From:	Linguard, Christie
Subject:	Meeting Notice - The Commission of the SCDDSN - Policy Committee Meeting - November 8, 2022
Date:	Friday, November 4, 2022 1:41:03 PM
Attachments:	November 8, 2022 Policy Committee Packet.pdf

Everyone,

The South Carolina Commission on Disabilities and Special Needs will hold an in-person Policy Committee meeting on Tuesday, November 8, 2022, at 3:00 p.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 https://ddsn.sc.gov**.**

Please see the attached meeting material 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

November 8, 2022 **3:00 p.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 October 11, 2022 Meeting (pg. 1)

6. Old Business:

A. Administrative Agency Standards (pg. 2-30)

7. New Business:

A. 367-08-DD: Central Office Telephone Call Coverage Backup Policy (pg. 31-32)
B. 367-11-DD: Telephone Policy (pg. 33-36)
C. 367-20-DD: Portable Computing Devices (pg. 37-41)
D. 104-01-DD: Certification and Licensure of DDSN Residential and Day Facilities (pg. 42-61)
E. 100-28-DD: Quality Management (pg. 62-80)

8. Adjournment – Next Meeting January 10, 2022

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

IN ATTENDANCE: Chairman, Barry Malphrus; Commissioner David Thomas, Commissioner Michelle Woodhead and Commissioner Stephanie Rawlinson Dr. Michelle Fry, Lori Manos, Courtney Crosby, Harley Davis, Ann Dalton, Quincy Swygert and Christie Linguard

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 September 6, 2022 Meeting

Chairman Malphrus requested committee members to adopt the summary notes.

As there were no objections, the summary notes from the September 6, 2022 meeting were adopted.

3. Old Business:

A. 505-02-DD: Death or Impending Death of Persons Receiving Services from DDSN

The directive was posted for external review. Several comments were received and staff made additional changes. The Chairman requested several additional changes. As there were no objections, the directive will be presented to the full Commission for approval and signing.

4. New Business:

A. Administrative Agency Standards

Staff presented to the Committee for approval to post for external review. After a brief discussion, staff were asked to make additional changes before submitting for external review. As there were no objections, the standard will go out for public comment (10-day review) and will be presented at the next Policy meeting.

B. 275-05-DD: General Duties of the Internal Audit Division

The Director of Internal Audit gave a brief overview of the staff changes. The Policy Committee Chairman requested several additional changes. As there were no objections, the directive will be sent to the Finance and Audit Committee for review per the Audit Divisions charter.

5. Adjournment

The next meeting will take place on November 8, 2022.

South Carolina Department
of
Disabilities and Special Needs

ADMINISTRATIVE AGENCY STANDARDS

Effective July 1, 2012

Effective July 17, 2015

Effective August 31, 2017

Effective January 1, 2023

Commented [HC1]: Ralph Courtney – Aiken DSN Board

Have you or will you set up a performance scoring system whereby total "N" varies between DSN Boards and QPLs. This would be important in producing comparable percentages. I am relatively sure you have, but just wanted to make note of this need since the number of items applicable to QPLs is fewer than those that apply to the DSN Boards.

As always, thank you for the opportunity to provide comment.

Commented [HC2R1]: DDSN Response:

The Administrative Agency Standards are a separate document from the Key Indicator Review Tool used by Quality Improvement Organization (QIO), currently Alliant ASO, to measure compliance. Not all Standards and Directives are selected for measurement in any given year, but DDSN does consider the individual differences among service providers within individual quality management activities.

INTRODUCTION

The mission of the South Carolina Department of Disabilities and Special Needs (DDSN) is to assist people with disabilities and their families through choice in meeting needs, pursuing possibilities, and achieving life goals, and minimize the occurrence and reduce the severity of disabilities through prevention.

DDSN has embraced certain values that guide it in its efforts to assist people and their families and principles that are expected to be features of all services and supports. They are:

Values: Our Guiding Beliefs

Health, safety and well-being of each person
Dignity and respect for each person
Individual and family participation, choice, control, and responsibility
Relationships with family, friends, and community connections
Personal growth and accomplishments

Principles: Features of Services and Supports

Person-Centered
Responsive, efficient, and accountable
Practical, positive, and appropriate
Strengths-Based, results-oriented
Opportunities to be productive, and maximize potential
Best and promising practices

These Administrative Agency Standards serve as a foundation on which DDSN ~~sponsored~~ contracted services and supports are provided. The standards set forth in this document, unless otherwise noted, will be used to evaluate all Agencies receiving funds from DDSN for service provision. Therefore, these standards are applicable to DSN Boards and Contracted Service Providers, including Financial Management Service providers.

GENERAL - 100

GENERAL OPERATIONS		
	STANDARD	GUIDANCE
101	The Agency has a clear statement of its mission that is consistent with DDSN's mission and is reviewed regularly by the governing board/body.	
102	The Agency provides information about its mission, services, and relationships with major funding sources to service users, their family members/advocates, and the community at large.	
103	The Agency complies with all applicable federal and state laws and regulations.	
104	The Agency complies with all applicable policies, procedures, and standards issued by DDSN.	See Attachment 1
105	The Agency complies with the terms of its contract with DDSN.	
106	The Agency protects the rights of people.	
107	The Agency uses positive approaches in all service and support activities.	
108	The Agency promotes consumer choice and decision making in service delivery.	
107109	The Agency engages in activities that educate and inform people about the Agency itself, the abilities and talents of people with disabilities, local, state, and federal resources, and DDSN.	
108110	The Agency has a records management system for tracking and safeguarding individual and Agency records and complies with applicable laws, regulations, and policies.	Reference: DDSN Directive 167-06-DD: Appeal procedure for facilities licensed or certified by DDSN DDSN Directive 368-01-DD: Individual service delivery records management
109111	As required by DDSN, the Agency keeps information about its service users up to date on Therap, DDSN's Consumer Data Support System/Service Tracking System and Waiver Tracking Systems.	The Therap modules required by DDSN can be found at: www.therapservices.net/southcarolina. https://secure.therapservices.net/auth/login

Commented [HC3]: Ralph Courtney – Aiken DSN Board

I suggest this be removed. Its intent can be obtained through the compliance measurements throughout the administrative and other standards and procedural/policy reviews already present within the compliance monitoring system. If noncompliance with any standard in any review were found to exist then the requirements for meeting this wide-reaching standard would not have been achieved. In other words, you would have to attain 100% compliance in all program areas in order for this standard to be met. That would be redundant, since the citation would already have occurred elsewhere.

Commented [HC4R3]: DDSN Response: Compliance with Administrative Agency Standards is expected across providers and service types. As stated previously, not all Standards and Directives are scored as a part of the Contract Compliance Review.

Commented [HC5]: Laura Villeponteaux – Charleston DSN Board

How will these new standards be measured or reviewed? What documentation will be required to demonstrate compliance?

Commented [HC6R5]: DDSN Response: While the inclusion of these specific Standards in the Administrative Agency Standards is new, the concepts have been included within individual service standards and DDSN Directives as general expectations for the past 10+ years. A provider's policies and procedures should include these concepts and how they are operationalized.

~~110~~	~~Agencies providing Residential Habilitation and/or Employment/Day services shall develop and implement a policy that specifies how the T-Log Module of Therap will be used by the Agency in all Residential and Employment/Day service locations.~~	"~~Employment/Day Services" includes Employment-Individual, Employment-Group, Day Activity, Career Preparation, Community Services and Support Center.~~ ~~Agency policy must require the use of the T-Log Module. The policy must specify the minimum frequency with which entries will be made and by whom. The policy must specify how the T-Log designation (high, medium, low) will be used by the Agency.~~
112	The Agency has established internal monitoring processes to ensure the health, safety, and welfare of participants.	
113	The Agency has established internal monitoring processes to ensure the integrity of the services provided meets the scope of the defined service(s), DDSN, and Medicaid requirements.	
114	The Agency has established clear policies/procedures for documenting service delivery, consistent with the scope of the defined service(s), DDSN, and Medicaid requirements.	

DISABILITIES AND SPECIAL NEEDS (DSN) BOARD: GOVERNING BOARD – 200

GOVERNING BOARD: DISABILITIES AND SPECIAL NEEDS (DSN) BOARD

	STANDARD	GUIDANCE
201	When the Administrative Agency is a DSN Board, the Board of Directors (BOD) meets all state and local laws and regulations related to composition and operation. Refer to S.C. Code Ann. § 44-20-375 to 385 (2018)	SC Code Ann. §44-20-375 to 385 (Supp. 2011)
202	The membership of the BOD is representative of the community it serves.	
203	The BOD is the governing body and determines the general direction for the Agency by establishing policies pertaining to the operation of the Agency. These policies are reviewed at least annually by the Executive Director and reaffirmed by the Board. The Board of Directors will review, approve and document the vote in the minutes and the spending limits, to include credit cards, of the Executive Director on an annual basis. Polices include, but are not limited to: • Agency structure. • Personnel. • Preventing and Reporting Abuse. • Reporting Critical Incidents. • Fiscal Accountability. • Staff training and Development. • Emergency Response/Disaster Preparedness. • Program and Services. • Code of Ethics. • Records Retention Policy covering Individual Service Records and Official Agency business.	Polices include but are not limited to: • Agency structure • Personnel • Preventing and Reporting Abuse • Reporting Critical Incidents • Fiscal Accountability • Staff training and Development • Emergency Response/Disaster Preparedness • Program and Services • Code of Ethics
204	Training is provided to members of the BOD within 90 days of appointment to the Board and their participation is documented.	See Attachment 2
205	The BOD participates in and oversees the fiscal management of the Agency and approves the annual budget, reviews comprehensive financial reports at every meeting and reviews an annual audit report including a written management audit letter. • Management audit letter comments are presented to the BOD by the external auditor or CPA.	Management audit letter comments are presented to the BOD by the external auditor or CPA.

GOVERNING BOARD: DISABILITIES AND SPECIAL NEEDS (DSN) BOARD		
	STANDARD	**GUIDANCE**
206	All board meetings and minutes comply with the South Carolina's Freedom of Information Act. • All boards must adopt consistent rules of procedure including a records retention policy for all official agency business. • Minutes, policies, and by-laws must be consistent with state and local laws (S.C. Code Ann. § 30-4-20 (Supp. 2022)).	Minutes, policies, and by-laws must be consistent with state and local laws (SC Code Ann. §44-20-378).
207	The BOD: • Employs an Executive Director with at least a bachelor's degree from an accredited college or university in a human services field of study and at least three (3) years of experience working with people who have disabilities with at least one (1) year of experience in supervision/administration, and • Delegates the authority for the day-to-day management of the Agency in accordance with written policy.	
208	The BOD defines the expectations for the Executive Director's performance and at least annually evaluates and provides feedback regarding performance.	

PRIVATE PROVIDERS: GOVERNING BODY - 300

GOVERNING BOARD/BODY: QUALIFIED PROVIDERS		
	STANDARD	**GUIDANCE**
301	When the Administrative Agency is a Contracted Provider, the governing body of the Contracted Provider determines the general direction for the Agency by establishing policies pertaining to the operation of the Agency. These policies are reviewed at least annually by the President/Chief Executive Officer (CEO) unless the provider agency is a sole proprietor partnership. Polices include but are not limited to: • Agency structure. • Personnel. • Preventing and Reporting Abuse. • Reporting Critical Incidents. • Fiscal Accountability. • Staff training and Development. • Emergency Response/Disaster Preparedness. • Program and Services. • Code of Ethics.	Polices include but are not limited to: • Agency structure • Personnel • Preventing and Reporting Abuse • Reporting Critical Incidents • Fiscal Accountability • Staff training and Development • Emergency Response/Disaster Preparedness • Program and Services • Code of Ethics •
302	The governing body participates in the fiscal management of the Agency and approves the annual budget, reviews comprehensive financial reports at every meeting and reviews an annual audit report including a written management audit letter for SCDDSN contracted services. • Management audit letter comments are presented to the governing board by the external auditor or CPA.	Management audit letter comments are presented to the governing board by the external auditor or CPA.
303	The governing body: • Employs a President/CEOExecutive leadership with at least a bachelor's degree from an accredited college or university in a human services field of study and at least three (3) years' experience working with people who have disabilities with at least one (1) year of experience in supervision/administration, and • Delegates the authority for the day-to-day management of the Agency in accordance with written policy. **Does not apply to sole proprietor partnership**	

GOVERNING BOARD/BODY: QUALIFIED PROVIDERS		
	STANDARD	GUIDANCE
304	The governing body defines the expectations for the President/CEO's performance and at least annually evaluates and provides feedback regarding performance. **Does not apply to sole proprietor partnership**	
305	All board meetings and minutes related to DDSN contracted services comply with the South Carolina's Freedom of Information Act. • All boards must adopt consistent rules of procedure including a records retention policy for all official agency business. Minutes, policies, and by-laws must be consistent with state and local laws (S.C. Code Ann. § 30-4-20 (Supp. 2022)). **Does not apply to sole proprietor partnership**	

~~MANAGEMENT – 400~~

	MANAGEMENT STRUCTURE	
	STANDARD	~~**GUIDANCE**~~
401	The Agency has in place clear lines of authority and written responsibilities for all staff members.	
402	A specific staff member must be named to administer the Agency in the absence of the President/CEO or Executive Director and be fully authorized to make decisions as the acting President/CEO or Executive Director.	
~~403~~	~~The President/CEO or Executive Director reviews all internal and external quality assurance reports and ensures implementation of Plans of Correction.~~	~~Examples of Quality Assurance Reports include, but are not limited to, Licensing Review Reports, DDSN Contract Compliance Review Reports, Certification Survey Reports for ICFs/ID.~~
~~404~~ 403	When the Agency provides residential services, the Agency's upper level management staff will conduct quarterly, unannounced visits to all residential settings, to assure that the staffing is sufficient and supervision is provided. • "Residential setting" means a licensed, certified or assessed location in which Residential Habilitation is provided. • When the residential setting uses a shift model for staffing, visits during a year must include a visit made during each shift • When the residential setting does not utilize a shift model (e.g., CTH-I, SLP-I), visits need only to be conducted quarterly and need not be conducted on third or overnight shifts. • When the residential setting is an SLP-II, overnight or 3rd shift visits in each apartment is not required. • Quarterly mean four times per year with no more than four months between visits. • When managers are used to conduct the unannounced visits, managers are not allowed to conduct visits in homes for which they are directly responsible, but are allowed to visit homes for which their counterparts are responsible. NOTE: A manager, who is the immediate supervisor of any staff of the home, is considered to be "directly responsible."	~~• "Residential setting" means a licensed, certified or assessed location in which Residential Habilitation is provided.~~ ~~• When the residential setting uses a shift model for staffing, visits during a year must include a visit made during each shift.~~ ~~• When the residential setting does not utilize a shift model (e.g., CTH-I, SLP-I), visits need only to be conducted quarterly and need not be conducted on third or overnight shifts.~~ ~~• When the residential setting is an SLP-II, overnight or 3rd shift visits in each apartment is not required.~~ ~~• Quarterly mean four times per year with no more than four months between visits.~~ ~~• When managers are used to conduct the unannounced visits, managers are not allowed to conduct visits in homes for which they are directly responsible, but are allowed to visit homes for which their counterparts are responsible. *NOTE: A manager, who is the immediate supervisor of any staff of the home, is considered to be "directly responsible."*~~ • ~~Visits must be documented and documentation must include the date/time of the visit, the names of the staff/caregivers and residents present, notation of any concerns and the actions taken in response to the concern.~~

	• Visits must be documented and documentation must include the date/time of the visit, the names of the staff/caregivers and residents present, notation of any concerns and the actions taken in response to the concern.	
405	The Agency has a process for soliciting and analyzing feedback on services and supports from service users, their families/advocates, employees and as appropriate, other agencies.	
406	The Agency uses solicited feedback to improve or expand services.	
407	The Agency uses positive approaches in all service and support activities.	
408	The Agency promotes consumer choice and decision making in service delivery.	

PERSONNEL ADMINISTRATION – 500

PERSONNEL ADMINISTRATION		
	STANDARD	GUIDANCE
501	Adequate numbers of qualified staff are employed to enable the Agency to conduct business and provide services in accordance with applicable local, state and federal rules, regulations, and standards and with the Agency's mission.	
502	The Agency maintains personnel policies and procedures which meet all governmental fair labor regulations, are approved by the Governing Board/Body, and are reviewed at least annually by the President/CEO or Executive Director.	
503	The Agency has personnel policies and procedures for screening employees in order to minimize unnecessary and unreasonable risk and include, but are not limited to, the Agency's position on the following: a. Employee benefits; b. Procedures for hiring and recruiting including its position regarding the prohibition of hiring of people with substantiated allegations of abuse or neglect; c. Procedures for verifying references, previous employment, and credentials; d. Rules for employee conduct; e. Lines of authority for handling personnel matters including the disciplinary system to be used; f. The probationary period for new employees; g. The schedules for wages, hours, and salaries; h. Employee vacations, holidays, annual leave, sick leave, family sick leave, and staff absences; i. Initial and ongoing training, orientation, and skill developments for all staff; j. Criminal background check; k. Drug screening; and, l. The use of screening, training, and supervision of volunteers.	DDSN Directive 406-04-DD: Criminal record checks and reference checks of direct caregivers, states, "As provided for in the SC Code of Laws Title 41, Chapter 1, Section 65, upon the written request by a prospective employer the following information may be released on a former employee: a. Written employee evaluations; b. Official personnel notices that formally record the reasons for separation; c. Whether the employee was voluntarily or involuntarily released from service and the reason for the separation; and, d. Information about job performance. Unless otherwise provided by law, an employer who responds in writing to a written request concerning a current employee or former employee from a prospective employer of that employee shall be immune from civil liability for disclosure of the above information to which an employee or former employee may have access. This protection and immunity shall not apply where an employer knowingly or recklessly releases or discloses false information."

Commented [HC7]: Ralph Courtney – DSN Board

I suggest dropping "and procedures." The procedures will often not be a matter that needs the attention of a Board of Directors or governing body. Procedures can change frequently while, as a general rule, policies do not. Procedures are means utilized to comply with policies. If "procedures" remains in this standard, I would not know where to stop with Board approval.

Commented [HC8R7]: DDSN Response: "and procedures" has been removed to clarify that board approval for procedures is not required.

Commented [HC9]: Beth Cody – Beaufort DSN Board

Beaufort County Disabilities and Special Needs is a department of Beaufort County and is managed by County Council. We have an advisory board but they do not have financial or hiring/firing responsibilities. Referring to the "Board" having this authority has caused some significant misunderstandings with the community in Beaufort County.

Commented [HC10R9]: DDSN Response: "Governing Board/Body" should cover the management by County Council and your agency's advisory board.

Commented [HC11]: Ralph Courtney – Aiken DSN Board

I recommend removing the letter "s" from the word "developments."

Commented [HC12R11]: DDSN Response: "s" has been removed from the word developments.

PERSONNEL ADMINISTRATION		
	STANDARD	~~**GUIDANCE**~~
504	When the Agency is a DSN Board, it has a policy which prohibits the following: • The employment of or contracting with a Board member or relative of a Board member. • Employment of or contracting with a relative of the Executive Director. • A supervisor from supervising an employee who is a relative.	
505	A position/job description is available for each position.	
506	The Agency keeps comprehensive personnel records for all employees. Employee records may include, but are not limited to: a. Application form, signed and dated which contains education, past work history, references and verification of references, past employment, and appropriate credentials, for the particular job; b. Job description that is signed and dated; c. Cumulative leave records; d. Performance evaluation performed annually; e. Personnel actions such as raises, promotions, commendations, etc.; f. Disciplinary action, ~~in~~as applicable with documentation of consultation and action taken; g. Authorization allowing agency to perform a criminal investigation (this may be part of the application); h. ~~Systematic inspection of the official Department of Motor Vehicles driving record for employees who will be transporting participants;~~A record of inspection of the official Department of Motor Vehicles driving record for employees who will be transporting participants, as required by the Agency's insurance carrier.	~~Employee records may include but are not limited to:~~ ~~a. Application form, signed and dated which contains education, past work history, references and verification of references, past employment, and appropriate credentials, for the particular job;~~ ~~b. Job description that is signed and dated;~~ ~~c. Cumulative leave records;~~ ~~d. Performance evaluation performed annually;~~ ~~e. Personnel actions such as raises, promotions, commendations, etc.;~~ ~~f. Disciplinary action, in applicable with documentation of consultation and action taken;~~ ~~g. Authorization allowing agency to perform a criminal investigation (this may be part of the application);~~ ~~h. Systematic inspection of the official Department of Motor Vehicles driving record for employees who will be transporting participants;~~ ~~i. Verification, no more than 30 days old, that the employee is free from tuberculosis or other communicable diseases; and,~~ ~~j. Documentation via certified copies of educational and records that the employee meets all educational qualifications established by DDSN licensing and program standards.~~

Commented [HC13]: Ralph Courtney – Aiken DSN Board

1. The substitution of the word "as" for the word "in" would appear appropriate.
2. I am a bit reluctant to allow reviewers to review records of disciplinary actions taken by the agency, unless this involves matters of abuse, neglect, exploitation, failure to report incidents in a timely manner, or Medicaid fraud. "Loose tongues" of reviewers can result in much needless gossip and a loss of confidentiality. While our service delivery system appears to most of us to be quite large, many of us move in the same circles with some regularity.

Commented [HC14R13]: DDSN Response: 1. Corrected. 2. The Administrative Agency Standards define expectations of provider agencies to maintain employee records. The review of individual disciplinary actions has not been identified as indicator to be measured as any part of a QIO Review.

Commented [HC15]: Ralph Courtney – Aiken DSN Board

If this is to be included. There needs to be more specificity than simply using the word "systematic." How often does a "systematic inspection" mean? (We review records every year.)

Commented [HC16R15]: DDSN Response: Wording has been changed to reflect that this is driven by the Agency's insurance carrier.

PERSONNEL ADMINISTRATION		
	STANDARD	GUIDANCE
	i. Verification, no more than 30 days old, that the employee is free from tuberculosis or other communicable diseases; and, j. Documentation via certified copies of educational and records that the employee meets all educational qualifications established by DDSN licensing and program standards.	
507	The Agency regularly evaluates and provides feedback to employees on their performance.	
508	The Agency informs employees annually of the False Claims Recovery Act, that the Federal government can impose penalties for false claims, that abuse of the Medicaid program can be reported, and that reporters are covered by Whistleblowers' laws.	A written statement is signed annually by all employees.
508	The Agency will ensure all employees are informed and sign annual statements of understanding that fraud, abuse, neglect or exploitation can lead to arrest and conviction and termination of employment. New employee training shall cover these issues. The Annual Statement should also include the following statement concerning the False Claims Recovery Act: "I am aware of the False Claims Act and that the Federal Government can impose a penalty on any person who submits a claims to the federal government that he or she knows (or should know) is false. I am also aware that I must report abuse of the Medicaid program and that I am protected by Whistleblower Laws."	
509	The Agency complies with the provisions of the Deficit Reduction Act of 2005 - False Claims Recovery a. Establish written procedures for all employees, including management, and contractor or agent detailing information about the False Claims Recovery Act. b. Must have written policies detailing the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.	

Commented [HC17]: Ralph Courtney – Aiken DSN Board

The word "and" needs to be deleted.

Commented [HC18R17]: DDSN Response: The word "and" has been deleted.

PERSONNEL ADMINISTRATION		
	STANDARD	~~GUIDANCE~~
	c. Formal Employee ~~handbook~~ communications must contain: • Discussion of the laws described in the written policies; • Rights of the employees to be protected as whistleblowers, and • Discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.	
~~510~~	~~The Agency shall comply with DDSN minimum salary requirements for direct care staff, service coordinators and early interventionists.~~	
511	The DSN Board shall comply with State of South Carolina Employee Bonus Guidelines.	
~~512~~	~~Employee Agreements concerning Fraud, Abuse, Neglect, and Exploitation:~~ ~~All Provider employees shall sign an annual statement that they understand that fraud, abuse, neglect or exploitation can lead to arrest and conviction and termination of employment. New employee training shall cover these issues.~~ ~~The Annual Statement should also include the following statement concerning the False Claims Recovery Act:~~ ~~"I am aware of the False Claims Act and that the Federal Government can impose a penalty on any person who submits a claims to the federal government that he or she knows (or should know) is false. I am also aware that I can report abuse of the Medicaid program and that I am protected by Whistleblower Laws."~~	

Commented [HC19]: Ralph Courtney – Aiken DSN Board

1. We do not have an Employee Handbook, per se. Our policies are available online to all staff members. I am fine with this being a required part of orientation and a requirement that it be made available to all staff at any time. We are not a State Agency and Employee Handbooks should not be made required documents.
2. The words "employee" and "whistleblowers" are not in agreement. Employee is singular and whistleblowers is plural. Both words should be in agreement. "Employee" should be used with "whistleblower" or "employees" used with "whistleblowers."

Commented [HC20R19]: DDSN Response: 1. "Employee Handbook" was replaced with "Formal Employee Communications."
2. Corrected

Commented [HC21]: Ralph Courtney – Aiken DSN Board

It was my understanding that minimum salary requirements were to have gone out the window when providers moved to direct billing DHHS. This happened after DDSN found money with which to provide significant increases to its employees which broke the system of pay parity with the provider network that had existed for many years.

Commented [HC22R21]: DDSN Response: Standard removed.

~~FISCAL MANAGEMENT 600~~

	FISCAL MANAGEMENT	
	STANDARD	~~**GUIDANCE**~~
601	The Agency manages its fiscal affairs in accordance with generally accepted accounting principles (GAAP) and sound business principles.	
602	The Agency's assets and resources are properly insured. To include, but not limited to: a. Fire and Causality; b. Liability; c. Vehicle; d. Bonding of officers, employees, and agents of the Agency who are authorized to handle or be responsible for the Agency's and/or service users' funds; e. Directors and Officer's insurance; f. Tort liability; and, g. Workers' Compensation.	~~To include but not limited to:~~ ~~a. Fire and causality;~~ ~~b. Liability;~~ ~~c. Vehicle;~~ ~~d. Bonding of officers, employees, and agents of the Agency who are authorized to handle or be responsible for the Agency's and/or service users' funds;~~ ~~e. Directors and officers insurance;~~ ~~f. Tort liability; and,~~ ~~g.~~a. ~~Workers' compensation.~~
603	Insurance types and amounts are reviewed and approved by the Governing Board/Body.	
604	All contracts and agreements to provide services are reviewed annually for appropriateness by the Governing Board/Body.	~~The method and review is determined by the Governing Board/body.~~
605	When an Agency charges for ~~services~~DDSN Contracted Service Delivery, it has a fee schedule that has been approved in writing by the Governing Board/Body and by DDSN. The fee schedule is provided to the service users or their guardians upon request.	
606	DSN Boards grant equal access to Individual Family Support Funds to all who are eligible.	~~Refer to DDSN Directive 734-01-DD: Individual and family support stipend – state funding~~
607	The DSN Board shall provide DDSN copies of financial statements as of the end of each calendar quarter at a minimum. These financial statements shall include, but not be limited to, a statement of financial position and results of operations of fiscal year to date. The Provider shall present these financial statements to the DSN Board's Board of Directors.	

Commented [HC23]: Ralph Courtney

In the first line, after "services" I would put "to individuals." Agencies charge for many services, but I believe DDSN is and should only be interested in those fees that apply to charges made to individuals served. Even with "to individuals" being added, there are still items that I don't believe should have to be approved by DDSN or even go to the Agencies' Governing Boards/Bodies. These include: cost of bakery items (these can change from day to day with sales, surpluses, etc.) and canteen items. Also, I believe the cost of fundraising dinners and other events should be exempted. An area which would be clarified as being exempted from complying with this standard, if the words "to individuals" or "to participants" were added, would be the costs for services under contracts with area businesses for janitorial services, grounds keeping, packing, sorting, etc. I realize that this re-write might possibly be difficult.

Commented [HC24R23]: DDSN Response: Has been changed to "When an Agency charges for DDSN Contracted Service Delivery…"

Commented [HC25]: Ralph Courtney – Aiken DSN Board

I know it would be helpful to include the department or email address at DDSN to which the required financial statements should be sent.

Commented [HC26R25]: DDSN Response: Considered, but no change made.

608	The DSN Board shall submit an annual cost allocation plan prepared in accordance with Medicaid cost principles in accordance with DDSN Directive 250-05-DD: Cost Principles for Grants and Contracts with Community Providers.	
609	All expenditures of DDSN funds shall be in accordance with DDSN Directive 250-05-DD: Cost Principles for Grants and Contracts with Community Providers.	
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702	The President/CEO or Executive Director reviews all internal and external quality assurance reports and ensures implementation of Plans of Correction.
703	The Agency has a process for soliciting and analyzing feedback on services and supports from service users, their families/advocates, employees and as appropriate, other agencies.
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705	The Agency participates in statewide surveys to evaluate the service delivery system. This includes surveys for service participants, staff, and family members.
706	The Agency has a Risk Management Committee that meets on a quarterly basis to review data collection, training and monitoring activities, and the completion of tracking/trending/analysis.
707	The Agency completing the administrative review must follow reporting requirements and track/trend/analyze Allegations of Abuse, Neglect or Exploitation on a quarterly basis using the following information: 1. The total number of allegations made; 2. The types of allegations, including a trend of when and where they were reported; 3. The number of substantiated allegations, as determined by local law enforcement, SLED, DSS, or the Attorney General's Office; 4. The number of Administrative Findings, as determined by verified Standard of Care allegations, through DSS or the State Long Term Care Ombudsman's Office or a Regional Ombudsman. A distinction should be made between allegations with known and unknown perpetrators and the types of violations cited (i.e., Administrative Oversight, Dignity & Respect, Supervision, etc.); 5. The number of initial reports submitted in compliance with policy; and 6. The number of final reports submitted in compliance with policy. Narrative information may also be analyzed in order to identify more specific trends.

Commented [HC27]: Susan John – Horry DSN Board

I do not disagree that providers should have a comprehensive quality management plan, but they cite measures should be drawn from multiple sources. Are these inside sources within the system or are they asking providers to go outside of the system? Currently Horry County tracks major areas of need and the majority of concerns noted thru our consumer interviews with individuals and families can be lumped into the following areas.

1) Lack of respite care providers and difficulty in getting providers thru the process to deliver a service
2) Lack of nursing services (LPN and RN)
3) Lack of expertise and amount of time it takes to get an environmental modification or vehicle modification thru the system if successful at all
4) Extensive waiting lists for services or having an authorization but cannot find a provider
5) Inability to get someone on the residential critical list

All of the above are concerns on services or process' that we as an agency are not in control of with possibly the exception of one. DDSN is asking for us to provide and "action plan" but these are action plans of outside entities. Again, additional training and clarification will be needed by the provider network.

Thanks for the opportunity to comment.

Commented [HC28R27]: DDSN Response: The multiple sources can be internal or external to the agency.

Commented [HC29]: Susan John – Horry DSN Board

While I believe that most providers already track several areas of quality/compliance (med errors, GER's, ANE's, Critical Incident, etc.) There is a great deal of words below, but when you drill down into it, what exactly do they mean and how/what tools, methods, data sources, etc. is DDSN specifically looking for. There is a big difference between compliance and quality, and it seems to me (maybe not everyone) that these changes are compliance driven on the side of DDSN due to WVR assurances, WVR administration, etc. Will training on this directive be provided to understand expectations?

Commented [HC30R29]: DDSN Response: Training will be provided.

Commented [HC31]: Ralph Courtney – Aiken DSN Board

I am not sure how to apply this standard to Case Management. As you are aware all instances of alleged Abuse, Neglect or Exploitation are to be reported by the residential and day service providers to Case Management. Am I to assume that DDSN only is requiring CM and EI providers to include in their analyses those instances for which their agency made the required report to SLED? These could be allegations against a family member, or personnel in a group home, a school, a day program, or elsewhere in the community, etc. This is very confusing and warrants further clarification. I am thinking that DDSN, DHHS, and CMs, would not want statistics to include duplications of the same alleged events. Example: An allegation occurs at Tri-Development Center and Tri-Development Center reports it to SLED and to us at Aiken County Board of Disabilities, if we are the provider of the individual's Case Management. I am fine with reviewing the outcomes of these cases but, of course, we don't do the reports. We are able to see if one place has a higher incidence than others, etc., and do this through the Risk Management Committee. We don't, however, do the initial or the final reports, or the administrative reviews. It needs to be made clear which of the numerical items apply to CM and EI entities.

Commented [HC32R31]: DDSN Response: Each agency is expected to monitor reports where they have completed the administrative review. Wording was changed to reflect this.

708	The Agency will must follow reporting requirements and track/trend/analyze Critical incidents and General Event Reports on a quarterly basis using the following information: 1. The type and frequency of incidents reported, including a trend of when and where they were reported, and ensuring the appropriate reporting category has been selected; 2. The number of initial reports submitted in compliance with policy; and 3. The number of final reports submitted in compliance with policy. Narrative information may also be analyzed in order to identify more specific trends.
709	The Agency must follow reporting requirements and track/trend/analyze Medication Errors/Events on a quarterly basis using the definitions and procedures contained in DDSN Directive 100-29-DD: Medication Error/Event Reporting. Three (3) categories of errors/events will be analyzed: A. Medication errors; B. Transcription/documentation errors; and C. Red flag events. Providers are required to maintain a monthly medication error rate, per service location, to identify trends related to specific settings.
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Commented [HC33]: Laura Villepointeaux – Charleston DSN Board

Please provide clarification of "restrictive procedures." For example, locking food in a house, employing a restraint-free alarm, and restrictive supervision are all "restrictive procedures," but should not be considered Critical Incidents.

Commented [HC34R33]: DDSN Response: This Administrative Agency Standard is not limited to restrictive interventions labeled as Critical Incidents. It is inclusive of all restrictive procedures. The review of this data will enable the Agency to determine whether the restrictive procedure is consistent with the person's behavior support plan and policy requirements, as well as whether the intervention should have been reported as a Critical Incident due to the emergency implementation.

South Carolina Department
of
Disabilities and Special Needs

ADMINISTRATIVE AGENCY STANDARDS

Effective July 1, 2012

Effective July 17, 2015

Effective August 31, 2017

Effective January 1, 2023

INTRODUCTION

The mission of the South Carolina Department of Disabilities and Special Needs (DDSN) is to assist people with disabilities and their families through choice in meeting needs, pursuing possibilities, and achieving life goals, and minimize the occurrence and reduce the severity of disabilities through prevention.

DDSN has embraced certain values that guide it in its efforts to assist people and their families and principles that are expected to be features of all services and supports. They are:

Values: Our Guiding Beliefs

Health, safety and well-being of each person
Dignity and respect for each person
Individual and family participation, choice, control, and responsibility
Relationships with family, friends, and community connections
Personal growth and accomplishments

Principles: Features of Services and Supports

Person-Centered
Responsive, efficient, and accountable
Practical, positive, and appropriate
Strengths-Based, results-oriented
Opportunities to be productive, and maximize potential
Best and promising practices

These Administrative Agency Standards serve as a foundation on which DDSN contracted services and supports are provided. The standards set forth in this document, unless otherwise noted, will be used to evaluate all Agencies receiving funds from DDSN for service provision. Therefore, these standards are applicable to DSN Boards and Contracted Service Providers, including Financial Management Service providers.

GENERAL OPERATIONS	
	STANDARD
101	The Agency has a clear statement of its mission that is consistent with DDSN's mission and is reviewed regularly by the governing board/body.
102	The Agency provides information about its mission, services, and relationships with major funding sources to service users, their family members/advocates, and the community at large.
103	The Agency complies with all applicable federal and state laws and regulations.
104	The Agency complies with all applicable policies, procedures, and standards issued by DDSN.
105	The Agency complies with the terms of its contract with DDSN.
106	The Agency protects the rights of people.
107	The Agency uses positive approaches in all service and support activities.
108	The Agency promotes consumer choice and decision making in service delivery.
109	The Agency engages in activities that educate and inform people about the Agency itself, the abilities and talents of people with disabilities, local, state, and federal resources, and DDSN.
110	The Agency has a records management system for tracking and safeguarding individual and Agency records and complies with applicable laws, regulations, and policies.
111	As required by DDSN, the Agency keeps information about its service users up to date on Therap, DDSN's Consumer Data Support System/Service Tracking System and Waiver Tracking Systems. The Therap modules required by DDSN can be found at: https://secure.therapservices.net/auth/login
112	The Agency has established internal monitoring processes to ensure the health, safety, and welfare of participants.
113	The Agency has established internal monitoring processes to ensure the integrity of the services provided meets the scope of the defined service(s), DDSN, and Medicaid requirements.
114	The Agency has established clear policies/procedures for documenting service delivery, consistent with the scope of the defined service(s), DDSN, and Medicaid requirements.

GOVERNING BOARD: DISABILITIES AND SPECIAL NEEDS (DSN) BOARD	
	STANDARD
201	When the Administrative Agency is a DSN Board, the Board of Directors (BOD) meets all state and local laws and regulations related to composition and operation. Refer to S.C. Code Ann. § 44-20-375 to 385 (2018)
202	The membership of the BOD is representative of the community it serves.
203	The BOD is the governing body and determines the general direction for the Agency by establishing policies pertaining to the operation of the Agency. These policies are reviewed at least annually by the Executive Director and reaffirmed by the Board. The Board of Directors will review, approve and document the vote in the minutes and the spending limits, to include credit cards, of the Executive Director on an annual basis. Polices include, but are not limited to: • Agency structure. • Personnel. • Preventing and Reporting Abuse. • Reporting Critical Incidents. • Fiscal Accountability. • Staff training and Development. • Emergency Response/Disaster Preparedness. • Program and Services. • Code of Ethics. • Records Retention Policy covering Individual Service Records and Official Agency business.
204	Training is provided to members of the BOD within 90 days of appointment to the Board and their participation is documented.
205	The BOD participates in and oversees the fiscal management of the Agency and approves the annual budget, reviews comprehensive financial reports at every meeting and reviews an annual audit report including a written management audit letter. • Management audit letter comments are presented to the BOD by the external auditor or CPA.
206	All board meetings and minutes comply with the South Carolina's Freedom of Information Act. • All boards must adopt consistent rules of procedure including a records retention policy for all official agency business. • Minutes, policies, and by-laws must be consistent with state and local laws (S.C. Code Ann. § 30-4-20 (Supp. 2022)).
207	The BOD: • Employs an Executive Director with at least a bachelor's degree from an accredited college or university in a human services field of study and at least three (3) years of experience working with people who have disabilities with at least one (1) year of experience in supervision/administration, and • Delegates the authority for the day-to-day management of the Agency in accordance with written policy.
208	The BOD defines the expectations for the Executive Director's performance and at least annually evaluates and provides feedback regarding performance.

GOVERNING BOARD/BODY: QUALIFIED PROVIDERS

<table>
<tr><th></th><th>STANDARD</th></tr>
<tr><td>301</td><td>When the Administrative Agency is a Contracted Provider, the governing body of the Contracted Provider determines the general direction for the Agency by establishing policies pertaining to the operation of the Agency. These policies are reviewed at least annually by the President/Chief Executive Officer (CEO) unless the provider agency is a sole proprietor partnership.

Polices include but are not limited to:

• Agency structure.
• Personnel.
• Preventing and Reporting Abuse.
• Reporting Critical Incidents.
• Fiscal Accountability.
• Staff training and Development.
• Emergency Response/Disaster Preparedness.
• Program and Services.
• Code of Ethics.</td></tr>
<tr><td>302</td><td>The governing body participates in the fiscal management of the Agency and approves the annual budget, reviews comprehensive financial reports at every meeting and reviews an annual audit report including a written management audit letter for SCDDSN contracted services.

• Management audit letter comments are presented to the governing board by the external auditor or CPA.</td></tr>
<tr><td>303</td><td>The governing body:

• Employs a Executive leadership with at least a bachelor's degree from an accredited college or university in a human services field of study and at least three (3) years' experience working with people who have disabilities with at least one (1) year of experience in supervision/administration, and

• Delegates the authority for the day-to-day management of the Agency in accordance with written policy.

Does not apply to sole proprietor partnership</td></tr>
<tr><td>304</td><td>The governing body defines the expectations for the President/CEO's performance and at least annually evaluates and provides feedback regarding performance.

Does not apply to sole proprietor partnership</td></tr>
<tr><td>305</td><td>All board meetings and minutes related to DDSN contracted services comply with the South Carolina's Freedom of Information Act.

• All boards must adopt consistent rules of procedure including a records retention policy for all official agency business.

Minutes, policies, and by-laws must be consistent with state and local laws (S.C. Code Ann. § 30-4-20 (Supp. 2022)).

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</table>

MANAGEMENT STRUCTURE		
	STANDARD	
401	The Agency has in place clear lines of authority and written responsibilities for all staff members.	
402	A specific staff member must be named to administer the Agency in the absence of the President/CEO or Executive Director and be fully authorized to make decisions as the acting President/CEO or Executive Director.	
403	When the Agency provides residential services, the Agency's upper level management staff will conduct quarterly, unannounced visits to all residential settings, to assure that the staffing is sufficient and supervision is provided. • "Residential setting" means a licensed, certified or assessed location in which Residential Habilitation is provided. • When the residential setting uses a shift model for staffing, visits during a year must include a visit made during each shift • When the residential setting does not utilize a shift model (e.g., CTH-I, SLP-I), visits need only to be conducted quarterly and need not be conducted on third or overnight shifts. • When the residential setting is an SLP-II, overnight or 3rd shift visits in each apartment is not required. • Quarterly mean four times per year with no more than four months between visits. • When managers are used to conduct the unannounced visits, managers are not allowed to conduct visits in homes for which they are directly responsible, but are allowed to visit homes for which their counterparts are responsible. NOTE: A manager, who is the immediate supervisor of any staff of the home, is considered to be "directly responsible." • Visits must be documented and documentation must include the date/time of the visit, the names of the staff/caregivers and residents present, notation of any concerns and the actions taken in response to the concern.	

PERSONNEL ADMINISTRATION		
	STANDARD	
501	Adequate numbers of qualified staff are employed to enable the Agency to conduct business and provide services in accordance with applicable local, state and federal rules, regulations, and standards and with the Agency's mission.	
502	The Agency maintains personnel policies which meet all governmental fair labor regulations, are approved by the Governing Board/Body, and are reviewed at least annually by the President/CEO or Executive Director.	
503	The Agency has personnel policies and procedures for screening employees in order to minimize unnecessary and unreasonable risk and include, but are not limited to, the Agency's position on the following: a. Employee benefits; b. Procedures for hiring and recruiting including its position regarding the prohibition of hiring of people with substantiated allegations of abuse or neglect; c. Procedures for verifying references, previous employment, and credentials; d. Rules for employee conduct; e. Lines of authority for handling personnel matters including the disciplinary system to be used; f. The probationary period for new employees; g. The schedules for wages, hours, and salaries; h. Employee vacations, holidays, annual leave, sick leave, family sick leave, and staff absences; i. Initial and ongoing training, orientation, and skill development for all staff; j. Criminal background check; k. Drug screening; and, l. The use of screening, training, and supervision of volunteers.	
504	When the Agency is a DSN Board, it has a policy which prohibits the following: • The employment of or contracting with a Board member or relative of a Board member. • Employment of or contracting with a relative of the Executive Director. • A supervisor from supervising an employee who is a relative.	
505	A position/job description is available for each position.	
506	The Agency keeps comprehensive personnel records for all employees. Employee records may include, but are not limited to: a. Application form, signed and dated which contains education, past work history, references and verification of references, past employment, and appropriate credentials, for the particular job;	

PERSONNEL ADMINISTRATION		
	STANDARD	
	b. Job description that is signed and dated; c. Cumulative leave records; d. Performance evaluation performed annually; e. Personnel actions such as raises, promotions, commendations, etc.; f. Disciplinary action, as applicable with documentation of consultation and action taken; g. Authorization allowing agency to perform a criminal investigation (this may be part of the application); h. A record of inspection of the official Department of Motor Vehicles driving record for employees who will be transporting participants, as required by the Agency's insurance carrier. i. Verification, no more than 30 days old, that the employee is free from tuberculosis or other communicable diseases; and, j. Documentation via certified copies of educational records that the employee meets all educational qualifications established by DDSN licensing and program standards.	
507	The Agency regularly evaluates and provides feedback to employees on their performance.	
508	The Agency will ensure all employees are informed and sign annual statements of understanding that fraud, abuse, neglect or exploitation can lead to arrest and conviction and termination of employment. New employee training shall cover these issues. The Annual Statement should also include the following statement concerning the False Claims Recovery Act: "I am aware of the False Claims Act and that the Federal Government can impose a penalty on any person who submits a claim to the federal government that he or she knows (or should know) is false. I am also aware that I must report abuse of the Medicaid program and that I am protected by Whistleblower Laws."	
509	The Agency complies with the provisions of the Deficit Reduction Act of 2005 - False Claims Recovery a. Establish written procedures for all employees, including management, and contractor or agent detailing information about the False Claims Recovery Act. b. Must have written policies detailing the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. c. Formal Employee communications must contain: • Discussion of the laws described in the written policies; • Rights of the employees to be protected as whistleblowers, and • Discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.	
510	The DSN Board shall comply with State of South Carolina Employee Bonus Guidelines.	

FISCAL MANAGEMENT	
	STANDARD
601	The Agency manages its fiscal affairs in accordance with generally accepted accounting principles (GAAP) and sound business principles.
602	The Agency's assets and resources are properly insured. To include, but not limited to: a. Fire and Causality; b. Liability; c. Vehicle; d. Bonding of officers, employees, and agents of the Agency who are authorized to handle or be responsible for the Agency's and/or service users' funds; e. Directors and Officer's insurance; f. Tort liability; and, g. Workers' Compensation.
603	Insurance types and amounts are reviewed and approved by the Governing Board/Body.
604	All contracts and agreements to provide services are reviewed annually for appropriateness by the Governing Board/Body.
605	When an Agency charges for DDSN Contracted Service Delivery, it has a fee schedule that has been approved in writing by the Governing Board/Body and by DDSN. The fee schedule is provided to the service users or their guardians upon request.
606	DSN Boards grant equal access to Individual Family Support Funds to all who are eligible.
607	The DSN Board shall provide DDSN copies of financial statements as of the end of each calendar quarter at a minimum. These financial statements shall include, but not be limited to, a statement of financial position and results of operations of fiscal year to date. The Provider shall present these financial statements to the DSN Board's Board of Directors.
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PROPOSED TO MARK OBSOLETE

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Susan Kreh Beck
Associate State Director
Policy
Thomas P. Waring
Associate State Director
Administration

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

COMMISSION
Eva R. Ravenel
Chairman
Gary C. Lemel
Vice Chairman
Mary Ellen Barnwell
Secretary
Sam F. Broughton, Ph.D.
William O. Danielson
Catherine O. Fayssoux
Vicki A. Thompson

Reference Number:	367-08-DD	
Title of Document:	Central Office Telephone Call Coverage Backup Policy	
Date of Issue:	May 25, 1995	
Effective Date:	May 25, 1995	
Last Review Date:	September 29, 2017	
Date of Last Revision:	September 29, 2017	**(REVISED)**
Applicability:	DDSN Central Office	

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS (DDSN). THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. DDSN RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS POLICY, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

PURPOSE

The purpose of this directive is to document the Department's policy, regarding the proper procedures to be followed by all Central Office employees relative to answering telephones and providing for incoming telephone call coverage during normal business hours within each division and section. The manner and efficiency in which incoming telephone calls are answered and processed is basic to providing quality service to both internal and external customers of each division and section within Central Office.

P.O. Box 239
Clinton, SC 29325-5328
Phone: (864) 938-3497

DISTRICT I
Midlands Center - Phone: 803/935-7500
Whitten Center - Phone: 864/833-2733

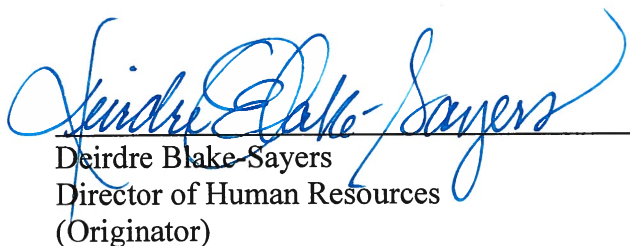
9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

DISTRICT II
Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone: 843/332-4104

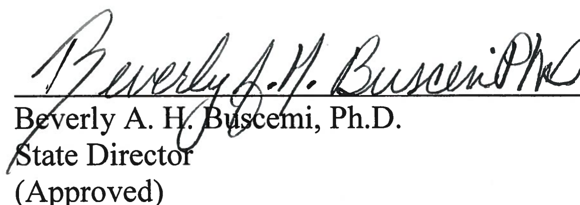
POLICY

Each division and section within Central Office is responsible for answering incoming telephone calls to their area, and must provide coverage within their section or division during all normal business hours (8:30 to 5:00), Monday through Friday. Incoming calls should not be allowed to ring through to the Receptionist or Executive Suite Administrative Support. Every effort should be made within the divisions and sections to avoid this situation. When a call does ring through to the Receptionist or Executive Suite, it should be only because all telephones within the division or section are busy. The answering of "ring through" calls from within Central Office should be an **extremely rare** occurrence.

Employees should help answer ringing telephones in their area, by using the call pickup feature, when they are aware that a telephone is not going to be answered by the intended recipient.



Deirdre Blake-Sayers
Director of Human Resources
(Originator)



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

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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
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Reference Number:	367-11-DD	
Title of Document:	Telephone Policy	
Date of Issue:	January 22, 2003	
Date of Last Revision:	~~June 16, 2022~~XXXX, 2023	(**REVISED**)
Effective Date:	~~June 16, 2022~~XXXX, 2023	
Applicability:	All DDSN Employees	

PURPOSE:

The purpose of this policy is to document the Department of Disabilities and Special Needs (DDSN) procedures regarding the management and utilization of stationary telephones.~~, cellular telephones, and State telephone credit cards~~. This policy also follows the regulations established by the South Carolina Department of Administration for local and long-distance calls. Employees who violate the provisions of this policy will be subject to disciplinary action, in accordance with the department's progressive discipline policy and will be required to reimburse the department actual charges. This policy also documents the procedures to be followed by all Central Office employees relative to answering telephones and providing for incoming telephone call coverage during normal business hours within each division and section. The manner and efficiency in which incoming telephone calls are answered and processed is basic to providing quality service to both internal and external customers of each division and section within Central Office.

SECTION I: STATIONARY TELEPHONES

The South Carolina Department of Administration has issued statewide regulations establishing the proper use of South Carolina state government telephone systems. These guidelines permit South

Carolina state government employees to make reasonable use of state telephones while simultaneously guarding against abuse.

A. The use of state government telephone services is limited to official business. It is a violation of S.C. Code Ann. § 16-13-400 (Supp. ~~2021~~2022), to abuse state telecommunication services. In addition to official business calls, the following non-business telephone calls may be made using state telephone services.~~, including, if necessary, long distance services paid for by the state.~~

1. Calls to notify the family, physician, etc., when an employee is injured on the job.

2. Calls to notify family of a schedule change when an employee (traveling on state government business) is delayed due to official business or a transportation delay.

3. An employee, traveling in the United States for more than one (1) night on state government business, makes a brief call to his or her residence (averaging no more than one (1) call per day).

4. An employee is required to work overtime without advance notice and calls within the local commuting area (the area from which the employee regularly commutes) to advise his or her family of the change in schedule or to make alternate transportation or childcare arrangements.

B. Permissible Calls

The following calls are considered permissible calls under this policy and when necessary, employees may make such brief calls. However, an employee may be prohibited from placing such calls if, in the discretion of the supervisor, the employee's telephone usage is interfering with the employee's job performance or if the usage otherwise impacts upon the division's operations. If the listed calls generate or activate a long-distance ~~change~~charge, the employee must charge the call to a personal credit card~~,~~ or to the employee's home telephone number.~~, or place the call collect.~~ Under no circumstances shall an employee charge a personal, long distance call to a government or DDSN telephone number.

The following calls, ~~if of a short~~ up to 15 minutes in duration, may be placed by an employee while on duty:

1. An employee makes brief daily calls to locations within the local commuting area to speak to a spouse or minor children (or those responsible for them, i.e., a school or day care center) to make certain of their well-being and/or safety.

2. The employee makes brief calls to locations within the local commuting area that can be reached only during normal working hours, such as a local government agency or a physician.

3. An employee makes brief calls to locations within the local commuting area to arrange for emergency repairs to his or her residence or automobile.

4. A call that reasonably could not be made at another time if it is of moderate duration and it does not adversely affect the performance of the state telephone system (e.g., unauthorized calls made in rapid succession to call-in contest on radio stations are considered detrimental to telephone system service levels).

C. Collect calls

Collect calls should not be accepted under any circumstances.~~may be accepted if the person calling identifies the call as an emergency or the call is from a DDSN employee, commission member, client, or client family member. While the use of collect calls is not favored, if an employee anticipates or expects to make a collect call to DDSN, the switchboard should be informed in advance. Employees are encouraged to secure a state telephone credit card prior to travel for use in making official business calls while in travel status. If a collect call is accepted, the name of the calling party and purpose of the call should be recorded and forwarded to the Facility Administrator, if at a DDSN Regional Center, or the Associate State Director-Administration otherwise.~~

D. Visitors may be given use of telephones as needed, but under no circumstances may a visitor charge a long-distance call to the state telephone system.~~ The DDSN employee responsible for the visitor may allow the visitor to use a state telephone to place a long-distance call if the call will not disrupt official business and if the call is charged to a personal or business credit card, to the caller's home telephone number, or if the call is placed collect.~~

SECTION II: ~~CELLULAR TELEPHONES~~TELEPHONE COVERAGE

Each division and individual in each section within Central Office is responsible for answering incoming telephone calls to their direct line during normal business hours (8:30 to 5:00), Monday through Friday. ~~Officials and employees who have been assigned a cellular telephone by DDSN must adhere to the following guidelines.~~

~~A. To the extent possible, mobile communication device usage should be limited to official state government business. The employee will reimburse DDSN for any personal or unauthorized calls. Employees should use stationary phones when available and practical.~~

~~B. No wireless device will be issued to any employee without the approval of the Chief Information Officer. Justification for the mobile device must be submitted by the requesting employee's supervisor detailing the need and usage.~~

~~C. The Division of Information Technology will maintain a current inventory of all mobile communication devices. At a minimum the inventory shall include device description, employee who was issued the device and cellular vendor.~~

~~D. The Division of Information technology will monitor the use of mobile communication devices. All unauthorized use will be reported to the Chief Information Officer and the employee's supervisor.~~

~~E. All agency issued cell phones capable of storing data must have security activated that requires a password, passcode, or Personal Identification Number to unlock the phone and gain access to its data.~~

~~SECTION III: STATE TELEPHONE CREDIT CARDS~~

~~Telephone calls charged to state telephone credit cards should be limited to official state government business. In addition to official business calls, DDSN considers the non-business calls listed in Section I-A & B to be permissible under this policy. The use of a state telephone credit card for purposes other than those established by this policy, in addition to progressive disciplinary action, may result in the revocation of the state telephone credit card.~~

Barry D. Malphrus Vice Chairman	Stephanie M. Rawlinson Chairman

Reference Number: 367-20-DD

Title of Document: Portable Computing Devices

Date of Issue: December 10, 2014
~~Late Review Date: December 10, 2014~~
Date of Last Revision: ~~July 13, 2016~~XXXX, 2023 (~~**NEW**~~**REVISED**)
Effective Date: ~~December 10, 2014~~XXXX, 2023

Applicability: All DDSN Employees

~~I. PURPOSE~~

~~The purpose of the Portable Computing Devices security policy is to establish security mechanisms to protect both portable computing devices, such as laptops, and the information they contain.~~

~~II. Access Control for Mobile Devices~~

- ~~DDSN employs whole disk encryption to protect the confidentiality and integrity of information stored on portable computing devices, including laptops.~~

- ~~DDSN prohibits any passwords to be written or notated on any portable computing devices, including laptops.~~

- ~~DDSN configures portable computing devices operating system so that only approved services are enabled and/or installed by a DDSN information technology (IT) administrator.~~

- ~~DDSN utilizes a configuration management process that includes flaw remediation, installs the most current stable security patches, critical security updates and hot fixes for the relevant operating system.~~

- ~~DDSN utilizes antivirus management tools to automatically update virus definition files on laptops and other portable computing devices susceptible to viruses.~~

- ~~DDSN installs firewall software on laptops and implements mechanisms that prevent users from making firewall configuration changes.~~

- ~~DDSN does not allow unauthorized software to be installed on laptops and/or other portable computing devices. Approval shall be obtained for the installation of any software that may be required for business use. A DDSN IT administrator will install any approved software.~~

- ~~DDSN places asset tags on portable computing devices.~~

- ~~DDSN does not allow Bluetooth, Infrared, or other wireless technologies to transfer unencrypted data.~~

- ~~DDSN shall disable Peer-to-Peer wireless connections, otherwise known as "Ad-Hoc Connections," on all portable computing devices, including laptops.~~

- ~~Employees must notify the DDSN IT Division immediately in the event of a theft or loss using the Helpdesk phone number at 1-803-898-9767 or by email at Helpdesk@ddsn.sc.gov.~~

- ~~DDSN IT Division shall securely remove Agency data from portable computing devices rendered inoperable or retired.~~

~~III. LAPTOP COMPUTER CUSTODY RECEIPT~~

~~The Laptop Computer Custody Receipt must be signed by any employee who is issued or returns a permanently assigned laptop. The IT Division maintains a log of short term loaner laptops.~~

~~IV. IMPLEMENTATION, MAINTENANCE, AND COMPLIANCE~~

- ~~DDSN's designated Information Security Officer is responsible for insuring that this policy is implemented and communicated throughout DDSN.~~

- ~~Any revisions to this policy shall be developed by the designated Information Security Officer and follow the normal approval process according to DDSN Directive 100-02-DD: Implementation Procedures for the Internal Communications System.~~

- ~~Violation of the provisions of this directive will be subject to disciplinary action in accordance with DDSN's progressive discipline policy.~~

~~Tom Waring~~	~~Beverly A.H. Buscemi, Ph.D.~~
~~Associate State Director-Administration~~	~~State Director~~
~~(Originator)~~	~~(Approved)~~

~~*Reference: NIST SP 800-53 Revision 4: AC 19 Access Control for Mobile Devices*~~

To access any Guidance references, please see the attached link at: http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53Ar4.pdf

OVERVIEW

Mobile computing devices (smartphones, tablets, laptops, etc.) are becoming an implementation standard in today's computing environment. Their size, portability, and ever- increasing functionality are making the devices desirable in replacing traditional desktop devices. However, the portability offered by these devices can also increase security exposure to individuals using the devices.

PURPOSE

The purpose of this directive is to establish the procedures and protocols for the use of Department of Disabilities and Special Needs (DDSN) mobile devices and their connection to the network.

SCOPE

This directive applies to all DDSN staff who use agency issued mobile computing devices.

GENERAL

All DDSN mobile devices that have access to agency systems and applications are governed by this policy. Applications, including cloud storage software used by staff on their own personal devices are also subject to this policy. The following general procedures and protocols apply to the use of mobile devices:

- Mobile computing devices must be protected with a password or Personal Identification Number (PIN) required at the time the device is powered on.
- Passwords/PINs must meet the requirements outlined in the DDSN Access Control and Password Policy.
- Mobile Device Management (MDM) will be used to enforce security standards and configurations on devices.
- All mobile device physical storage partitions shall be encrypted.
- Wireless encrypted security and access protocols shall be used with all wireless network connections.
- Staff shall refrain from using public or unsecured network connections while using their mobile device.

- Unattended mobile computing devices shall be physically secured.

- Mobile computing devices that access the DDSN network shall have active and up-to-date virus, anti-malware and firewall protection.

- Lost or stolen devices shall have locations services enabled and the units wiped of all information so they are unusable until recovered or destroyed.

MOBILE DEVICE USE

- Mobile communication devices are to be used for official use just as other office equipment, subject only to limited incidental personal use that does not increase the state's cost or violate any laws or ethical standards.

- Employees must reimburse DDSN for any incidental personal use that results in an additional expense to the Department.

- Managers for each Division where these devices are assigned are responsible for collecting any required reimbursement.

- Employees have no expectation of privacy as to the use of a Department issued mobile communication device. Management will have access to detailed records of mobile communication device usage from the service provider, which will be subject to audit.

- Employees who, as part of their official job duties, must use DDSN mobile communication devices while operating a motor vehicle, must follow all South Carolina wireless telecommunication laws (S.248).

USER DEVICE RESPONSIBILITIES

The following procedures and requirements shall be followed by all users of mobile devices:

- Staff must immediately report any lost or stolen devices to the Chief Information Officer or the Chief Information Security Officer.

- Unauthorized access to a mobile device or company data must be immediately reported to the Chief Information Officer or the Chief Information Security Officer.

- Mobile devices shall not be "rooted" or have unauthorized software/firmware installed.

- Staff shall not load illegal content or pirated software onto any DDSN mobile device.

- Only DDSN approved applications are allowed on mobile devices.

- Mobile devices and applications shall be kept up-to-date.

- Operating system and application patches should be installed upon release.

- Personal firewalls will be installed and active where available.

ADMINISTRATIVE RESPONSIBILITIES

- Specific configuration settings shall be defined for personal firewall and malware protection software to ensure that that this software is not alterable by users of mobile devices.

- Mobile Device Management (MDM) software is used to manage risk, limit security issue, and reduce costs and business risks related to mobile devices. The software shall include the ability to inventory, monitor (e.g. application installations), issue alerts (e.g. disabled passwords, categorize system software (operating systems, rooted devices), and issue various reports (e.g. installed applications, carriers).

- MDM software enforces security features such as encryption, password or PIN requirements, remote wiping, inactivity timeouts and key lock on mobile devices.

- MDM software shall include the ability to distribute applications, data, and global configuration settings against groups and categories of devices.

- Regular reviews and updates of security standards and strategies used with mobile computing devices.

- Procedures and policies exist to manage requests for exemptions and deviations from this policy.

ENFORCEMENT

Failure to comply with the mobile device directive may, at full discretion of DDSN, result in the suspension of technology use and connectivity privileges, disciplinary action, and possibly termination of employment.

Barry D. Malphrus Vice Chairman	Stephanie M. Rawlinson Chairman

Michelle G. Fry, J.D., Ph.D.
State Director
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David L. Thomas
Michelle Woodhead

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~~XXXX, 2023 **(REVISED)**
Effective Date:	~~June 16, 2022~~XXXX, 2023
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~~2022), 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~~2022) 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.

E. Supervised Living Program-I (SLP-I): Supports are provided by qualified and trained staff to adults who need intermittent supervision and supports. Participants need support in their own apartment or home setting. Support is provided through a 15 minute-unit and support is available 24 hours per day by phone. An annual assessment is completed for each participation to verify support needs in their own setting.

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 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 (Attachment A) 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 Residential Services Request/Notification 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 700-09-DD: Determining Need for Residential Services.

For CTH-I Settings, a supplemental application is required (Attachment D). For SLP-I participants, an approved Assessment is required prior to service delivery, and annually thereafter (Attachment E).

**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.

SITE CLOSURE:

Whenever a DDSN licensed or certified setting must close, whether temporarily or permanently, a Site Closure Notification Form (Attachment F) must be submitted to DDSN. The reason for the closure must be stated, including the effective date and the expected duration of the closure. If renovations are completed within the setting, a new licensing inspection will be required prior to occupancy.

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)
Attachment D:	Supplemental Application for CTH-I Settings
Attachment E:	Supported Living Assessment
Attachment F:	Site Closure Form

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 DEPARTMENTOF DISABILITIES AND SPECIAL NEEDS
APPLICATION TO OPERATE/CHANGE
RESIDENTIAL, DAY OR RESPITE FACILITY

Date of Application: ______________________

REASON FOR APPLICATION

☐ Initial Application for Contracted Operation with other Agency License (DHEC or DSS) ☐ Renewal

☐ DDSN Contracted Operation of DHEC Licensed Facility (Residential Habilitation)
☐ DDSN Contracted Operation of DHEC Licensed Facility (ICF/IID Services)

☐ Initial Application for DDSN License ☐ Renewal

Facility Type: ☐ SLP-I ☐ SLP-II ☐ CIRS ☐ CTH-I ☐ CTH-II ☐ Respite ☐ Adult Activity Center
☐ Work Activity Center ☐ Unclassified Program

Termination/Closure: ☐ Permanent ☐ Temporary
Reason for Termination/closure: ______________________

Change: ☐ In Location ☐ In Facility Type ☐ In Number of people Served
Notes: ______________________

LICENSEE INFORMATION
(The Licensee is the name of the legal entity licensed to operate the business at the facility named below. This entity must be qualified as a provider with DDSN).

Licensee Name: ______________________ County: __________

Physical Address *(include zip code)*: ______________________

The License is: ☐ For Profit ☐ Not Profit

Executive Director *(Name)*: ______________________

Mailing Address *(include zip code)*: ______________________

Phone Number *(include area code)*: __________ Email Address: __________

Name of Alternate Staff for Licensing Contact: ______________________

Phone Number *(include area code)*: __________ Email Address: __________

FACILITY INFORMATION

Facility Name: ______________________

Physical Address *(include zip code)*: ______________________

Phone Number *(include area code)*: __________ Contact Person: __________

Will this location be licensed by any other agency? ☐ Yes ☐ No If yes, state agency: __________

Occupancy Requested:
(The maximum capacity for CTH-II Settings is four (4). SLP-I, SLP-II, and CTH-I settings may not exceed two (2) occupants per setting, unless prior approval has been granted.)

☐ Children (under 21): ______ ☐ Adult(s): ______ ☐ Respite: ______ ☐ Male ☐ Female ☐ Co-Ed

Is the building where services are offered leased/rented? ☐ Yes ☐ No

If yes, please complete the following on the building property owner and provide a copy of the lease agreement.

Name: ______________________

Address *(include zip code)*: ______________________

Phone Number *(include area code)*: __________ Fax Number *(include area code)*: __________

INDIVIDUALIZED SETTINGS – REQUIRED ATTACHMENTS

For SLP-I settings, please attach the Supported Living Assessment. This assessment is individual and location specific and non-transferrable. An explanation must be provided for any indicators scored "no." For CTH-I's, please submit the CTH-I Application Attachment.

HOME AND COMMUNITY-BASED SETTINGS RULE REQUIREMENTS

The Home and Community-Based Services (HCBS) Settings Regulation, issued by the Centers for Medicare and Medicaid Services (CMS) requires that all home and community-based settings meet certain requirements. The DDSN Licensing Standards reflect the agency's values and incorporate the HCBS Settings Rule requirements which are listed below:

- The setting is integrated in and supports full access to the greater community.
- The setting is selected by the individual from among setting options.
- The setting is physically accessible.
- Individual rights of privacy, dignity and respect, and freedom from coercion and restraint are ensured.
- Autonomy and independence in making life choices are optimized.
- Choice regarding services and who provides them is facilitated.
- The individual has a lease or other legally enforceable agreement providing similar protections.
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit.
- The individual controls his/her own schedule including access to food at any time.
- The individual can have visitors at any time.

For settings initially licensed on or after July 1, 2020, the setting must be free from qualities that may be presumed institutional. Settings that may have qualities presumed to be institutional include:

- Settings in a publicly or privately-owned facility that provides inpatient treatment; and
- Settings on the grounds of or adjacent to a public institution.

Refer to: 42 CFR§441.301(c)(5) (i-iv)

For settings initially licensed on or after July 1, 2020, the setting must be free from characteristics that have the effect of discouraging integration of residents from the broader community. Settings that may have characteristics that have the effect of discouraging integration of residents from the broader community include, but may not be limited to:

- Settings completely enclosed by walls or fences with locked gates;
- Settings in a multi-unit housing complex whose owners or lessees are limited to only those with ID/RD, HASCI or Autism Spectrum Disorder; and
- An additional setting added to an existing cluster (i.e., 2 or more) of DDSN-licensed residential or day settings.

Refer to: 42 CFR§441.301(c)(5)(v)

OTHER INSPECTIONS REQUIRED FOR SUBMISSION

When requesting a new license, please submit Electrical, HVAC and State Fire Marshal Inspection reports with the Application to Operate. All documents should be submitted together as a single packet. Submit the packet to Licensing/Quality Management at License@ddsn.sc.gov. Please allow a minimum of two (2) weeks from the receipt of the completed packet to schedule the licensing inspection.

ATTESTATION

The Licensee listed above attests to their ability to demonstrate compliance with DDSN Directives, Administrative and Service Standards, and Medicaid Policies. This includes, but is not limited to: compliance with Staff Qualifications and Training Requirements, Medication Administration Requirements, Infection Control Procedures, Incident Management Reporting (including allegations of Abuse/Neglect/Exploitation, Critical Incidents, and Death Reporting), Human Rights Committees, Risk Management, Quality Management, and timely handling of participant grievances.

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: Certification and Licensure of DDSN Residential and Day Facilities, and/or the DDSN/Provider Contract. The provider is responsible for maintaining evidence of service delivery to support claims.

____ Date: ____________________

Signature of Executive Director/CEO of Provider Organization

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CERTIFICATION AND LICENSING STANDARDS
<u>REQUEST FOR EXCEPTION</u>

~~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:~~	

Provider Requesting Exception: _______________________________ Date: __________

Facility/Program: _______________________________

Signature of Provider Executive

Participant or Staff for whom Exception is Requested: _______________________________

Policy/Standard from which Exception is requested (e.g., 000-00- DD, DDSN Residential Habilitation Standards, etc.)	Nature and Reason for Exception Request	Explain how the health, safety, and welfare of participants will be maintained and the Quality and Quantity of Services will continue:

DDSN Comments:

Time Limited Approval: ☐Yes ☐No Effective Dates: _______________________________

Unless otherwise stated, the exception is in effect for as long as the conditions noted in the justification remain current

_______________________________ ☐Approved ☐Denied Date: __________

Signature – Director-Quality Management

_______________________________ ☐Approved ☐Denied Date: __________

Signature – State Director/Designee

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
SUPPLEMENTAL APPLICATION TO OPERATE FOR COMMUNITY TRAINING HOME I (CTH-I) LICENSES

In the Community Training Home-I (CTH-I) Model, personalized care, supervision and individualized training are provided in accordance with a service plan and the participant lives in a support provider's home where they essentially become one of the family. CTH-I Support Providers are qualified and trained private citizens. They may be employed or contracted by a Residential Habilitation provider agency. Residential Habilitation services are coordinated through the direction and management of a Qualified Provider or Disabilities and Special Needs Board (herein known as the "licensee").

A CTH-I Support Provider and all family members residing at their home address must meet background check requirements, as defined in DDSN Directive 406-04-DD: Criminal Record Checks and Reference Checks of Direct Caregivers. If additional adult family members return to the family home after the initial license is issued, the Provider/licensee must update their records and ensure appropriate background checks are completed. In addition, the Provider/Licensee sponsoring the CTH-I must attest to their ability to demonstrate compliance with DDSN Directives, Administrative and Service Standards, and Medicaid Policies. This includes, but is not limited to: compliance with Staff Qualifications and Training Requirements, Medication Administration Requirements, Infection Control Procedures, Incident Management Reporting (including allegations of Abuse/Neglect/Exploitation, Critical Incidents, and Death Reporting), Human Rights Committees, Risk Management, Quality Management, and timely handling of participant grievances.

CTH-I homes are private family homes and meet Office of State Fire Marshal Foster Home Regulations. Many CTH-I Support Providers previously served as Foster Parents and continue to support the participants in their home. It is important to distinguish the difference between Foster Care and the surrogate role with the paid service provider of an adult receiving Residential Habilitation, as a Medicaid service. Training must be provided to ensure the CTH-I Supports Provider understands their role in providing Care, Skills Training, and Supervision according to a specifically developed Plan of Support for the individual. The CTH-I Support Provider and Licensee are fully responsible for evidence of service delivery to support claims for Residential Habilitation.

CTH-I SETTING:

CTH-I Setting/Name:____

Physical Address *(include zip code)*:________________________________

Phone Number *(include area code)*:________________ Email Address:____________________

LICENSEE INFORMATION:

Licensee/Qualified Provider Agency:________________________________

Name of Alternate Staff for Licensing Contact:____________________________

Phone Number *(include area code)*:________________ Email Address:____________________

CTH-I SUPPORT PROVIDER/FAMILY SETTING

For CTH-I or Respite locations, please identify all household members (including child(ren):

FULL NAME	AGE	RELATIONSHIP TO CAREGIVER	BACKGROUND CHECKS COMPLETED

RESPITE/EMERGENCY CONSIDERATIONS

The Residential Services Provider must have an Emergency Plan available in the event the authorized CTH-I Support Provider becomes incapacitated or experiences an emergency which renders them unable to provide service delivery. In addition, the Residential Services Provider will need to establish procedures with the CTH-I Support Provider for any Respite needs and how the individual will continue to be supported in his/her home, or comparable setting of their choosing.

TRANSFER TO ANOTHER RESIDENTIAL SERVICES PROVIDER ORGANIZATION

A CTH-I Support Provider may choose to contract with any Qualified Residential Services Provider. Each Residential Services Provider may establish the terms of their contracts with CTH-I Support Providers and any process for sharing licensing, training, or other records in the event the CTH-I Support Provider desires to contract with a different Qualified Provider organization. In addition, in compliance with DDSN Directive 406-04-DD: Criminal Record Checks and Reference Checks of Direct Caregivers, Residential Service Providers must provide a reference check for prospective CTH-I Support Providers when inquiries are made from other organizations. CTH-I Support Providers who are not in good standing are not eligible for transfer to another organization.

TRAINING ASSURANCES FOR CTH-I SUPPORT PROVIDERS

☐Yes ☐No Has the CTH-I Support Provider been trained on the Licensee's policies for reporting allegations of Abuse, Neglect, and Exploitation, as well as other types of Critical Incidents?

☐Yes ☐No Has the CTH-I Support Provider been trained on the Licensee's competency-based Medication Technician Curriculum and documentation requirements regarding Medication Administration?

☐Yes ☐No Has the CTH-I Support Provider been trained on the Licensee's policies for resident's rights, behavior support, and prohibited practices?

☐Yes ☐No Have the CTH-I Support Provider and the Residential Habilitation participant agreed to the terms of a legally enforceable lease or residential agreement?

☐Yes ☐No Has the CTH-I Support Provider been trained on the individual's Support Plan and the expectations for Residential Habilitation, to include Care, Skills Training and Supervision?

☐Yes ☐No Has the CTH-I Support Provider been trained on the Licensee's expectations to maintain documentation to support Medicaid Claims for each date of service?

ATTESTATION

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: Certification and Licensure of DDSN Residential and Day Facilities and/or the DDSN/Provider Contract. The provider is responsible for maintaining evidence of service delivery to support claims.

Print Name:____ Date:__________________________

____
Signature of Executive Director/CEO of Provider Agency

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
SUPPORTED LIVING I (SLP-I) ASSESSMENT

Provider Agency Responsible for Residential Habilitation:____

Date of Assessment:_________________________ Assessment Completed By:________________________________

Participant's Name:____

Address *(include zip code)*:____

Purpose: ☐Annual Review ☐New Site

The SLP-I Assessment is participant and location specific. This assessment is not transferrable. The Assessment must be completed prior to receiving residential habilitation and annually thereafter. Any item unmet at the time of review requires an explanation and a detailed description of the plan to address the issue. If the person moves to another location, a new assessment must be completed. The assessment must be kept on file at the Provider site and a copy sent to DDSN via email at license@ddsn.sc.gov.

#	REQUIREMENT	SCORE	COMMENTS	PLAN TO ADDRESS ISSUE	COMPLETION DATE
1	Hot and cold running water. *(If water temperature exceeds 130 degrees, assessment results must be available to show that the person is capable of regulating the temperature and is not at risk.)*	☐YES ☐NO			
2	Functioning heating system.	☐YES ☐NO			
3	Operable electricity.	☐YES ☐NO			
4	Functioning tub or shower with hot and cold running water.	☐YES ☐NO			
5	Mattress and bedding for each resident *(married couples may elect to share a bed).*	☐YES ☐NO			
6	Functional toilet.	☐YES ☐NO			
7	Lockable doors and windows.	☐YES ☐NO			
8	Sanitary environment.	☐YES ☐NO			
9	Free from obvious hazards.	☐YES ☐NO			
10	Medications stored safely on site unless contraindicated. *(If contraindicated, a plan must be available for how/where medications will be stored.)*	☐YES ☐NO			
11	When more than one resident lives in a site, there is sufficient space and opportunity for privacy *(bathroom and bathing facilities must be behind lockable doors, lockable doors on bedroom/ sleeping areas, each person must have lockable storage).*	☐YES ☐NO			

12	For residents unable to self-medicate, a log is maintained which records: • Name of medication. • Name of staff giving medication. • Time and date medication was given. • Amount of medication given.	☐YES ☐NO			
13	Resident successfully demonstrates the ability to evacuate the site in under three (3) minutes in response to fire alarm *(Prior to receiving residential habilitation and annually thereafter).*	☐YES ☐NO			
14	The site has at least one fire extinguisher that is operable.	☐YES ☐NO			

The Provider Agency listed above attests to their ability to demonstrate compliance with DDSN Directives, Administrative and Service Standards, and Medicaid Policies. This includes, but is not limited to: compliance with Residential Habilitation Standards, Administrative Agency Standards, Staff Qualifications and Training Requirements, Medication Administration Requirements, Infection Control Procedures, Incident Management Reporting (including allegations of Abuse/Neglect/Exploitation, Critical Incidents, and Death Reporting), Human Rights Committees, Risk Management, Quality Management, and timely handling of participant grievances.

The results of this assessment are correct as of the date of assessment and I understand the assessment must be completed annually or whenever the participant moves to a new location. 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: Certification and Licensure of DDSN Residential and Day Facilities, and/or the DDSN/Provider Contract. The provider is responsible for maintaining evidence of service delivery to support claims.

Print Name:____ Date:________________________

____
Signature of Executive Director/CEO of Provider Agency

****A copy of the Assessment must be maintained in the Participant's Case Management and Residential Habilitation Provider files. All Supported Living participants must be included in the DDSN database for Residential Habilitation.****

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
SITE CLOSURE NOTIFICATION

Date of Notification:____________________________________

This form is used to report the emergency closure of a licensed or provider operated service location for one (1) or more days. This is reported as a site report and does not apply to person's who reside in homes owned, rented or leased solely by the person and/or family member.

In the event of temporary closure due to an emergency, the facility shall notify DDSN in writing within 24 hours of the closure. At a minimum this notification shall include, but not be limited to, the reason for the temporary closure, the manner in which the records are being stored, the identification of those participants displaced, the relocated site, and the anticipated date of reopening. DDSN shall consider, upon appropriate review, the necessity of inspecting and determining the applicability of current construction standards to the facility prior to its reopening.

The facility shall notify DDSN no later than the following workday when evacuees have been relocated to the facility by providing the names of the individuals received.

LICENSEE INFORMATION:

Licensee's Name:____

Address *(include zip code)*:____ County:____________________

Executive Director:____

Phone Number *(include area code)*:____________________ Email Address:______________________________

Name of Alternate Staff for Licensing Contact:____

Phone Number *(include area code)*:____________________ Email Address:______________________________

FACILITY INFORMATION:

Closure is: ☐Permanent ☐Temporary (expected re-opening date:___________________________)

REASON FOR SITE CLOSURE:

☐**Communicable Diseases** - Epidemic outbreaks or other unusual occurrences that threaten the health and safety of clients or staff and require facility closure.

☐**Infestation** - The closure of a site due to the need to treat for animal, insect, or other pests.

☐**Loss of Utilities** - The closure of a site due to loss of utility that was not related to a failure on the part of the operating entity. This includes electrical outages, issues with water and/or sewer systems and heating and/or cooling system failures.

☐**Natural Disaster/Weather Related** - The closure of a site due to a natural disaster or weather conditions. The facility shall immediately notify DDSN regarding any fire, regardless of size or damage that occurs in the facility, or any natural disaster in the facility which requires displacement of participants or jeopardizes or potentially jeopardizes the safety of the participants.

☐**Structural** - The closure of a site due to structural issues.

☐**Zero Census -** No participants are receiving services at the designated facility and there are no immediate plans to provide services at that address.

ADDITIONAL NOTES:

Facility Name:____

Facility Type: ☐SLP-I ☐SLP-II ☐CIRS ☐CTH-I ☐CTH-II ☐Respite ☐Adult Activity Center ☐Work Activity Center ☐Unclassified Program

Physical Address *(include zip code)*:____

Phone Number *(include area code)*:____________________ Contact Person:____________________________

PERMANENT FACILITY CLOSURE:

Prior to the permanent closure of a facility, the licensee shall notify DDSN in writing of the intent to close and the effective closure date. Within ten (10) days of the closure, the facility shall notify DDSN of the provisions for the maintenance of the facility records, the identity of those participants displaced, and the relocated site. On the date of closure, the current license shall be terminated.

ATTESTATION:

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: Certification and Licensure of DDSN Residential and Day Facilities, and/or the DDSN/Provider Contract. The provider is responsible for maintaining evidence of service delivery to support claims.

Print Name:____ Date:__________________________

____
Signature of Executive Director/CEO of Provider Organization

****The Site Closure Notification Form must be submitted to License@ddsn.sc.gov.****

Reference Number:	100-28-DD	
Title of Document:	Quality Management	
Date of Issue:	July 1, 2001	
Last Review Date:	May 21, 2015	
Date of Last Revision:	May 21, 2015XXXX, 2023	(**REVISED**)
Effective Date:	July 1, 2001XXXX, 2023	
Applicability:	All DDSN Community-Based Programs and Contracted Services	

PURPOSE

The purpose of this departmental directive is to establish the conceptual framework for the South Carolina Department of Disabilities and Special Needs (DDSN) Quality Management (QM) Systems oversight of services delivered to those eligible for DDSN's services.

DEFINITIONS

Continuous Quality Improvement (CQI) -a quality management strategy that is based on the idea that most processes can be improved and made more efficient. Instead of focusing on an issue only when a problem is inevitable, and a dramatic intervention is necessary, CQI advocates for incremental, but regular changes that become a part of an organization's day-to-day activities.

Quality Assurance (QA) - measures quality as a function of compliance with standards/rules/expectations. QA activities most often involve gathering data via a look-behind (monitoring) of objective standards/rules/expectations.

Quality Improvement (QI) - often measures quality in subjective terms as a function of an opinion/perception/experience of something in the service system. QI typically involves a proactive approach, includes continuous learning, and includes qualitative measures that align with subjective expectations.

Risk Management (RM) - The efforts to eliminate, reduce, and/or control exposure to risk, loss and injury. A broad-based agency Risk Management program should fulfill the following purposes: a) Improve the safety and quality of life for those supported and employees; b) Conserve financial resources; and c) Maintain relationships of trust among stakeholders.

CONTEXTBACKGROUND

The organizational context within which DDSN provides services and supports has been well established through the creation and publication of its Vision, Mission, and Values Statements.

VISION: To provide the very best services to assist individuals with disabilities and their families.

MISSION: Our mission is to assist individuals with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals; and minimize the occurrence and reduce the severity of disabilities through prevention.

VALUES: Health, safety and well-being of each individual; dignity and respect for each individual; individual and family participation, choice, control and responsibility; relationships with family, friends and community connections; personal growth and accomplishments.

SUMMARY

DDSN shifted from a quality assurance process oriented toward inspection and licensing to a quality enhancement process based in person-centered outcomes and customer satisfaction in 1998. DDSN has a nine-tiered, multifaceted, coordinated risk management/quality assurance/quality improvement program that is based on national best practices.

A. Risk Management: Risk management activities and programs strive to prevent negative occurrences in the lives of consumers. DDSN conducts many risk management activities using several different sources and measures. We call this purposeful redundancy so we can assess from multiple angles the status of the health and welfare of the individuals we support. The three primary risk management activities are:

1) Traditional Activities: DDSN and its provider network are involved in all of the traditional areas of risk management that are common to any operating business that owns buildings, vehicles, equipment and that hires employees and deals with the public. These activities include ensuring the safety of buildings, complying with OSHA standards, and taking appropriate measures to protect against loss through pre-employment screening, pre-service training, insurance coverage, financial auditing and legal consultation.

2) Consumer Oriented Activities: Since DDSN and its providers are not manufacturers of products, but rather are a service and support network that is

~~intimately involved in the lives of thousands of consumers, much of the risk that occurs is a result of the responsibility that the provider has to care for people with individualized special needs 24-hours a day, 7 days a week, 365 days a year. Activities under this heading include the tracking and review of, and response to allegations of abuse, neglect and exploitation, critical incidents, complaints/appeals, and mortality.~~

~~3) Consumer Determined Activities: This is an area of Risk Management that has developed as a result of the paradigm shift in the treatment and services that has empowered consumers to be more in control of their lives/choices and the decisions that are made regarding the services and supports they receive. These consumer determined risk factors may relate to issues of diet, exercise, use of potentially harmful substances, sexual practices, hygiene, conformance with medical advice, acceptance of behavioral health services and acceptance of staffing levels of supervision, to name a few. At the core of all of these issues is the balance between the individual's right to determine the direction and quality of his/her life and DDSN's duty to protect the individual from foreseeable harmful occurrences. Some of the tools DDSN and its network of providers use in this area are consumer and family councils, circles of support, pre-approval of plans of service, ongoing Case Management monitoring of service delivery, the annual planning process, and human rights committees.~~

~~B. Quality Assurance: Quality Improvement Activities - Once appropriate risk management activities are in place, then a strong quality assurance and quality improvement program must rest on a foundation of health, safety, and financial integrity. Quality Assurance/Quality Improvement activities strive to increase positive occurrences in the lives of individuals served.~~

~~1) Licensing Activities: DDSN uses licensing activities to assist in providing a foundation of health and safety upon which other quality of life initiatives may be built. South Carolina state law requires licensing of day programs and residential facilities. The law permits the establishment of standards for the qualifications of staff, staff ratios, fire safety, medication management, consumer health and safety and the like. DDSN contracts with a licensing entity to coordinate licensing inspection activities. Additional inspections may also be coordinated with the Department of Social Services (DSS) and the State Fire Marshall's Office. Follow-up licensing reviews are completed to assure that corrective action for deficiencies has been taken.~~

~~2) Contract Compliance Activities: The second component of this elaborate Quality Assurance/Quality Improvement system is the work done by a private company, a Quality Improvement Organization designated by the Federal Centers for Medicare and Medicaid Services (CMS). DDSN, under contract with the Quality Improvement Organization, conducts a Quality Assurance review on every provider in the system to measure and evaluate the health and welfare of people receiving services. The reviews may take place every 12 to 18 months, depending~~

on provider performance. As part of their activities, the Quality Improvement Organization, with the assistance of the Human Services Research Institute, uses three (3) nationally recognized surveys which are administered to 10% of DDSN consumers and their families on an annual to bi-annual basis, and if funding is available. The surveys have been tested by the Human Services Research Institute for reliability and validity on persons with an intellectual disability or related disability and their families and 43 states across the country use or have used these survey instruments.

3) Personal Outcomes Measures: Another way DDSN assesses consumers' health, welfare, and satisfaction is through a contract DDSN has with The Council on Quality and Leadership, a nationally recognized accrediting organization. Historically, measures of quality were often far removed from the actual impact services had in the lives of the consumers. As the nation's long term care system's quality measures have evolved, the indicators over the past 20 years have continued to focus more on the service users and their personal goals. The Council on Quality and Leadership uses Personal Outcome Measures to help DDSN determine how well services and supports are helping an individual achieve personal goals.

4) Consumer/Family Satisfaction Measures: These measures typically have a larger affective component than personal outcomes. It is very possible for a consumer to have met all of his/her personal goals, but still feel dissatisfied with life or the services and supports he/she is receiving. Thus, measures of consumer satisfaction must go hand in hand with person-centered goals in order for an agency to be truly person-centered. Consumer and family satisfaction surveys are conducted annually to bi-annually using a planned redundancy model. Each service provider is required to develop and administer their own satisfaction survey. Results are tabulated and identified areas of weakness are addressed for correction. In addition, as mentioned earlier, DDSN through its contract with a Quality Improvement Organization administers three (3) national standardized satisfaction surveys to 10% of its service population on an annual to biannual basis.

5) Quality Enhancement Activities: With the many different approaches DDSN uses to measure and improve quality, it became important to develop a process that would allow the synthesis of all data in order to understand overall performance of the DDSN system. In collaboration with the Council on Quality and Leadership, DDSN designed a quality enhancement process that allows for just such an assessment. The process is built on a technical assistance and learning approach to quality enhancement. The effort is grounded in the Council's Basic Assurances® and Shared Values®; therefore, much of the work focuses on the organization's leadership, systems and quality management and planning. Team members talk with a variety of employees throughout the organization, meet with individuals receiving services and their families, read policies and literature, observe team meetings, identify current data collection strategies and processes,

~~learn how data is used, observe services in motion, and attend meetings/staffings/psychotropic drug reviews and self-advocacy efforts. Ultimately the team synthesizes all the information and jointly, with the provider, identifies the strengths of their system and develop, or build upon, existing quality management plans.~~

~~6) Other Quality Management Activities: Another important aspect of DDSN's Quality Assurance System that both assures and improves the quality of the services being provided is the official body of policies, directives, and procedures. These documents represent a significant source of guidance to the system as a whole and outline the expectations for service delivery. A system is in place to regularly review and revise these policies (see DDSN Directive 100-02-DD: Implementation Procedures for the Internal Communications System). Further, independent CPA's are utilized to conduct audits of providers' financial activities and DDSN Internal Audit assesses other financial performance issues.~~

~~PRINCIPLES~~

~~The following seven (7) principles provide the framework within which the quality management systems and initiatives are designed and implemented.~~

~~I. CONTINUOUS QUALITY IMPROVEMENT~~

~~The achievement of quality requires efforts at continuous improvement and on-going, repeated attention.~~
~~The principles of Continuous Quality Improvement will be applied by DDSN in assessing whether its policies encourage the meeting of consumers' expectations and which service and support providers are striving for the same goal. Service providers are required to design and modify supports and services to meet the expectations of the individuals who benefit from those services.~~

~~II. TOTAL QUALITY MANAGEMENT~~

~~Quality does not just happen; it requires the management and orchestration of the total system. It crosses all facets of an organization. Quality is everybody's business; it cannot be isolated or delegated in a way that absolves anyone from some responsibility.~~

~~In order to benefit from the best thinking in quality, a quality management plan should be broad-based in nature and draw from the many models and approaches that have merit.~~

~~Quality requires a willingness on the part of all stakeholders to work collaboratively to identify and then solve problems.~~

~~Quality requires strategic planning initiatives that maintain consistent parameters over a period of time. It is an iterative process where repeated efforts contribute to progressive cycles of quality enhancement.~~

~~Quality requires attending to all aspects of an organization and service delivery system.~~

III. CUSTOMER-DRIVEN

DDSN utilizes a customer- driven approach, and the primary customer is the individual with the disability. Needs, both met and unmet, are identified. System changes are planned to increase consumer and family satisfaction and increase service provider productivity and efficiency. Increases in efficiencies are re-deployed to address unmet service and support needs. This approach maintains DDSN's accountability to the citizens of South Carolina.

Customer satisfaction is a priority in DDSN's approach to planning quality service delivery. Customer satisfaction measures/guides DDSN in determining whether service providers are meeting their responsibilities, and also whether DDSN policies are facilitating this goal. A primary measure of quality is how the individual with the disability and the family view the responsiveness of the services being provided.

Customer satisfaction assessments are performed by all service providers and DDSN throughout the state on a regular basis. DDSN and service providers are required to use this data to design and modify policies, supports and services to meet the expectations of the individuals who benefit from those services.

IV. COMPREHENSIVE

A comprehensive quality management plan should draw ideas, standards, and measures from a number of important and/or controlling sources that may include: local ordinances, state statutes and regulations, federal statutes and regulations, applicable case law and court orders, funding source standards/requirements, professional practice board standards, specific consumer goals, consumer/family satisfaction surveys, other stakeholder satisfaction surveys, national accreditation boards (i.e., The Council on Quality on Leadership, CARF, Malcolm Baldridge Award criteria), "best practices" that are emerging from educational and research organizations, and using previously met departmental quality goals as benchmarks against which to measure progress.

Quality requires a carefully thought out system of planning, delegating, implementing, data gathering, analyzing, synthesizing, reporting, and problem solving, that is comprehensive, reliable, valid, timely, documented and on-going.

Quality programs take into consideration some process indicators (i.e., how things are done), but more importantly, outcome indicators (i.e., what has really been accomplished).

V. DASHBOARD INDICATORS

Dashboard indicators are data sets, either quantitative or more qualitative/narrative in nature that can quickly indicate the overall health, safety, stability and quality performance of a service and support provider. DDSN strongly encourages the below listed dashboard indicators be collected and used by DDSN Regional Centers, DSN Boards, and Contracted Service Providers to monitor the basic health, safety, stability and quality of the services and supports they provide. The dashboard indicators should become an integral component of the provider's overall Quality Assurance/Risk Management process. It is recommended that each data set, applicable to the organization, be monitored by the provider's quality assurance/risk management staff and/or appropriate standing committees on a regularly scheduled basis.

Data collected should be historically compiled and analyzed for trends. A plan of action should be developed and implemented when adverse trends are identified.

Providers may decide to add additional indicators as local conditions seem to warrant. Also, not all dashboard indicators will apply to all service and support providers. Operational definitions of these dashboard indicators are also included for consideration.

a) Allegations of Abuse, Neglect or Exploitation:

Abuse, Neglect or Exploitation will be tracked by using:

i) The total number of allegations made, and
ii) The number of those substantiated, using the definitions and procedures contained in DDSN Directive 534-02-DD: Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contracted Provider Agency.

These figures may be used in conjunction with the total number of consumers receiving services to develop a rate per 100 on an annual basis. Narrative information may also be analyzed in order to identify more specific trends.

b) Critical Incidents:

Critical incidents will be tracked using the definitions and procedures contained in DDSN Directive 100-09-DD: Critical Incident Reporting. These figures may be used in conjunction with the total number of consumers receiving services to develop a rate per 100 on an annual basis. Narrative information may also be analyzed in order to identify more specific trends.

c) Medication Errors/ Events:

Medication errors/events will be tracked using the definitions and procedures contained in DDSN Directive 100-29-DD: Medication Error/Event Reporting. Three (3) categories of errors/events will be analyzed:

i) Medication errors,
ii) Transcription/documentation errors, and
iii) Red flag events.

In addition, providers are required to maintain a medication error rate per service location to identify trends related to specific settings.

d) Use of Restraints:

Use of restraints (physical and mechanical) may be calculated by the total duration of uses in hours divided by number of consumers served annually. Consumer/staff injury resulting from the use of restraints should be collected and analyzed. Narrative information may also be analyzed in order to identify more specific trends with a continual emphasis on restraint reduction and elimination.

~~e) Use of Psychotropic Medications by individuals receiving residential supports:~~

~~Use of psychotropic medications (other than for seizure control) may be calculated as a percentage of consumers served. Some providers may choose to track the percentage of polypharmacy in this area as well.~~

~~f) Mortality:~~

~~Deaths will be tracked using the definitions and procedures contained in DDSN Directive 505-02-DD: Death or Impending Death of Persons Receiving Services from DDSN.~~

~~g) Employee Injuries:~~

~~Employee injuries will be tracked using the number of employee injuries that have occurred and been reported to their Worker's Compensation insurance carrier. Providers may also want to establish a rate per 100 employees on an annual basis.~~

~~h) Vehicular Accidents:~~

~~Vehicular accidents will be tracked using the number of traffic accidents that have occurred involving provider vehicles. These should be broken out by "employee's fault" versus "fault of other."~~

~~i) Licensing Activity:~~

~~Each provider will track the major themes of weakness or deficiency that appear in annual and follow-up licensing reports, particularly those themes that were also reported in previous reviews. Plan of Correction dates should be tracked and monitored as well as evaluation of implemented corrections.~~

~~j) Contractual Compliance Review:~~

~~Percent of compliance with key indicators in the three (3) major domain areas (i.e., Administrative, General Provider, and Early Intervention); plus major themes of weakness or deficiency that appear in the regular reviews and follow-up reports. Plan of Correction dates should be tracked and monitored as well as evaluation of implemented corrections.~~

~~k) Contracted Licensing Entity Activity:~~

~~The citation numbers of standards and/or conditions found to be out of compliance; plus major themes of weakness or deficiency that appear in annual and follow-up ICF/IID or CRCF surveys.~~

~~l) Independent Financial Audit & Internal Audit Activity:~~

~~Major themes of weakness or deficiency that appear in the provider's annual audit by an independent CPA firm, plus any DDSN Division of Internal Audit reports.~~

m) Quality Enhancement Review Activity:

Progress towards the provider's Quality Enhancement Plan should be monitored and revised, as needed.

n) Consumer/Family Satisfaction Surveys:

Major areas of need identified as a result of the annual consumer/family satisfaction surveys and action planned and taken.

o) Monthly Provider Financial Statements:

This data set may include the expenditure-to-budget variance reports, an analysis of Cash Flows, Cash Reserve Position, percentage of administrative expenditure to total expenditures, and other financial reports as deemed helpful.

p) Staffing Reports:

This data set may include an analysis of the annual direct care staff turnover rates, report of position vacancies and length of time vacant, total staff-to-consumer ratio, as measured by total employed staff divided by the number of consumers served, and other staffing reports as deemed helpful.

VI. RESULTS- ORIENTED

Quality requires a provider to move beyond mere program evaluation and into the arena of true personal outcome measures.

Important quality outcome measures should include:

1) Serving individuals in a healthy and safe environment;
2) Consumer/family satisfaction;
3) Effectiveness (did we meet the desired goals);
4) Efficiency (did we make good use of our resources);
5) Other stakeholders' satisfaction; and
6) Is the provider/program "state of the art" and consistent with "best practice" nation-wide and world-wide.

VII. EDUCATION-BASED

Quality requires hiring good staff, a strong, well-coordinated pre-service orientation program, and then sustaining staff's enthusiasm through ongoing in-service training and professional development programs.

Quality requires on-going educational efforts for all stakeholders (i.e., consumers, families, employees, advocacy groups, payees, regulators, legislators, the media, and the public at large).

Quality requires constant vigilance in monitoring the emergence of "best practice" trends nation-wide and world-wide. This requires being in communication with service providers and policy makers through personal communication, newsletters, periodicals, and national meetings on an on-going basis.

DDSN, as the oversight entity for both Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services and Home and Community-Based Services (HCBS) services, must provide assurances to the South Carolina Department of Health and Human Services (SCDHHS) that Medicaid-funded services are delivered as authorized. Additionally, DDSN must ensure both State-Funded services Medicaid services are also delivered as authorized. There is an expectation that each service provider engages in internal monitoring of the services they deliver. The basic requirements for internal monitoring, including Risk Management and Quality Assurance activities, are outlined in the DDSN Administrative Agency Standards. In addition, DDSN monitors the provider agencies to ensure continued compliance with basic requirements and efforts towards quality improvement.

DDSN believes quality services must be:

- Person-centered and Community Inclusive;
- Responsive, efficient and accountable;
- Practical, positive and appropriate;
- Strengths-based, results-oriented;
- Inclusive of opportunities to be productive and maximize potential, and
- Based on best and promising practices.

DDSN's QM Strategy is a comprehensive approach that includes utilizing quality assurance (QA) and quality improvement (QI) activities to drive continuous quality improvement (CQI). This QM strategy is developed and implemented to:

- Offer the highest quality services that promote choice and control in people's lives;
- Promote and protect the health, safety and rights of people receiving services;
- Implement promising practices; and
- Ensure compliance with standards, policies and/or other requirements.

A successful QM strategy combines the use of QA and QI activities in such a way that processes are built into every day work and quality outcomes are possible as a result. It is important to remember that QA, or compliance with minimum standards, is only the quality floor, not the ceiling. To go beyond, for systemic improvement, QI is also needed.
DDSN must also imbed requirements set forth by the Centers for Medicare and Medicaid Services (CMS) into QM strategy/plans. Specifically, DDSN addresses the requirements set forth in CMS HCBS waiver applications and the HCBS Quality Framework in QM activities.

The HCBS Quality Framework establishes common language for QM functional priorities. The framework focuses attention on seven participant-centered desired outcomes:

1. Participant Access;
2. Participant-Centered Service Planning and Delivery;
3. Provider Capacity and Capabilities;
4. Participant Safeguards;
5. Participant Rights and Responsibilities;
6. Participant Outcomes and Satisfaction, and
7. System Performance.

RISK MANAGEMENT ACTIVITIES

DDSN has included measurable risk management activities in the Administrative Agency Standards. Risk management activities strive to prevent negative occurrences in the lives of those supported. DDSN conducts many risk management activities using several sources and measures. This purposeful redundancy is necessary to assess from multiple angles the status of the health and welfare of those supported. The four primary risk management activities are:

1) Traditional Activities: DDSN and its provider network are involved in all of the traditional areas of risk management that are common to any operating business that owns buildings, vehicles, equipment, and that hires employees and deals interacts with the public. These activities include ensuring the safety of buildings, complying with OSHA standards, and taking appropriate measures to protect against loss through pre-employment screening, pre-service training, insurance coverage, financial auditing, and legal consultation.

2) Participant Oriented Activities: Since DDSN and its providers are not manufacturers of products, but rather are a service and support network that is intimately involved in the lives of thousands of people, much of the risk that occurs is a result of the responsibility that the provider has to care for people with 24-hours a day, 7 days a week, 365 days a year. Activities under this heading include the tracking and review of, and response to allegations of abuse, neglect and exploitation, critical incidents, complaints/appeals, and mortality.

3) Participant Determined Activities: This is an area of Risk Management that has developed as a result of the paradigm shift in the treatment and services that has empowered participants to be more in control of their lives/choices and the decisions that are made regarding the services and supports they receive. These participant determined risk factors may relate to issues of diet, exercise, use of potentially harmful substances, sexual practices, hygiene, conformance with medical advice, acceptance of behavioral health services, and acceptance of levels of supervision, to list a few but not all possible factors. At the core of all of these issues is the balance between the person’s right to determine the direction and quality of his/her life and the duty to protect the person from foreseeable harmful occurrences. Some of the tools DDSN used in this area are participant and family councils, circles of support, pre-approval of plans of service, ongoing Case Management monitoring of service delivery, the annual planning process, and human rights committees.

4) Internal and External Audit Activities: Internal Audit provides independent and objective assurance and advice to DDSN and the DDSN Commission on the adequacy and effectiveness of governance and risk management, including internal controls, to support the achievement of organizational objectives, and to promote and facilitate continuous improvement. External audit activities provide additional assurance to satisfy expectations that serve to protect the interest of stakeholders and satisfy requests by management and the Commission to complement internal sources of assurance.

QUALITY ASSURANCE/QUALITY IMPROVEMENT ACTIVITIES

Once appropriate risk management activities are in place, then a strong quality assurance and quality improvement program must rest on a foundation of health, safety, and financial, and operational/administrative integrity. Quality Assurance/Quality Improvement activities strive to increase positive occurrences in the lives of persons served. DDSN has included measurable quality assurance/quality improvement activities in the Administrative Agency Standards.

1) Licensing Activities: DDSN uses licensing activities to assist in providing a foundation of health and safety upon which other quality of life initiatives may be built. South Carolina state law requires licensing of day programs and residential settings. The law permits the establishment of standards for the qualifications of staff, staff ratios, fire safety, medication management, and health and safety. DDSN contracts with an entity to coordinate licensing inspection activities. Additional inspections may also be coordinated with the State Fire Marshall's Office. Follow-up licensing reviews are completed to assure that corrective action for deficiencies has been taken.

2) Contract Compliance Activities: The second component of the DDSN Quality Management system is the work done performed by a Quality Improvement Organization (QIO), as designated by the CMS. The QIO, pursuant to its contract with DDSN, conducts a Quality Assurance review of every provider to measure and evaluate the health and welfare of people receiving services. The reviews may take place every 12 to 18 months, depending on the provider's prior performance

3) Post-Payment Claims Review: DDSN performs a post payment claims review of a representative, random sample of Medicaid claims for services rendered annually to determine if those claims are supported by documentation which substantiates that authorized services were delivered. Post-Payment Claims Reviews will be conducted as a desk review versus on-site review, and providers are required to submit to DDSN documentation to substantiate the sampled claims. Claims from each provider will be reviewed no less than once every three (3) years.

4) Observation of Residential and Day Services: The Day and Residential Observation/Participant Experience Survey stands alone as a distinct measure of QI/QM. Day Observation/Participant Experience Surveys will be completed annually at all DDSN-licensed facility-based Day Services locations. Residential Observations/Participant Experience Surveys will be completed annually at 25% of Residential Habilitation settings operated by the provider. The Observation/Participant Experience Surveys may be completed in conjunction with other QA/QI activities or may conducted as a separate activity.

5) Participant/Family Satisfaction Measures: It is very possible for a participant to receive needed services and supports but still feel dissatisfied with life or the services and supports he/she is receiving. Thus, measures of participant with the services and supports received must be considered in order for an agency's services to be truly person-centered and as an important component of data triangulation. Participant and family satisfaction surveys are conducted annually using a planned redundancy model. Each service provider is required to develop and administer its own satisfaction survey. Each provider must comprehensively analyze results must be tabulated and identify areas of weakness, and design and implement a plan of correction. In addition, approximately 500 participants must complete National Core Indicator (NCI) Surveys each year with the assistance of their Case Manager completing Background Documents. The NCI Surveys are coordinated through the Human Services Research Institute (HSRI). This survey information can be used to compare various data for the state to data from other states.

6) Personal Outcomes Measures: Another way participants' health, welfare, and satisfaction is assessed is through Personal Outcome Measures© were developed by The Council on Quality and Leadership (CQL), a nationally recognized accrediting organization, Personal Outcome Measures© can be used to determine how well services and supports are being received by the person.

7) Quality Enhancement Activities: With the multiple approaches the DDSN system uses to measure and improve quality, it is important for providers to have a process that allows for the synthesis of all data to understand overall performance of their services. As a part of the provider's Quality Management Plan, the provider's assessment process should include discussion with a variety of employees throughout the organization, meeting with persons receiving services and their families, reading policies and literature, observing team meetings, identifying current data collection strategies and processes, learning how data is used, observing services in motion, and attending meetings/staffings and self-advocacy efforts. Ultimately, the team synthesizes all the information identifies the strengths of their system and develops, or builds upon, existing quality management plans.

QUALITY MANAGEMENT PLAN

Each DDSN Contracted Provider Agency is required to have a Quality Management Plan, which shall include the following information:

- Performance measures;
- Performance improvement targets and strategies;
- Methods to obtain feedback relating to personal experience from individuals, staff persons and other affected parties;
- Data sources used to measure performance; and
- Roles and responsibilities of the staff persons related to the practice of quality management.

The provider shall revise the quality management plan no less than every three (3) years. A comprehensive quality management plan should draw ideas, standards, and measures from multiple sources and align with the Mission, Vision, Values, Principles, and Priorities of DDSN. Providers are encouraged to seek consultation and accreditation from nationally recognized leaders in the field.

DDSN QUALITY MANAGEMENT OVERSIGHT ACTIVITIES

DDSN employs a Quality Management system that includes the cycle of design, discovery, remediation, and improvement. Through its Risk Management and Quality Assurance/Quality Improvement processes, DDSN ensures that individual services are being implemented as planned and based on the needs of the person supported, compliance with contract and/or funding requirements, and implement best practices. In addition, the provider's administrative and operational capabilities are routinely reviewed to ensure compliance with DDSN standards, contracts, policies, and procedures.

Meeting service standards and employing qualified staff are basic expectations for service delivery. In addition, DDSN and its provider network have the responsibility to prevent, as much as possible, the occurrence of unfavorable events in the lives of people served. Examples of unfavorable events for people supported include the following: abuse, mistreatment, exploitation, critical incidents, accidents/injuries, medication errors, preventable illnesses, preventable restraints, and preventable deaths. It is very important that service providers have reliable systems for reporting, analyzing, and following up on unfavorable events for people supported. Each of these systems should be governed by policies and procedures and have sufficient resources at their disposal to assure that corrective actions are undertaken to prevent the reoccurrence of unfavorable events in the future. As additional oversight, DDSN has implemented Administrative Reviews, Material Deficiencies Notices, and Corrective Action Plans, and Sanctions to prompt corrective actions necessary for quality improvement.

PROVIDER REPORTING DASHBOARD

The need for improved transparency among government-funded services continues to increase as the public demands more accountability. DDSN believes it is important to maintain a transparent reporting system as a resource for a variety of stakeholders. This resource must reflect reliable measures that will help inform participants and family members when selecting service providers.

The Provider Reporting Dashboard is a resource featured on the DDSN Website. It is available to all stakeholders to learn about the service providers DDSN. The Dashboard includes a three (3)-year trend for compliance reviews, licensing, health and safety reporting, finance and business reporting, and quality indicators. The provider's size, the frequency of reviews, and any special certification information is also included. If a provider has had any Contract Enforcement Actions taken in the past three (3) years that information is also noted.

As additional information for stakeholders, information about the review processes is provided in a prelude to the data. This will include a description of the criteria to qualify for an 18-month

review and the process for determining how often a particular site is licensed, reporting requirements for allegations of Abuse, Neglect, and Exploitation or Critical Incident Reporting, Plan of Correction timelines, and possible enforcement actions.

Each indicator or scoring area will have an icon available for the reader to view a description of the measures used to determine compliance.

DDSN ADMINISTRATIVE REVIEWS

The DDSN Risk Management Division may conduct an Administrative Review of Incident Management Report(s) or conduct a review in response to significant concerns related to service delivery. The level of Administrative Review will be determined using the following criteria:

- Significant Injury: Incidents involving significant injury.
- Significant risk: Concerns resulting from the supervision and supports rendered being inconsistent with those outlined in the person's Plan.
- Multiple reports of unauthorized activities, gaps in oversight, or concerns regarding the physical condition of the service settings.
- Complaints and/or observations noted through OA/QI activities, or through contacts with, or contacts related to, the provider.
- Inconsistent documentation related to incident reports.
- A noticeable change in reporting trends.
- Upon the request of the provider agency or another state agency.

The Administrative Review is designed to ensure appropriate safeguards for DDSN service recipients and that compliance with DDSN Standards/Directives/policies is maintained.

MATERIAL DEFICIENCIES and CORRECTIVE ACTION PLANS

When providers fail to meet compliance through the typical remediation process, or when there are documented trends adversely affecting service delivery, a notice of material deficiencies will be issued. When such notice is issued, the provider must submit a Corrective Action Plan (CAP) to the Quality Management Division outlining the actions it will take to thoroughly remediate the areas of deficiency, including, but not limited to, updates in policy(ies), procedures, training(s) by appropriately-credentialed entities or individuals, and/or increased oversight by the agency management.

Criteria for issuing a Notice of Material Deficiencies may include, but are not limited to, the following:

- Incident Management Reports demonstrating a trend of significant injuries or staff actions/inactions that pose a risk to individuals supported;
- 86% (or below) compliance with timely submission of Incident Management Reports for two consecutive quarters;
- Two (2) or more Class I Deficiencies cited for any settings operated by the provider within a 12-month review period;

- 75% (or below) compliance with licensing requirements at two (2) or more settings operated by the provider within a 12-month review period. The compliance score will be determined by the final Report of Findings;
- 60% (or below) compliance with Staff Qualifications and Staff Training requirements as determined through the appropriate review tool for a service (e.g., Contract Compliance or Licensing Reviews). The compliance score will be determined by the final Report of Findings;
- 60% (or below) compliance with service specific requirements as determined through the Contract Compliance Review for a service (e.g., Day Service, Residential Habilitation, Early Intervention, etc.). The compliance score will be determined by the final Report of Findings;
- Evidence of systemic non-compliance in maintaining service delivery documentation to support claims for services rendered; and/or
- Evidence of systemic non-compliance in monitoring participant funds and personal property.

DDSN will specify requirements for a CAP, but will not provide its content. Each provider will be expected to rely upon or develop their internal capacities to reach compliance.

The CAP must identify, with specificity, each of the following elements:

- The dates by which each component will be completed;
- Specific topics and goals of any staff trainings;
- The credentials and experience of the person/entity conducting any staff training that were basis for selection;
- What policies, procedures, or practices will be amended and how; and
- The strategies to be employed to ensure the actions identified in the CAP are implemented and effective to both correct the problem noted and prevent reoccurrence.

Upon receipt of a CAP, DDSN will accept or reject elements of the proposed CAP or the plan in its entirety. In the event of a rejection, the provider shall be required to resubmit a revised CAP. Upon acceptance of the CAP, the provider shall implement the corrective action plan and submit to DDSN an update of progress toward CAP fulfillment every 90 days. If actions from the CAP are not completed by the date specified in the plan, sanctions may be applied.

SANCTIONS

DDSN Licensed Settings

When DDSN Director of Quality Management determines that a licensed setting is in violation of any statutory provision, rule, or regulation relating to the operation or maintenance of such setting, DDSN, upon proper notice to the licensee, may impose a sanction, including but not limited to:

- Deny, suspend, or revoke licenses;

- Require implementation a system for Competency Based Training that includes an evaluation/measure of the effectiveness of staff training to ensure staff members demonstrate the skills necessary to consistently provide the individualized supports;
- Require specific changes in leadership/oversight personnel;
- Implement Enhanced Monitoring. Enhanced Monitoring is a short term, intense intervention that leads to issue resolution and increased capacity to promote the health, safety and welfare of people supported by DDSN;
- DDSN may make referrals to the South Carolina Department of Labor, Licensing and Regulation (SCLLR) for matters related to professional licensing;
- DDSN may recommend that SCDHHS terminate the Medicaid provider agreement;
- DDSN may refer the provider to South Carolina Law Enforcement Division (SLED) and/or the Office of the Inspector General for investigation;
- DDSN may impose any other sanctions in accordance with DDSN policies and procedures.

DDSN shall utilize inspections, investigations, consultations, and other pertinent documentation regarding the licensed setting to enforce DDSN Standards and Directives.

In determining sanctionable activity, DDSN shall consider the specific conditions and their impact or potential impact on health, safety or well-being of participants including, but not limited to: serious deficiencies in medication management; serious housekeeping/maintenance/fire and life safety related problems that pose a health threat to the residents; unsafe condition of the building; direct evidence of abuse, neglect, or exploitation with untimely reporting/response; lack of food or evidence that participants are not being fed properly; no staff available at the setting with participants present; and/or unsafe procedures/treatment being practiced by staff. DDSN may also consider any other pertinent conditions that may be applicable to current Directives and Standards.

The Director of Quality Management will make a recommendation for penalties to the DDSN Sanctions Review Committee. The recommendation will include documentation of the deficiency, the provider's appeal, if applicable, and corresponding Plan of Correction. The Sanctions Review Committee will be composed of the Associate State Director of Operations, the Associate State Director of Policy, the Chief Administrative Officer, the DDSN General Counsel, a member selected by I.M.P.A.C.T. S.C., a DDSN Provider representative elected among their peers, and a representative from the State Long Term Care Ombudsman Program and will meet on a quarterly basis. Upon recommendation from the Sanctions Review Committee, the Licensee will receive prompt, formal notification of the Sanction and the terms required to satisfy remaining requirements.

Community-Based Services

DDSN may also impose sanctions for non-compliance with Administrative Agency Standards, including staff qualifications and training requirements. DDSN may also impose sanctions for failure to meet key elements of service delivery which are not subject to post-payment claims review.

The Director of Quality Management will make a recommendation for sanction to the DDSN Sanctions Review Committee. The recommendation will include documentation of the deficiency, the provider's appeal, if applicable, and corresponding Plan of Correction. The Sanctions Review Committee will be composed of the Associate State Director of Operations, the Associate State Director of Policy, the Chief Administrative Officer, the DDSN General Counsel, a member selected by I.M.P.A.C.T. S.C., and a DDSN Provider representative elected among their peers. and will meet on a quarterly basis. Upon recommendation from the Sanctions Review Committee, the provider will receive formal notification of the Sanction and the terms required to satisfy remaining requirements.

When a provider demonstrates non-compliance in one or more areas of contractual responsibility or failure to submit or implement a CAP, DDSN, upon proper notice, may impose a sanction, including but not limited to:

- Require implementation a system for Competency Based Training that includes an evaluation/measure of the effectiveness of staff training to ensure staff members demonstrate the skills necessary to consistently provide the individualized supports;
- Require specific changes in leadership/oversight personnel;
- Implement Enhanced Monitoring. Enhanced Monitoring is a short term, intense intervention that leads to issue resolution and increased capacity to promote the health, safety and welfare of people supported by DDSN;
- DDSN may make referrals to SCLLR for matters related to professional licensing;
- DDSN may recommend that SCDHHS terminate the Medicaid provider agreement;
- DDSN may refer the provider to SLED and/ or the Office of the Inspector General for investigation;
- DDSN may impose any other sanctions in accordance with DDSN policies and procedures.

DDSN will empanel a Sanctions Board to review circumstances which could lead to the imposition of a sanction. The Sanctions Board will make a recommendation regarding the specific sanction to be imposed to the DDSN State Director. The DDSN State Director will determine the sanction, if any, to be imposed.

POST-PAYMENT CLAIMS REVIEW

Performance Measures in the DDSN-operated HCBS Waivers require DDSN and DHHS to assure that services are provided in accordance with the service definitions and/or are supported by documentation of service delivery. To that end, DDSN will conduct Post Payment Claims Reviews (PPCR). The PPCR is used to verify that service authorized to a person was delivered by the provider on every date reimbursement for the service was sought. This Review will include a determination of whether:

- The person was eligible for services at the time of the claim;
- The service was authorized in the person's Case Management Plan;
- The units of service align with the authorized units in the plan; and

- There is sufficient documentation to support the service was delivered in accordance with the applicable service standards and service definitions. Supporting documentation will vary depending on the service delivered. Documentation may include, but is not limited to: evidence of training goal/objective implementation, evidence of implementation of supervision plan, service notes, T-Logs, evidence of recreation/leisure activities, behavior support data, meeting notes, medication administration records, medical appointment records, etc.

Provider agencies must have an established internal monitoring processes to ensure the integrity of the services provided meets the scope of the defined service(s), DDSN, and Medicaid requirements. The agencies must also have policies/procedures for documenting service delivery, consistent with the scope of the defined service(s), DDSN, and Medicaid requirements. Discrepancies found within the service documentation and actual service delivery will be reported to SCDHHS Program Integrity for further investigation.

~~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