ICF/IID Programs

After discussion, the Committee agreed to accept staff recommended changes. As there were no objections, the directive will be sent for external review and will be brought to the Committee at the next meeting for discussion to forward the directive to the full Commission for approval and signing.

4. Status Update on Directives Referred to Staff

Ms. Lori Manos gave an update on the following directives:

100-25-DD: Disaster Preparedness Plan for DDSN and Other DDSN Providers of Services to Persons with Disabilities and Special Needs
603-02-DD: Employee Health Requirements
603-05-DD: Policy for Management of Occupational Exposures of Health Care Personnel to Potential Blood Borne Pathogens

The three directives went out for public comment (expires April 21, 2022). No comments were received. Accordingly, staff will present to the Commission for approval and signing at the May Commission meeting.

6. Adjournment

The next meeting will take place on June 14, 2022.

3440 Harden Street Extension
Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

Reference Number: 567-04-DD

Title of Document: DDSN Approved Crisis Prevention Curricula List and Curriculum Approval Process

Date of Issue: January 1, 2009
~~Effective Date: January 1, 2009~~
~~Last Review Date: November 19, 2020~~
Date of Last Revision: ~~November 19, 2020~~ XXXX 2022 (**REVISED**)
Effective Date: ~~January 1, 2009~~XXXX, 2022

Applicability: DDSN Regional Centers, DDSN Operated Community Settings, DSN Boards, Adult Companion Providers, Day Service Providers (Career Prep, Day Activity, Community Services, Support Center), Early Intervention Providers, Employment Service Providers, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), Residential Habilitation Providers and Respite Providers

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PURPOSE

This document establishes the requirement for all South Carolina Department of Disabilities and Special Needs (DDSN) operated programs (DDSN Regional Centers and DDSN Operated Community Settings), DSN Boards, and Contract Service Providers to choose and utilize a validated, competency-based curriculum or system for teaching and certifying staff to prevent and respond to disruptive behavior and crisis situations.

This document also establishes the requirement for the DDSN approval of curricula and includes procedures for submission of curricula to DDSN for review.

POLICY

Any system utilized to prevent and respond to disruptive behavior and crisis situations must reflect the values and principles of DDSN. A Crisis Prevention Management Curriculum is only approved once it has been determined that it aligns with DDSN philosophies and it has a strong focus of training in the area of interpersonal skills (e.g., active listening, problem solving, negotiation, and conflict management). ~~In addition, DDSN prohibits training curricula that include techniques involving the use of force (such as chokeholds that would cut of air in any form that would prevent breathing, prone restraints or other techniques that inhibit breathing etc.) for self-defense or control that entities such as law enforcement would utilize.~~ Providers should refer to DDSN Directive 600-05-DD: Behavior Support, Psychotropic Medications and Prohibited Practices.

~~Only the techniques included in the approved system/curriculum shall be used. Techniques included in the chosen system/curriculum shall only be employed by staff members who have been fully trained and deemed competent in the application of the techniques. The use of techniques not included in the chosen system/curriculum including homemade techniques or placing hands on someone in anyway, and/or the application of techniques by untrained staff shall constitute abuse.~~

Staff members (professional and paraprofessional) who provide direct support/services or supervise those who provide direct supports/services must be certified in the system chosen before performing the skill (refer to DDSN Directive 567-01-DD: Employee Orientation, Pre-service and Annual Training Requirements). When those supported are present and under the supervision of staff, at least one staff member who is certified in the chosen system must be, ~~present. By present, staff who are certified must, at a minimum, be within a five (5) minute response time of any who are not certified.~~ at a minimum, within a five (5) minute response time of any who are not certified. Certified staff must be clearly identified and known to non-certified staff so, if needed, assistance can be obtained.

Neither this directive nor the content of the chosen curriculum in any way affects the requirements for individualized Behavior Support Plans (refer to DDSN Directive 600-05-DD: Behavior Support, Psychotropic Medications and Prohibited Practices). The techniques employed by a chosen system are for use during emergency situations when no Behavior Support Plan has been designed (i.e., unpredictable occurrences) or when the current Behavior Support Plan fails to protect those involved from harm. In the event a person's Behavior Support Plan and the crisis response techniques within are unable to safely manage the situation, staff may call 911.

APPROVED CURRICULA

Only the systems/curricula listed below have been approved for use by DDSN:

1. MANDT
2. Crisis Prevention Institute
3. PCM – Professional Crisis Management
4. Therapeutic Options Training Curriculum

5. PCS Life Experience Model

6. TCI – Therapeutic Crisis Intervention System

7. Safety-Care

8. Ukeru Systems

9. The Aegis System

This directive will be updated when additional systems/curricula are approved. Any system on the list may be selected for use. Appropriate use of an approved system/curriculum includes competency-based assessment of employee skills and re-certification on the schedule required by the system/curriculum for trainers and staff.

When a system or curriculum that has not previously been approved is desired, the board/provider must submit to ~~DDSN Central Office, Intellectual Disabilities/Related Disabilities Division~~ the DDSN Quality Management Director a request that includes the name of the system for which approval is sought and either information about the system or a Web-address where system information can be located. Once information is reviewed, the board/provider will be notified of the decision in writing.

Barry D. Malphrus
Vice-Chairman

Stephanie M. Rawlinson
Chairman

Reference Number:	600-05-DD
Title of Document:	Behavior Support, Psychotropic Medications, and Prohibited Practices
Date of Issue:	June 1, 1987
~~Effective Date:~~	~~June 1, 1987~~
~~Last Review Date:~~	~~January 17, 2019~~
Date of Last Revision:	~~January 17, 2019~~XXXX, 2022 **(REVISED)**
Effective Date:	~~June 1, 1987~~XXXX, 2022
Applicable for Receiving:	Intermediate Care Facilities for Individuals with Persons Intellectual Disabilities (ICF/IID), Residential Habilitation, and Employment/Day Services (Day Activity, Career Preparation, Community Services, Employment Services, Support Center Services)

PURPOSE

The purpose of this directive is to establish the expectations of the South Carolina Department of Disabilities and Special Needs (DDSN) regarding interventions used to address concerning or problem behaviors exhibited by those served in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), those receiving Residential Habilitation in a DDSN-sponsored residential setting, and those for whom such interventions are necessary in order for them to participate in a DDSN-licensed employment/day program. Those interventions include~~:~~ Behavior Support Plans; Psychotropic Medications; Emergency Interventions; and Health-Related Protections.

- ~~Behavior Support Plans which are defined as specific plans that teach or assist someone to build positive behaviors to replace or reduce problem behaviors and, when necessary, include strategies to be used to protect the person when dangerous and unsafe behaviors are exhibited.~~

- ~~Psychotropic Medications which are defined as any medication used for the primary purpose of affecting overt maladaptive behavior, mood, or thought processes, or alleviating symptoms related to a specific diagnosed psychiatric condition.~~

- ~~Emergency Interventions which are defined as procedures used to provide protection from harm in situations where the person is endangering him/herself or, others with severely aggressive, self-injurious, or destructive behavior. These behaviors could not reasonably have been anticipated in the current setting and there is no approved behavioral, medical or psychiatric program in effect that provides adequate protection from harm.~~

- ~~Health-Related Protections which are defined as restraint (chemical, physical, or mechanical) used during the conduct of a specific medical, dental, or surgical procedure or used out of necessity during the time a medical condition exists. Examples of devices used as a health-related protection include, but are not limited to: splints, braces, bed rails, wheelchair harnesses, helmets, and lap belts.~~

NOTE:

- Throughout this directive, DDSN Regional Centers and ICFs/IID operated by DSN Boards or contracted service providers will be referred to as "facility." When referring to agencies (DDSN, DSN Boards or contracted service providers) that provide Residential Habilitation and/or Employment/Day Services, "provider" will be used.

- Throughout this directive, "client representative" is used. In the context of this directive, "client representative" means the parent, guardian, legal counsel or other person who acts on behalf or in the best interest of a person with Intellectual Disability or a Related Disability (ID/RD) including Autism. This definition is consistent with S. C. Code Ann. § 44-26-10 et. seq. (2018).

- Client representative does not apply to those receiving services under the category of HASCI as there is no statutory authority for such.

DEFINITIONS

- Behavior Support Plans: Specific plans that teach or assist someone to build positive behaviors to replace or reduce problem behaviors and, when necessary, include strategies to be used to protect the person when dangerous and unsafe behaviors are exhibited.

- Psychotropic Medications: Any medication used for the primary purpose of affecting overt maladaptive behavior, mood, or thought processes, or alleviating symptoms related to a specific diagnosed psychiatric condition.

- Emergency Interventions: Restrictive procedures (manual restraint and chemical restraint) used to provide protection from harm in situations where the person is endangering him/herself or others with severely aggressive, self-injurious, or destructive

behavior. These behaviors could not reasonably have been anticipated in the current setting and there is no approved behavioral, medical or psychiatric program in effect that provides adequate protection from harm.

- Health-Related Protections: Restraints (manual or mechanical) used during the conduct of a specific medical, dental, or surgical procedure or used out of necessity during the time a medical condition exists. Examples of devices used as a health-related protection include, but are not limited to: splints, braces, bed rails, wheelchair harnesses, helmets, and lap belts.

- Manual restraint: Any physical method that purposely limits or restricts a person's freedom of movement, or normal functioning of, or normal access to, a portion or portions of a person's body. Manual restraint means and includes the term "physical restraint."

- Mechanical restraint: Any device, material or equipment attached to a person's body which cannot easily be removed and is used to restrict a person's free movement or access to the person's body. Examples include, but are not limited to: humane wraps, blanket wraps, transport jackets, mittens, four-point restraints, head straps, camisoles, helmets with fasteners, belts, cuffs, chest restraints, etc. Mechanical restraint would also include the unauthorized use of a person's adaptive equipment such as lap trays, gait belts, Merry Walkers, bean bags, etc.

- Chemical restraint: The use of psychotropic medication for the specific and exclusive purpose of controlling acute, episodic behavior that is not standard treatment or dosage for the individual's medical or psychiatric condition.

- Planned restraint: The use of a very specific and identified manual or mechanical restraint, on which staff have been trained, in response to a specific and identified behavior, based upon the results of the functional behavioral assessment, and that is incorporated into a behavior support program.

- Time-out room: A room outside the normal environment that is devoid of positive reinforcers and where an individual is safely placed and prevented from leaving until specific exit criteria have been met;

- Simple correction: Requiring the individual to only restore the environment to the pre-problem behavior state;

- Overcorrection: Corrective efforts which go beyond a simple correction by requiring an individual to vastly improve the condition of the environment, which may be considered a form of punishment;

- Response cost: The loss of either a previously earned reinforcer, or the opportunity to obtain future reinforcers, in response to undesirable or disruptive behavior;

- Differential reinforcement: Reinforcing a specific target behavior while withholding reinforcement from an unwanted behavior;

- Social disapproval: A response to an unwanted behavior where staff members provide a statement of disapproval that may include a re-directive prompt or reminder of social rules.

PHILOSOPHY

Consistent with DDSN's values, it is expected that all supports and interventions to address problem behavior:

- Ensure the health, safety, and well-being of each person;
- Ensure that each person is treated with dignity and respect;
- Encourage participation, choice, control and responsibility;
- Encourage relationships with family and friends, and connections in the community; and
- Result in personal growth and accomplishment.

Consistent with DDSN's principles, it is expected that supports and interventions to address problem behavior will:

- Be person-centered and community inclusive;
- Be responsive, effective and accountable;
- Be practical, positive and appropriate;
- Be strengths-based and results-oriented;
- Offer opportunities to be productive and maximize potential; and
- Feature best and promising practices.

As a foundation of all supports, DDSN embraces positive behavior support. Positive behavior support recognizes that people exhibit problem behavior because it serves a useful purpose for them in their current situation/circumstances. The focus of positive behavior support begins with understanding the purpose or function of the problem behavior. Once it is known why the behavior occurs, interventions to promote positive behavior that serves the same function can be developed.

The goal of positive behavior support is not solely to eliminate problem behavior but to create environments and patterns of support that make the problem behavior irrelevant, inefficient or ineffective while making the positive behavior that is promoted as an alternative, relevant, effective and efficient.

DDSN believes that all who develop intervention strategies for people with disabilities must be knowledgeable in the values, theory, and practices of positive behavior support. Literature such as Functional Assessment and Program Development for Problem Behavior: A Practical Handbook (O'Neill, Horner, et. al., 2014) or similar guides to evidence-based practices in positive behavior support are recommended for review and study.

POLICY

Those supported will be free from any serious risk to physical and psychological health and safety at all times, including while the function of the problem behavior is being determined and while the interventions to address the behavior are being developed.
DDSN prohibits the use of the following:

- Procedures or devices used for disciplinary purposes, for the convenience of staff, or as a substitute for needed supports;
- The use of medication for disciplinary purposes, for the convenience of staff, as a substitute for training or engagement, or in quantities that interfere with someone's quality of life;
- Seclusion which is defined as placing someone alone in a locked room;
- Enclosed cribs;
- Interventions that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
- Encouraging/using someone supported to discipline a peer;
- Prone ~~basket hold~~ restraint ~~(i.e., person held face down with arms folded under the chest)~~;
- Restraints that obstruct the airway or impair breathing by putting pressure on the torso;
- Any strategy in which a pillow, blanket or other item is used to cover the individual's face as part of restraint process;
- Any restraint that causes hyperextension of joints;
- Physical holds that rely on pain inducement;
- Time out rooms;
- Aversive consequences which are defined as the use or threatening the use of startling, unpleasant or painful consequences; ~~;~~

- As needed (PRN) orders for psychotropic medications ~~or mechanical restraint~~ except when prescribed by a physician while treating the person in a hospital setting or prescribed as part of the palliative care provided by Hospice;

- As needed (PRN) order for manual restraint or mechanical restraint;

- Use of psychotropic medications in the absence of a Behavior Support Plan or an authorized Emergency Intervention ~~for problem behavior and/or psychiatric symptoms that pose a risk to the person, peers, or the environment and interfere with the person's daily functioning;~~

- The planned use of restrictive procedures and/or restraint (manual, chemical or mechanical) prior to the exhaustion of less intrusive measures;

- The use of restraint (manual or mechanical) for more than one (1) continuous hour (60 continuous minutes);

- The use of restraint (manual, chemical or mechanical) when not necessary to protect the person or others from harm;

- Coercion/use of intimidation or use of force to gain compliance;

- Contingent use of painful body contact;

- Untested or experimental procedures.

Each DDSN Regional Center, DDSN-operated Residential Services, DSN Board or contracted service provider of ICF/IID, Residential Habilitation and/or DDSN-sponsored Employment/Day Services shall adopt written policies and procedures governing the prevention and management of problem behavior. These policies and procedures shall focus on the prevention of problem behavior and specify the facility, program or DDSN-approved procedures that may be used. If consequence-based procedures are approved for use, the policies and procedures shall include each procedure on a hierarchy ranging from most positive/least restrictive to least positive/most restrictive. The policies and procedures shall address the use of restraint, the use of medications to manage problem behavior, and the practices prohibited by the facility, program or board/provider.

For ICF/IID residents, consent for programming, including Behavior Support, must be obtained pursuant to DDSN Directive 535-07-DD: ~~Obtaining Health Care Consent for Minors and Adults~~Obtaining Consent for Individuals Regarding Health Care – Making Health Care Decisions.

In accordance with DDSN Directive 535-02-DD: Human Rights Committee, each facility or provider must designate and use a Human Rights Committee to review and approve planned interventions which involve risk to individual protection and rights. Pursuant to the DDSN Directive 535-02-DD: Human Rights Committee, the Human Rights Committee must review

and approve of the use of planned interventions prior to implementation and appropriate consents/approvals have been obtained. Additionally, the Human Rights Committee must be notified of the use of any Emergency Interventions.

I. BEHAVIOR SUPPORT PLANS

Behavior Support Plans must be developed and monitored in accordance with the regulations governing ICFs/IID when developed for ICF/IID residents and in accordance with DDSN Residential Habilitation Standards for those receiving Residential Habilitation.

Behavior Support Plans include specific procedures or techniques to be utilized to prevent and respond to behavior. These procedures or techniques may be nonrestrictive, restrictive, or employ restraint.

A. BEHAVIOR SUPPORT PLANS: NONRESTRICTIVE

When the procedures or techniques within a Behavior Support Plan do not limit freedom, rights, or allow for the loss of access to personal property, the Behavior Support Plan is considered nonrestrictive. Examples of nonrestrictive procedures or techniques include, but are not limited to, teaching appropriate and functionally-equivalent replacement behavior; differential reinforcement, social disapproval, simple correction, re-directions and interrupting with educative prompts.

NOTE: Behavior Support Plans which accompany the use of psychotropic medications **ARE** considered restrictive.

Prior to implementation of a Behavior Support Plan that utilizes only nonrestrictive procedures/techniques for an ICF/IID resident, the Behavior Support Plan must be approved by the ICF/IID resident's Interdisciplinary Team which includes the person, his/her legal guardian or the person authorized to make health care decisions on behalf of the person, or client representative of a person with an Intellectual Disability/Related Disability and incorporated into the person's Individualized Program Plan (IPP).

Prior to implementation of a Behavior Support Plan for those receiving Residential Habilitation, the Behavior Support Plan must be approved by the person, client representative of a person with ID/RD, and the person responsible for the development of the Residential Habilitation Support Plan. If the Behavior Support Plan is to also be implemented by other service providers (i.e., Employment/Day Services providers), the Behavior Support Plan must be approved by the person(s) who develop the Service Plan(s) for the other services (i.e., the person who develops the Individual Plan for Supported Employment if the plan is to be implemented as part of the provision of Employment Services).

Prior to the implementation of a Behavior Support Plan that utilizes only nonrestrictive procedures/techniques for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and participate in a DDSN-sponsored Employment/Day Service, the

Behavior Support Plan must be approved by the person, client representative of a person with ID/RD, and the person who develops the Employment/Day Service Plan.

Behavior Support Plans that utilize only nonrestrictive procedure/techniques must be monitored in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, DDSN Residential Habilitation Standards, Day Activity Standards, etc.).

B. BEHAVIOR SUPPORT PLANS: RESTRICTIVE

When the procedures or techniques within a Behavior Support Plan limit the person's rights, freedom of movement, or cause loss of access to personal property, the Behavior Support Plan is considered restrictive. Examples of restrictive procedures/techniques include, but are not limited to, increasing the level of supervision provided in response to behavior, one-on-one supervision, response cost, overcorrection, and separation lasting more than five (5) minutes (excluding time-out rooms which are prohibited).

NOTE: Behavior Support Plans which accompany the use of psychotropic medication **are** considered restrictive.

Prior to implementation of a Behavior Support Plan that includes restrictive procedures/techniques, appropriate approvals must be obtained.

Additionally, for ICF/IID residents, the Behavior Support Plan must be approved by the person's Interdisciplinary Team which includes the person, his/her legal guardian, or person authorized to make health care decisions on behalf of the person and the facility's Human Rights Committee.

For those receiving Residential Habilitation, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those receiving Residential Habilitation, the Behavior Support Plan must be approved by the person or his/her legal guardian and the person responsible for the development of the Residential Habilitation Support Plan. If the Behavior Support Plan is also to be implemented by other service providers (i.e., Employment/Day Service providers), it must be approved by the person responsible for developing the Service Plan or the other service (i.e., person who develops the Individual Plan for Supported Employment if being implemented as part of Employment Services). The Behavior Support Plan must be approved by the provider's Human Rights Committee.

For those who reside in their own homes (i.e., not receiving ICF/IID services or Residential Habilitation) and who receive DDSN-Sponsored Employment/Day Services, written informed consent must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and who receive DDSN-sponsored Employment/Day Services, the Behavior Support Plan must be approved by the person or client representative of a person with ID/RD, the person who develops the Employment/Day Service Plan, and the provider's Human Rights Committee.

Behavior Support Plans that include restrictive procedures/techniques must be monitored by the Human Rights Committee and in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, Residential Habilitation Standards, Career Preparation Standards, etc.).

C. BEHAVIOR SUPPORT PLAN: RESTRAINT

~~Restraint is defined as a procedure/technique that involves holding someone (i.e., manual restraint) or applying a device (i.e., mechanical restraint) that restricts the free movement of or normal access to a portion or portions of one's own body.~~

Only when necessary to protect the person or others from harm and only when the procedure/technique is the least restrictive/intrusive alternative possible to meet the needs of the person may ~~restraint procedures/techniques~~ planned restraints be included in Behavior Support Plans.

NOTE: The use of mechanical devices to support proper body positioning, even when movement may be restricted, is not considered restraint. Devices used for proper body positioning must only be used when the medical necessity for the device is clearly documented.

NOTE: ~~Restraint~~ Planned restraints ~~(manual or mechanical) procedures~~ may only be included as an integral part of a ~~in~~ Behavior Support Plan~~s~~ that is intended to lead to less restrictive means of managing and eliminating the behavior that will immediately result in harm. ~~as a planned response to behavior that will immediately result in harm~~. Planned ~~M~~mechanical restraints ~~procedures~~ may also be included in a Behavior Support Plan~~s~~ to address behavior that does not immediately result in harm, but due to the chronic/long term nature of the behavior (i.e., hand mouthing that results in skin breakdown, head banging, removing/picking post-operative sutures, etc.), will result in harm.

When ~~restraint procedures (manual or mechanical) are included in~~ Behavior Support Plans incorporate planned restraints, the Behavior Support Plan must include strategies directed toward decreasing or eliminating their use. These Behavior Support Plans must also include provisions for the use of less intrusive techniques prior to the application of the planned restraint when the problem behavior is occurring.

When ~~restraint procedures (manual or mechanical) are included in~~ Behavior Support Plans ~~as a planned response to problem behavior that will immediately result in harm to self, others, or the environment,~~incorporate planned restraints~~,~~ the plan must direct that, when applied, the person will be released from the planned restraint when he/she is calm and no longer dangerous (not to exceed one continuous hour). When a mechanical restraint ~~procedures are~~ is utilized, the ~~procedures~~ mechanical restraint must be designed and used in a manner that causes no injury and minimizes discomfort.

When mechanical restraint is utilized in a Behavior Support Plan as a response to behavior that will immediately result in harm, the Behavior Support Plan must ~~specify~~ direct staff members to ~~how the person will be supervised~~ maintain visual supervision during the time the mechanical

restraint is applied. The person's response to the mechanical restraint application and his/her physical condition (i.e., breathing, circulation) must be continually monitored ~~at least every 30 minutes~~. Documentation of response and condition must be completed and maintained every 15 minutes during the duration of the mechanical restraint.

When mechanical restraint is utilized in a Behavior Support Plan ~~in~~ as a response to chronic/long term behavior that will result in harm, the Behavior Support Plan must specify the schedule for the use of the mechanical restraint. The schedule must provide for release from restraint for 10 minutes ~~every hour~~ following every 50-minute restraint period. The Behavior Support Plan must include the specific plan for supervising the person when the mechanical restraint is not in use (i.e., during times of release) and specify that the mechanical restraint is not to automatically be reapplied unless the behavior recurs. The person's response to mechanical restraint application and his/her physical condition (i.e., breathing, circulation), must be monitored at least every ~~30~~ 15 minutes. Documentation of response and condition must be completed and maintained.

When, for an ICF/IID resident, a physician-ordered mechanical restraint is employed during sleeping hours to avoid interruption of sleep, release from the mechanical restraint is not required every hour. However, the application of the restraint must be monitored every 60 minutes (1 hour) to ensure it is properly applied and the person is comfortable.

When, for those receiving Residential Habilitation, mechanical restraints are employed during sleeping hours to avoid interruption of sleep, release from the mechanical restraint is not required every hour. However, the application of the restraint must be monitored every 60 minutes (1 hour) to ensure it is properly applied and the person is comfortable.

Prior to the implementation of a Behavior Support Plan that include~~s~~ a planned restraint ~~(manual or mechanical) procedures~~, appropriate approvals must be obtained.

For ICF/IID residents, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with an Intellectual Disability/Related Disability, or the person authorized to make health care decisions on behalf of the ICF/IID resident.

Additionally, for ICF/IID residents, the Behavior Support Plan that includes ~~manual or mechanical restraint~~ planned restraint must be approved by the person's Interdisciplinary Team, which includes the person, his/her legal guardian or person authorized to make health care decisions on behalf of the persons and either the DDSN Regional Center Facility Administrator or the Executive Director of the facility. The Behavior Support Plan must be approved by the facility's Human Rights Committee.

For those receiving Residential Habilitation, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those receiving Residential Habilitation, the Behavior Support Plan that includes ~~manual or mechanical restraint procedures~~ planned restraint must be approved by the person or client representative of a person with ID/RD, the staff responsible for developing the Residential Habilitation Support Plan, the Executive Director of the Residential Habilitation provider, and the provider's Human Rights Committee.

If the Behavior Support Plan requires implementation by other service providers (i.e., Employment/Day Service providers), it must also be approved by the staff responsible for developing the service plan for the other service (i.e., the person who develops the Day Activity Plan of Service) and as appropriate, the other service provider's Executive Director/CEO.

For those who reside in their own homes (i.e., not receiving ICF/IID services or Residential Habilitation) and who receive DDSN-Sponsored Employment/Day Services, written informed consent must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and receive DDSN-sponsored Employment/Day Services, a Behavior Support Plan that includes restraint (manual or mechanical) must be approved by the provider's Human Rights Committee, the person or client representative of a person with ID/RD, the provider staff responsible for developing the Employment/Day Service Plan and the Executive Director of the Employment Day Service board/provider.

Behavior Support Plans that include ~~restraint (manual or mechanical) procedures~~ planned restraint must be monitored by the Human Rights Committee and in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, Residential Habilitation Standards, etc.). Additionally, the use of planned restraints ~~procedures~~ will be monitored by DDSN. When a Behavior Support Plan which includes specific ~~restraint procedures~~planned restraints ~~(manual or mechanical)~~ is approved, the approved Plan must be submitted to DDSN within 20 business days of approval. When the restraint procedure is employed, its actual use must be reported to DDSN. A report of the use of planned manual or mechanical restraint will be made to DDSN quarterly. Reports must be made to DDSN by the 15th day of January, April, July and October for any planned restraint employed during the previous quarter.

January 1st – March 31st	April 15
April 1st – June 30th	July 15
July 1st – September 30th	October 15
October 1st – December 31st	January 15

II. PSYCHOTROPIC MEDICATION

Before psychotropic medications are used as an intervention to address problem behavior, the potential risks of those medications must be carefully weighed against the risk of the behavior for which the medication will be given. The specific concerning behaviors/symptoms for which the medication will be given must be documented along with the consideration of the associated risk.

When psychotropic medications are given, DDSN Directive 603-01-DD: Tardive Dyskinesia Monitoring, must be followed.

When given, psychotropic medications must be reviewed based on the person's needs as determined by the psychiatrist or physician but must be reviewed at least quarterly. Through this review, the Psychotropic Drug Review, the combination of the psychotropic medication and Behavior Support Plan are monitored using the behavioral data collected as part of the Behavior

Support Plan for effectiveness with addressing the specific behaviors/symptoms for which the medication is given. The Psychotropic Drug Review should provide for gradually diminishing medication dosages and ultimately discontinuing the medication unless clinical evidence justifies that the medication is necessary. The Psychotropic Drug Review should be completed with those who know the person well. Those involved in the Psychotropic Drug Review should include, but are not limited to, the physician and/or psychiatrist, the person and/or his/her legal guardian, the person responsible for the Behavior Support Plan, the person responsible for the ICF/IID Individual Program Plan or Residential Habilitation Support Plan, the ICF/IID Nurse and a direct support professional who knows the person well. The health care provider responsible for prescribing the psychotropic medication is responsible for ensuring compliance with the Adult Health Care Consent Act.

For ICF/IID residents, when psychotropic medication is given outside an emergency intervention, a Behavior Support Plan is also required. The Behavior Support Plan must address the behaviors/symptoms for which the medication is given. In combination, the psychotropic medication and the Behavior Support Plan should lead to a less restrictive/intrusive way of managing and, if possible, eliminating the problem behavior and/or psychiatric symptoms for which they are employed.

For those receiving Residential Habilitation in a DDSN-sponsored residential setting, when psychotropic medication is given, outside an emergency intervention, to address problem behavior that poses a significant risk to the person (i.e., self-injury), others (i.e., physical aggression), or the environment (i.e., property destruction), a Behavior Support Plan is required. The Behavior Support Plan must address the specific behaviors/symptoms for which the medication is given. In combination, the psychotropic medication and the Behavior Support Plan should lead to a less restrictive/intrusive way of managing and if possible, eliminating the behaviors/symptoms for which they are employed. For those receiving Residential Habilitation, a Behavior Support Plan is not required in conjunction with psychotropic medication when the person's record clearly documents that he/she:

- Does not exhibit behavior that poses a significant risk to him/herself, others or the environment, and/or;

- Has reached the lowest effective dosage of the medication based on data regarding the occurrence of the specific behavior/symptoms for which the medication is prescribed which is confirmed in writing each quarter by the physician/psychiatrist prescribing the psychotropic medication.

When, for those receiving Residential Habilitation, a Behavior Support Plan is not used in conjunction with psychotropic medication, the specific behavior/psychiatric symptoms targeted for change by the use of psychotropic medications must be clearly noted. Data must be collected on the occurrence of those behaviors/symptoms targeted for change. The collected data must be provided as part of the Psychotropic Drug Review to inform the decisions made therein. Any other problem behavior, especially those which pose a significant risk to the person, others, or the environment, must also be documented and shared as part of the Psychotropic Drug Review.

When psychotropic medications are prescribed for those who participate in a DDSN-sponsored Employment/Day Program and reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation), efforts must be made to obtain information about those medications and the specific problem behaviors or symptoms for which they were prescribed. If those behaviors/symptoms interfere with the person's ability to fully benefit from Employment/Day Services or are sufficiently severe to likely jeopardize the person's ability to continue to live in his/her own home, the need for Behavior Support Services must be discussed with the person's case manager.

NOTE: Services are available through:

- State Funded Community Supports;
- State Funded Follow Along;
- Intellectual Disabilities/Related Disabilities (ID/RD) Waiver;
- Community Supports Waiver; or
- Head and Spinal Cord Injury (HASCI) Waiver.

III. EMERGENCY INTERVENTIONS

DDSN Directive 567-04-DD: Preventing and Responding to Disruptive Behavior and Crisis Situations, establishes the requirement that all DDSN-operated facilities/programs, DSN Board operated facilities/programs and DDSN-qualified service providers utilize a DDSN approved system for teaching and certifying staff to prevent and respond to disruptive behavior and crisis situations. Only the techniques that are part of a DDSN-approved system may be used. ~~in situations where someone is endangering him/herself or others with severely aggressive, self-injurious, or destructive behavior and, because the behavior could not have reasonably been anticipated, there is no approved plan or program in effect that provides adequate protection from harm.~~ When manual restraint techniques are employed as an emergency response~~,~~ the Facility Administrator or the ~~provider~~ Executive Director must be immediately notified. Within 24 hours of the incident, a written report of the incident must be provided to the Facility Administrator/Executive Director and either the person's Interdisciplinary Team or the staff responsible for the person's service plan development.

When a manual restraint is implemented during an emergency intervention, the manual restraint must only be applied until the person is calm and no longer dangerous. While the manual restraint is applied, the person's response to its application must be continually monitored.

~~A chemical restraint is the use of medication for the specific and exclusive purpose of controlling acute, episodic behavior that is not standard treatment or dosage for the individual's medical or psychiatric condition.~~ Chemical restraints are permitted in emergency interventions; however, the Facility Administrator or Executive Director must have given prior written authorization when possible, or prior verbal authorization that must be followed by written authorization within 24 hours of the verbal authorization. The written authorization must document the initial attempt(s) of less intrusive measures being implemented, the specific medication and dosage to

be administered, the time of the verbal authorization, and specify the date and time period for which the authorization is valid.

~~The emergency use of manual restraint is considered a critical incident and must be reported to DDSN in accordance with DDSN Directive 100-09-DD: Critical Incident Reporting.~~

~~As soon as possible following the emergency use of manual restraint, the person's legal guardianmust be notified of the incident. With the consent of the person, his/her family correspondent should be notified of the incident unless the person communicates that they do not want their family to be contacted. If the person is unable to communicate, the family will be contacted. The person must be provided any needed augmentative or alternative communication devices/technology to assist in that dialogue.~~

~~The facility or provider's Human Rights Committee must be notified of the emergency use of manual restraint. The notification must be made in accordance with facility/board/provider policy.~~

~~Each time manual restraint is used as an emergency response, consideration must be given to the circumstances under which the incident occurred and the frequency with which the emergency use of manual restraint is necessary for the person. Once a pattern emerges or when manual restraint is employed twice in a 30 day period or employed three (3) times during any three (3) consecutive month's period, a specific plan must be developed to prevent and/or respond to the behavior.~~

~~In rare circumstances, psychotropic medications or mechanical restraints may be used to provide protection from harm in unanticipated situations where the person is endangering him/herself or others. Prior to use, authorization by the Facility Administrator or provider Executive Director must be given. When possible, prior written authorization should be given. When not possible, prior verbal authorization may be given, but must be followed with written authorization that is completed, signed, and available within 24 hours of the verbal authorization. The written authorization must justify the use of the emergency intervention including the less intrusive measures that were tried but failed. The written authorization must include the specific medication and dosage to be given or the specific mechanical restraint to be applied. If prior verbal authorization was given, the time of the verbal authorization must be included. The authorization must specify the date and time period for which the authorization is valid; authorizations may not exceed 12 hours.~~

~~When mechanical restraint is authorized as an emergency intervention, the restraint may only be applied until the person is calm and no longer dangerous or for a maximum of one (1) continuous hour. While the restraint is applied, the person's response to its application and his/her condition must be monitored at least every 30 minutes. Documentation of the monitoring must be maintained.~~

The emergency use of ~~psychotropic medications~~ manual restraint or chemical~~mechanical~~ restraint is considered a critical incident and must be reported to DDSN in accordance with DDSN Directive 100-09-DD: Critical Incident Reporting.

As soon as possible following the emergency intervention, the person's legal guardian must be notified of the incident. With the consent of the person, his/her family or correspondent should be notified of the incident ~~unless the person communicates that they do not want their family to be contacted~~. If the person is unable to communicate, the family will be contacted.

The facility or provider's Human Rights Committee must be notified of the emergency use of these interventions. ~~The notification must be made~~ in accordance with facility/board/provider policy.

Each time these interventions are used as an emergency response, consideration must be given to the circumstances under which the incident occurred and with which emergency interventions are necessary for the person. Should a pattern emerge, or if manual~~echanical~~ restraint or ~~psychotropic medications~~chemical restraint is~~are~~ employed in response to an emergency twice in a 30 day period or three (3) times during any three (3) consecutive month's period, a specific plan must be developed to prevent and respond to the behavior.

IV. HEALTH RELATED PROTECTIONS

When during the conduct of a specific medical, dental or surgical procedure or during the time in which a medical condition exists, the person requires protection, restraint (~~chemical,~~ manual or mechanical) may be used. These health-related protections must be ordered by the person's physician/dentist. The physician/dentist must specify the schedule for its use and how the use of the protection is to be monitored. Examples of restraints that may be used as a health-related protection include, but are not limited to, splints, braces, bed rails, wheelchair harness, helmets, lap belts and abdominal/torso belts. Because the primary purpose of a health-related protection is not to manage behavior, a Behavior Support Plan is not required.

For an ICF/IID resident receiving services in a DDSN Regional Center, DDSN Directive 603-03-DD: ~~Medical and Dental Treatment of Uncooperative Consumers~~Safety Precautions for Medical and Dental Treatment, must be followed.

~~Gary C. Lemel~~	~~Eva R. Ravenel~~
~~Vice Chairman~~	~~Chairman~~
~~(Originator)~~	~~(Approved)~~
Barry D. Malphrus	Stephanie M. Rawlinson
Vice Chairman	Chairman

To access the following attachment, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

Attachment: Reporting the Use of Planned Restraint

Reporting the Use of Planned Restraint to DDSN

Submitting Behavior Support Plans That Include Restraint Procedures

When any approved Behavior Support Plan (BSP) includes planned restraint (mechanical or manual) procedures, a copy of the BSP must be provided to DDSN. Additionally, a copy of any amendments to BSPs which include planned restraint (mechanical or manual) procedures must be provided to DDSN. "Planned restraint" is intended to mean when mechanical or manual restraint is specifically indicated in the BSP as a planned response to problem behavior that will immediately, or cumulatively result in harm. This does not include the use of restraint as a response to unanticipated dangerous or disruptive behavior or crisis situations.

~~A copy of any BSP which includes planned restraint procedures in use on October 1, 2017 must be provided to DDSN no later than November 1, 2017. Any amendments to these BSPs must be submitted to DDSN within 20 days of approval.~~

~~After October 1, 2017, w~~When a new BSP which includes the use of planned restraint (mechanical or manual) procedures is approved for use or when any existing BSP is amended and approved to add planned restraint procedures, the BSPs must be submitted to DDSN within 20 days of approval.

Copies of BSPs and amendments must be submitted to Mark Morgan through Therap's S-Comm system.

Reporting the Use of Restraint

When, in accordance with the Behavior Support Plan, planned restraint (manual or mechanical) is employed, the use of the planned restraint must be reported to DDSN. These reports should be made quarterly based on the following schedule:

Reporting Period	Report to DDSN
January 1 – March 31	April 15
April 1 – June 30	July 15
July 1 – September 30	October 15
October 1 – December 31	January 15

The report must include the following:

- The Residential Habilitation or ICF/IID provider's name.
- The name of the person for whom restraint was employed.
- The date the restraint was employed. If released and restraint reapplied, two (2) applications should be reported.
- The nonoccurrence of planned restraint procedures during the review period.

These quarterly reports should be submitted to Mark Morgan and should be submitted through Therap's S-Comm system.

Reference Number:	100-30-DD
Title Document:	Eligibility Determination
Date of Issue:	November 7, 2008 (Created from Existing Policy)
~~Effective Date:~~	~~November 7, 2008~~
~~Last Review Date:~~	~~March 14, 2018~~
Date of Last Revision:	~~March 14, 2018~~XXXX, 2022 (REVISED
Effective Date:	~~November 7, 2008~~XXXX,2022
Applicability:	DDSN Eligibility Division, Intake Providers

INTRODUCTION

The following Departmental Directive sets forth the policy, process and procedures used in the determination of eligibility for services and supports through the South Carolina Department of Disabilities and Special Needs (DDSN).

Criteria designated within South Carolina Code of Laws indicate seven (7) different categories of eligibility under the authority of DDSN:

Intellectual Disability (n/k/a, Intellectual Developmental Disorder) (ID);
Related to Intellectual Disability (RD);
High Risk Infant;
Autism Spectrum Disorder (ASD);
Head Injury (i.e., Traumatic Brain Injury); (TBI); Spinal Cord Injury (SCI); and
Similar Disability (SD).

Some individuals may meet DDSN eligibility criteria under more than one (1) category. In such situations, DDSN will consider which category will offer the most appropriate resources and service models to address the needs of the particular person. Individuals with primarily medical

conditions such as Diabetes, Hypertension, Multiple Sclerosis, Parkinson's Disease, Cancer, etc., will not necessarily meet DDSN eligibility criteria under any category. To be determined eligible, the criteria described herein must be met.

DDSN services are available to those who meet the specific criteria described herein and meet residency requirements in at least one of the following categories:

1. The applicant or his spouse, parent, with or without legal custody, or legal guardian is domiciled in South Carolina.

2. The applicant or his/her spouse, parent, with or without legal custody, or legal guardian lives outside South Carolina, but retains legal residency in this State and demonstrates to DDSN's satisfaction his/her intent to return to South Carolina.

3. The applicant or his spouse or parent, with or without legal custody, or legal guardian is a legal resident of a state which is an active member of the Interstate Compact on Mental Health and qualifies for services under it.

Eligibility for DDSN services is determined in ~~three~~ four (~~3~~4) phases. Those phases are:

1. screening,
2. intake,
3. determination of eligibility, and
4. notification of Decision and Right to Appeal.

~~Based on the category in which the applicant is likely to qualify or the age of the applicant, the required phases may vary. For that reason, the remainder of this document is organized as follows:~~

~~**I. SCREENING**~~

~~A. Children less than two (2) years, 11 months of age.~~

~~B. Applicants older than two (2) years, 11 months of age applying under the category of ID, RD, or ASD.~~

~~C. Applicants older than two (2) years, 11 months of age applying under the category of TBI, SCI or both or SD.~~

~~**II. INTAKE**~~

~~A. Children less than two (2) years, 11 months of age.~~

~~B. Applicants older than two (2) years, 11 months of age applying under the category of ID, RD,orASD.~~

~~C. Applicants older than two (2) years, 11 months of age applying under the category of TBI, SCI or both or SD.~~

~~III. DETERMINATION OF ELIGIBILITY~~

~~A. Intellectual Disability~~
~~B. Related Disability~~
~~C. High Risk Infant~~
~~D. Autism Spectrum Disorder~~
~~E. Head and Spinal Cord Injury and Similar Disability~~

~~IV. NOTIFICATION OF DECISION AND RIGHT TO APPEAL~~

I. SCREENING

Screening is used to ensure that those interested in DDSN services are likely to qualify under one of the eligibility categories established by the South Carolina Code of Laws. During screening, questions are asked of the applicant or someone who knows the applicant well in order to identify those who are likely eligible from those with other non-qualifying disabilities. If an individual's needs may be met by another entity, he/she will be referred elsewhere.

~~A. Children less than two (2) years. 11 months of age~~

~~BabyNet is South Carolina's interagency early intervention system for infants and toddlers under three years of age with developmental delays, or who have conditions associated with developmental delays. BabyNet is funded and regulated through the Individuals with Disabilities Education Act, and managed through South Carolina Department of Health and Human Services. Therefore, if a child is less than two (2) years, 11 months of age, the child must be referred to BabyNet before any referral to DDSN can be processed.~~

~~If a child who is less than two (2) years, 11 months of age is receiving Early Intervention services through BabyNet from a DDSN-qualified provider, screening is not required.~~

~~If a child who is less than two (2) years, 11 months of age is receiving Early Intervention services through BabyNet from an Early Intervention provider that is not affiliated with DDSN, the child will be screened using the process outlined in under section II., B. of this document.~~

~~Note: When determined eligible for DDSN services, children who are less than two (2) years, 11 months of age are typically eligible under the category of High Risk Infant. By definition, the High Risk Infant category may only be applied to children who are less than 36 months of age. Therefore, except when in pursuit of DDSN eligibility under the ASD category, children who reach 37 months of age and have not been determined eligible for DDSN services under a category other that High Risk Infant will be closed.~~

~~B. ID, RD, ASD and for Applicants 2 years, 11 Months of Age or older~~

The applicant, his/her legal guardian or someone familiar with the applicant must call DDSN's call center at 1-800-289-7012 to answer questions about the applicant.

If determined by the responses to the questions that the applicant is not likely to be eligible for services (i.e., they are screened out), the applicant/legal guardian will be informed of other community resources or providers from whom assistance may be sought.

If determined by the responses to the questions to likely be eligible for services (i.e., screened in) in the categories of Intellectual Disability (ID), ~~or~~ Related Disability (RD), High-Risk Infant/At Risk Child, Traumatic Brian Injury (TBI), Spinal Cord Injury (SCI) or Similar Disability (SD), the screener will refer the applicant to the provider of their choosing for Intake.

If determined by the responses to the questions to likely be eligible for services (i.e., screened in) in the category of Autism Spectrum Disorder, the screener will refer the applicant to the DDSN Autism Division for Determination of Eligibility.

~~C. TBI, SCI, or both or SD~~

~~The applicant, his/her legal guardian or someone familiar with the applicant must call DDSN's call center at 1-800-289-7012 to answer questions about the applicant.~~

~~If determined by the responses to the questions that the applicant is not likely to be eligible for services (i.e., they are screened out), the applicant/legal guardian will be informed of other community resources or providers from whom assistance may be sought.~~

~~If determined by the responses to the questions to likely be eligible for services (i.e., screened in) in the categories of TBI, SCI or both or SD, the screener will refer the applicant to the provider of their choosing for Intake.~~

II. INTAKE

Intake is defined as the collection and submission of an accurate and complete set of documents in order for DDSN to determine if the applicant is eligible for DDSN services. The document set includes a properly executed "Permission to Evaluate" form; the current, appropriate psychological, medical, social, and/or educational records/reports required in order for DDSN eligibility to be determined.

~~A. Children less than two (2) years, eleven (11) months of age~~

For children who have a diagnosis, as recognized by the Individuals with Disabilities Education Act (IDEA) Part C program (BabyNet) Established Risk Condition List, confirmed by a medical professional and are actively receiving Early Intervention services through Baby Net, Intake will be conducted in one of the two following ways:

1. For a child who is actively receiving Early Intervention services through BabyNet from a DDSN-qualified provider, the DDSN-qualified Early Intervention provider may begin Intake for the child when the child's legal guardian so requests. "Actively receiving" is defined as having received Early Intervention services within six (6) months prior to the

submission of the set of Intake documents. Intake ends when the accurate and complete set of documents is submitted to DDSN for Determination of Eligibility.

2. For a child who is actively receiving Early Intervention services through BabyNet, but not from a DDSN-qualified provider, Intake begins when the child is determined to likely be eligible for services (i.e., screened in) under the ID or RD category and the child's legal guardian either:

a) Chooses to personally collect and submit the complete set of documents needed to determine eligibility to DDSN; or

b) Chooses a DDSN-qualified Intake provider to collect and submit the complete set of documents to DDSN on behalf of the applicant.

~~For a child who is actively receiving Early Intervention services through BabyNet from a DDSN-qualified provider, the DDSN-qualified Early Intervention provider may begin Intake for the child when the child's legal guardian so requests. "Actively receiving" is defined as having received Early Intervention services within six (6) months prior to the submission of the set of Intake documents. Intake ends when the accurate and complete set of documents is submitted to DDSN for Determination of Eligibility.~~

~~For a child who is actively receiving Early Intervention services through BabyNet, but not from a DDSN-qualified provider, Intake begins when the child is determined to likely be eligible for services (i.e., screened in) under the ID or RD category and the child's legal guardian either:~~

- ~~Chooses to personally collect and submit the complete set of documents needed to determine eligibility to DDSN; or~~
- ~~Chooses a DDSN-qualified Intake provider to collect and submit the complete set of documents to DDSN on behalf of the applicant.~~

Intake ends when the complete set of documents is submitted to DDSN.

When a child who is actively receiving Early Intervention services through BabyNet, but not from a provider that is not affiliated with DDSN, has been determined to likely be eligible for services (i.e., screened in) under the ASD category, Intake is not required.

~~B. ID, RD, ASD and for Applicants 2 years, 11 Months of Age or older~~

For applicants determined to likely be eligible for services (i.e., screened in) under the categories of ID or RD, TBI, SCI or both or SD, Intake begins when the applicant/legal guardian either:

1. Chooses to personally collect and submit the complete set of documents needed to determine eligibility to DDSN; or

2. Chooses a DDSN-qualified Intake provider to collect and submit the complete set of documents to DDSN on behalf of the applicant.

Intake ends when the accurate and complete set of documents is submitted to DDSN for Determination of Eligibility.

For applicants determined to likely be eligible for services (i.e., screened in) under the category of ASD, Intake is not required.

~~C. TBI, SCI, or both or SD~~

~~For applicants determined to likely be eligible for services (i.e., screened in) under the categories of TBI, SCI or both or SD, Intake begins when the applicant/legal guardian either:~~

- ~~Chooses to personally collect and submit the complete set of documents needed to determine eligibility to DDSN; or~~

- ~~Chooses a DDSN-qualified Intake provider to collect and submit the complete set of documents to DDSN on behalf of the applicant.~~

~~Intake ends when the accurate and complete set of documents is submitted to DDSN for Determination of Eligibility.~~

III. DETERMINATION OF DDSN ELIGIBILITY

In accordance with S.C. Code Ann. § 44-20-390 - 430 (2018), no individual believed to have Intellectual Disability, a Related Disability, Head Injury, Spinal Cord Injury, Similar Disability or Autism Spectrum Disorder may be admitted to the services of DDSN until he/she has been determined eligible by DDSN on the basis of acceptable data to have Intellectual Disability, a Related Disability, Head Injury, Spinal cord Injury, Similar Disability or Autism Spectrum Disorder unless he/she is an infant at risk of a developmental disability and in need of DDSN services. The Determination of Eligibility for DDSN services is made by DDSN ~~using the accurate and complete set of documents collected and submitted as part of Intake or appropriate testing which confirms the presence of ASD.~~following the procedures outlined in S.C. Code Regs. § 88-505-520 (2022).

~~The criteria for DDSN eligibility are:~~

~~A. Intellectual Disability~~

~~Definition~~

~~S.C. Code Ann. § 44-20-30 (2018) defines "Intellectual Disability" as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.~~

Diagnostic Criteria

DDSN evaluates referred individuals in accordance with the definition of Intellectual Disability outlined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, (DSM-5).

Intellectual Disability refers to substantial limitations in present functioning. Diagnosis of Intellectual Disability based on the DSM-5 definition requires the following three (3) criteria be met:

1. Significantly sub-average intellectual functioning; an IQ of approximately 70 or below on an individually administered intelligence test (for infants, a clinical judgment of significantly sub-average intellectual functioning); and

2. Concurrent deficits in present overall adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his/her age by his/her cultural group) with deficits in at least two (2) of the following adaptive skills areas:

    - communication,
    - self-care,
    - home living,
    - social/interpersonal skills,
    - use of community resources,
    - self-direction,
    - functional academic skills,

    - work,
    - leisure,
    - health, and safety; and

3. The onset of Intellectual Disability is prior to age 22.

There must be concurrent deficits in intellectual and adaptive functioning that fall approximately two (2) or more standard deviations below the mean (approximately 70 or below) on standardized measures in order to meet criteria for diagnosis of Intellectual Disability. However, a score of 70 on any intelligence and/or adaptive test does not equate to a diagnosis of Intellectual Disability.

DDSN relies on qualified testing providers to administer psychological testing to applicants. This includes testing conducted by school psychologists and other professionals who regularly administer psychological tests to persons with disabilities. The tests are then analyzed by the DDSN Eligibility Division to determine if they are reliable and valid, and to determine whether they are consistent with other psychological tests, school records including academic achievement scores, placement in special education and Individualized Education Plan (IEP) data, medical reports, psychiatric and mental health records, family history, and other pertinent information. In order to ensure the reliability and validity of the tests administered to applicants,

only standardized measures are used to determine if criteria for Intellectual Disability are met. Therefore, DDSN maintains a list of all approved psychometric tests that must be used for eligibility purposes.

In the event that assessment results are unavailable or updated assessment information is needed, DDSN will contact the intake provider to assist in coordinating for testing to take place at a location convenient to the applicant.

B. Related Disability

Definition and Diagnostic Criteria

S.C. Code Ann. § 44-20-30 and 42 CFR 435.1009 defines eligibility for DDSN services under "Related Disability" as follows:

A severe, chronic condition found to be closely related to Intellectual Disability or to require treatment similar to that required for persons with Intellectual Disability and must meet all four (4) of the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with Intellectual Disability and requires treatment or services similar to those required for these persons; and

2. The Related Disability is likely to continue indefinitely; and

3. It results in substantial functional limitations in three (3) or more of the following areas of major life activity:

    - Self-care,
    - Understanding and use of language,
    - Learning,
    - Mobility,
    - Self-direction,
    - and Capacity for Independent Living; and

4. The onset is before age 22 years.

DDSN relies on qualified testing providers to administer psychological testing to applicants. This includes testing conducted by school psychologists and other professionals who regularly administer psychological tests to persons with disabilities. The tests are then analyzed by the DDSN Eligibility Division to determine if they are reliable and valid, and to determine whether they are consistent and congruent with other psychological tests, school records including academic achievement scores, placement in special education and Individualized Education Plan

(IEP) data, medical reports, psychiatric and mental health records, family history, and other pertinent information. In order to ensure the reliability and validity of the decisions made, DDSN uses standardized measures to determine if criteria for a Related Disability are met. Specifically, a standardized test of functional abilities that yields a composite score of two standard deviations or more below the mean (i.e., Composite < 70) must be met to qualify for eligibility under the Related Disability category. DDSN maintains a list of all approved psychometric tests that will be used to determine if criteria for a related condition are met.

In the event that assessment results are unavailable or updated assessment information is needed, DDSN will contact the intake provider to assist in coordinating for testing to take place at a location convenient to the applicant.

C. High-Risk Infant

Definition

S.C. Code Ann.§ 44-20-30 defines "high-risk infant" as a child less than 36 months of age whose genetic, medical or environmental history is predictive of a substantially greater risk for a developmental disability than that for the general population.

Diagnostic Criteria

Children younger than 36 months of age are served under this category when they:

- Exhibit significant documented delays in three or more areas of development; or
- Have an approved diagnosis confirmed by a medical professional and exhibit significant documented delays in two areas of development.

This category of eligibility allows DDSN to provide services to infants and young children under 36 months in instances where the future diagnosis is not absolutely clear due to situations (genetic, environmental or medical) present at birth or manifesting themselves thereafter, including accident and injury. In such instances, eligibility may be established in a time-limited fashion until a more comprehensive and conclusive assessment can be made regarding the presence or absence of a qualifying disability (not to exceed 36 months of age). Infants and young children under 36 months are eligible to receive all DDSN services for which they qualify based on need and resource availability. Once the child turns 36 months of age, he/she must qualify for DDSN eligibility in another category, such as Intellectual Disability, a Related Disability, Autism, Traumatic Brain Injury or Spinal Cord Injury to continue to receive services from DDSN. The one exception is for those children ages three (3) to six (6) years of age eligible in the at-risk category. These children may continue to receive Early Intervention services (i.e., family training and case management provided by an Early Interventionist) until further notified by the State Director. Any child 36 months of age or older whose eligibility is not updated by DDSN's Eligibility Division by their 37th month of age must have their file closed. The child is no longer eligible to receive any service from DDSN.

D. Autism Spectrum Disorder

Definition

DDSN uses the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) definition of "Autism Spectrum Disorder" (i.e., ASD) which states Autism Spectrum Disorder is "persistent deficits in social communication and social interaction across multiple contexts defined by restricted, repetitive patterns of behavior, interests, or activities."

Diagnostic Criteria

DDSN evaluates referred individuals in accordance with the definition of Autism Spectrum Disorder outlined in the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5).

1) Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following three (3) criteria, currently or by history:

    a) Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

    b) Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

    c) Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

2) Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two (2) of the following, currently or by history:

    a) Stereo-typed or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

    b) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

c) Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

d) Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

3) Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

4) Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

5) These disturbances are not better explained by Intellectual Disability (intellectual developmental disorder) or global developmental delay. Intellectual Disability and Autism Spectrum Disorder frequently co-occur; to make comorbid diagnoses of Autism Spectrum Disorder and Intellectual Disability, social communication should be below that expected for general developmental level.

E. Head and Spinal Cord Injury and Similar Disability

Definition

Under S.C. Code Ann. § 44-38-370, which establishes DDSN legislative authority for the Head and Spinal Cord Injury (HASCI) Division, a person is eligible for case management services under this article when at the time of determining eligibility the person has a severe chronic limitation that:

1. Is attributed to a physical impairment, including head injury, spinal cord injury or both, or a similar disability, regardless of the age of onset, but not associated with the process of a progressive degenerative illness or disease, dementia, or a neurological disorder related to aging;

2. Is likely to continue indefinitely without intervention;

3. Results in substantial functional limitation in at least two (2) of these life activities:

a) Self-care;

b) Receptive and expressive communication;

c) Learning;

d) Mobility;

e) Self-direction;

f) Capacity for independent living;

g) Economic self-sufficiency; and

4. Reflects the person's need for a combination and sequence of special interdisciplinary or generic care or treatment or other services, which are of lifelong or extended duration and are individually planned and coordinated.

Diagnostic Criteria

S.C. Code Ann. § 44-38-20, which relates to the South Carolina Head and Spinal Cord Information System, defines head injury and spinal cord injury:

"Head injury" means an insult to the skull or brain, not of a degenerative or congenital nature, but one caused by an external physical force that may produce a diminished or altered state of consciousness, which results in impairment of cognitive abilities or physical functioning and possibly in behavioral or emotional functioning. It does not include cerebral vascular accidents or aneurysms.

"Spinal cord injury" means an acute traumatic lesion of neural elements in the spinal canal resulting in any degree of sensory deficit, motor deficit, or major life functions. The deficit or dysfunction may be temporary or permanent.

"Similar disability" is not specifically defined within South Carolina Codes of Law; however, S.C. Code Ann. § 44-38-370 states that similar disability is "not associated with the process of a progressive degenerative illness or dementia, or a neurological disorder related to aging." There must be medical documentation and functional/adaptive assessments to substantiate that Traumatic Brain Injury, Spinal Cord Injury or Similar Disability occurred and produced ongoing substantial functional limitations. There must be documentation of pre-existing/concurrent conditions, which impact functioning.

IV. NOTICE OF DECISIONS AND RIGHT TO APPEAL

Following the Determination of Eligibility by DDSN, written notice of the results of the Determination will be provided to the applicant/legal guardian. If the applicant is determined to not be eligible for DDSN services, the notice will outline the basic reasons why the applicant did not meet eligibility criteria. Upon request of the applicant/legal guardian, a DDSN Eligibility Division staff member will read or explain the eligibility decision and appeal process to the applicant/legal guardian.

The notice of the decision will also include information on the applicant's right to appeal the eligibility determination and the process for doing so in accordance with S.C. Code Ann. Regs 88-705-715. As established by the SC Code of Laws, the State Director of DDSN or his/her designee has the final authority over applicant eligibility.

Eligibility information for applicants and those determined eligible is available to providers through DDSN's electronic health record system.

~~Susan Kreh Beck, Ed.S., LPES, NCSP~~	~~Patrick J. Maley~~
~~Associate State Director-Policy (Originator)~~	~~Interim State Director~~
~~(Originator)~~	~~(Approved)~~
Barry D. Malphrus	Stephanie M. Rawlinson
Vice Chairman	Chairman

To access the following attachments, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

Attachment: DDSN Intake and Eligibility Process Flow Chart

PROPOSED TO MARK OBSOLETE

SOUTH CAROLINA Department OF Disabilities AND Special Needs

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PO Box 4706, Columbia, South Carolina 29240
803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

Reference Number:	535-09-DD
Title of Document:	Research Involving DDSN Resources and/or Persons Receiving Services from or Staff Employed by DDSN – Review and Approval
Date of Issue:	September 21, 1990
Effective Date:	September 21, 1990
Last Review Date:	July 7, 2016
Date of Last Revision:	July 7, 2016 **(REVISED)**
Applicability:	DDSN Regional Centers, DSN Boards and Contracted Service Providers

PURPOSE

This directive contains guidelines and procedures for the review and approval of research proposals which use the Department of Disabilities and Special Needs (DDSN) resources and/or use as research participants persons receiving services from or staff employed by or through contractual arrangements with DDSN. It does not apply to analysis of summary data such as those related to provision of services, since these data do not enable identification of any person or reveal any private information. It also does not apply to data collected on individual service recipients when these data are for the evaluation of DDSN services and/or are part of required or customary management practices.

POLICY

Research involving persons receiving services from or staff employed by a DDSN Regional Center, county DSN board, or contracted community service provider may be conducted by facility or program staff or by outside investigators. The same policy and procedures for reviewing, approving, and conducting research are in effect whether the investigator is an

employee or non-employee. Research shall be conducted only when assurance is provided that the rights, welfare and dignity of the participants are adequately protected, that appropriate methods are used to obtain informed consent where required, that the risks involved are minimal and the research directly benefits or contributes to the understanding or treatment (including provision of supports) of an Intellectual Disability or a Related Disability, Autism Spectrum Disorder, or a Head or Spinal Cord Injury.

DEFINITIONS

Research is defined as a trial, special observation, or data collection usually made under conditions determined by the investigator, which aims to test a hypothesis or to discover some previously unknown principle, effect, or relationship. Research is further defined as a systematic investigation designed to contribute to generalized knowledge.

Activities which use experiments, tests, and/or observations designed to elicit information which is not publicly available are considered types of research.

Research participant is defined as an individual about whom an investigator conducting the research obtains (1) data through intervention or interaction with the participant, or (2) identifiable private information.

Minimal risk means the risk of harm anticipated in the proposed research is not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

Categories of research

Research proposals will be divided into two categories depending upon the level of risk involved.

Category-I: Activities involving the collection or study of existing data, documents, or records, if these sources are not publicly available. Research participants are not used directly in the gathering of information. This type of research does not involve any personal contact, observation or interaction with the participants.

Category-II: Research activities in which there is minimal risk and the research participants involved have no more than customary, every day risks (e.g., interviews, data survey, general observation, routine medical, behavioral support procedures, etc.). Any research that involves personal contact, observation, or interaction falls into this category.

Review and approval of research proposals

DDSN Research Review Committee

The DDSN Research Review Committee is chaired by the DDSN State Director or a designee and includes DDSN executive staff and others as appointed by the chairman. They retain authority for final approval for research involving persons served or employed by DDSN or that involves DDSN resources. The committee will have at least three (3) members with varying backgrounds to promote complete and appropriate review of proposed activities. Membership may include representatives from organizations such as universities or colleges in South Carolina, DDSN, provider organizations, S.C. Protection & Advocacy System, Parent/Consumer organizations and individuals such as an attorney, physician, ethicist, consumer or family member of a consumer, etc. Other members may include ad hoc members with specific expertise and representatives of a DDSN Regional Center or County DSN board if the research proposal involves participation of two or more programs or facilities. The DDSN Research Review Committee shall review all Category-II research proposals to ascertain the acceptability of the proposed research in terms of departmental commitments and regulations, applicable laws, participant protections and standards of professional conduct and practice. Category-I proposals may be administratively reviewed by the DDSN Research Review Committee Chair without full review by the committee. The committee chair can require review by the full committee if it appears needed upon review of the proposal.

Review Process

1. Prior to the start of research project, the investigator shall submit a proposal to the DDSN Research Review Committee. The brief proposal should include information on: contact information for the person with overall responsibility for the proposed study, the purpose of the study including objectives and intended outcomes, the characteristics of the intended participants, the procedures to be used and how the participants would be involved, potential benefits and risks to participants, and how informed consent would be obtained, and how confidentiality will be maintained (in compliance with HIPAA). A copy of the approved proposal by an Institutional Review Board (IRB) appropriate to the employer of the investigator should be attached to the proposal

2. A local Human Rights Committee shall review any Category-II research proposal before it is submitted to the DDSN Research Review Committee to ensure that the rights and welfare of the research participants are protected; that informed consent is obtained by adequate and appropriate methods; that individuals served are not used as a captive source of research not associated with an intellectual disability or a related disability, autism, or a head and spinal cord injury; and that the research is in no way detrimental to their welfare.

3. Investigators shall be notified in writing of the decision to approve or disapprove the proposed research activity or modifications required to secure approval. Approval may be granted for up to five (5) years (e.g., for a five (5) year proposed project). However, approval for more than one (1) year is contingent upon submission of an annual report to the committee that assures continued compliance with committee guidelines.

4. Written approval from the DDSN Research Review Committee must be received by the investigator prior to initiating the proposed research. The investigator must also obtain written approval from this committee before deviating in any way from the procedures previously approved.

5. A local staff liaison person shall be assigned to each research project conducted by an outside investigator.

6. The principal investigator for a research project will provide a written report at the end of each 12-month period for an approved project. This is to ensure that approved procedures are followed. Research findings and reports shall be sent by the investigator to the DDSN Research Review at the conclusion of the study.

Special Exemption:

As a general rule, only Category-I and Category-II research will be endorsed by DDSN. However, DDSN recognizes that there may be rare occasions when a research opportunity may exceed minimal risk, yet offer extraordinary potential benefit to the participants. For example, the situation may arise that a medication approved for clinical trials by the Food and Drug Administration to treat an otherwise fatal or debilitating condition such as AIDS. Such a trial may represent the only potentially beneficial treatment, yet constitutes risk that is appropriate, yet greater than minimal. Other examples may arise from the tremendous recent advances in genetic diagnosis and treatment of previously untreatable diseases. In such cases, research approval can be sought using the process described in this directive with the appropriate justification.

PROTECTION OF RIGHTS AND WELFARE OF RESEARCH PARTICIPANTS

1. Any research conducted must conform to the scientific, legal, and ethical principles which justify all research and should emerge from a sound theoretical basis or follow previously accepted research design.

2. Any Category-II research involving routine medical examinations or behavioral intervention techniques shall be conducted only by qualified professionals in adequately equipped settings and with the appropriate liaison or supervision during which a suitably qualified clinician is used. Where body integrity may be violated or when otherwise appropriate, medical liaison or supervision shall be included.

3. All caution in exercise of research is limited not only to physical harm, but also includes unwarranted psychological or emotional impairment to the individual or their family.

4. All experimentation shall be planned in such a way as to avoid pain, suffering, or inconvenience to the research participant and his/her family or guardian.

5. All investigators who are not employees of DDSN, a county DSN board or a provider and who are allowed access to information about individuals served or staff must sign a

confidentiality statement. This shall be maintained in the file containing the research proposal and approval at DDSN.

6. Facilities and programs are required to meet provisions of the federal regulations 45CRF46 (6/18/91), Protection of Human Subjects.

7. Any concerns or complaints regarding the research may be addressed directly to the chairperson of the DDSN Review Committee. The name and address of the chairperson will be provided to each research participant and/or their parent or guardian. It will also be provided to the staff working with research participants. All concerns/complaints will be investigated and the DDSN Research Review Committee notified.

8. A copy of the signed informed consent form shall be placed in the permanent file of each participant (including an employee's file when appropriate).

INFORMED CONSENT

Written informed consent, obtained prior to a person's participation, is required for all Category-II research. The investigator must obtain written or documented informed consent from the parent/legal guardian if the person is under the age of 18. If the person is 18 or older and has not been adjudicated incompetent, then they may give informed consent. Continued parental involvement is desirable for persons who are 18 years of age or older or who are unable to give informed consent. Procedures for obtaining informed consent as outlined in DDSN Directive 535-07-DD: Obtaining Consent for Minor and Adults shall be followed.

Specific detailed information shall be provided to all potential research participants and/or their parents, or legal guardians when obtaining informed consent.

PUBLICATIONS

The investigator shall provide a copy of the final research report to the participating programs, facilities, and the chair of the DDSN Research Review Committee. A copy shall also be forwarded to the State Director (if the chair is the designee of the State Director) prior to submission for publication.

DDSN staff is encouraged to develop training materials and conduct research consistent with sound professional practice which advances knowledge about the prevention, causes, or treatment of intellectual disability or a related disability, autism, or a head and spinal cord injury. However, all manuscripts submitted for publication which bear the facility or DDSN name and sponsorship must be approved by the State Director prior to submission to a professional journal or publishing company. Once the manuscript has been approved by the State Director, the employee may submit the manuscript for publication.

Susan Kreh Beck, Ed.S., NCSP
Associate State Director-Policy
(Originator)

Beverly A.H. Buscemi, Ph.D.
State Director
(Approved)

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All DDSN Divisions; DDSN Regional Centers; DSN Boards and Contract Service Providers

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INTRODUCTION:

This directive establishes policies and procedures for appeal of decisions concerning eligibility for and services solely state-funded by the South Carolina Department of Disabilities and Special Needs (DDSN), Disabilities and Special Needs Boards, and Contracted Providers. Authority for this procedure is set forth in S.C. Code Ann. § 44-26-80 (2018) relating to the rights of individuals receiving services from DDSN. ~~Additionally, this~~This directive establishes the procedure for the reconsideration of decisions made by DDSN and/or its network of providers that affect the receipt of Medicaid services by Medicaid participants.

POLICY:

It is the policy of DDSN that each applicant or service recipient has the right to appeal or request reconsideration of decisions made by DDSN, DSN Boards, or Contracted Service Providers. DDSN DSN Boards, and Contracted Service Providers shall ensure that all concerns of applicants and service recipients are handled appropriately and in a timely manner.

DDSN utilizes funding appropriated by the South Carolina General Assembly to support those eligible for the agency's services. For some DDSN services, the funding appropriated by the South Carolina General Assembly is the only source of funding. However, in order to maximize the appropriated funding, DDSN also partners with the South Carolina Department of Health and Human Services (SCDHHS) to utilize Medicaid as a source of funding for services. Therefore, DDSN has final authority

over some decisions, but when Medicaid funding is used or affected, SCDHHS, the Medicaid Agency, has final authority over the decision.

DDSN has the final authority over decisions that are solely state-funded by DDSN (i.e., not funded by Medicaid) and those solely within its established authority. Appeals procedures for adverse decisions solely state-funded by DDSN are outlined in S.C. Code Reg. § 88-705-715. These procedures are outlined in Attachment C: Process for Appeal of DDSN Decisions. ~~In the context of this document those decisions will be referred to as "**DDSN Decisions**." When an applicant or service recipient disagrees with a decision that was made by or on behalf of DDSN, the applicant or service recipient can appeal the decision to DDSN. Appeals of DDSN decisions that fall within DDSN's purview to hear are those decisions related to eligibility for DDSN services and decisions about services that are solely funded by DDSN. **DDSN decisions** that may be appealed include, but may not be limited to:~~

- ~~Eligibility for DDSN services~~
- ~~Determination of Critical Needs or Placement on Residential Waiting list for people not enrolled in the Intellectual Disability/Related Disability (ID/RD) or the Head and Spinal Cord Injury (HASCI) Waiver~~
- ~~Individual and Family Support and State Funded Respite~~
- ~~State Funded Case Management~~
- ~~State Funded Follow Along~~
- ~~State Funded Community Supports~~
- ~~Calculation of Room and Board~~

SCDHHS, the Medicaid Agency, has final authority over decisions made regarding programs and services funded by Medicaid. In the context of this document, these decisions will be referred to as "**SCDHHS decisions.**" While the final authority for Medicaid decisions rests with SCDHHS, because DDSN operates Medicaid Home and Community Based Services (HCBS) Waivers on behalf of the SCDHHS and is a provider of Medicaid-funded services, SCDHHS allows DDSN to reconsider decisions made by DDSN or its network of providers before providing a Fair Hearing to a Medicaid participant. The reconsideration by DDSN is allowed to ensure that established Medicaid policy and procedures were followed and appropriately applied when the decision was made.

SCDHHS decisions that may be reconsidered by DDSN include, but may not be limited to:

- Denial of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care.
- Denial of Nursing Facility (NF) Level of Care when reevaluated.
- Other:
  - Denial of Placement on an HCBS Waiver waiting list
  - Denial of ID/RD Waiver Reserved Capacity
  - Denial of HASCI Waiver Reserved Capacity
  - Denial of Community Supports (CS) Waiver Reserved Capacity
  - Denial, suspension, reduction or termination of a HCBS Waiver funded service
  - Denial, suspension, reduction or termination of a Medicaid State Plan service authorized by a Waiver Case Manager
  - Denial of the choice of HCBS Waiver service provider

DEFINITIONS:

Applicant:

a. One who has contacted DDSN (via the toll-free telephone number) to seek a determination of eligibility for DDSN services or by proxy, contact was made by the applicant's legal guardian.

b. One who has contacted DDSN or a DDSN qualified Case Management provider to seek enrollment or one for whom enrollment is sought by a legal guardian in one of the Home and Community Based Services Waivers operated by DDSN.

c. One who has contacted their Case Management provider or DDSN to seek a determination of ICF/IID Level of Care or one for whom a determination is sought by a legal guardian.

Service Recipient:

a. One who has been determined by DDSN to meet the criteria for eligibility for DDSN services, or his/her legal guardian.

b. One who is enrolled in a Home and Community Based Services Waiver operated by DDSN or by proxy, his/her legal guardian.

Representative:

a. One, who with the consent of an individual who is not adjudicated incompetent, assists the applicant or service recipient.

b. One, who with the consent of an individual's legal guardian, assists the applicant or service recipient.

Appeal:

A procedure by which a party dissatisfied with a decision, determination or ruling may refer the matter to a higher authority for review. In the context of this document, an appeal is a request by a DDSN applicant ~~or service recipient~~ to reverse a decision regarding DDSN eligibility or a service or program solely state funded by DDSN. Procedures for appeal of adverse decisions solely state-funded by DDSN are outlined in S.C. Code Reg. § 88-705-715. Refer to Attachment C: Process for Appeal of DDSN Decisions for an outline of this process.

Reconsideration:

A review of a decision to ensure the decision comports with applicable Medicaid policy or procedures. In the context of this document, a reconsideration is a review by DDSN of a decision made by DDSN or its network of service providers to ensure that applicable Medicaid policy and/or procedures were appropriately applied when making the decision. If dissatisfied with the outcome of the reconsideration, the Medicaid participant may request a Fair Hearing from the Division of Appeals and Hearings at SCDHHS.

PROCEDURES FOR APPEAL OF DDSN DECISIONS:

A. Eligibility for DDSN Services

Step 1: Appeal in Writing:

When an appeal is desired by the applicant, a signed and dated written appeal of the denial must be made within 30 calendar days of the date of the eligibility decision. The appeal must state the reason(s) the denial was in error, and include any additional supporting information. The appeal must be made in writing to the State Director and sent by letter to the South Carolina Department of Disabilities and Special Needs-Appeals, 3440 Harden Street Extension, Columbia, South Carolina 29203 or by email to appeals@ddsn.sc.gov. Reasonable accommodations to assist with communication will be provided upon request. (See Attachment C: PROCESS FOR APPEAL OF DDSN DECISIONS)

Step 2: Review of Decision:

Upon receipt of the written appeal, all information shall be reviewed by the State Director using the eligibility criteria as set forth in the Department's regulation addressing "Eligibility." If the State Director determines new evaluation data is needed, no decision shall be made until this new evaluation data is received.

The applicant shall be notified in writing that the new evaluation is needed within 30 calendar days of receipt of the written appeal.

Step 3: Decision Rendered:

A written decision shall be provided to the applicant within 30 calendar days of receipt of the written appeal or receipt of the new evaluation data. In accordance with S.C. Code Ann. § 44-20-430 (2018), the decision of the State Director is final.

B. Services Solely Funded By DDSN or Issues Solely Within The Established Authority of DDSN

Step 1: Appeal in Writing:

When an appeal is desired by the person eligible for services from the Department, a signed and dated written appeal of a decision to deny, suspend, reduce or terminate a service solely funded by the Department shall be made within 30 calendar days of the notification of the decision. The appeal shall state the reason(s) the denial/suspension/reduction/termination was in error including any additional supporting information. The appeal shall be made by letter: South Carolina Department of Disabilities and Special Needs-Appeals, 3440 Harden Street Extension, Columbia, South Carolina 29203 or email: appeals@ddsn.sc.gov sent to the State Director of the Department. Reasonable accommodations to assist with communication will be provided upon request. (See Attachment C: PROCESS FOR APPEAL OF DDSN DECISIONS)

Step 2: Review of Decision:

Upon receipt of the appeal, all available information shall be reviewed by the State Director.

~~Step 3: Decision Rendered:~~

~~A written decision shall be provided to the person eligible for services within 30 calendar days of receipt of the written appeal. The decision of the State Director shall be final.~~

RECONSIDERATION OF SCDHHS DECISIONS:

A. ICF/IID Level of Care

An adverse decision regarding an initial determination or an annual re-determination of ICF/IID Level of Care made by or upheld by the DDSN Eligibility Division may be reconsidered if relevant information not previously considered is available. Requests for reconsideration must be made in writing by the applicant/representative within 30 calendar days of the adverse decision. Written requests for reconsideration may be sent to the State Director of DDSN by email to appeals@ddsn.sc.gov or by mail to 3440 Harden Street Extension, Columbia, SC 29203. (See Attachment A: PROCESS FOR RECONSIDERATION OF SCDHHS DECISIONS)

If after reconsideration, including consideration of new information, the determination remains unchanged, the applicant may appeal to DHHS-Division of Appeals and Hearings. (See Attachment B: SCDHHS MEDICAID FAIR HEARING PROCESS)

NOTE: For those applying for Medicaid through the Tax Equity and Fiscal Responsibility Act **(**TEFRA), appeals of adverse ICF/IID Level of Care decisions must be made directly to DHHS-Division of Appeals and Hearings. DDSN cannot reconsider these decisions.

B. Nursing Facility Level of Care Re-Evaluations

An adverse decision regarding an annual re-evaluation of a Nursing Facility Level of Care by a Waiver Case Manager will automatically be reviewed by staff of DDSN's Head and Spinal Cord Injury (HASCI) Division prior to the expiration of the current Level of Care determination. A written request to DDSN for reconsideration is not required.

If the adverse decision is upheld by HASCI Division staff, an appeal may be made by the waiver participant to DHHS-Division of Appeals and Hearings. (See Attachment B: SCDHHS MEDICAID FAIR HEARING PROCESS)

C. Other SCDHHS Decisions

Written requests for reconsideration may be sent to the State Director of DDSN by email to appeals@ddsn.sc.gov or by mail to 3440 Harden Street Extension, Columbia, SC 29203. A formal request must be made in writing within 30 calendar days of receipt of notification of the adverse decision. A copy of the written notification of the adverse decision must be submitted along with the basis of the complaint and the relief sought. The request must be dated and signed by the Medicaid participant/representative. Reasonable accommodations to assist with communication will be provided upon request. (See Attachment A: PROCESS FOR RECONSIDERATION OF SCDHHS DECISIONS)

If, after reconsideration, the decision is upheld, a Fair Hearing may be requested by the Medicaid participant to SCDHHS-Division of Appeals and Hearings. (See Attachment B: SCDHHS MEDICAID FAIR HEARING PROCESS)

Barry D. Malphrus Vice Chairman	~~Gary C. Lemel~~Stephanie M. Rawlinson Chairman

To access the following attachments, please see the agency website page "Attachments to Directives" under this directive number at https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

Attachment A: PROCESS FOR RECONSIDERATION OF SCDHHS DECISIONS

Attachment B: SCDHHS MEDICAID FAIR HEARING PROCESS

Attachment C: PROCESS FOR APPEAL OF DDSN DECISIONS

Related Policies:

535-08-DD: Concerns of People Receiving Services: Reporting and Resolution

700-02-DD: Compliance with Title VI of the Civil Rights Act of 1964, Americans with Disabilities Act of 1990, Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 and Establishment of a Complaint Process

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS (DDSN) PROCESS FOR APPEAL OF DDSN DECISIONS

"**DDSN decisions**" are decisions made by DDSN or its network of providers regarding services that are solely state funded by DDSN (i.e., not funded by Medicaid) and those solely within its established authority. When an applicant ~~or service recipient~~ disagrees with a decision that was made by or on behalf of DDSN, the applicant ~~or service recipient~~ can appeal the decision to DDSN. Appeals of DDSN decisions that fall within DDSN's purview to hear are those decisions related to eligibility for DDSN services and decisions about services that are solely state-funded by DDSN.

When an appeal is desired by an applicant ~~or service recipient~~, a signed and dated written appeal of the ~~decision~~ denial must be made within 30 calendar days ~~of~~ from the date of the ~~decision~~ written correspondence from DDSN which communicates the eligibility decision of the Department. The appeal must state the reason(s) the ~~decision~~ denial was in error, and include any additional supporting information. The appeal shall be made ~~in writing to~~ by letter or email to:

~~**State Director**~~
South Carolina Department of Disabilities and Special Needs - Appeals
3440 Harden Street Extension
Columbia, SC 29203
appeals@ddsn.sc.gov

Reasonable accommodations to assist with communication will be provided upon request.

Upon receipt of ~~an~~ the appeal ~~of a DDSN eligibility decision by the State Director, all of the information on which the decision was based shall be reviewed~~ all information shall be reviewed by the State Director using the eligibility criteria as set forth in the Department's regulation addressing "Eligibility," S.C. Reg. § 88-705-715. If~~, based on this review,~~ the State Director determines new evaluation data is needed, no decision shall be made until ~~the new evaluation~~ this data is received. The applicant shall be notified ~~that the~~ a new evaluation is needed within 30 business days of receipt of the written appeal.

A written decision ~~regarding eligibility~~ shall be provided ~~by mail~~ to the applicant within 30 business ~~calendar~~ days of receipt of the written appeal or receipt of the new evaluation data. In accordance with S.C. Code Ann. § 44-20 430 (2018), the decision of the State Director is final.

~~A written decision regarding services solely funded by DDSN shall be provided by mail to the service recipient within 30 calendar days of receipt of the written appeal.~~

Reference Number:	104-01-DD
Title of Document:	Certification and Licensure of DDSN Residential and Day Facilities
Date of Issue:	October 21, 1988
~~Effective Date:~~	~~January 5, 2015~~
~~Last Review Date:~~	~~December 1, 2017~~
Date of Last Revision:	~~December 1, 2017~~XXXX, 2022 (**REVISED**)
Effective Date:	~~January 5, 2015~~XXXX, 2022
Applicability:	DDSN and Contracted Providers of Residential, Day, and Respite Facilities (Excluding Family-Arranged Respite) ~~and Recreational Camps~~

PURPOSE:

To identify authority and guidance for the South Carolina Department of Disabilities and Special Needs (DDSN) to contract with an independent entity that is CMS-certified as a Quality Improvement Organization to certify and/or license residential and day facilities.

AUTHORITY:

S.C. Code Ann. § 44-20-710 (~~Supp. 2016~~2018), authorizes DDSN to license or contract for licensure day facilities for adults. Facilities may be licensed ~~as Residential, Day Camps,~~ Adult Activity Centers, Work Activity Centers, or Unclassified Programs. These settings provide Career Preparation, Community Services, Day Activity, and Employment Services, as authorized, to DDSN eligible participants.

S.C. Code Ann. § 44-7-260 (Supp. ~~2016~~2021), authorizes DDSN to sponsor, certify, or license community-based housing for adults or contract for these functions. These settings provide Residential Habilitation, as authorized, to DDSN eligible participants.

S.C. Code Ann. § 44-7-110 (~~2002~~2018), § 44-20-10 (~~Supp. 2016~~2018), and § 44-21-10 (~~Supp. 2016~~2018), grants DDSN authority to license or contract the licensure function for respite facilities for children and/or adults. Respite services are provided, as authorized, to DDSN eligible participants.

Since 1985 DDSN has maintained a Memorandum of Agreement (MOA) with the Department of Social Services (DSS), which grants DDSN authority to license Community Training Homes (CTH) for children. The MOA is in accordance with provisions of S.C. Code Ann. § 44-20-1000 (~~Supp. 2016~~2018). DDSN standards meet Child Foster Care Regulation S.C. Regs. § 114-550 (Supp. ~~2012~~2021) for homes licensed as a CTH-I and for homes licensed as a CTH-II as approved annually by DSS. DSS defines a child as a person under the age of 21 and any movement of these children within DDSN Residential Services must be coordinated through the ~~District Offices~~ DDSN Operations Division and the Quality Management Division.

South Carolina Law grants DHEC the authority to license Community Residential Care Facilities (CRCF) for adults and Intermediate Care Facilities for Individuals with an Intellectual or Related Disability (ICF/IID). ~~CRCF Providers are required to submit a copy of their DHEC CRCF Licensing Inspection Reports and a copy of their license certificate within 15 days of receipt to the DDSN Quality Management Division.~~

GENERAL:

No residential, day or respite facility shall provide services and supports unless the service provider is:

1. Qualified by DDSN;

2. Compliant with applicable federal, state and local laws;

3. Compliant with all applicable DDSN policies, procedures, and standards; and,

4. Issued a license or certification by DDSN or DHEC.

For services and supports contracted by DDSN, the facilities shall only provide the type of service that is identified on the certificate or license, and shall serve no more than the maximum number of individuals identified on the certificate and/or license.

The certificate and/or license shall be maintained in the facility at all times. Certificates and/or licenses are non-transferable. *Reviews of facilities may be conducted at any time, without prior notice.*

When a license or certificate is issued by DDSN, the DDSN Director of Quality Management is responsible for insuring reviews conducted by DDSN, or its contractor, are conducted according to DDSN protocol.

SUPPORT MODELS LICENSED/CERTIFIED BY DDSN OR ITS CONTRACTOR:

I. Residential:

Residential Habilitation, as defined by the DDSN Residential Habilitation Standards, is provided in each of the models for residential support listed below:

A. **Community Training Home-I (CTH-I) including the enhanced CTH-I:**

Personalized care, supervision and individualized training provided in accordance with the resident's service plan to no more than two (2) individuals who live in a support provider's home unless an exception has been granted by DDSN. The enhanced CTH-I model builds in additional respite, personal care and enhanced payment to the caregiver due to the significant needs of the individual with disability. Both CTH-I models are licensed/certified using the same criteria. Support providers are qualified and trained private citizens.

B. **Community Training Home-II (CTH-II):**

A home environment in the community where no more than four (4) individuals live.

Care, supervision and skills training are provided by qualified and trained staff in accordance with the resident's service plan.

C. **Supervised Living Program-II (SLP-II):**

Supports are provided by qualified and trained staff to adults who need intermittent supervision and supports. Staff are available on-site or in a location from which they can be on-site within 15 minutes of being called, 24 hours a day, seven (7) days a week.

D. **Community Inclusive Residential Services (CIRS):**

Supports promote the development and independence of individuals with disabilities in homes leased by the individuals. A customized plan is developed to transition the individual from a 24-hour setting to a semi-independent living arrangement. Individuals with a disability are the focus. They choose where they live, with whom they live, and which support staff work with them in their new home. Staffing is provided according to the participant's assessed need and assistive technology may be used to assist with monitoring.

DDSN's contracted provider organizations may provide additional residential options, including CRCFs and ICFs/IID. These homes are licensed by DHEC. For any CRCF or ICF/IID contracted for services by DDSN, a copy of the license and corresponding licensing inspection report (and any applicable Plan of Correction) must be forwarded to DDSN Quality Management within 15 days of receipt.

II. Respite:

Services may be provided in the individual's home, another residence selected by the individual/family, or a home licensed/certified by DDSN or DHEC.

III. Day:

A. Adult Activity Center:

A goal-oriented program of developmental, prevocational services designed to develop, maintain, increase or maximize an individual's functioning in activities of daily living, physical growth, emotional stability, socialization, communication, and vocational skills. Participants must be at least 18 years of age.

B. Work Activity Center:

A ~~workshop~~ center-based setting having an identifiable program designed to provide therapeutic activities for individuals with intellectual and related disabilities whose physical or mental impairment ~~is so severe as to~~ which would otherwise interfere with ~~normal productive capacity~~ a typical work setting or schedule. Work or production is not the main purpose of the program; however, the development of work skills is its main purpose. The program must have a certificate from the United States Department of Labor designating it as a Work Activity Program when applicable.

C. Unclassified Program:

A program that provides a beneficial service and observes appropriate standards to safeguard the health and safety of ~~clients~~ its participants, staff and the public. This would include non-work-related day supports. Participates must be at least 12 years of age.

~~IV. Recreational Day Camps:~~

~~A program of recreational activities with an emphasis on outdoor and camping activities that utilize trained leadership and the natural or man-made outdoor surroundings to contribute to the camper's mental, physical, and social growth. Services are provided for less than 24 hours a day to adults and/or children.~~

SCHEDULE FOR REVIEWS

Facilities licensed or certified by a DDSN contractor will be reviewed on an annual inspection cycle. A review of all applicable Licensing Standards/indicators will take place during the annual review process. A provider staff must be on-site during the inspection at the time indicated by the licensing contractor. Documentation required on-site is specified in the Licensing Standards. Providers are advised to be review ready at all times.

APPLICATION PROCESS:

A. For A New Home or Facility:

To initiate licensing/certification reviews of new homes and facilities, all sections of the DDSN Licensing/Certification Application to Operate must be completed with sufficient time to allow a licensing inspection prior to the opening of the facility. A notice of at least three (3) weeks is suggested, as the Licensing Contractor may need up to two (2) weeks to complete the inspection from the date they receive the packet. The Application must be submitted with all required inspections, to include the applicable State Fire Marshal, Electrical, and HVAC inspection reports. This information should be submitted as a single packet. The projected opening date of the home or facility must be noted. ~~DDSN must approve all new facilities prior to licensure by DDSN.~~ The home/facility must not be occupied prior to the licensing inspection and receipt of an actual license/certificate from DDSN. The provider must ensure receipt of required authorizations for services prior to acceptance of any participants. Admission/Discharge/Transfer forms must be submitted for each occupant as required in DDSN Directive 502-01-DD: Admission/Discharge/Transfer of Individuals To/From DDSN Contracted Residential Settings.

**During designated emergencies, DDSN will expedite the initial application process, as necessary, to arrange for short-term placement options.*

B. To Update Existing Application:

A DDSN Licensing/Certification Application must be completed when/if any information contained in the previously submitted application changes. The provider must ensure that the address, occupancy, and contact information for the location are current and accurate in the DDSN Service Provider Management Module (SPM) within the Applications Portal and Therap.

~~**C. For A Residential Home Serving Children under 21 years(CTH-I or CTH-II):**~~

~~A completed DDSN Licensing/Certification Application to Operate must be submitted with sufficient time to allow a licensing inspection prior to the opening of the facility. A notice of at least three (3) weeks is suggested, as the Licensing Contractor may need up to two (2) weeks to complete the inspection from the date they receive the packet. The Application must be submitted with all required inspections, to include the State Fire Marshal, Electrical, and HVAC inspection reports. For CTH-I or CTH-II serving DDSN participants under 21 years, a DHEC Health and Sanitation inspection must also be included. This information should be submitted as a single packet and the projected opening date of the home must be noted. DDSN must approve all new homes prior to licensure by DDSN.~~

~~Completed applications should be mailed to the address noted on the application.~~

FIRE SAFETY INSPECTIONS:

Initial Fire Safety Inspections, when required, must be made by a Fire Marshal employed by the State Fire Marshal's Office. Fees for this service are pre-paid by DDSN, but inspections must be requested. Requests should only be made via ~~the Internet following these steps:~~ the Office of State Fire Marshal's On-line Request Portal. www.fire.llr.sc.gov/portal Please follow the prompts to set-up an account for your provider agency and each site requiring an inspection.

~~Step 1: Go to www.llr.state.sc.us/fmarshal/;~~
~~Step 2. Select "Online Inspection Report;"~~
~~Step 3. Enter password "america" in lower case letters;~~
~~Step 4. Selection "Request For Inspection - Other" (Residential) **OR** "Work Camps" (Day);~~
~~Step 5. Fill in all sections of the request; and~~
~~Step 6. Submit the request.~~

Requests for annual inspections and/or follow-up inspections must be completed in the portal on or before the 15th of the month in order to be scheduled for the following month. The State Fire Marshal Deputy completing the inspection will contact the designated staff to schedule the inspection time. It is important for staff to be on-site at the time of the inspection.

For CTH-I and CTH-II Settings, the State Fire Marshal's Office will also complete a Health and Sanitation Inspection at the time of their annual fire/safety inspection. No additional request is required for this inspection.

~~Requests must be made at least 90 days in advance. For additional guidance, please contact the Senior Deputy Fire Marshal at (803) 896-9880.~~

~~Annual Fire Safety Inspections will be coordinated by the Office of State Fire Marshal, based on the licensing expiration date for existing licenses.~~

FINDINGS/PLANS OF CORRECTION/RECONSIDERATION

Staff from the Licensing Contractor will make an on-site annual review of the physical plant and records, then compare their finding with the requirements as set forth in standards, policies, and procedures. Standards not in compliance at the time of the licensing inspection will be noted. As a result of these activities, a report will be issued to the provider organization within 30 days.

Each report will include the standard, policy, or procedure determined to be deficient at the time of the licensing review, a statement of the specific findings and the classification of the deficiency. Each standard cited as deficient will be classified as one of the following:

- Class 1 Deficiency: An individual's physical, emotional, and financial well being is in immediate jeopardy. Immediate correction is required.
- Class 2 Deficiency: A failure of organizational safeguards which could put the individual's physical, emotional, and financial well being in jeopardy. The Plan of

Correction from the provider is either required before the end of the survey or within 15 days of receiving the written licensing report. The nature, circumstances, and extent of the deficiency will be evaluated by the surveyor to determine the time frame requirements for the Plan of Correction. Corrections are required to be completed no later than 60 days after receiving the written licensing report unless otherwise specified and subsequently approved by DDSN or its designee.

- Class 3 Deficiency: All other reportable deficiencies. The Plan of Correction from the provider is required within 15 days of receiving the written licensing report. The nature, circumstances, and extent of the deficiency will be evaluated by the surveyor to determine the time frame requirements for the Plan of Correction. Corrections are required to be completed no later than 60 days after receiving the written licensing report unless otherwise specified.

Upon receipt of the report, the provider will have 15 days to submit a written Plan of Correction on the QIO portal. The Plan of Correction should not only address the individual deficiency cited, but should also include a systemic response to ensure correction across the organization. Corrections are required to be completed no later than 60 days after receiving the written licensing report unless otherwise specified and subsequently approved by the Licensing Contractor or DDSN.

If the provider does not agree with the content of the report, reconsideration may be requested. The provider may request reconsideration of the deficiencies by submitting, in writing, the standard, policy, or procedure cited; the finding related to the standard, policy, or procedure; the nature of their disagreement with the finding; and any documentation to support its position. The provider is allowed one reconsideration request for each citation per survey cycle. The provider must submit the request of citation reconsideration within 15 days of receiving the licensing report. The Appeal/Reconsideration Request form must be completed on the QIO Portal, with the form and supporting documentation uploaded as an attachment for the review in question. Upon receipt, the appeal/reconsideration request will be reviewed by the appropriate program staff at DDSN for the particular service area.

If reconsideration is requested, a Plan of Correction for the indicated citation is not required to be submitted until a decision regarding the reconsideration is reached. However, any deficiency not being reconsidered must be corrected according to the timelines as outlined in this document.

The reconsideration will be completed within 30 days of receiving the request. Based on the results of the reconsideration, if needed, a revised report will be issued. A Plan of Correction for all deficiencies upheld must be submitted through the QIO portal within 15 days of the reconsideration decision. Corrections are required to be completed no later than 60 days after receiving the reconsideration decision unless otherwise specified and subsequently approved by DDSN.

FOLLOW-UP

All deficiencies cited in a licensing report will require a follow-up review. Most follow-up reviews will be completed as a remote desk review, with the provider submitting documentation on the QIO portal to validate that the actions described in the Plan of Correction have taken place

by the target date. A provider may have two follow-up reviews for annual surveys, if necessary to ensure remediation. All timeframes identified above apply to these follow-up surveys. All citations identified on the reports will be individually reviewed by the Licensing Contractor to determine the type of follow up needed (i.e., documentation request or onsite review). All Class I citations will be resolved onsite at the time of the review. Each Class II or Class III citation will be reviewed individually by the Licensing Contractor to determine the most appropriate method for follow-up. Results of the Follow-up Review will be included in a report format that is similar to the annual inspection report and will provide a percentage score for compliance.

DDSN's Licensing Contractor will contact the provider organization and discuss the follow-up process, as it relates to their review. Contact will be made within 90 days of the approved Plan of Correction, but providers may choose to upload documentation on the QIO portal at any time. ~~Citation determinations will be identified as follows:~~

~~1. Need documentation review; or~~
~~2. Need onsite review.~~

Any findings of repeat/recurring citations and the use of documentation for citation correction will be discussed at the exit meeting and a report will be sent to the provider within 30 days. A written Plan of Correction will be submitted by the provider in response to any citations that remain after the follow-up review.

SANCTIONS:

Unannounced follow-up visits will be conducted by DDSN or the Licensing Contractor in situations where the severity and/or prevalence of deficiencies may adversely impact someone's health and safety and will determine if deficiencies have been corrected. Failure to correct deficiencies result in the following sanctions:

- Sanction 1 – Failure to correct a Class 1 deficiency, no matter what level or quantity of deficiency existing, will result in the removal of the license/contract and movement of the individual.

- Sanction 2 – Depending on the level or quantity of deficiencies, any of the following sanctions may be issued:

  1) Ongoing site monitoring;
  2) Required technical assistance;
  3) The issuance of a provisional license/certificate with a shortened expiration date;
  4) The license/certificate capacity of the program may be reduced;
  ~~5) Financial payments for that program may be held in a reserve account;~~
  ~~6) Financial payments may be reduced; or~~
  ~~7~~5) The license/certificate may be denied, suspended, revoked, or rescinded.

  For example, if there is a combination of deficiencies across licensed facilities with no repeated findings, step 1 or 2 may be used. If multiple deficiencies are discovered across licensed facilities and systemic problems that exist are not resolved after step 1 through ~~6~~4 have been issued, then step ~~7~~5 will be applied.

APPEALS:

The imposition of the specific sanction that involves denial, suspension or revocation of a license may be appealed. DDSN Directive 167-01-DD: Appeal Procedure for Facilities Licensed or Certified by DDSN, governs these appeals.

EXCEPTIONS:

DDSN reserves the right to make exceptions to standards or policies if the exception will not jeopardize the health and safety of the service recipient, staff or the public, and when the exception will not significantly reduce the quality or quantity of services provided. No exception should be implemented until first approved, in writing, by the Director of Quality Management and the State Director/designee.

The request for exception should be submitted to the DDSN Quality Management Director using the DDSN Request for Exception Form (Attachment B). All sections of the form must be complete and accurate. The form must be signed by the Executive Director and Board Chairperson.

Unless otherwise noted, exceptions to Adult Day Standards ~~and Recreation Camp Standards~~ will be valid for one (1) year from the date approved.

Unless otherwise requested and approved, exceptions to Residential and Respite Standards will remain valid for as long as the information contained on the initial request remains the same.

~~Susan Kreh Beck, Ed.S., NCSP~~	~~Beverly A.H. Buscemi, Ph.D.~~
~~Associate State Director-Policy~~	~~State Director~~
~~(Originator)~~	~~Approved~~
Barry D. Malphrus	Stephanie M. Rawlinson
Vice Chairman	Chairman

To access the following attachments, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

ATTACHMENTS:

Attachment A:	Application to Operate Residential, Day, or Respite Facility~~, or Camp~~
Attachment B:	Request for Exception Form
Attachment C:	SC State Fire OSFM Informational Bulletin #18-2001 (March 1, 2022)

APPLICATION TO OPERATE
RESIDENTIAL, DAY, OR RESPITE ~~OR CAMP~~ FACILITY

Date of Application:_____

Reason for Application: ☐Initial Licensing of a New Facility

☐Termination/Closure
Reason for termination/closure:_____

☐Change
☐in location ☐in facility type
☐in number of people served

1. Facility Information (Name):_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

Type of Facility:

☐SLP-II ☐CIRS ☐CTH-I ☐CTH-II ☐ASW

☐AAC ☐WAC ☐Respite ☐Camp ☐Unclassified Program

Capacity (Number of): Children:_____ Adult(s):_____ Respite:_____
(under age 21)

2. Changed Information (Updated):_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

Type of Facility:

☐SLP-II ☐CIRS ☐CTH-I ☐CTH-II ☐ASW

☐AAC ☐WAC ☐Respite ☐Camp ☐Unclassified Program

Capacity (Number of): Children:_____ Adult(s):_____ Respite:_____
(under age 21)

3. For CTH-I or Respite locations: Please Identify all household members (including child(ren) 21 years or younger):

Full Name	Age	Relationship to Caregiver
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____

4. List all licenses and/or certificates maintained by the facility:

Type of license and/or certificate	By Whom
_____	_____
_____	_____

5. Provider organization having jurisdiction over the facility:

Name:_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

When requesting a new license, please submit Electrical, HVAC and State Fire Marshal Inspection reports. If a consumer is under 21 years of age and moving into a CTH-I or CTH-II, also submit DHEC Sanitation Inspection. Send to Central Office Attn: Quality Management/Licensing. Documents should be submitted as a single packet.

Statements contained in this application are correct. I understand the facility must be in compliance with all applicable Federal, State, and local laws and regulations, and all applicable DDSN contracts, policies, procedures, and standards, and that noncompliance with these terms may results in enforcement actions as identified in DDSN Directive 104-01-DD and/or DDSN/Provider Contract.

_____ _____

Signature/Head of the Provider Organization Title

_____

Notary Public

_____County, South Carolina

My Commission Expires: _____

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CERTIFICATION AND LICENSING STANDARDS
REQUEST FOR EXCEPTION

Provider Requesting Exception:		Date:
Facility Type:	Signature of Provider Executive Director:	
Name of Facility:	Signature of Governing Board Chairperson:	
Policy or Standard from which Exception is requested (e.g., 000-00-DD, DDSN Respite Standards, etc.)	Nature and reason for Exception Request (specify if for one individual (give name), one Facility (give name), for all residential programs, day, etc., or for the entire Organization along with the reason)	Explain how the safety of program participant(s), the staff or the public will not be endangered, if this Exception is Granted
Explain how this Exception, if granted, the Quality and Quantity of Services will be maintained		
Comments:		
Signature: _____ Director-Quality Management	Recommendation: ☐Approved ☐Deny Date:	
Signature: _____ State Director/Designee	Recommendation: ☐Approved ☐Deny Date:	

SOUTH CAROLINA STATE FIRE

OSFM
INFORMATIONAL BULLETIN

NUMBER:	*18-2001*	
EFFECTIVE DATE:	April 2, 2018	Revision March 1, 2022
FROM:	Shawn Stickle, Chief Deputy State Fire Marshal	
APPROVED:	Nathan Ellis, Assistant State Fire Marshal	
SECTION:	Code Enforcement	
SUBJECT:	Fire Inspection Requirements for DSS Foster Homes and DDSN CTHI's – Health Inspections for DSS Foster Homes, DDSN CTHI's, and DDSN CTH II's	

I. Objectives:

A. To provide Deputy State Fire Marshals with guidance and clarification on South Carolina Code of Regulations - R.71-8301.3, R.144-550, and R.144-592 for consistent application statewide.

B. To provide DSS Caseworkers, Child Placement Agencies, Foster Parents, and DDSN CTHI providers with fire inspection requirements prior to requesting the inspection in the State Fire Informational Management System (IMS).

C. To provide DSS Caseworkers, Child Placement Agencies, Foster Parents, DDSN CTHI, and DDSN CTHII providers with health inspection requirements prior to requesting the inspection in the State Fire IMS.

II. Procedures

A. Inspection request periods will run from the 16th of each month to C.O.B. the 15th of the following month. Inspections will be scheduled for the period within 5 business days of the inspection request period end. Providers will submit requests for annual and re-inspections into the State Fire IMS 90 days prior to license expiration. Requests for initial inspection of homes shall be submitted for the following inspection period.

B. Only approved requesting agencies may request and/or cancel inspections. Inspections will not be scheduled without a proper request in the IMS. No Show/Cancellations for Initial Homes shall be requested as Initial Homes until an in person inspection occurs,

C. Requesting Agencies shall list the home owner/operator as the owner on the individual tab of the IMS, with correct contact information (including email) to guarantee delivery of this bulletin of requirements prior to the fire inspection.

D. Reports will no longer contain health inspection "collected data" and will only reflect deficiencies found. Both Fire and Health deficiencies will be cited as applicable, or the report will notate "No fire inspection deficiencies noted at the time of inspection" and "No health inspection deficiencies noted at the time of inspection" as a reference.

III. Contents

A. Fire Safety

1. Approved address numbers shall be placed in a position that is plainly legible and visible from the street.

- **a.** Address number shall be a minimum of 4 inches high with a minimum stroke width of 0.5 inch and shall contrast with their background.

2. Foster Home shall be designed and constructed with the intent to be used as a dwelling.

3. One (1) portable fire extinguisher with a minimum classification of 2A:10BC shall be readily accessible and installed near cooking areas on your way to an exit outside.

- **a.** Fire extinguishers shall be visually inspected monthly to ensure the needle is in the green.
- **b.** Annual maintenance is not required for foster homes, however, extinguishers shall be replaced or serviced by a fire equipment dealer every 6 years from the manufacture date.

4. All egress doors and pathways shall not be obstructed, diminished, reduced, or require special knowledge, effort or a key to exit. No more than three actions, including opening the door, are permitted. (e.g. **1**. Unlock deadbolt. **2.** Unlock door knob. **3.** Turn door knob and open the door.)

- **a.** Dual Cylinder locks are not permitted (lock requires a key to lock and unlock on the inside).
- **b.** Doors are permitted to be equipped with a night latch, dead bolt or security chain, provided such devices are openable from the inside without the use of a key or tool, however, shall be installed no higher than 48" inches and it requires no more than three total actions.

5. Each sleeping room shall have an operable door that closes and latches to provide compartmentation that protects occupants in case of a fire event. A residential automatic fire sprinkler system will be considered an alternate method to compartmentation requirements.

- **a.** Doors shall be positive latching (self-latch when pushed closed and require an action to unlatch/open) that resist not less than 5 pounds of force. Roller latches are prohibited.
- **b.** Bedroom walls shall terminate at the ceiling, without unprotected openings, or lofts.
- **c.** Barn Doors are permitted, however:
  - **i.** The barn door edges shall overlap the opening on the sides, top, and bottom if applicable.
  - **ii.** If provided with a latch, the latching mechanism shall be hardware that is manufactured for the purpose of latching sliding barn doors in place. Homemade solutions for latches, such as hook and eye or staple hasp latches, are not permitted.

6. All sleeping rooms below the fourth story shall have operable emergency escape and rescue openings that open from the inside. Emergency and escape rescue openings shall meet the dimensions illustrated below and have a net clear opening of not less than 5.7 square feet. Exception: Grade floor is permitted to be 5.0 square feet. Foster homes that do not comply with

minimum dimensions* of emergency escape and rescue opening shall have either smoke alarms interconnected in such a manner that the activation of one alarm will activate all of the alarms in the dwelling unit, or a have a residential automatic fire sprinkler system installed. Regardless, at the Deputy's discretion, openings are still be required to allow an average size adult to escape and sill height shall not be higher than 44 inches from the floor.

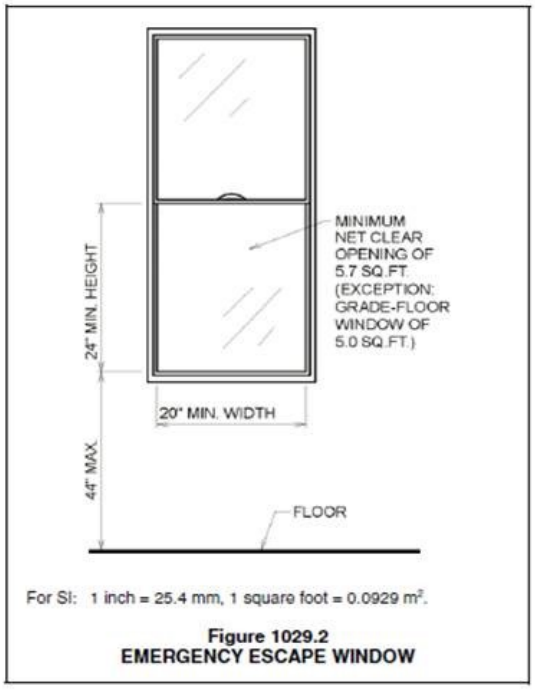


Figure 1029.2
EMERGENCY ESCAPE WINDOW

Equation: (Length x Width) ÷ 144

Example: (20" x 24") = 480 ÷ 144 = 3.33 Square feet

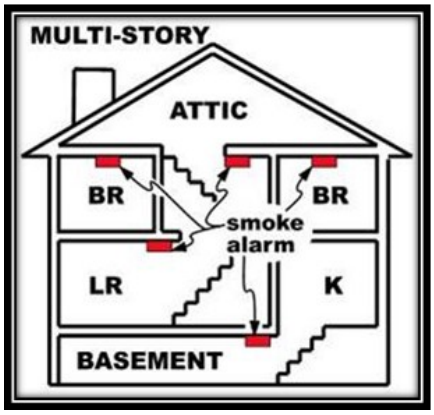
Note: The example shown does NOT meet the minimum area required, though it does meet the minimum dimensions. Thus, interconnected smoke alarms or a residential automatic fire sprinkler system are required.

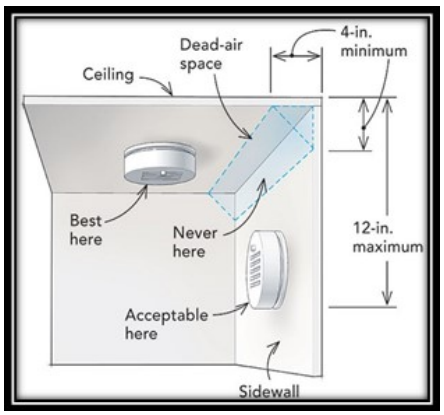
a. Below Grade: Where the sill height is below grade, it shall be provided with a window well with the horizontal area of the window well shall be not less than 9 square feet with a horizontal projection and width of not less than 36 inches. The area of the window well shall allow the emergency escape and rescue opening to be fully opened. The ladder or steps required shall be permitted to encroach not more than 6 inches into the required dimensions of the window well. Nothing shall obstruct these openings.

7. Listed smoke alarms shall be installed on the ceiling or wall outside of each separate sleeping area in the immediate vicinity of bedrooms (within 21 feet per NFPA 72), in each room used for sleeping purposes, and on each habitable story within a dwelling (including basements).

a. Smoke alarms expire based on the manufacture's guidelines or 10 years from the date of manufacture, whichever is less, and shall be installed per illustrations below.
b. Hardwired and/or interconnected alarms are required to be maintained if installed per illustrations below.
c. Homes without hardwired interconnected alarms shall be provided with a sealed 10-year life battery if emergency escape and rescue openings meet minimum size and dimensions.
  i. If emergency escape and rescue openings do not meet minimum size requirements, listed wireless interconnected smoke alarms shall be installed.
  ii. If the home is provided with hardwired in the common areas and installed properly, a wireless "bridge" unit shall be installed to communicate with wireless alarms in the bedrooms.

d. Fire Alarm Systems need to comply with regulations and NFPA 72, and may only be approved by a supervisor.





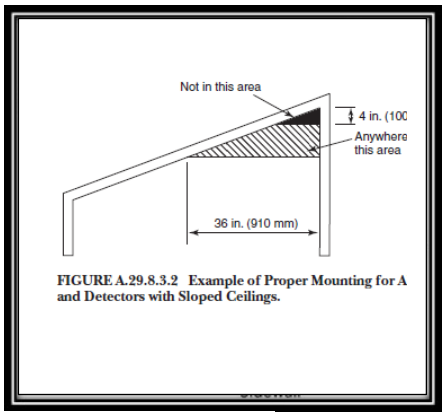


FIGURE A.29.8.3.2 Example of Proper Mounting for A and Detectors with Sloped Ceilings.

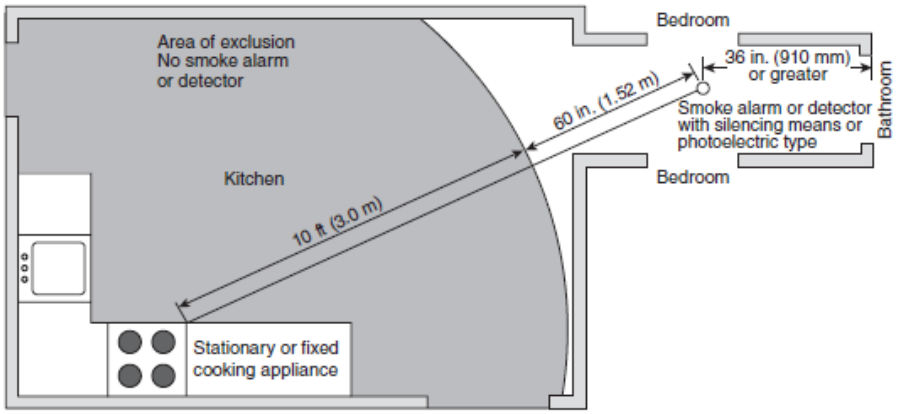


FIGURE A.29.8.3.4(4)(b) Example of Smoke Alarm or Smoke Detector Placement Between 10 ft (3.0 m) and 20 ft (6.1 m) Away in Hallway from Center of Stationary or Fixed Cooking Appliance.

8. An approved carbon monoxide alarm shall be installed and maintained* outside of **each** separate sleeping area in the immediate vicinity of the bedrooms** if home has:

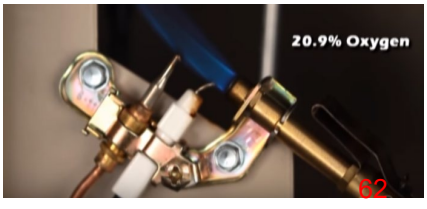
- **a.** Fuel fired appliances are installed.
- **b.** Attached garages (3 sides enclosed).
- **c.** Fireplaces.
- **d.** Combination smoke/carbon monoxide alarms are permissible.

* Carbon monoxide alarms expire based on the manufacture's guidelines.

**Bedrooms with fuel fired appliances or fireplaces shall also have carbon monoxide alarms.

9. All heating devices shall be installed per manufacturer's guidelines.

- **a.** Unvented gas heaters shall have an operating oxygen depletion device that shuts off at 18% oxygen (picture below), an operating safety shutoff device, and shall be located or guarded to prevent burn injuries.



b. Portable, unvented heaters are not permitted; e.g. Kerosene heaters.
c. Fireplaces shall be equipped with fire screens, partitions, or other means to protect clients from burns.
d. Listed space heaters shall have a tip over switch, have a three foot clearance on all sides and be directly plugged into an outlet.

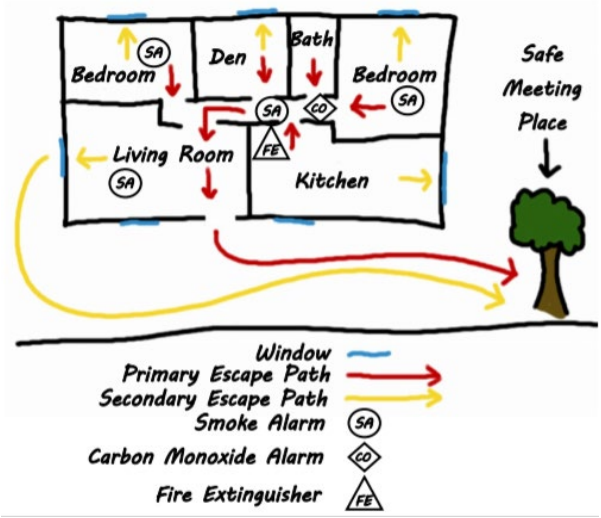
10. The dwelling shall be free of dangers that constitute an obvious fire hazard such as the following:

a. Hoarding conditions (contact supervisor).
b. Electrical Hazards, including using extension cords as permanent wiring.
c. Improperly installed/maintained dryer vent.
d. Storage of flammable liquids or gases.
e. Items considered a fire hazard by the Deputy's judgement (contact supervisor)

11. A fire escape plan describing what actions are to be taken by the family in the event of a fire must be developed and posted in one location.

a. Recommended example found on our website, not required:

Foster Home Fire Drill Planner



Draw the layout of your home as best you can. Include:

- ❑ Doorways
- ❑ Windows
- ❑ Each room
- ❑ Smoke alarm locations (label "SA") *Date installed_____
- ❑ Carbon monoxide alarm location(s) (label "CO") *Date installed_____
- ❑ Fire extinguisher location(s) (label "FE") *Date Serviced_____

Visit each room in your home and:

- ❑ Find two ways out
- ❑ Draw arrows on your "Fire Drill Planner" showing two ways out

Draw a separate floor plan for:

- ❑ Basements, 2nd or 3rd floors, Finished room over garage (FROG)

Mark your Fire Drill Planner with your safe meeting place:

- ❑ Pick a solid object that isn't easily moved, such as a tree
- ❑ Make sure the object is far enough from your home so it's safe to stand there

b. A fire escape drill shall be conducted every three (3) months and records of the drills shall be maintained on the premises for three (3) years.

i. The records shall give the date, time, and weather conditions during the drill, number evacuated, description, and evaluation of the fire drill. Fire drills shall include complete evacuation of all persons from the building.
ii. A fire escape drill shall be conducted within twenty-four (24) hours of the arrival of each new foster child.

B. Health Safety – All Initial Foster/Kinship Homes, Annual CTH I and CTH II Inspections

1. *Health Hazards – South Carolina Code of Regulations – Foster Homes R.114-550
- CTH II's - R.114-592

b. Water temperature below 120 degrees Fahrenheit - R.114-550.N.2.c
- CTH II Water temperature between 100 to 120 degrees Fahrenheit - R.114-592.A.5.f

c. Excessive garbage and uncleanliness. (contact supervisor) - R.114-550.L.2
- CTH II - R.114-592.C.1.a

d. Insect/rodent Infestations. - R.114-550.L.3.b
- CTH II – R.114-592.B.5.b

e. *Prevent the child's access, as appropriate for his or her age and development, to all medications, poisonous materials, cleaning supplies, other hazardous materials, and alcoholic beverages - R.114.550.N.5.a
- Poisonous materials, cleaning supplies and Hazardous materials shall not be stored in a manner that spills or leaks may come in contact with consumables or be mistaken as a consumable. - R.114-550. N.5.a
- CTHII – R.114-592.B.4.a

f. Be free from objects, materials, and conditions that constitute a danger to health or life safety by the Deputy's judgement. (contact supervisor) - R.114-550.L.3.a
- CTH II - R.114-592.A.4.b

2. Public Water/Waste or Well Water Sample R.114-550.N.2 (OSFM not citing pending tests).
a. Shall be negative for Coliform and E.coli.
b. Positive samples will be handled by the Senior Deputy – Notification will be made to the caseworker and homeowner for disinfection procedures in accordance with SCDHEC.
- DDSN providers perform annual tests. State Fire does not collect DDSN Well samples for testing.

3. Septic hazards that constitute a danger to health - R.114-550.L.3.a
- CTH II - R.114-592.A.5.d

4. Pet Inoculations annual per SC Code of Laws §47-5-60. - R.114-550.N.3.b
a. Pet Inoculations are required for Cats, Dogs, and Ferrets
- CTH II - R.114-592.B.3.a

5. CTH II Fridge Temperatures maintained at or below 41 degrees Fahrenheit (5 degrees Celsius) per DDSN. Items in Freezer shall be maintained frozen, - R.61-25 3-501.12 (A).

a. Refrigerators shall be equipped with ambient air temperature measuring devices. - R.61-25 4-204.112 (A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.

***Note: State Fire does not inspect Swimming pools, medications, weapons, alcoholic beverages, or any other item covered in R.114-550 or R.114-592 not included above.**

IV. Interpretation Contact

A. Senior Deputy State Fire Marshal
B. Chief Deputy State Fire Marshal
C. Assistant State Fire Marshal

3440 Harden Street Extension
Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

Reference Number:	104-01-DD
Title of Document:	Certification and Licensure of DDSN Residential and Day Facilities
Date of Issue:	October 21, 1988
Date of Last Revision:	June 16, 2022 (**REVISED**)
Effective Date:	June 16, 2022
Applicability:	DDSN and Contracted Providers of Residential, Day, and Respite Facilities (Excluding Family-Arranged Respite)

PURPOSE:

To identify authority and guidance for the South Carolina Department of Disabilities and Special Needs (DDSN) to contract with an independent entity that is CMS-certified as a Quality Improvement Organization to certify and/or license residential and day facilities.

AUTHORITY:

S.C. Code Ann. § 44-20-710 (2018), authorizes DDSN to license or contract for licensure day facilities for adults. Facilities may be licensed Adult Activity Centers, Work Activity Centers, or Unclassified Programs. These settings provide Career Preparation, Community Services, Day Activity, and Employment Services, as authorized, to DDSN eligible participants.

S.C. Code Ann. § 44-7-260 (Supp.2021), authorizes DDSN to sponsor, certify, or license community-based housing for adults or contract for these functions. These settings provide Residential Habilitation, as authorized, to DDSN eligible participants.

S.C. Code Ann. § 44-7-110 (2018), § 44-20-10 (2018), and § 44-21-10 (2018), grants DDSN authority to license or contract the licensure function for respite facilities for children and/or adults. Respite services are provided, as authorized, to DDSN eligible participants.

Since 1985 DDSN has maintained a Memorandum of Agreement (MOA) with the Department of Social Services (DSS), which grants DDSN authority to license Community Training Homes (CTH) for children. The MOA is in accordance with provisions of S.C. Code Ann. § 44-20-1000 (2018). DDSN standards meet Child Foster Care Regulation S.C. Regs. § 114-550 (Supp. 2021) for homes licensed as a CTH-I and for homes licensed as a CTH-II as approved annually by DSS. DSS defines a child as a person under the age of 21 and any movement of these children within DDSN Residential Services must be coordinated through the DDSN Operations Division and the Quality Management Division.

South Carolina Law grants DHEC the authority to license Community Residential Care Facilities (CRCF) for adults and Intermediate Care Facilities for Individuals with an Intellectual or Related Disability (ICF/IID).

GENERAL:

No residential, day or respite facility shall provide services and supports unless the service provider is:

1. Qualified by DDSN;

2. Compliant with applicable federal, state and local laws;

3. Compliant with all applicable DDSN policies, procedures, and standards; and,

4. Issued a license or certification by DDSN or DHEC.

For services and supports contracted by DDSN, the facilities shall only provide the type of service that is identified on the certificate or license, and shall serve no more than the maximum number of individuals identified on the certificate and/or license.

The certificate and/or license shall be maintained in the facility at all times. Certificates and/or licenses are non-transferable. *Reviews of facilities may be conducted at any time, without prior notice.*

When a license or certificate is issued by DDSN, the DDSN Director of Quality Management is responsible for insuring reviews conducted by DDSN, or its contractor, are conducted according to DDSN protocol.

SUPPORT MODELS LICENSED/CERTIFIED BY DDSN OR ITS CONTRACTOR:

I. Residential:

Residential Habilitation, as defined by the DDSN Residential Habilitation Standards, is provided in each of the models for residential support listed below:

A. **Community Training Home-I (CTH-I) including the enhanced CTH-I:**

Personalized care, supervision and individualized training provided in accordance with the resident's service plan to no more than two (2) individuals who live in a support provider's home unless an exception has been granted by DDSN. The enhanced CTH-I

model builds in additional respite, personal care and enhanced payment to the caregiver due to the significant needs of the individual with disability. Both CTH-I models are licensed/certified using the same criteria. Support providers are qualified and trained private citizens.

B. **Community Training Home-II (CTH-II):**

A home environment in the community where no more than four (4) individuals live.

Care, supervision and skills training are provided by qualified and trained staff in accordance with the resident's service plan.

C. **Supervised Living Program-II (SLP-II):**

Supports are provided by qualified and trained staff to adults who need intermittent supervision and supports. Staff are available on-site or in a location from which they can be on-site within 15 minutes of being called, 24 hours a day, seven (7) days a week.

D. **Community Inclusive Residential Services (CIRS):**

Supports promote the development and independence of individuals with disabilities in homes leased by the individuals. A customized plan is developed to transition the individual from a 24-hour setting to a semi-independent living arrangement. Individuals with a disability are the focus. They choose where they live, with whom they live, and which support staff work with them in their new home. Staffing is provided according to the participant's assessed need and assistive technology may be used to assist with monitoring.

DDSN's contracted provider organizations may provide additional residential options, including CRCFs and ICFs/IID. These homes are licensed by DHEC. For any CRCF or ICF/IID contracted for services by DDSN, a copy of the license and corresponding licensing inspection report (and any applicable Plan of Correction) must be forwarded to DDSN Quality Management within 15 days of receipt.

II. <u>Respite</u>:

Services may be provided in the individual's home, another residence selected by the individual/family, or a home licensed/certified by DDSN or DHEC.

III. <u>Day</u>:

A. **Adult Activity Center:**

A goal-oriented program of developmental, prevocational services designed to develop, maintain, increase or maximize an individual's functioning in activities of daily living, physical growth, emotional stability, socialization, communication, and vocational skills. Participants must be at least 18 years of age.

B. **Work Activity Center**:

A center-based setting having an identifiable program designed to provide therapeutic activities for individuals with intellectual and related disabilities whose physical or mental impairment which would otherwise interfere with a typical work setting or schedule. Work or production is not the main purpose of the program; however, the development of work skills is its main purpose. The program must have a certificate from the United States Department of Labor designating it as a Work Activity Program when applicable.

C. **Unclassified Program:**

A program that provides a beneficial service and observes appropriate standards to safeguard the health and safety of its participants, staff and the public. This would include non-work-related day supports. Participates must be at least 12 years of age.

SCHEDULE FOR REVIEWS:

Facilities licensed or certified by a DDSN contractor will be reviewed on an annual inspection cycle. A review of all applicable Licensing Standards/indicators will take place during the annual review process. A provider staff must be on-site during the inspection at the time indicated by the licensing contractor. Documentation required on-site is specified in the Licensing Standards. Providers are advised to be review ready at all times.

APPLICATION PROCESS:

A. For A New Home or Facility:

To initiate licensing/certification reviews of new homes and facilities, all sections of the DDSN Licensing/Certification Application to Operate must be completed with sufficient time to allow a licensing inspection prior to the opening of the facility. A notice of at least three (3) weeks is suggested, as the Licensing Contractor may need up to two (2) weeks to complete the inspection from the date they receive the packet. The Application must be submitted with all required inspections, to include the applicable State Fire Marshal, Electrical, and HVAC inspection reports. This information should be submitted as a single packet. The projected opening date of the home or facility must be noted. The home/facility must not be occupied prior to the licensing inspection and receipt of an actual license/certificate from DDSN. The provider must ensure receipt of required authorizations for services prior to acceptance of any participants. Admission/Discharge/Transfer forms must be submitted for each occupant as required in DDSN Directive 502-01-DD: Admission/Discharge/Transfer of Individuals To/From DDSN Contracted Residential Settings.

**During designated emergencies, DDSN will expedite the initial application process, as necessary, to arrange for short-term placement options.*

B. To Update Existing Application:

A DDSN Licensing/Certification Application must be completed when/if any information contained in the previously submitted application changes. The provider must ensure that the address, occupancy, and contact information for the location are current and accurate in the DDSN Service Provider Management Module (SPM) within the Applications Portal and Therap.

FIRE SAFETY INSPECTIONS:

Initial Fire Safety Inspections, when required, must be made by a Fire Marshal employed by the State Fire Marshal's Office. Fees for this service are pre-paid by DDSN, but inspections must be requested. Requests should only be made via the Office of State Fire Marshal's On-line Request Portal www.fire.llr.sc.gov/portal. Please follow the prompts to set-up an account for your provider agency and each site requiring an inspection.

Requests for annual inspections and/or follow-up inspections must be completed in the portal on or before the 15th of the month in order to be scheduled for the following month. The State Fire Marshal Deputy completing the inspection will contact the designated staff to schedule the inspection time. It is important for staff to be on-site at the time of the inspection.

For CTH-I and CTH-II Settings, the State Fire Marshal's Office will also complete a Health and Sanitation Inspection at the time of their annual fire/safety inspection. No additional request is required for this inspection.

FINDINGS/PLANS OF CORRECTION/RECONSIDERATION

Staff from the Licensing Contractor will make an on-site annual review of the physical plant and records, then compare their finding with the requirements as set forth in standards, policies, and procedures. Standards not in compliance at the time of the licensing inspection will be noted. As a result of these activities, a report will be issued to the provider organization within 30 days.

Each report will include the standard, policy, or procedure determined to be deficient at the time of the licensing review, a statement of the specific findings and the classification of the deficiency. Each standard cited as deficient will be classified as one of the following:

- Class 1 Deficiency: An individual's physical, emotional, and financial well being is in immediate jeopardy. Immediate correction is required.

- Class 2 Deficiency: A failure of organizational safeguards which could put the individual's physical, emotional, and financial well-being in jeopardy. The Plan of Correction from the provider is either required before the end of the survey or within 15 days of receiving the written licensing report. The nature, circumstances, and extent of the deficiency will be evaluated by the surveyor to determine the time frame requirements for the Plan of Correction. Corrections are required to be completed no later than 60 days after receiving the written licensing report unless otherwise specified and subsequently approved by DDSN or its designee.

- Class 3 Deficiency: All other reportable deficiencies. The Plan of Correction from the provider is required within 15 days of receiving the written licensing report. The nature, circumstances, and extent of the deficiency will be evaluated by the surveyor to determine the time frame requirements for the Plan of Correction. Corrections are required to be completed no later than 60 days after receiving the written licensing report unless otherwise specified.

Upon receipt of the report, the provider will have 15 days to submit a written Plan of Correction on the QIO portal. The Plan of Correction should not only address the individual deficiency cited, but should also include a systemic response to ensure correction across the organization. Corrections are required to be completed no later than 60 days after receiving the written licensing report unless otherwise specified and subsequently approved by the Licensing Contractor or DDSN.

If the provider does not agree with the content of the report, reconsideration may be requested. The provider may request reconsideration of the deficiencies by submitting, in writing, the standard, policy, or procedure cited; the finding related to the standard, policy, or procedure; the nature of their disagreement with the finding; and any documentation to support its position. The provider is allowed one reconsideration request for each citation per survey cycle. The provider must submit the request of citation reconsideration within 15 days of receiving the licensing report. The Appeal/Reconsideration Request form must be completed on the QIO Portal, with the form and supporting documentation uploaded as an attachment for the review in question. Upon receipt, the appeal/reconsideration request will be reviewed by the appropriate program staff at DDSN for the particular service area.

If reconsideration is requested, a Plan of Correction for the indicated citation is not required to be submitted until a decision regarding the reconsideration is reached. However, any deficiency not being reconsidered must be corrected according to the timelines as outlined in this document.

The reconsideration will be completed within 30 days of receiving the request. Based on the results of the reconsideration, if needed, a revised report will be issued. A Plan of Correction for all deficiencies upheld must be submitted through the QIO portal within 15 days of the reconsideration decision. Corrections are required to be completed no later than 60 days after receiving the reconsideration decision unless otherwise specified and subsequently approved by DDSN.

FOLLOW-UP

All deficiencies cited in a licensing report will require a follow-up review. Most follow-up reviews will be completed as a remote desk review, with the provider submitting documentation on the QIO portal to validate that the actions described in the Plan of Correction have taken place by the target date. A provider may have two follow-up reviews for annual surveys, if necessary to ensure remediation. All timeframes identified above apply to these follow-up surveys. All citations identified on the reports will be individually reviewed by the Licensing Contractor to determine the type of follow up needed (i.e., documentation request or onsite review). All Class I citations will be resolved onsite at the time of the review. Each Class II or Class III citation will be reviewed individually by the Licensing Contractor to determine the most appropriate method for follow-up. Results of the Follow-up Review will be included in a report format that is similar to the annual inspection report and will provide a percentage score for compliance.

DDSN's Licensing Contractor will contact the provider organization and discuss the follow-up process, as it relates to their review. Contact will be made within 90 days of the approved Plan of Correction, but providers may choose to upload documentation on the QIO portal at any time.

Any findings of repeat/recurring citations and the use of documentation for citation correction will be discussed at the exit meeting and a report will be sent to the provider within 30 days. A written Plan of Correction will be submitted by the provider in response to any citations that remain after the follow-up review.

SANCTIONS:

Unannounced follow-up visits will be conducted by DDSN or the Licensing Contractor in situations where the severity and/or prevalence of deficiencies may adversely impact someone's health and safety and will determine if deficiencies have been corrected. Failure to correct deficiencies result in the following sanctions:

- Sanction 1 – Failure to correct a Class 1 deficiency, no matter what level or quantity of deficiency existing, will result in the removal of the license/contract and movement of the individual.

- Sanction 2 – Depending on the level or quantity of deficiencies, any of the following sanctions may be issued:

    1) Ongoing site monitoring;
    2) Required technical assistance;
    3) The issuance of a provisional license/certificate with a shortened expiration date;
    4) The license/certificate capacity of the program may be reduced;

    5) The license/certificate may be denied, suspended, revoked, or rescinded.

    For example, if there is a combination of deficiencies across licensed facilities with no repeated findings, step 1 or 2 may be used. If multiple deficiencies are discovered across licensed facilities and systemic problems that exist are not resolved after step 1 through 4 have been issued, then step 5 will be applied.

APPEALS:

The imposition of the specific sanction that involves denial, suspension or revocation of a license may be appealed. DDSN Directive 167-01-DD: Appeal Procedure for Facilities Licensed or Certified by DDSN, governs these appeals.

EXCEPTIONS:

DDSN reserves the right to make exceptions to standards or policies if the exception will not jeopardize the health and safety of the service recipient, staff or the public, and when the exception will not significantly reduce the quality or quantity of services provided. No exception should be

implemented until first approved, in writing, by the Director of Quality Management and the State Director/designee.

The request for exception should be submitted to the DDSN Quality Management Director using the DDSN Request for Exception Form (Attachment B). All sections of the form must be complete and accurate. The form must be signed by the Executive Director and Board Chairperson.

Unless otherwise noted, exceptions to Adult Day Standards will be valid for one (1) year from the date approved.

Unless otherwise requested and approved, exceptions to Residential and Respite Standards will remain valid for as long as the information contained on the initial request remains the same.

Barry D. Malphrus Vice Chairman	Stephanie M. Rawlinson Chairman

To access the following attachments, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

ATTACHMENTS:

Attachment A:	Application to Operate Residential, Day, or Respite Facility
Attachment B:	Request for Exception Form
Attachment C:	SC State Fire OSFM Informational Bulletin #18-2001 (March 1, 2022)

APPLICATION TO OPERATE
RESIDENTIAL, DAY OR RESPITE FACILITY

Date of Application:_____

Reason for Application: ☐Initial Licensing of a New Facility

☐Termination/Closure
Reason for termination/closure:_____

☐Change
☐in location ☐in facility type
☐in number of people served

1. Facility Information (Name):_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

Type of Facility:

☐SLP-II ☐CIRS ☐CTH-I ☐CTH-II ☐ASW

☐AAC ☐WAC ☐Respite ☐Camp ☐Unclassified Program

Capacity (Number of): Children:_____ Adult(s):_____ Respite:_____
(under age 21)

2. Changed Information (Updated):_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

Type of Facility:

☐SLP-II ☐CIRS ☐CTH-I ☐CTH-II ☐ASW

☐AAC ☐WAC ☐Respite ☐Camp ☐Unclassified Program

Capacity (Number of): Children:_____ Adult(s):_____ Respite:_____
(under age 21)

3. For CTH-I or Respite locations: Please Identify all household members (including child(ren) 21 years or younger):

Full Name	Age	Relationship to Caregiver
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____
_____ Add/Delete/Same	_____	_____

4. List all licenses and/or certificates maintained by the facility:

Type of license and/or certificate	By Whom
_____	_____
_____	_____

5. Provider organization having jurisdiction over the facility:

Name:_____

Address:_____

County:_____ Telephone Number (*include area code*):_____

When requesting a new license, please submit Electrical, HVAC and State Fire Marshal Inspection reports. If a consumer is under 21 years of age and moving into a CTH-I or CTH-II, also submit DHEC Sanitation Inspection. Send to Central Office Attn: Quality Management/Licensing. Documents should be submitted as a single packet.

Statements contained in this application are correct. I understand the facility must be in compliance with all applicable Federal, State, and local laws and regulations, and all applicable DDSN contracts, policies, procedures, and standards, and that noncompliance with these terms may results in enforcement actions as identified in DDSN Directive 104-01-DD and/or DDSN/Provider Contract.

_____ _____

Signature/Head of the Provider Organization Title

_____

Notary Public

_____County, South Carolina

My Commission Expires: _____

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CERTIFICATION AND LICENSING STANDARDS
REQUEST FOR EXCEPTION

Provider Requesting Exception:		Date:
Facility Type:	Signature of Provider Executive Director:	
Name of Facility:	Signature of Governing Board Chairperson:	
Policy or Standard from which Exception is requested (e.g., 000-00-DD, DDSN Respite Standards, etc.)	Nature and reason for Exception Request (specify if for one individual (give name), one Facility (give name), for all residential programs, day, etc., or for the entire Organization along with the reason)	Explain how the safety of program participant(s), the staff or the public will not be endangered, if this Exception is Granted
Explain how this Exception, if granted, the Quality and Quantity of Services will be maintained		
Comments:		
Signature: _____ Director-Quality Management	Recommendation: ☐Approved ☐Deny Date:	
Signature: _____ State Director/Designee	Recommendation: ☐Approved ☐Deny Date:	

SOUTH CAROLINA STATE FIRE

OSFM
INFORMATIONAL BULLETIN

NUMBER:	*18-2001*	
EFFECTIVE DATE:	April 2, 2018	Revision March 1, 2022
FROM:	Shawn Stickle, Chief Deputy State Fire Marshal	
APPROVED:	Nathan Ellis, Assistant State Fire Marshal	
SECTION:	Code Enforcement	
SUBJECT:	Fire Inspection Requirements for DSS Foster Homes and DDSN CTHI's – Health Inspections for DSS Foster Homes, DDSN CTHI's, and DDSN CTH II's	

I. Objectives:

A. To provide Deputy State Fire Marshals with guidance and clarification on South Carolina Code of Regulations - R.71-8301.3, R.144-550, and R.144-592 for consistent application statewide.

B. To provide DSS Caseworkers, Child Placement Agencies, Foster Parents, and DDSN CTHI providers with fire inspection requirements prior to requesting the inspection in the State Fire Informational Management System (IMS).

C. To provide DSS Caseworkers, Child Placement Agencies, Foster Parents, DDSN CTHI, and DDSN CTHII providers with health inspection requirements prior to requesting the inspection in the State Fire IMS.

II. Procedures

A. Inspection request periods will run from the 16th of each month to C.O.B. the 15th of the following month. Inspections will be scheduled for the period within 5 business days of the inspection request period end. Providers will submit requests for annual and re-inspections into the State Fire IMS 90 days prior to license expiration. Requests for initial inspection of homes shall be submitted for the following inspection period.

B. Only approved requesting agencies may request and/or cancel inspections. Inspections will not be scheduled without a proper request in the IMS. No Show/Cancellations for Initial Homes shall be requested as Initial Homes until an in person inspection occurs,

C. Requesting Agencies shall list the home owner/operator as the owner on the individual tab of the IMS, with correct contact information (including email) to guarantee delivery of this bulletin of requirements prior to the fire inspection.

D. Reports will no longer contain health inspection "collected data" and will only reflect deficiencies found. Both Fire and Health deficiencies will be cited as applicable, or the report will notate "No fire inspection deficiencies noted at the time of inspection" and "No health inspection deficiencies noted at the time of inspection" as a reference.

III. Contents

A. Fire Safety

1. Approved address numbers shall be placed in a position that is plainly legible and visible from the street.

- **a.** Address number shall be a minimum of 4 inches high with a minimum stroke width of 0.5 inch and shall contrast with their background.

2. Foster Home shall be designed and constructed with the intent to be used as a dwelling.

3. One (1) portable fire extinguisher with a minimum classification of 2A:10BC shall be readily accessible and installed near cooking areas on your way to an exit outside.

- **a.** Fire extinguishers shall be visually inspected monthly to ensure the needle is in the green.
- **b.** Annual maintenance is not required for foster homes, however, extinguishers shall be replaced or serviced by a fire equipment dealer every 6 years from the manufacture date.

4. All egress doors and pathways shall not be obstructed, diminished, reduced, or require special knowledge, effort or a key to exit. No more than three actions, including opening the door, are permitted. (e.g. **1**. Unlock deadbolt. **2.** Unlock door knob. **3.** Turn door knob and open the door.)

- **a.** Dual Cylinder locks are not permitted (lock requires a key to lock and unlock on the inside).
- **b.** Doors are permitted to be equipped with a night latch, dead bolt or security chain, provided such devices are openable from the inside without the use of a key or tool, however, shall be installed no higher than 48" inches and it requires no more than three total actions.

5. Each sleeping room shall have an operable door that closes and latches to provide compartmentation that protects occupants in case of a fire event. A residential automatic fire sprinkler system will be considered an alternate method to compartmentation requirements.

- **a.** Doors shall be positive latching (self-latch when pushed closed and require an action to unlatch/open) that resist not less than 5 pounds of force. Roller latches are prohibited.
- **b.** Bedroom walls shall terminate at the ceiling, without unprotected openings, or lofts.
- **c.** Barn Doors are permitted, however:
  - **i.** The barn door edges shall overlap the opening on the sides, top, and bottom if applicable.
  - **ii.** If provided with a latch, the latching mechanism shall be hardware that is manufactured for the purpose of latching sliding barn doors in place. Homemade solutions for latches, such as hook and eye or staple hasp latches, are not permitted.

6. All sleeping rooms below the fourth story shall have operable emergency escape and rescue openings that open from the inside. Emergency and escape rescue openings shall meet the dimensions illustrated below and have a net clear opening of not less than 5.7 square feet. Exception: Grade floor is permitted to be 5.0 square feet. Foster homes that do not comply with

minimum dimensions* of emergency escape and rescue opening shall have either smoke alarms interconnected in such a manner that the activation of one alarm will activate all of the alarms in the dwelling unit, or a have a residential automatic fire sprinkler system installed. Regardless, at the Deputy's discretion, openings are still be required to allow an average size adult to escape and sill height shall not be higher than 44 inches from the floor.

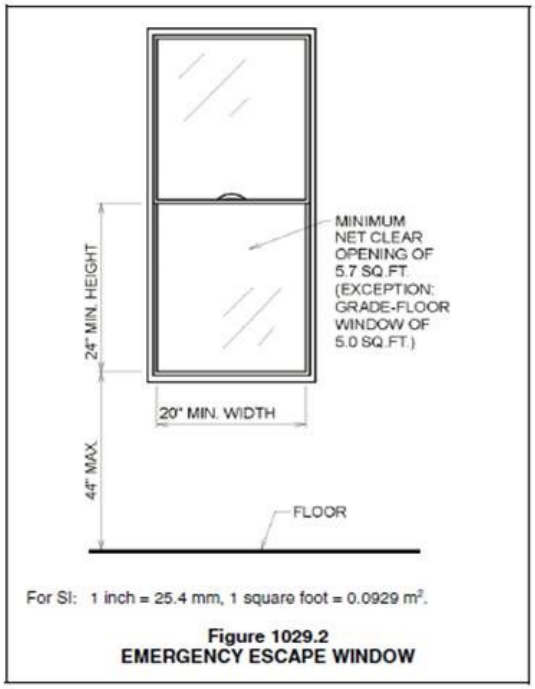


Figure 1029.2
EMERGENCY ESCAPE WINDOW

Equation: (Length x Width) ÷ 144

Example: (20" x 24") = 480 ÷ 144 = 3.33 Square feet

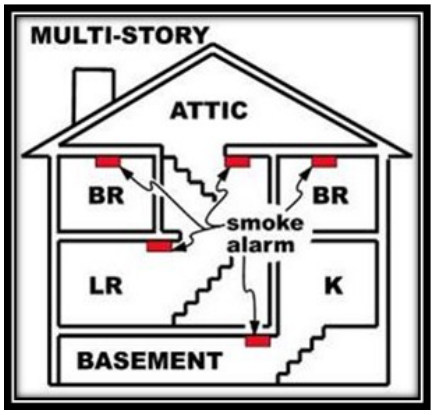
Note: The example shown does NOT meet the minimum area required, though it does meet the minimum dimensions. Thus, interconnected smoke alarms or a residential automatic fire sprinkler system are required.

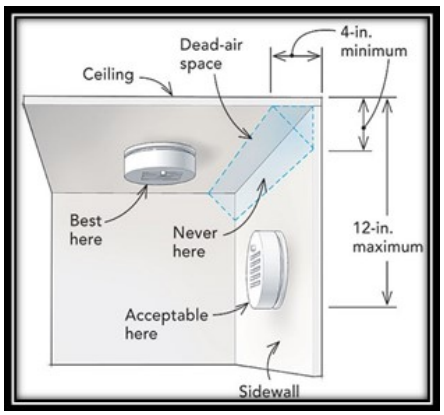
a. Below Grade: Where the sill height is below grade, it shall be provided with a window well with the horizontal area of the window well shall be not less than 9 square feet with a horizontal projection and width of not less than 36 inches. The area of the window well shall allow the emergency escape and rescue opening to be fully opened. The ladder or steps required shall be permitted to encroach not more than 6 inches into the required dimensions of the window well. Nothing shall obstruct these openings.

7. Listed smoke alarms shall be installed on the ceiling or wall outside of each separate sleeping area in the immediate vicinity of bedrooms (within 21 feet per NFPA 72), in each room used for sleeping purposes, and on each habitable story within a dwelling (including basements).

a. Smoke alarms expire based on the manufacture's guidelines or 10 years from the date of manufacture, whichever is less, and shall be installed per illustrations below.
b. Hardwired and/or interconnected alarms are required to be maintained if installed per illustrations below.
c. Homes without hardwired interconnected alarms shall be provided with a sealed 10-year life battery if emergency escape and rescue openings meet minimum size and dimensions.
  i. If emergency escape and rescue openings do not meet minimum size requirements, listed wireless interconnected smoke alarms shall be installed.
  ii. If the home is provided with hardwired in the common areas and installed properly, a wireless "bridge" unit shall be installed to communicate with wireless alarms in the bedrooms.

d. Fire Alarm Systems need to comply with regulations and NFPA 72, and may only be approved by a supervisor.





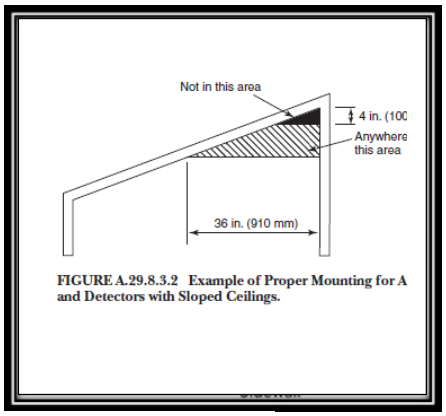


FIGURE A.29.8.3.2 Example of Proper Mounting for A and Detectors with Sloped Ceilings.

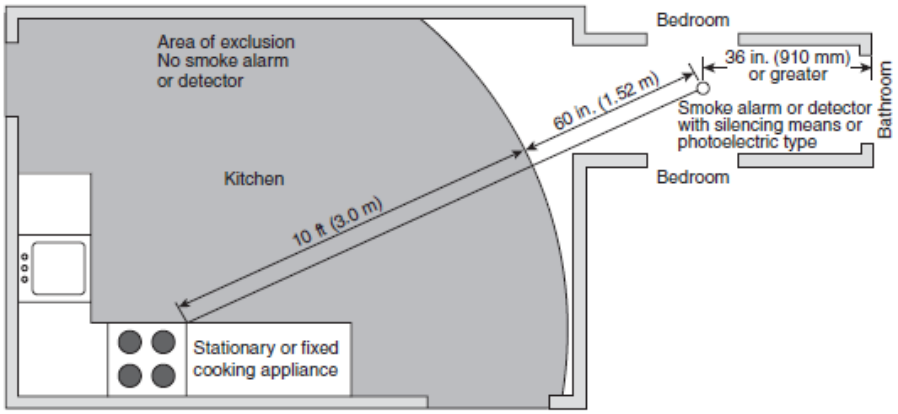


FIGURE A.29.8.3.4(4)(b) Example of Smoke Alarm or Smoke Detector Placement Between 10 ft (3.0 m) and 20 ft (6.1 m) Away in Hallway from Center of Stationary or Fixed Cooking Appliance.

8. An approved carbon monoxide alarm shall be installed and maintained* outside of **each** separate sleeping area in the immediate vicinity of the bedrooms** if home has:

- **a.** Fuel fired appliances are installed.
- **b.** Attached garages (3 sides enclosed).
- **c.** Fireplaces.
- **d.** Combination smoke/carbon monoxide alarms are permissible.

* Carbon monoxide alarms expire based on the manufacture's guidelines.

**Bedrooms with fuel fired appliances or fireplaces shall also have carbon monoxide alarms.

9. All heating devices shall be installed per manufacturer's guidelines.

- **a.** Unvented gas heaters shall have an operating oxygen depletion device that shuts off at 18% oxygen (picture below), an operating safety shutoff device, and shall be located or guarded to prevent burn injuries.

b. Portable, unvented heaters are not permitted; e.g. Kerosene heaters.
c. Fireplaces shall be equipped with fire screens, partitions, or other means to protect clients from burns.
d. Listed space heaters shall have a tip over switch, have a three foot clearance on all sides and be directly plugged into an outlet.

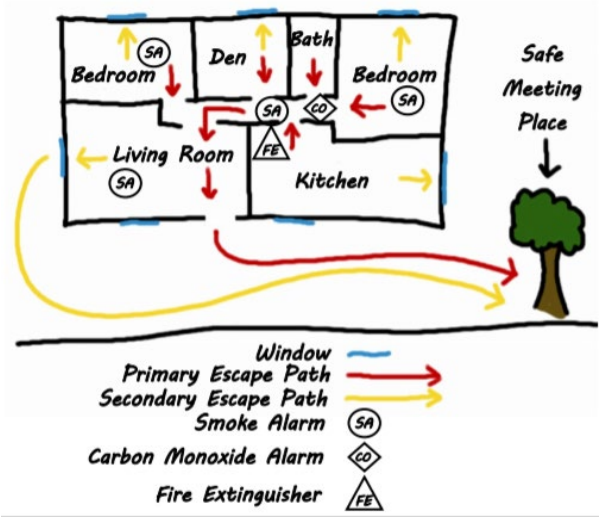
10. The dwelling shall be free of dangers that constitute an obvious fire hazard such as the following:

a. Hoarding conditions (contact supervisor).
b. Electrical Hazards, including using extension cords as permanent wiring.
c. Improperly installed/maintained dryer vent.
d. Storage of flammable liquids or gases.
e. Items considered a fire hazard by the Deputy's judgement (contact supervisor)

11. A fire escape plan describing what actions are to be taken by the family in the event of a fire must be developed and posted in one location.

a. Recommended example found on our website, not required:

Foster Home Fire Drill Planner



Draw the layout of your home as best you can. Include:

- ❑ Doorways
- ❑ Windows
- ❑ Each room
- ❑ Smoke alarm locations (label "SA") *Date installed_____
- ❑ Carbon monoxide alarm location(s) (label "CO") *Date installed_____
- ❑ Fire extinguisher location(s) (label "FE") *Date Serviced_____

Visit each room in your home and:

- ❑ Find two ways out
- ❑ Draw arrows on your "Fire Drill Planner" showing two ways out

Draw a separate floor plan for:

- ❑ Basements, 2nd or 3rd floors, Finished room over garage (FROG)

Mark your Fire Drill Planner with your safe meeting place:

- ❑ Pick a solid object that isn't easily moved, such as a tree
- ❑ Make sure the object is far enough from your home so it's safe to stand there

b. A fire escape drill shall be conducted every three (3) months and records of the drills shall be maintained on the premises for three (3) years.

i. The records shall give the date, time, and weather conditions during the drill, number evacuated, description, and evaluation of the fire drill. Fire drills shall include complete evacuation of all persons from the building.
ii. A fire escape drill shall be conducted within twenty-four (24) hours of the arrival of each new foster child.

B. Health Safety – All Initial Foster/Kinship Homes, Annual CTH I and CTH II Inspections

1. *Health Hazards – South Carolina Code of Regulations – Foster Homes R.114-550
- CTH II's - R.114-592

b. Water temperature below 120 degrees Fahrenheit - R.114-550.N.2.c
- CTH II Water temperature between 100 to 120 degrees Fahrenheit - R.114-592.A.5.f

c. Excessive garbage and uncleanliness. (contact supervisor) - R.114-550.L.2
- CTH II - R.114-592.C.1.a

d. Insect/rodent Infestations. - R.114-550.L.3.b
- CTH II – R.114-592.B.5.b

e. *Prevent the child's access, as appropriate for his or her age and development, to all medications, poisonous materials, cleaning supplies, other hazardous materials, and alcoholic beverages - R.114.550.N.5.a
- Poisonous materials, cleaning supplies and Hazardous materials shall not be stored in a manner that spills or leaks may come in contact with consumables or be mistaken as a consumable. - R.114-550. N.5.a
- CTHII – R.114-592.B.4.a

f. Be free from objects, materials, and conditions that constitute a danger to health or life safety by the Deputy's judgement. (contact supervisor) - R.114-550.L.3.a
- CTH II - R.114-592.A.4.b

2. Public Water/Waste or Well Water Sample R.114-550.N.2 (OSFM not citing pending tests).
a. Shall be negative for Coliform and E.coli.
b. Positive samples will be handled by the Senior Deputy – Notification will be made to the caseworker and homeowner for disinfection procedures in accordance with SCDHEC.
- DDSN providers perform annual tests. State Fire does not collect DDSN Well samples for testing.

3. Septic hazards that constitute a danger to health - R.114-550.L.3.a
- CTH II - R.114-592.A.5.d

4. Pet Inoculations annual per SC Code of Laws §47-5-60. - R.114-550.N.3.b
a. Pet Inoculations are required for Cats, Dogs, and Ferrets
- CTH II - R.114-592.B.3.a

5. CTH II Fridge Temperatures maintained at or below 41 degrees Fahrenheit (5 degrees Celsius) per DDSN. Items in Freezer shall be maintained frozen, - R.61-25 3-501.12 (A).

a. Refrigerators shall be equipped with ambient air temperature measuring devices. - R.61-25 4-204.112 (A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.

***Note: State Fire does not inspect Swimming pools, medications, weapons, alcoholic beverages, or any other item covered in R.114-550 or R.114-592 not included above.**

IV. Interpretation Contact

A. Senior Deputy State Fire Marshal
B. Chief Deputy State Fire Marshal
C. Assistant State Fire Marshal

Reference Number:	104-03-DD
Title of Document:	DDSN Contract Compliance~~/Quality Assurance~~ Reviews for Non-Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Programs
Date of Issue:	November 18, 2013
~~Effective Date:~~	~~November 18, 2013~~
~~Last Review Date:~~	~~January 22, 2015~~
Date of Last Revision:	~~January 22, 2015~~XXXX, 2022 (**REVISED**)
Effective Date:	~~November 18, 2013~~XXXX, 2022
Applicability:	DSN County Board and Contracted Providers (Excludes ICFs/IID Programs)

PURPOSE:

To establish guidance for the implementation of the contract between the Department of Disabilities and Special Needs (DDSN) and providers selected to conduct ~~quality assurance reviews~~ Contract Compliance Reviews (CCR).

GENERAL:

In order to determine compliance with applicable DDSN standards and policies, reviews of DDSN qualified providers are completed approximately every 12 to 18 months, based on the provider's prior performance. Providers scoring at or above ~~75~~85% ~~on their overall review score in each service area~~ will be placed on an approximate 18-month review cycle and providers scoring below ~~75~~85% (i.e., 84.9% or less) will be placed on an approximate 12-month review cycle. ~~In addition, providers scoring below 70% in any one or more individual areas of the review (administrative indicators, or day, residential, case management, or early intervention service areas) will be placed on an approximate 12-month review cycle.~~ The reviews include an assessment of the provider's administrative capabilities~~, review of consumer records and observation of staff~~ and a review of participant records. Any deficiencies found with the

provider's compliance will require a written Plan of Correction (POC) that addresses the deficiency both individually and systemically. ~~The providers will receive technical assistance from the District Office to address when the overall score is under 75% or any individual service area(s) below 70%.~~ A follow-up review will be conducted approximately six (6) to eight (8) months after the original review to determine if the corrections have been made. Failure to comply with certain performance requirements and failure to correct noted deficiencies may result in the imposition of sanctions by DDSN.

~~For providers scoring below 65% in any one service area during their Contract Compliance Review (regardless of the overall score), will be placed on an approximate 12 month review cycle and receive technical assistance from the District Office and assistance in developing their Plan of Correction.~~

~~For providers scoring below 60% in any one service area during their Contract Compliance Review (regardless of the overall score), will be placed on an approximate 12 month review cycle and receive technical assistance from the District Office and assistance in developing their Plan of Correction. In addition, the Executive Director/CEO/staff will be required to meet formally with DDSN personnel to address performance issues and develop a separate corrective provider action plan. The corrective plan of action may involve the suspension of any new referrals to the provider.~~

REVIEW PROCESS

DDSN will contract with a Quality Improvement Organization (QIO) selected from those certified by the Centers for Medicare and Medicaid Services (CMS). The QIO will utilize Key Indicators to evaluate the administrative capability of each provider reviewed ~~and General Agency indicators for each service provided to consumers~~ along with a sample of participant records to verify service delivery in accordance with applicable standards. A statistically valid and random sampling methodology will be used for all providers. For each case reviewed, the QIO will review the consumer's primary record/file as well as those records/files pertaining to ancillary supports/services as provided by DDSN. Each case review will include an evaluation of the most current assessment data used in developing the consumer's current plan(s). The review also will have an evaluation of the consumer's "Plan" or "Individual Family Services Plan (IFSP)" or "Family Service Plan (FSP)" as well as an evaluation of progress notes and file documentation pertinent to the quality of services delivered. ~~The QIO also will observe and evaluate the implementation of Residential Habilitation and Day Services standards promulgated by DDSN.~~ To the extent possible, participant records will be reviewed using documentation available in the agency's electronic record. At the conclusion of the review, a conference between the QIO representatives and the provider reviewed will be conducted to discuss preliminary findings of the review.

All newly qualified providers will be reviewed between three (3) to six (6) months of accepting their first consumer. Qualified providers who are beyond their first year, will be reviewed on a schedule of approximately 12 to 18 months, depending on prior performance. Follow-up reviews are conducted approximately six (6) ~~to eight (8)~~ months following the regular 12 to 18 month review. Patterns of poor performance may result in sanctions against the provider and could result in contract termination.

PLANS OF CORRECTION

All providers will be required to submit a Plan of Correction to the QIO for all citations within 30 days of receipt of the report of findings from the QIO. The POC will address the findings in each individual record as well as systemic findings related to the citations and as identified by the QIO. The latest completion date for any correction or action cannot exceed 90 calendar days following the report of findings. A response will be provided by the QIO within 30 calendar days. The Plan of Correction must be submitted to the QIO for approval, via their online portal.

~~For providers scoring below 65% in any one service area during their Contract Compliance Review (regardless of the overall score), will be placed on an approximate 12-month review cycle and receive technical assistance from the District Office and assistance in developing their Plan of Correction within 30 calendar days of receipt of the Report of Findings. Due to the number of citations resulting in a score of less than 65% compliance, the provider will also be required to develop an action plan that goes beyond the typical requirements of the Plan of Correction submitted to the QIO. The action plan must address systemic issues within the organization that have resulted in the low scores. The District Director and/or designee will provide guidance to the provider, as necessary, regarding the provider's Action Plan. This Plan will be submitted to the District Director for review.~~

FOLLOW-UP REVIEWS

The QIO will conduct a follow-up review to assure that all elements detailed in the provider's Plan of Correction have been implemented. The QIO review will include the criteria and timeframes for evaluating the extent to which the provider's Plan of Correction has been implemented. Follow-up reviews will include records/consumers from the original sample as well as new records. Upon receipt of the report, the Provider will have 30 days to submit a written Plan of Correction. The Plan of Correction should not only address the individual deficiency cited, but should also include a systemic response to ensure correction across the provider's system of services. Corrections are required to be completed no later than 90 days after receiving the written quality assurance report unless otherwise specified and subsequently approved by the QIO or DDSN. If a provider scores at less than ~~75~~85% (i.e., 84.9% or less) compliance on the follow-up visit, the provider will be required to participate in enhanced monitoring and technical assistance from ~~the District Office~~DDSN. In addition, the provider will be required to work collaboratively with the District Office to develop a Plan of Correction to address continuing citations. ~~The District Director and/or designee~~ DDSN Program staff will provide guidance to the provider, as necessary, regarding the Plan of Correction. The Plan of Correction must be submitted to the QIO for approval, via their online portal, and a second follow-up review will be scheduled through the QIO.

SPECIAL CIRCUMSTANCE REVIEWS

The QIO may complete special circumstance reviews at the direction of DDSN. The Special Circumstance Review follows the same format and scope as a Follow-up Review.

APPEALS

If the provider does not agree with the content of the report of findings, reconsideration may be requested through a formal appeal. The provider may request reconsideration of the deficiencies

by submitting, in writing, the Key Indicator cited, the finding, the nature of the disagreement with the finding, and any documentation to support their position. The provider is allowed one appeal request per identified deficient practice per survey cycle. The provider may submit their appeal with their Plan of Correction (i.e., within 30 days of receiving the QIO report). Requests for appeal should be submitted via the QIO Reporting Portal with notification to DDSN Quality Management. DDSN program staff will review the appeal request and the supporting documentation to make a determination to uphold or remove the citation and notify the provider of the outcome. The QIO will be advised of the outcome of the appeal so that future reviews will be conducted in accordance with DDSN's decision.

If an appeal is submitted, a Plan of Correction is not required to be submitted until a decision regarding the reconsideration is reached. However, any citation not being appealed must be corrected according to the timelines as outlined in this document.

The appeal review will be completed within 30 days of receiving the request. Based on the results of the appeal, if needed, a revised report will be issued. A Plan of Correction for all citations must be submitted to the QIO within 30 days of the appeal decision. Corrections are required to be completed no later than 90 days after receiving the QIO report unless otherwise specified and subsequently approved by DDSN.

TECHNICAL ASSISTANCE:

For providers scoring below 85% (i.e., 84.9% or less) in any one service area during their Contract Compliance Review (regardless of the overall score), will be placed on an approximate 12-month review cycle and receive technical assistance from DDSN and assistance in developing their Plan of Correction. In addition, the Executive Director/CEO/staff will be required to meet formally with DDSN personnel to address performance issues and develop a separate corrective provider action plan. The corrective plan of action may involve the suspension of any new referrals to the provider.

Due to the number of citations resulting in a score of less than 85% (i.e., 84.9% or less) compliance, the provider may also be required to develop an action plan that goes beyond the typical requirements of the Plan of Correction submitted to the QIO. If required, the action plan must address systemic issues within the organization that have resulted in the low scores. DDSN Program Staff will provide guidance to the provider, as necessary, regarding the provider's Action Plan. This Plan will be submitted to DDSN Quality Management for review.

Technical assistance (TA) should be a collaborative and coordinated approach between the provider and DDSN subject matter experts. TA should be provided to assist the provider in improving their policies/procedures and promoting compliance with DDSN directives and standards. Technical assistance should be the first step in assisting a provider with items needed to be successful and to try to prevent the need for any future corrective measures. The intensity of TA should be based on the provider's CCR score. For example, a score of 80% to 84.9%, may require a less intrusive approach, such as a phone call, to offer clarification regarding the interpretation of a standard. A score below 80%, may warrant a more structured approach, such as an on-site visit or desk review. The ultimate goal in TA is to offer guidance and constructive feedback in hopes to alleviate the need for any corrective measures.

Process:

Quality Management (QM) staff will review provider performance on Contract Compliance Reviews each quarter. The quarterly review will take place 60 days after the end of the quarter. During the quarterly review, QM staff will identify low performing providers. For providers that score below 85% (i.e., 84.9% or less) in any area, QM staff will send a report outlining any trends or patterns in citations (i.e. low percentage on specific areas, areas of concerns) to DDSN Operations and appropriate program staff (DDSN Subject Matter Experts). The DDSN "Subject Matter Expert" will contact the provider to arrange technical assistance. The type and/or intensity of TA will be based on the following threshold:

Threshold - Providers scoring within 84.9% - 80%:

- DDSN Subject Matter Expert (Program or Operations staff) contacts the provider within 45 to 60 days.
- Contact can be an email or phone call.
- TA is offered to the provider. Provider may accept or decline assistance.
- If assistance is not needed, the provider must indicate how the citations were corrected. For example, the provider may indicate that organizational changes were made, training was provided, citations were not valid, etc.
- DDSN staff documents the provider's corrective action plan and submits the information to QM for the record.

Threshold - Providers scoring within 79.9% - 70%:

- DDSN Subject Matter Expert (Program or Operations staff) contacts the provider within 45 days.
- TA is conducted. At this level, the provider may not decline assistance from DDSN.
- Once contact is made, DSN staff can determine if TA can be completed via phone call, review of POC, desk review of records, or on-site visit, etc.
- DDSN staff may request that the provider attend meetings related to the citations, group training, or a 1:1 training session.
- DDSN staff should review the provider's plan of corrective action submitted to the QIO.
- DDSN staff may request additional information to determine if the provider's POC is sufficient in correcting the citation and preventing future occurrences.
- DDSN staff will document the provider's corrective action plan and submit the information to QM for the record.

Threshold - Providers scoring below 70%:

- DDSN Subject Matter Expert (Program or Operations staff) contacts the provider within 45 to 60 days.
- Contact can be an email or phone call.
- TA is scheduled with the provider. Provider may not decline assistance.
- DDSN staff documents the provider's corrective action plan and submits the information to QM for the record.

EXCEPTIONS:

DDSN reserves the right to make exceptions to standards or policies if the exception does not jeopardize the health and safety of the service recipient, staff or the public, and when the exception does not significantly reduce the quality or quantity of services provided. No exception may be implemented until first approved by the Director of Quality Management/designee and the State Director/designee. The QIO will be advised of the approval of any exceptions so that future reviews will be conducted in accordance with DDSN's decision.

The request for exception should be submitted to the DDSN Quality Management Director using the DDSN Request for Exception form. All sections of the form must be complete and accurate. The form must be signed by the Executive Director and Board Chairperson, when applicable. Unless otherwise noted, exceptions remain valid for as long as the information contained on the initial request remains the same.

~~Susan Kreh Beck, Ed.S, NCSP~~	~~Beverly A.H. Buscemi, Ph.D.~~
~~Associate State Director-Policy~~	~~State Director~~
~~(Originator)~~	~~Approved~~
Barry D. Malphrus	Stephanie M. Rawlinson
Vice Chairman	Chairman

To access the following attachment, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

ATTACHMENT~~S~~:

Request for Exception Form

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CERTIFICATION AND LICENSING STANDARDS
REQUEST FOR EXCEPTION

Provider Requesting Exception:		Date:
Facility Type:	Signature of Provider Executive Director:	
Name of Facility:	Signature of Governing Board Chairperson:	
Policy or Standard from which Exception is requested (e.g., 000-00-DD, DDSN Respite Standards, etc.)	Nature and reason for Exception Request (specify if for one person (give name), one Facility (give name), for all residential programs, day, etc., or for the entire Agency along with the reason)	Explain how the safety of program participant(s), the staff or the public will not be endangered, if this Exception is Granted
Explain how this Exception, if granted, the Quality and Quantity of Services will be maintained		
Comments:		

Signature: _____ Director-Quality Management	Recommendation: ☐Approved ☐Deny Date:
Signature: _____ State Director/Designee	Recommendation: ☐Approved ☐Deny Date:

3440 Harden Street Extension
Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

Reference Number:	104-03-DD
Title of Document:	DDSN Contract Compliance Reviews for Non-Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services
Date of Issue:	November 18, 2013
Date of Last Revision:	June 16, 2022 (**REVISED**)
Effective Date:	June 16 2022
Applicability:	DDSN Contracted Providers (Excludes ICFs/IID Programs)

PURPOSE:

To establish guidance for the implementation of the contract between the Department of Disabilities and Special Needs (DDSN) and providers selected to conduct Contract Compliance Reviews (CCR).

GENERAL:

In order to determine compliance with applicable DDSN standards and policies, reviews of DDSN qualified providers are completed approximately every 12 to 18 months, ("Annual Reviews") based on the provider's prior performance. Providers scoring at or above 86% in each service area will be reviewed approximately every 18-months and providers scoring below 86% (i.e., 85.9% or less) will be reviewed approximately every 12-months. The Contract Compliance Reviews are comprised of an evaluation of the provider's compliance with administrative agency requirements as well as compliance with service specific requirements for each service delivered and a review of participant records. Any deficiencies will require a written Plan of Correction (POC) that addresses the deficiency both individually and systemically, and a follow up review will be completed approximately six (6) months after the original review to determine if the corrections have been made.

REVIEW PROCESS:

DDSN will contract with a Quality Improvement Organization (QIO) selected from those certified by the Centers for Medicare and Medicaid Services (CMS). The QIO will utilize Key Indicators to evaluate the administrative capability of each provider reviewed along with a sample of participant records to verify service delivery in accordance with applicable standards. A statistically valid and random sampling methodology will be used for all providers. For each case reviewed, the QIO will review the Case Management file as well as those records/files pertaining to services as provided by DDSN (i.e., Residential Habilitation, Career Preparation, Day Activity, Employment, Respite, etc.). Each file review will include an evaluation of the most current assessment data used in developing the consumer's current plan(s). The review also will have an evaluation of the progress notes and file documentation pertinent to the quality of services delivered. To the extent possible, participant records will be reviewed using documentation available in the agency's electronic record. At the conclusion of the review, a conference between the QIO representatives and the provider will be held to discuss preliminary findings of the review.

All newly qualified providers will be reviewed between three (3) to six (6) months of accepting their first participant. Qualified providers who are beyond their first year, will be reviewed on a schedule of approximately 12 to 18 months, depending on prior performance. Follow-up reviews are conducted approximately six (6) months following the regular 12 to 18 month review.

PLANS OF CORRECTION:

All providers will be required to submit a Plan of Correction to the QIO for all citations within 30 days of receipt of the report of findings from the QIO. The POC will address the findings in each individual record as well as systemic findings related to the citations and as identified by the QIO. The latest completion date for any correction or action cannot exceed 90 calendar days following the report of findings. A response will be provided by the QIO within 30 calendar days. The Plan of Correction must be submitted to the QIO for approval, via their online portal.

FOLLOW-UP REVIEWS:

The QIO will conduct a follow-up review to assure that all elements detailed in the provider's Plan of Correction have been implemented. The QIO review will include the criteria and timeframes for evaluating the extent to which the provider's Plan of Correction has been implemented. Follow-up reviews will include records/consumers from the original sample as well as new records. Upon receipt of the report, the Provider will have 30 days to submit a written Plan of Correction. The Plan of Correction should not only address the individual deficiency cited, but should also include a systemic response to ensure correction across the provider's system of services. Corrections are required to be completed no later than 90 days after receiving the written quality assurance report unless otherwise specified and subsequently approved by the QIO or DDSN. The Plan of Correction must be submitted to the QIO for approval, via their online portal, and a second follow-up review will be scheduled through the QIO.

If a provider scores at less than 86% (i.e., 85.9% or less) compliance on the follow-up visit, DDSN staff will review documentation related to the original review results and the follow-up review results. DDSN will contact the provider to discuss the findings, ascertain the provider's intended actions toward correction, and, if needed, offer technical assistance or guidance regarding the actions necessary to achieve and sustain compliance.

SPECIAL CIRCUMSTANCE REVIEWS:

The QIO may complete special circumstance reviews at the direction of DDSN. The Special Circumstance Review follows the same format and scope as a Follow-up Review and will focus on the area(s) specified by DDSN.

APPEALS:

If the provider does not agree with the content of the report of findings, reconsideration may be requested through a formal appeal. The provider may request reconsideration of the deficiencies by submitting, in writing, the Key Indicator cited, the finding, the nature of the disagreement with the finding, and any documentation to support their position. The provider is allowed one appeal request per identified deficient practice per survey cycle. The provider may submit their appeal with their Plan of Correction (i.e., within 30 days of receiving the QIO report). Requests for appeal should be submitted via the QIO Reporting Portal. DDSN program staff will review the appeal request and the supporting documentation to make a determination to uphold or remove the citation. The provider will be informed of the decision and the Report of Findings will be updated by the QIO.

If an appeal is submitted, a Plan of Correction is not required to be submitted until a decision regarding the reconsideration is reached. However, any citation not being appealed must be corrected within 90 days, according to the timelines as outlined in this document.

DDSN will complete the appeal review within 30 days of receiving the request. Based on the results of the appeal, if needed, a revised report will be issued by the QIO. A Plan of Correction for all citations must be submitted to the QIO Portal within 30 days of the appeal decision. Corrections are required to be completed no later than 90 days after receiving the QIO report unless otherwise specified and subsequently approved by DDSN.

POST-PAYMENT CLAIMS REVIEW:

In order to meet Home and Community-Based Waiver performance measures required by the Center for Medicaid/Medicare Services (CMS) for financial integrity/accountability, DDSN will complete a Provider Post Payment Claim Review process. The intended outcome of this process is to compliment the Contract Compliance Review process and assure the following for paid claims for waiver participants:

1. The person was eligible for services at the time of the claim.
2. The service was authorized in the person's service plan.
3. There is sufficient documentation to support the service was delivered per the Medicaid Home and Community-Based Waiver service definition. Supporting documentation will vary depending on the nature of the service delivered. Documentation includes but is not limited to: Provider service notes, community integration notes, behavior support data, meeting notes, medication administration records, medical appointment records, etc.
4. The units of service align with the authorized units in the service plan.

Through this process, providers will submit documentation of all services for which a claim has been submitted. DDSN (or its contractor) will review the claims and supporting documentation to determine

compliance as outlined above. Providers with claims identified as non-compliant on any of the evaluation criteria will receive a request for remediation via a Plan of Correction (POC). The provider will respond to the POC within 15 calendar days, providing evidence of remediation. Remediation may include locating documentation to support that services rendered are consistent with claim submission; staff training; and voiding and/or recovering payments. Upon verification that the POC response is acceptable, the Provider will receive notification from DDSN. Additional records may be selected by DDSN as an expanded review or audit.

EXCEPTIONS:

DDSN reserves the right to make exceptions to standards or policies if the exception does not jeopardize the health and safety of the service recipient, staff or the public, and when the exception does not significantly reduce the quality or quantity of services provided. No exception may be implemented until first approved by the Director of Quality Management/designee and the State Director/designee. The QIO will be advised of the approval of any exceptions so that future reviews will be conducted in accordance with DDSN's decision.

The request for exception should be submitted to the DDSN Quality Management Director using the DDSN Request for Exception form. All sections of the form must be complete and accurate. The form must be signed by the Executive Director and Board Chairperson, when applicable. Unless otherwise noted, exceptions remain valid for as long as the information contained on the initial request remains the same.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

To access the following attachment, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

ATTACHMENT:

Request for Exception Form

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CERTIFICATION AND LICENSING STANDARDS
REQUEST FOR EXCEPTION

Provider Requesting Exception:		Date:
Facility Type:	Signature of Provider Executive Director:	
Name of Facility:	Signature of Governing Board Chairperson:	
Policy or Standard from which Exception is requested (e.g., 000-00-DD, DDSN Respite Standards, etc.)	Nature and reason for Exception Request (specify if for one person (give name), one Facility (give name), for all residential programs, day, etc., or for the entire Agency along with the reason)	Explain how the safety of program participant(s), the staff or the public will not be endangered, if this Exception is Granted
Explain how this Exception, if granted, the Quality and Quantity of Services will be maintained		
Comments:		

Signature: _____ Director-Quality Management	Recommendation: ☐Approved ☐Deny Date:
Signature: _____ State Director/Designee	Recommendation: ☐Approved ☐Deny Date:

Reference Number:	275-01-DD
Title of Document:	Missing Property Reporting
Date of Issue:	May 27, 1987
~~Effective Date:~~	~~May 27, 1987~~
~~Last Review Date:~~	~~February 2, 2016~~
Date of Last Revision:	~~February 2, 2016~~XXXX, 2022 (**REVISED**)
Effective Date:	~~May 27, 1987~~XXXX, 2022
Applicability:	DDSN Central Office, ~~DDSN District Offices, and~~ DDSN Regional Centers, and DDSN-Operated Residential Habilitation Settings ~~Autism Residential Homes~~

PURPOSE

This document establishes minimum procedures for reporting lost or stolen property. For the purpose of this document, "property" is defined as:

1. Items valued at $100 or more which are owned by the South Carolina Department of Disabilities and Special Needs (DDSN) including, but not limited to computers, cell phones, vehicles, tools, supplies and equipment (DDSN Property), and

2. Items owned by DDSN employees which are lost or stolen from the employee's workplace (personal property).

~~This document establishes minimum procedures for reporting lost, stolen, or missing property, which is under the jurisdiction of the South Carolina Department of Disabilities and Special Needs (DDSN). Each District Director is responsible for the implementation of these requirements in the Regional Offices. Each Facility Administrator is responsible for the implementation of these requirements in residential area. This system of reporting property~~

~~losses will ensure that all such losses are investigated and that adequate internal controls are established to prevent recurrence. This document does not affect the immediate reporting requirements of DDSN Directive 100-09-PD: Reporting of Critical Incidents.~~

PROCEDURES:~~RESPONSIBILITIES~~

I. DDSN Property

It is the responsibility of all DDSN employees to be good stewards of the DDSN property with which they are entrusted. Being "good stewards" of DDSN property at a minimum includes ensuring DDSN property is used for the benefit of agency and ensuring DDSN property is securely kept/maintained. While every effort may be made to securely keep DDSN property, it may still be lost or stolen.

When DDSN property valued at $100 or above is suspected or determined to be lost or stolen (missing), the employee entrusted with the property must report the occurrence as soon as the property is discovered to be missing. Failure to report missing property could result in disciplinary action. Reports of missing property must be made by the entrusted employee as follows:

- When the missing property is a mobile device including, but not limited to, cell phones, computers, tablets, and removable media, which is used to access DDSN data or the DDSN Network:
    - First, report to DDSN's Information Technology Division via the Helpdesk (Refer to DDSN Directive 367-32-DD: Information and Security Privacy).
    - Second, report to the:
        - Chief Information Security Officer when the employee is assigned to Central Office;
        - Facility Administrator (or his/her designee) of the DDSN Regional Center to which the employee is assigned; or
        - Director of Facility Operations (or his/her designee) when the employee is assigned to a DDSN-Operated Residential Habilitation setting.
- Other missing property (e.g., tools, equipment, supplies) must be reported to the:
    - Procurement Director when the employee is assigned to Central Office;
    - Facility Administrator (or his/her designee) of the DDSN Regional Center to which the employee is assigned; or
    - Director of Facility Operations (or his/her designee) when the employee is assigned to a DDSN-operated Residential Habilitation setting.

Chief Information Security Officer, Procurement Director, Facility Administrator, or Director of Facility Operations will be responsible for ensuring the occurrence is accurately documented, investigated (if appropriate) and reported to in accordance with other DDSN policy (e.g., a missing mobile device is reported to the Information Technology Division; missing property is reported as an adverse operational event).

The Missing Property Report form (Attachment) should be used to document the details of an occurrence, including:

- A description of the property (e.g., type, DDSN Decal number, etc.).
- The circumstances of the occurrence or discovery (date/time, place, etc.).
- Actions taken by the entrusted employee to recover. If a report made to a law enforcement entity, a copy of the report should be attached.
- The results of an internal investigation (if conducted).
- Confirmation of the completion of reporting to other DDSN staff (e.g, IT, Adverse Event, etc.).
- Any recommendations for prevention of future occurrences.

Completed Missing Property Report forms which document the loss of DDSN property will be maintained by the Procurement Director, Facility Administrator, or Director of Facility Operations. Copies of the completed forms will be provided to the following DDSN staff:

- Director of Internal Audit.
- Chief Financial Officer.
- Chief Information Security and Privacy Officer, if any confidential or protected health information was potentially compromised by the missing property.

II. Employee - Personal Property

While not prohibited, employees are strongly discouraged from bringing unnecessary personal property items into their workplace. Before choosing to bring personal property into the workplace, consideration should be given to the necessity having the item(s) at work and the ability to securely maintain the item(s) in the environment. DDSN will not be responsible for any lost or stolen personal property.

When the personal property of an employee is determined to be lost or stolen (missing) from the workplace, the employee should report the loss to the:

- Procurement Director when the employee is assigned to Central Office;
- Facility Administrator (or his/her designee) of the DDSN Regional Center to which the employee is assigned; or
- Director of Facility Operations (or his/her designee) when the employee is assigned to a DDSN-operated Residential Habilitation setting.

Note: The reporting of missing personal property to designated DDSN officials is not intended to limit in any way the right of an employee to report incidents perceived as unlawful to an appropriate policing authority.

The Missing Property Report form (Attachment) should be used to document:

- A description of the property.
- The circumstances of the occurrence or discovery (date/time, place, etc.).

- Actions taken to recover. If a report made to a law enforcement entity, a copy of the report should be attached.
- The results of an internal investigation (if conducted).
- Confirmation of the completion of reporting to other DDSN staff (e.g, IT, Adverse Event, etc.).
- Any recommendations for prevention of future occurrences.

Completed Missing Property Report forms which document the loss of an employee's personal property will be maintained by the Procurement Director, Facility Administrator, or Director of Facility Operations.

~~Any property which is determined to be missing, lost, or stolen from a residence, office, vehicle, or any section within DDSN should be reported, regardless of value, due to the nature of the item. For example, a flash drive with personal information or keys to a security box, these items would need an investigation on how it was lost or stolen and a report filed. The "Missing Property Report" (Attachment) will be used to report the loss of state owned property, any individual's personal property, or the property of a DDSN employee from state-owned property.~~

~~Each District Office/Regional IT Coordinator, as well as the DDSN Central Office-IT Division must be notified immediately of any missing electronic equipment (i.e. cellphone, laptop, IPAD, etc.).~~

~~It is the responsibility of each employee to report a suspected loss of any property from DDSN jurisdiction to his immediate supervisor. Failure to do so may result in disciplinary action.~~

~~The reporting employee's immediate supervisor will verify that a loss has occurred and notify the Facility Administrator, or security and safety officer (herein known as "investigating officer"). The immediate supervisor will complete Section I of the Missing Property Report, then forward it on to the investigating officer for review and initiate an investigation as deemed necessary. A copy of the report should be sent up the chain of command and the Facility Administrator will notify the State Director if outside assistance was called and the final disposition of the missing item. The Missing Property Report will remain a part of the facilities permanent file.~~

~~After an investigation, Section II of the Missing Property Report will be completed and distributed as follows:~~

- ~~Facility Administrator;~~
- ~~DDSN internal audit;~~
- ~~Security or safety officer, and~~
- ~~Originating section's program administrator.~~

~~If the missing property is equipment owned by DDSN, the investigating officer will notify the Regional Property Control Office so that action can be initiated to adjust the records of the fixed asset system.~~

~~If the missing property is owned by an individual, the loss will be recorded in the individual's property record in accordance with DDSN Directive 604-01-PD: Individual Clothing and Personal Property, and a copy of the Missing Property Report will be filed in the individual's record under the personal needs section.~~
~~Internal audit will review the Missing Property Report and follow-up as necessary on losses which have DDSN-wide implications.~~

~~Tom Waring~~	~~Beverly A.H. Buscemi, Ph.D.~~
~~Associate State Director-Administration~~	~~State Director~~
~~(Originator)~~	~~(Approved)~~
Barry D. Malphrus	Stephanie M. Rawlinson
Vice Chairman	Chairman

To access the following attachments, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

Attachment: Missing Property Report

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MISSING PROPERTY REPORT

Immediately notify DDSN's IT Helpdesk (803-898-9767), if the missing property is a device used to access DDSN data or the DDSN Network

Section I:

Type of Property: ☐DDSN Property ☐Employee's Personal Property

Name of Employee Reporting the Loss or Property Owner (*if personal property*): _____

Description of the Missing Property (*Provide as much information as possible. Include DDSN Decal number, if applicable*): _____

Date property was last seen, where it was seen, and by whom: _____

Date property was first discovered missing: _____

Circumstances leading to the discovery of the missing property: _____

Actions taken to attempt to recover the missing property: _____

Section II:

Name and Title of the Person to whom the loss is being reported: _____

Actions taken in response to report (*check if action taken and provide the additional information requested*):

☐DDSN IT Notification:

Name of person who called the Helpdesk: _____
Date and time of call to Helpdesk: _____

☐Internal Investigation:

Date investigation opened and Name of Investigator: _____

☐Report made to local law enforcement entity:

Name of entity: _____
Person making report: _____
Date of reporting: _____

Section III:

Follow-up actions taken (*check if action taken and provide the additional information requested*):

☐Internal Investigation completed. Attach report of the findings of the investigation.
☐Report made to local law enforcement entity. Attach report.
☐Incident reported as Adverse Operational Event as required by DDSN Directive 100-21-DD.
☐Actions taken to prevent other occurrences. List actions: _____

Date: _____
Signature/title of person completing this form

DISTRIBUTION (*Indicate to whom copies of this completed form has been sent*)

☐Chief Information Security and Privacy Officer ☐Director-Internal Audit Division ☐Director-Finance Division

SOUTH CAROLINA DISABILITIES AND SPECIAL NEEDS

MISSING PROPERTY REPORT

The DDSN Central Office, IT Division, must be notified immediately of any missing electronic equipment. Fax a copy of this form to: (803) 898-9658

SECTION I:

Date:__________ Building No.:______ Program:__________ Region:__________

LIST OF PROPERTY (please note if the property listed below includes any electronic devices (i.e., cell phone, IPAD, laptop, USB sticks, etc.), then the IT Security Officer MUST be notified immediately)

QUANTITY	DESCRIPTION	DECAL OR SERIAL NO.	ESTIMATED VALUE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
		TOTAL VALUE	_____

PROPERTY OWNED BY:

☐ DDSN CLIENT (NAME):__________ ☐ DDSN

☐ DDSN EMPLOYEE (NAME):__________ ☐ OTHER (Specify):__________

COMMENTS AND SPECIFIC INFORMATION CONCERNING THIS LOSS (Include how this low was discovered and where it originated if possible)

DISCOVERED BY:__________ POSITION:__________

REPORTED BY:__________ POSITION:__________

SECTION II: FOLLOW-UP AND PREVENTION (Include remarks and recommendations on how this type of loss could be prevented)

DDSN CENTRAL OFFICE
INFORMATION SECURITY OFFICER: __________ DATE:__________

SECURITY OFFICER: __________ DATE:__________

DISTRIBUTION: Facility Administrator, Security/Safety Officer, DDSN Central Office IT Division, DDSN Audit, Originating Section Program Administrator

Michelle G. Fry, J.D., Ph.D.
State Director
Janet Brock Priest
Associate State Director
Operations
Lori Manos
Associate State Director
Policy
Constance Holloway
General Counsel
Harley T. Davis, Ph.D.
Chief Administrative Officer
Nancy Rumbaugh
Interim Chief Financial Officer
Greg Meetze
Chief Information Officer

3440 Harden Street Extension
Columbia, South Carolina 29203
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

COMMISSION
Stephanie M. Rawlinson
Chairman
Barry D. Malphrus
Vice Chairman
Robin B. Blackwood
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Gary Kocher, M.D.
Eddie L. Miller
David L. Thomas
Michelle Woodhead

Reference Number:	275-01-DD
Title of Document:	Missing Property Reporting
Date of Issue:	May 27, 1987
Date of Last Revision:	June 16, 2022 (**REVISED**)
Effective Date:	June 16, 2022
Applicability:	DDSN Central Office, DDSN Regional Centers, and DDSN-Operated Residential Habilitation Settings

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PURPOSE

This document establishes minimum procedures for reporting lost or stolen property. For the purpose of this document, "property" is defined as:

1. Items valued at $100 or more which are owned by the South Carolina Department of Disabilities and Special Needs (DDSN) including, but not limited to computers, cell phones, vehicles, tools, supplies and equipment (DDSN Property), and

2. Items owned by DDSN employees which are lost or stolen from the employee's workplace (personal property).

PROCEDURES:

I. DDSN Property

It is the responsibility of all DDSN employees to be good stewards of the DDSN property with which they are entrusted. Being "good stewards" of DDSN property at a minimum includes ensuring DDSN property is used for the benefit of agency and ensuring DDSN property is securely kept/maintained. While every effort may be made to securely keep DDSN property, it may still be lost or stolen.

When DDSN property valued at $100 or above is suspected or determined to be lost or stolen (missing), the employee entrusted with the property must report the occurrence as soon as the property

is discovered to be missing. Failure to report missing property could result in disciplinary action up to and including termination. Reports of missing property must be made by the entrusted employee as follows:

- When the missing property is a mobile device including, but not limited to, cell phones, computers, tablets, and removable media, which is used to access DDSN data or the DDSN Network:
    - First, report to DDSN's Information Technology Division via the Helpdesk (Refer to DDSN Directive 367-32-DD: Information and Security Privacy).
    - Second, report to the:
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        - Facility Administrator (or his/her designee) of the DDSN Regional Center to which the employee is assigned; or
        - Director of Facility Operations (or his/her designee) when the employee is assigned to a DDSN-Operated Residential Habilitation setting.
- Other missing property (e.g., tools, equipment, supplies) must be reported to the:
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The Missing Property Report form (Attachment) should be used to document the details of an occurrence, including:

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- The circumstances of the occurrence or discovery (date/time, place, etc.).
- Actions taken by the entrusted employee to recover. If a report made to a law enforcement entity, a copy of the report should be attached.
- The results of an internal investigation (if conducted).
- Confirmation of the completion of reporting to other DDSN staff (e.g, IT, Adverse Event, etc.).
- Any recommendations for prevention of future occurrences.

Completed Missing Property Report forms which document the loss of DDSN property will be maintained by the Procurement Director, Facility Administrator, or Director of Facility Operations. Copies of the completed forms will be provided to the following DDSN staff:

- Director of Internal Audit.
- Chief Financial Officer.
- Chief Information Security and Privacy Officer, if any confidential or protected health information was potentially compromised by the missing property.

II. Employee - Personal Property

While not prohibited, employees are strongly discouraged from bringing unnecessary personal property items into their workplace. Before choosing to bring personal property into the workplace, consideration should be given to the necessity having the item(s) at work and the ability to securely maintain the item(s) in the environment. DDSN will not be responsible for any lost or stolen personal property.

When the personal property of an employee is determined to be lost or stolen (missing) from the workplace, the employee should report the loss to the:

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Note: The reporting of missing personal property to designated DDSN officials is not intended to limit in any way the right of an employee to report incidents perceived as unlawful to an appropriate policing authority.

The Missing Property Report form (Attachment) should be used to document:

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- The results of an internal investigation (if conducted).
- Confirmation of the completion of reporting to other DDSN staff (e.g, IT, Adverse Event, etc.).
- Any recommendations for prevention of future occurrences.

Completed Missing Property Report forms which document the loss of an employee's personal property will be maintained by the Procurement Director, Facility Administrator, or Director of Facility Operations.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

To access the following attachments, please see the agency website page "Current Directives" at:
https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

Attachment: Missing Property Report

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MISSING PROPERTY REPORT

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Name of Employee Reporting the Loss or Property Owner (*if personal property*):_____

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_____

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Date property was first discovered missing:_____

Circumstances leading to the discovery of the missing property:_____

Actions taken to attempt to recover the missing property:_____

Section II:

Name and Title of the Person to whom the loss is being reported:_____

Actions taken in response to report (*check if action taken and provide the additional information requested*):

☐DDSN IT Notification:

Name of person who called the Helpdesk:_____
Date and time of call to Helpdesk:_____

☐Internal Investigation:

Date investigation opened and Name of Investigator:_____

☐Report made to local law enforcement entity:

Name of entity:_____
Person making report:_____
Date of reporting:_____

Section III:

Follow-up actions taken (*check if action taken and provide the additional information requested*):

☐Internal Investigation completed. Attach report of the findings of the investigation.
☐Report made to local law enforcement entity. Attach report.
☐Incident reported as Adverse Operational Event as required by DDSN Directive 100-21-DD.
☐Actions taken to prevent other occurrences. List actions:_____

_____ Date:_____
Signature/title of person completing this form

DISTRIBUTION (*Indicate to whom copies of this completed form has been sent*)

☐Chief Information Security and Privacy Officer ☐Director-Internal Audit Division ☐Director-Finance Division

Reference Number:	535-02-DD	
Title Document:	Human Rights Committee	
Date of Issue:	May 31, 1996	
~~Effective Date:~~	~~May 31, 1996~~	
~~Last Review Date:~~	~~April 8, 2016~~	
Date of Last Revision:	~~April 8, 2016~~XXXX, 2022	**(REVISED)**
Effective Date:	~~May 31, 1996~~XXXX, 2022	
Applicability:	~~DDSN Autism Division~~ DDSN-Operated Residential Programs; DDSN Regional Centers; DSN Boards; and Contract Service Providers	

PURPOSE

This directive establishes policies and procedures for the establishment, and operation of a Human Rights Committee (HRC) at each Department of Disabilities and Special Needs (DDSN) Regional Center, ~~DDSN Autism Division~~ DDSN-Operated Residential Programs, Disabilities and Special Needs (DSN) Boards and Contract Service Providers, and sets forth guidelines for the authority, role, and responsibility of such committees.

PHILOSOPHY

Individuals with disabilities are entitled to exercise their civil, political, social, economic and cultural rights on an equal basis with others. Each individual who receives services from DDSN is encouraged and assisted to exercise his/her rights as a citizen and as a service recipient. When an individual is unable to fully exercise their rights, it is the responsibility of society to safeguard and protect those rights. The Human Rights Committee serves as society's representative to protect the due process rights of individuals receiving services from DDSN, DSN Boards, and contract service providers.

AUTHORITY

S.C. Code Ann. § 44-26-70 (~~Supp. 2015~~2018) relating to the rights of individuals receiving services from DDSN requires that each DDSN Regional Center and DSN Board establish a Human Rights Committee. Contract service providers may either use the Human Rights Committee of the local DSN Board or establish their own Committee.

~~DDSN Autism Division~~ DDSN-Operated Residential Programs may utilize an existing Human Rights Committee of a DSN Board or of a DDSN Regional Center or it may establish its own Committee.

The regulations governing Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) require the establishment of a specially constituted committee which functions as a Human Rights Committee to review, approve, and monitor programs to manage inappropriate behavior and other programs that involve risk to protection and rights. Policies and procedures of this directive are applicable to these specially constituted Committees.

ROLE

The role of the Human Rights Committee is to safeguard and protect the rights of individuals receiving services to ensure that they are treated with dignity and respect in full recognition of their rights as citizens as opposed to their rights as consumers, and to review and advise regarding issues which present ethical questions involving service recipients. It is not a "rubber stamp" committee which approves anything and everything that comes before it.

Members of the Human Rights Committee serve in an advisory capacity and are exempt from liability.

The Human Rights Committee is an entity separate from the service organization. It should not duplicate advocacy efforts that have been established to represent the rights and interests of individuals with disabilities or special needs, but shall serve in an adjunct capacity to those efforts.

Human Rights Committees shall develop bylaws for the conduct and operation of its committee that minimally include: a definition of "quorum," and the distribution of the current agenda and prior meeting minutes to the members before scheduled meetings. At the discretion of the Human Rights Committee, appropriate staff or an advocacy representative may attend meetings. However, information shared, obtained, or disclosed during the conduct of the meeting is confidential and must not be disclosed.

The Human Rights Committee may organize into subcommittees for specific purposes in order to meet its responsibilities (e.g., medication review, behavior support plan review, grievance appeal, ethics review, etc.). Any business conducted by the sub-committees must be brought before the full committee for review and approval.

Minutes shall be taken of each meeting and shall reflect the date and time of the meeting, those Committee members present and absent, and a record of decisions and recommendations in a manner that readily identifies the issues reviewed, the decisions reached, and the follow-up that is necessary. A tape recorder may be used for this purpose. The minutes shall also reflect the names of others attending the meeting.

RESPONSIBILITIES

The Human Rights Committee is charged with the responsibility of protecting the due process rights of individuals receiving services and supports and functions to provide a community perspective in advising the Facility Administrator/Executive Director/CEO on the acceptability of procedures and programs involving rights issues.

Specific responsibilities include:

1. Review and approve all actions, practices or policies which restrict any individual's rights.

2. Review and advise on policies and practices pertaining to the rights of individuals who receive services.

3. Review and approve individual habilitation plans prior to implementation which:

   a. Restrict personal freedoms or rights.

   b. Use restrictive or intrusive procedures as part of a Behavior Support Plan (e.g., restraint, door alarms, visual or auditory monitoring devices, locked cabinets or locked rooms where items needed or used by supported individuals are kept, time out, or aversive conditioning).

      NOTE: Time out and aversive conditioning also require prior written approval of the DDSN State Director.

   c. Use behavior control medications for behavior management.

4. Receive notification of the use of emergency restraints. Each Human Rights Committee, in coordination with DDSN, may establish its own mechanism for receipt of such reports.

5. Review and advise on research proposals to ensure that the rights, dignity and welfare of research participants are protected and they are not used as a source for research which is not associated with disability issues.

6. Receive notification of alleged abuse, neglect, or exploitation. Each Human Rights Committee, in coordination with DDSN, may establish its own mechanism to receive such reports.

7. Ensure that prior informed consent is obtained as set forth in S.C. Code Ann. § 44-66-10 (Supp. 2021) "Adult Health Care Consent Act" and DDSN Directive 535-07-DD: ~~Obtaining Consent for Minors and Adults~~ Obtaining Consent for Individuals Regarding Health Care - Making Health Care Decisions, when:

   a. An individual considers participation in a research proposal approved by DDSN.
   b. An activity, plan or procedure that intrudes physically, psychologically, socially, or has irreversible effects is proposed.

8. Review and advise on concerns of applicants for services, service recipients, or their representative when concerns cannot be resolved through other efforts. The Human Rights Committee shall review the concern at its next regularly scheduled meeting or within 30 days from the date of appeal to the Human Rights Committee. If a more expedient resolution (less than 30 days) is required as determined by the Human Rights Committee Chairperson or the Facility Administrator/Executive Director/CEO there should be a called meeting of the Human Rights Committee. Areas that may be reviewed by the Human Rights Committee include, but are not limited to:

    a. Habilitation plans (day, residential, service coordination).

    b. Program, supports, and service placement decisions.

    c. Restriction of personal freedoms and rights.

    d. Access to medical or habilitation (treatment) records.

    e. Determination of a person's ability to give informed consent.

    f. Program, supports, or service termination.

    g. Refusal of treatment services.

9. Educate individuals supported and staff about the structure and purpose of the Human Rights Committee.

10. Advise the DDSN Regional Center, DDSN-Operated Residential Program, ~~or~~ local DSN Board or contract provider on other matters pertaining to the rights of individuals receiving services and other issues identified by the Human Rights Committee or DDSN.

MEMBERSHIP

The DDSN State Director shall appoint members to each DDSN Regional Center Human Rights Committee upon recommendation of the Facility Administrator. Additionally, should the ~~DDSN Autism Division~~ DDSN-Operated Residential Program choose to have its own committee, members will be appointed by the DDSN State Director upon the recommendation of the Associate State Director-Policy. The Director of a DSN Board or contract service provider shall appoint members to the Human Rights Committee.

Current employees of a DDSN Regional Center, DDSN-operated Residential programs, local DSN Board, or contract provider may not serve on their respective Human Rights Committees. Former employees may not serve on their respective Human Rights Committee. They may; however, serve on any other provider's Human Rights Committee at any time.

The Human Rights Committee is an independent, impartial entity.

Membership should reflect the cultural, racial, and disabilities diversity of the community in which it functions.

A minimum of not less than five (5) individuals shall be appointed to each Human Rights Committee. Membership shall include:

1. A user of DDSN services from any service area, representing those receiving services or a self-advocate nominated by the local self-advocacy group.

2. A family member of an individual who has an intellectual disability or related disability, autism, head and spinal cord injury or similar disability.

3. A representative of the community at large with expertise or demonstrated interest in services to individuals with an intellectual disability or related disability, autism, head and spinal cord injuries, or similar disabilities.

4. A community professional with expertise in behavioral or medical fields. This may include a physician, nurse, pharmacist, psychologist, etc.

5. Other community representatives (e.g., clergy, educator, lay citizen, etc.).

Exceptions to the minimum number, composition, and terms of service must be approved by the Associate State Director-Policy or his/her designee.

Members shall be appointed for three (3) years with terms of service staggered for the purpose of continuity. Members may be reappointed for ~~one (1)~~two (2) additional consecutive term. A chairperson shall be elected annually by the membership.

An attendance log shall be maintained and when a member fails to attend three (3) meetings without excuse from the chairperson or 50% of scheduled meetings within one (1) year that member shall be removed from the committee.

Board/Provider responsibility is one of support and resource; therefore, staff shall not serve as a member of the Human Rights Committee, but may serve in a staff capacity to the Human Rights Committee. The board/provider will provide clerical support to the Human Rights Committee.

The board/provider shall ensure that appropriate resource staff are available to the Human Rights Committee to provide expertise and assistance. Resource staff may include a physician, nurse, pharmacist, psychologist, or other professionals.

TRAINING

All new Human Rights Committee members shall receive training and orientation before attending a meeting that requires a vote. Members shall be afforded an opportunity to tour programs and services and meet individuals receiving services. Ongoing training shall be provided to the Human Rights Committee members to assist them in carrying out their

responsibilities. This training shall occur at least annually or sooner if there is a change in the majority of committee members since the last training. A log of training shall be maintained and the training topics should include:

1. Rights of individuals with disabilities and special needs;

2. Due process;

3. Role and responsibilities of the Human Rights Committee;

4. Confidentiality, Informed consent, and release of information;

5. Disabilities (intellectual or a related disability, autism, head and spinal cord injuries, and related disabilities);

6. Behavior support;

7. Medications (including dosages, interactions, contraindications, and side effects);

8. Principles of least restrictive alternatives, normalization, inclusion, protection from harm, active treatment, individualized supports, quality of life issues, etc., and

9. HIPAA - members should receive privacy notice as a part of this training.

10. Other areas that may be specified by the Human Rights Committee or DDSN.

The Facility/Executive Director/CEO or his/her designee shall provide this training and shall be responsible for scheduling on-going training. A sample training manual compiled by DDSN is available on the agency website at Human Rights Committee Training.

MEETINGS

The Human Rights Committees shall meet as often as necessary, but at least every other month six (6) times a year. Exceptions to this rule must be approved by the Associate State Director-Policy or her designee.

The Human Rights Committee shall assure that individuals whose rights may be restricted are afforded the opportunity to be present at the Human Rights Committee meeting and that they have the opportunity to present their wishes.

The Human Rights Committee shall assure that individuals coming before the Human Rights Committee are offered a personal representative to accompany them to the meeting to support him/her to speak or to speak on his/her behalf.

Case presentations coming before the committee shall include a summary. The presentation shall include all of the information needed for the committee's deliberations; however, all

information that might identify the individual and the outcome of any discussion along with any recommendations shall be coded to protect the identity of the individual. If the individual and/or his/her representative attend the committee meeting, their attendance shall overrule the coding requirement.

Procedures shall be established for expedient review of emergency situations, which require a Human Rights Committee review and decision. Reviews may be accomplished through a subcommittee, telephone poll, mail, electronic mail, or other procedures established by the Human Rights Committee. The minimum number of contacts must equal the quorums defined in the By-Laws. Emergency review procedures should be used when it is in the individual's best interest not to wait until the next regularly scheduled Human Rights Committee as determined by the Human Rights Committee Chairperson or Facility/Executive Director/CEO.

At its next regularly scheduled meeting, the full Human Rights Committee should be informed and the full Human Rights Committee shall approve or rescind the action when emergency approval procedures have been utilized. This provision shall not apply to the review of abuse, neglect, exploitation, and critical incidents.

Case presentations should include the following:

- Statement of concerns
- History of the concern
- History of intervention
- Current data
- Tardive Dyskinesia (TD) scores when applicable
- Recommended course of action
- Informed consent
- Individual's concerns
- Family concerns
- Measures for follow up and review

CONFIDENTIALITY

All information concerning individuals receiving services and their families and staff shall be considered confidential. All members of the Human Rights Committee shall sign a statement of confidentiality upon appointment.

QUALITY ASSURANCE

~~DDSN Autism Division~~ DDSN-Operated Residential Programs, DDSN Regional Centers, DSN Boards, and contract service providers shall develop quality assurance/improvement procedures for implementing this directive.

These procedures shall be indicated in the Quality Assurance/Improvement Plan.

~~DDSN Autism Division~~ DDSN-Operated Residential Programs, DDSN Regional Centers, DSN Boards, and contract service providers shall also develop monitoring procedures to ensure compliance with this directive.

The Facility/Executive Director/CEO or his/her designee shall regularly attend the Human Rights Committee meetings to assure the proper functioning of the Human Rights Committee.

~~Susan Kreh Beck, Ed.S., NCSP~~	~~Beverly A.H. Buscemi, Ph.D.~~
~~Associate State Director Policy~~	~~State Director~~
~~(Originator)~~	~~(Approved)~~
Barry D. Malphrus	Stephanie M. Rawlinson
Vice Chairman	Chairman

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Reference Number:	535-02-DD
Title Document:	Human Rights Committee
Date of Issue:	May 31, 1996
Date of Last Revision:	June 16, 2022 **(REVISED)**
Effective Date:	June 16, 2022
Applicability:	DDSN-Operated Residential Programs; DDSN Regional Centers; DSN Boards; and Contract Service Providers

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PURPOSE

This directive establishes policies and procedures for the establishment, and operation of a Human Rights Committee (HRC) at each Department of Disabilities and Special Needs (DDSN) Regional Center, DDSN-Operated Residential Programs, Disabilities and Special Needs (DSN) Boards and Contract Service Providers, and sets forth guidelines for the authority, role, and responsibility of such committees.

PHILOSOPHY

Individuals with disabilities are entitled to exercise their civil, political, social, economic and cultural rights on an equal basis with others. Each individual who receives services from DDSN is encouraged and assisted to exercise his/her rights as a citizen and as a service recipient. When an individual is unable to fully exercise their rights, it is the responsibility of society to safeguard and protect those rights. The Human Rights Committee serves as society's representative to protect the due process rights of individuals receiving services from DDSN, DSN Boards, and contract service providers.

AUTHORITY

S.C. Code Ann. § 44-26-70 (2018) relating to the rights of individuals receiving services from DDSN requires that each DDSN Regional Center and DSN Board establish a Human Rights Committee. Contract service providers may either use the Human Rights Committee of the local DSN Board or establish their own Committee.

DDSN-Operated Residential Programs may utilize an existing Human Rights Committee of a DSN Board or of a DDSN Regional Center or it may establish its own Committee.

The regulations governing Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) require the establishment of a specially constituted committee which functions as a Human Rights Committee to review, approve, and monitor programs to manage inappropriate behavior and other programs that involve risk to protection and rights. Policies and procedures of this directive are applicable to these specially constituted Committees.

ROLE

The role of the Human Rights Committee is to safeguard and protect the rights of individuals receiving services to ensure that they are treated with dignity and respect in full recognition of their rights as citizens as opposed to their rights as consumers, and to review and advise regarding issues which present ethical questions involving service recipients. It is not a "rubber stamp" committee which approves anything and everything that comes before it.

Members of the Human Rights Committee serve in an advisory capacity and are exempt from liability.

The Human Rights Committee is an entity separate from the service organization. It should not duplicate advocacy efforts that have been established to represent the rights and interests of individuals with disabilities or special needs, but shall serve in an adjunct capacity to those efforts.

Human Rights Committees shall develop bylaws for the conduct and operation of its committee that minimally include: a definition of "quorum," and the distribution of the current agenda and prior meeting minutes to the members before scheduled meetings. At the discretion of the Human Rights Committee, appropriate staff or an advocacy representative may attend meetings. However, information shared, obtained, or disclosed during the conduct of the meeting is confidential and must not be disclosed.

The Human Rights Committee may organize into subcommittees for specific purposes in order to meet its responsibilities (e.g., medication review, behavior support plan review, grievance appeal, ethics review, etc.). Any business conducted by the sub-committees must be brought before the full committee for review and approval.

Minutes shall be taken of each meeting and shall reflect the date and time of the meeting, those Committee members present and absent, and a record of decisions and recommendations in a manner that readily identifies the issues reviewed, the decisions reached, and the follow-up that is necessary. A tape recorder may be used for this purpose. The minutes shall also reflect the names of others attending the meeting.

RESPONSIBILITIES

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        NOTE: Time out and aversive conditioning also require prior written approval of the DDSN State Director.

    c. Use behavior control medications for behavior management.

4. Receive notification of the use of emergency restraints. Each Human Rights Committee, in coordination with DDSN, may establish its own mechanism for receipt of such reports.

5. Review and advise on research proposals to ensure that the rights, dignity and welfare of research participants are protected and they are not used as a source for research which is not associated with disability issues.

6. Receive notification of alleged abuse, neglect, or exploitation. Each Human Rights Committee, in coordination with DDSN, may establish its own mechanism to receive such reports.

7. Ensure that prior informed consent is obtained as set forth in S.C. Code Ann. § 44-66-10 (Supp. 2021) "Adult Health Care Consent Act" and DDSN Directive 535-07-DD: Obtaining Consent for Individuals Regarding Health Care - Making Health Care Decisions, when:

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    a. Habilitation plans (day, residential, service coordination).

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    d. Access to medical or habilitation (treatment) records.

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9. Educate individuals supported and staff about the structure and purpose of the Human Rights Committee.

10. Advise the DDSN Regional Center, DDSN-Operated Residential Program, local DSN Board or contract provider on other matters pertaining to the rights of individuals receiving services and other issues identified by the Human Rights Committee or DDSN.

MEMBERSHIP

The DDSN State Director shall appoint members to each DDSN Regional Center Human Rights Committee upon recommendation of the Facility Administrator. Additionally, should the DDSN-Operated Residential Program choose to have its own committee, members will be appointed by the DDSN State Director upon the recommendation of the Associate State Director-Policy. The Director of a DSN Board or contract service provider shall appoint members to the Human Rights Committee.

Current employees of a DDSN Regional Center, DDSN-operated Residential programs, local DSN Board, or contract provider may not serve on their respective Human Rights Committees. Former employees may not serve on their respective Human Rights Committee. They may; however, serve on any other provider’s Human Rights Committee at any time.

The Human Rights Committee is an independent, impartial entity.

Membership should reflect the cultural, racial, and disabilities diversity of the community in which it functions.

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2. A family member of an individual who has an intellectual disability or related disability, autism, head and spinal cord injury or similar disability.

3. A representative of the community at large with expertise or demonstrated interest in services to individuals with an intellectual disability or related disability, autism, head and spinal cord injuries, or similar disabilities.

4. A community professional with expertise in behavioral or medical fields. This may include a physician, nurse, pharmacist, psychologist, etc.

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An attendance log shall be maintained and when a member fails to attend three (3) meetings without excuse from the chairperson or 50% of scheduled meetings within one (1) year that member shall be removed from the committee.

Board/Provider responsibility is one of support and resource; therefore, staff shall not serve as a member of the Human Rights Committee, but may serve in a staff capacity to the Human Rights Committee. The board/provider will provide clerical support to the Human Rights Committee.

The board/provider shall ensure that appropriate resource staff are available to the Human Rights Committee to provide expertise and assistance. Resource staff may include a physician, nurse, pharmacist, psychologist, or other professionals.

TRAINING

All new Human Rights Committee members shall receive training and orientation before attending a meeting that requires a vote. Members shall be afforded an opportunity to tour programs and services and meet individuals receiving services. Ongoing training shall be provided to the Human Rights Committee members to assist them in carrying out their responsibilities. This training shall occur at least annually or sooner if there is a change in the majority of committee members since the last training. A log of training shall be maintained and the training topics should include:

1. Rights of individuals with disabilities and special needs;

2. Due process;

3. Role and responsibilities of the Human Rights Committee;

4. Confidentiality, Informed consent, and release of information;

5. Disabilities (intellectual or a related disability, autism, head and spinal cord injuries, and related disabilities);

6. Behavior support;

7. Medications (including dosages, interactions, contraindications, and side effects);

8. Principles of least restrictive alternatives, normalization, inclusion, protection from harm, active treatment, individualized supports, quality of life issues, etc., and

9. HIPAA - members should receive privacy notice as a part of this training.

10. Other areas that may be specified by the Human Rights Committee or DDSN.

The Facility/Executive Director/CEO or his/her designee shall provide this training and shall be responsible for scheduling on-going training. A sample training manual compiled by DDSN is available on the agency website at Human Rights Committee Training.

MEETINGS

The Human Rights Committees shall meet as often as necessary, but at least every other month six (6) times a year. Exceptions to this rule must be approved by the Associate State Director-Policy or her designee.

The Human Rights Committee shall assure that individuals whose rights may be restricted are afforded the opportunity to be present at the Human Rights Committee meeting and that they have the opportunity to present their wishes.

The Human Rights Committee shall assure that individuals coming before the Human Rights Committee are offered a personal representative to accompany them to the meeting to support him/her to speak or to speak on his/her behalf.

Case presentations coming before the committee shall include a summary. The presentation shall include all of the information needed for the committee's deliberations; however, all information that might identify the individual and the outcome of any discussion along with any recommendations shall be coded to protect the identity of the individual. If the individual and/or his/her representative attend the committee meeting, their attendance shall overrule the coding requirement.

Procedures shall be established for expedient review of emergency situations, which require a Human Rights Committee review and decision. Reviews may be accomplished through a subcommittee, telephone poll, mail, electronic mail, or other procedures established by the Human Rights Committee. The minimum number of contacts must equal the quorums defined in the By-Laws. Emergency review

procedures should be used when it is in the individual's best interest not to wait until the next regularly scheduled Human Rights Committee as determined by the Human Rights Committee Chairperson or Facility/Executive Director/CEO.

At its next regularly scheduled meeting, the full Human Rights Committee should be informed and the full Human Rights Committee shall approve or rescind the action when emergency approval procedures have been utilized. This provision shall not apply to the review of abuse, neglect, exploitation, and critical incidents.

Case presentations should include the following:

- Statement of concerns
- History of the concern
- History of intervention
- Current data
- Tardive Dyskinesia (TD) scores when applicable
- Recommended course of action
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- Individual's concerns
- Family concerns
- Measures for follow up and review

CONFIDENTIALITY

All information concerning individuals receiving services and their families and staff shall be considered confidential. All members of the Human Rights Committee shall sign a statement of confidentiality upon appointment.

QUALITY ASSURANCE

DDSN-Operated Residential Programs, DDSN Regional Centers, DSN Boards, and contract service providers shall develop quality assurance/improvement procedures for implementing this directive.

These procedures shall be indicated in the Quality Assurance/Improvement Plan.

DDSN-Operated Residential Programs, DDSN Regional Centers, DSN Boards, and contract service providers shall also develop monitoring procedures to ensure compliance with this directive.

The Facility/Executive Director/CEO or his/her designee shall regularly attend the Human Rights Committee meetings to assure the proper functioning of the Human Rights Committee.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

Michelle G. Fry, J.D., Ph.D.
State Director
Janet Brock Priest
Associate State Director
Operations
Lori Manos
Associate State Director
Policy
Constance Holloway
General Counsel
Harley T. Davis, Ph.D.
Chief Administrative Officer
Nancy Rumbaugh
Interim Chief Financial Officer
Greg Meetze
Chief Information Officer

SOUTH CAROLINA Department OF Disabilities AND Special Needs

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COMMISSION
Stephanie M. Rawlinson
Chairman
Barry D. Malphrus
Vice Chairman
Robin B. Blackwood
Secretary
Gary Kocher, M.D.
Eddie L. Miller
David L. Thomas
Michelle Woodhead

Reference Number:	603-02-DD
Title of Document:	Employee Health Requirements
Date of Issue:	August 1, 1989
Date of Last Revision:	May 19, 2022 (**REVISED**)
Effective Date:	May 19, 2022
Applicability:	Department of Disabilities and Special Needs (DDSN) Regional Center Employees

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I. Pre-Placement Physical Examinations

A. All new employees, contract workers, and volunteers (working 10 hours or more per week) must have an assessment by a registered nurse, nurse practitioner, physician's assistant or physician prior to employment placement. This assessment must determine the potential employee to be:

1) Capable of and physically fit to perform the job for which he/she is to be hired. ~~Ability to lift 20 lbs., squat, and return to a standing position unassisted~~.

2) Free of obvious communicable disease.

All new and existing employees will receive screening for Tuberculosis in accordance with DDSN Directive 603-06-DD: Tuberculosis Screening.

II. Emergency Care

A. Emergency care for employees experiencing acute illness and acute non-work-related injuries should result in referrals to emergency medical services by calling 911.

B. For injuries which employees qualify for Workman's Compensation benefits, necessary emergency care will be provided by DDSN Regional Center medical employees, as is available, followed by respective DDSN Regional Center's approval.

C. DDSN Directive 603-05-DD: Policy for Management of Occupational Exposure of Health Care Personnel to Potential Blood Borne Pathogens, will be followed for any employee who has a blood exposure.

III. Infection Control Guidelines

A. Hepatitis B serology testing, if necessary, may be offered at no cost to the employees to help them decide whether or not to receive HBV vaccination. Hepatitis B vaccine shall be offered without cost to all employees.

1). Six to eight weeks after completion of the Hepatitis B vaccine series, the employee will be offered Hepatitis B serology testing to see if Hepatitis B antibodies are present.

2). If the person is sero-negative for hepatitis B antibodies after completion of the initial Hepatitis B vaccine series, the entire series should be offered again to the person. If the person refuses the second HBV series they will be considered a non-responder. If the person accepts the second HBV series, they should have Hepatitis B serology for antibodies repeated six to eight weeks after the last dose to determine antibody status. If the person's Hepatitis B antibody status remains negative, they will be considered a non-responder and no other HBV series will be given.

B. No person infected with or a carrier of a communicable disease which may be transmitted in the work place or having uncovered boils or infected skin lesions, or an acute respiratory infection accompanied by an elevated temperature shall work in any area in which contact with individuals may occur.

IV. Health File

A. A confidential health file will be kept on all employees for the duration of employment, plus 30 years. Access to/distribution of this information will be conducted in full compliance with appropriate state and federal law (to include HIPAA).

B. The medical records of employees of DDSN who have worked for less than one year, need not be retained beyond the term of employment if they are provided to the employee upon the termination of employment.

C. Employee Health records concerning an incident of exposure to bloodborne pathogens shall be maintained in a confidential file separate from other employee health records. They shall be maintained for the duration of employment, plus 30 years.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

References:

603-05-DD: Policy for Management of Employee Exposure to Blood, Bloody Body Fluid or Body Fluids Designated As Infectious Occupational Exposures of Health Care Personnel to Potential Blood Borne Pathogens

603-06-DD: Guidelines for Screening For Tuberculosis

CFR 1910.20 OSHA Standards "Access To Employee Exposure and Medical Records" http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10027.

To access the following attachment, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

DDSN Infection Control Manual

3440 Harden Street Extension
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Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

Reference Number:	603-02-DD
Title of Document:	Employee Health Requirements
Date of Issue:	August 1, 1989
Date of Last Revision:	June 16, 2022 (**REVISED**)
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All new and existing employees will receive screening for Tuberculosis in accordance with DDSN Directive 603-06-DD: Tuberculosis Screening.

II. Emergency Care

A. Emergency care for employees experiencing acute illness and acute non-work-related injuries should result in referrals to emergency medical services by calling 911.

B. For injuries which employees qualify for Workman's Compensation benefits, necessary emergency care will be provided by DDSN Regional Center medical employees, as is available, followed by respective DDSN Regional Center's approval.

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III. Infection Control Guidelines

A. Hepatitis B serology testing, if necessary, may be offered at no cost to the employees to help them decide whether or not to receive HBV vaccination. Hepatitis B vaccine shall be offered without cost to all employees.

1). Six to eight weeks after completion of the Hepatitis B vaccine series, the employee will be offered Hepatitis B serology testing to see if Hepatitis B antibodies are present.

2). If the person is sero-negative for hepatitis B antibodies after completion of the initial Hepatitis B vaccine series, the entire series should be offered again to the person. If the person refuses the second HBV series they will be considered a non-responder. If the person accepts the second HBV series, they should have Hepatitis B serology for antibodies repeated six to eight weeks after the last dose to determine antibody status. If the person's Hepatitis B antibody status remains negative, they will be considered a non-responder and no other HBV series will be given.

B. No person infected with or a carrier of a communicable disease which may be transmitted in the work place or having uncovered boils or infected skin lesions, or an acute respiratory infection accompanied by an elevated temperature shall work in any area in which contact with individuals may occur.

IV. Health File

A. A confidential health file will be kept on all employees for the duration of employment, plus 30 years. Access to/distribution of this information will be conducted in full compliance with appropriate state and federal law (to include HIPAA).

B. The medical records of employees of DDSN who have worked for less than one year, need not be retained beyond the term of employment if they are provided to the employee upon the termination of employment.

C. Employee Health records concerning an incident of exposure to bloodborne pathogens shall be maintained in a confidential file separate from other employee health records. They shall be maintained for the duration of employment, plus 30 years.

Barry D. Malphrus
Vice Chairman

Stephanie M. Rawlinson
Chairman

References:

603-05-DD: Policy for Management of Employee Exposure to Blood, Bloody Body Fluid or Body Fluids Designated As Infectious Occupational Exposures of Health Care Personnel to Potential Blood Borne Pathogens

603-06-DD: Guidelines for Screening For Tuberculosis

CFR 1910.20 OSHA Standards "Access To Employee Exposure and Medical Records" http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10027.

To access the following attachment, please see the agency website page "Current Directives" at: https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals/current-directives

DDSN Infection Control Manual