From: Linguard, Christie
Subject: Meeting Notice - The Commission of the SCDDSN - Policy Committee Meeting - October 11, 2022
Date: Friday, October 7, 2022 2:18:27 PM
Attachments: October 11 Policy Committee Packet - PAGE NUMBERED-WITH AGENDA (100322).pdf

Everyone,

The South Carolina Commission on Disabilities and Special Needs will hold an in-person Policy Committee meeting on Tuesday, October 11, 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

October 11, 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 September 6, 2022 Meeting (TAB 1, pg. 1)

6. Old Business: (TAB 2)

A. 505-02-DD: Death or Impending Death of Persons Receiving Services from DDSN (pg. 2-21)

7. New Business: (TAB 3)

A. Administrative Standards (pg. 22-38)
B. 275-05-DD: General Duties of the Internal Audit Division (pg. 39-47)

8. Adjournment – Next Meeting November 8, 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
September 6, 2022

IN ATTENDANCE: Chairman, Barry Malphrus; Commissioner David Thomas, and Commissioner Michelle Woodhead
Dr. Michelle Fry, Lori Manos, Greg Meetze, Janet Priest; Nancy Rumbaugh, Erin Oehler, PJ Perea, and Colleen Honey

1. Adoption of Agenda

Chairman Malphrus requested committee members to adopt the agenda.

As there were no objections, agenda was adopted.

2. Approval of Summary Notes from the August 9, 2022 Meeting

Chairman Malphrus requested committee members to adopt the summary notes.

After Chairman Malphrus requested one minor edit, the summary notes from the August 9, 2022 meeting were adopted.

3. Old Business:

A. 700-09-DD: Determining Need for Residential Services

The directive was posted for external review. Several comments were received and staff made additional changes. As there were no objections, the directive will be presented to the full Commission for approval and signing along with 502-01-DD: Admissions/Discharge of Individuals to/from DDSN Funded Community Residential Settings and 502-05-DD: Waiting List which were declared OBSOLETE at the July Policy meeting.

B. 700-03-DD: Informed Choice in Living Preference (Intermediate Care Facilities for Individuals with Intellectual Disabilities)

The directive was revised in conjunction with the previous directive (700-09-DD) and was posted for external review. One comment was received and staff made additional changes. As there were no objections, the directive will be presented to the full Commission for approval and signing.

4. New Business:

A. 502-02-DD: Death or Impending Death of Persons Receiving Services from DDSN

Staff presented to the Committee for approval to post for external review. Chairman Malphrus asked that several edits be made per his request before posting. As there were no objections, the directive will go out for public comment (10-day review) and will be presented at the next Policy meeting.

B. 275-04-DD: Procedures for Implementation of DDSN Audit Policy for DSN Boards

This directive was recently approved by the Commission in July; however, staff presented to the Committee for reapproval due to reverting back to pre-pandemic requirements regarding due dates and extension approval. As the change was minor and the directive was newly ratified, and there were no objections, the directive will be presented to the full Commission for approval and signing.

5. Adjournment

The next meeting will take place on October 11, 2022.

Reference Number:	505-02-DD
Title of Document:	Death ~~or Impending Death of Persons Receiving Services from DDSN~~ Reporting and Mortality Review Requirements
~~Effective Date:~~	~~April 1, 1989~~
Date of Issue:	April 1, 1989
~~Last Review Date:~~	~~February 2, 2017~~
Date of Last Revision:	~~February 2, 2017~~XXXX, 2022 (**REVISED**)
Effective Date:	~~April 1, 1989~~November 1, 2022
Applicability:	DDSN Regional Centers, DSN Boards, and Contracted Service Providers of Case Management, Day Services, and Residential Services

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I. Introduction

The purpose of this document is to establish procedures to be followed in the event of a ~~the impending death or~~ death of ~~persons receiving services from a Department of Disabilities and Special Needs (DDSN) sponsored program.~~individuals participating in a Department of Disabilities and Special Needs (DDSN) operated Home and Community Based (HCB) Waiver as well as individuals receiving DDSN contracted residential or day supports regardless of funding source.

Staff should always remain aware of the feelings and emotions of families whose loved one is critically ill or has just passed away. All contact with the family should be made in a sensitive and respectful manner. ~~If available, the physician should contact the family to answer questions and to assist them in understanding the person's medical condition or cause of death. If the physician is not available, the Facility Director/Executive Director/CEO should contact the family.~~ ~~Residential~~Direct Service Provider or Case Management staff who have worked closely with the critically ill or deceased person and family are ~~also~~ important in assisting the family and are generally the primary contact for the family.

~~II. Impending Death~~

Should a person's death become imminent due to accident or serious illness, and the person is residing in a DDSN ~~sponsored~~ operated or contracted residence, the physician or the ~~Facility Administrators/ Executive Directors/CEOs designee~~ DDSN Regional Center/Provider designee should inform the parents/next-of-kin of the critical nature of the accident or serious illness. The ~~residence social worker~~ residential staff or Case Manager, along with the physician will maintain contact with the family during the period the person remains in danger. If the family desires, a pastor or other religious person of their choice will be located to minister to the needs of the person and the family.

II. Definitions

Allegation of Abuse, Neglect, or Exploitation (ANE) – A person has reason to believe that another person has been or is at risk for abuse, neglect, or exploitation.

Administrative Review – The final step of the incident management process that reviews the circumstances of the incident; weighs evidence of policy or procedural violations or employee misconduct, and creates corrective action plans. The Administrative Review is intended to mitigate risks and prevent future incidents, where possible.

Case Manager - A person selected by the participant to coordinate assessment, planning, care coordination, evaluation, and services to meet a service recipient's needs. The Case Manager provides advocacy and information about available resources to ensure choice, satisfaction, and quality.

Corrective Actions – Actions implemented to increase protection to persons from similar future incidents. Corrective actions can be implemented for a single person and/or related to an organizational change to prevent similar incidents to all persons served.

Critical Incident – A type of incident that has been determined to be a sufficiently serious indicator of risk that it requires an administrative review.

Expected Death (Natural Causes) – Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. This includes a death that is medically determined, based on a death certificate and supporting documentation, to have resulted solely from a diagnosed degenerative condition or a death that occurs as the result of an undiagnosed condition resulting from an explained condition, such as the aging process.

Unexpected Death – An unexpected death is primarily attributed to an external unexpected force acting upon the person. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unexpected.

Unexplained Death – A death in which the cause of death noted on a person's death certificate is not supported by documentation found in the person's medical history and other documentation.

Incident Management- The response to an event, intended to ensure the adequate, appropriate, and effective protection and promotion of the health, safety, and rights for all people served.

III. Reporting the Death of Persons Supported ~~by~~ within DDSN Regional Centers or by DDSN Contracted Service Providers

~~In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons who reside in DDSN sponsored residential services, or whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person (e.g., individual rehabilitation supports).~~ In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons who reside in DDSN sponsored residential services, or whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person.

~~A. DEATHS OF PERSONS AGE 17 AND UNDER IN DDSN OPERATED HOMES OR THOSE HOMES CONTRACTED FOR OPERATION BY DDSN~~

~~1. Facility Administrators/Executive Directors/CEOs or their designee will report the death to DDSN using the Death Reporting function on the Incident Management System as soon as possible, but no later than 24 hours or the next business day.~~

~~2. A report must be made to DDSN, even if the child dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System.~~

~~3. If the death was unexpected or suspicious in nature, the Facility Administrator/Executive Director/CEO or their designee must call the DDSN District Director or their designee immediately. Immediately means within two (2) hours of the death. The DDSN District Director will then notify the Associate State Director-Operations and the State Director. The Death Reporting function on the Incident Management System must be completed as soon as possible, but no later than 24 hours, or the next business day. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.~~

~~4. All child deaths in ICFs/IID facilities must be reported in writing by the Facility Administrator/Executive Director/CEO or their designee to the Health Licensing Division of DHEC at the same time a report is made to DDSN.~~

~~5. The physician, Facility Administrator/Executive Director/CEO or their designee shall notify the county coroner's office immediately of all child deaths unless the death occurred in a hospital setting.~~

~~6. An internal review by management will be conducted of all child deaths. However, **the review should never interfere with any outside investigation if applicable.** Results of all reviews must be submitted to DDSN and to DHEC, as applicable, within ten (10) working days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The Facility Administrator/Executive Director/CEO or their designee will submit the final report.~~

A. Deaths of Persons Receiving Residential Services in a Home Operated by or Contracted for Operation by DDSN

1. The physician or DDSN Regional Center/Provider ensures that the county coroner's office is immediately notified of all deaths unless the death occurred in a hospital or Hospice setting.

2. For deaths involving persons age 18 and above, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Vulnerable Adult Investigations Unit immediately using SLED's toll-free number: 1-866-200-6066.

3. For deaths involving persons age 17 and under, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Child Fatality Unit immediately using SLED's toll-free number: 1-866-200-6066. The death must also be reported to the SC DSS Out of Home Abuse and Neglect Investigation Unit (OHAN).

4. The Initial Report of Death Form located in the Death Reporting function of the Incident Management System, must be completed-within 24 hours. A report must be made to DDSN and SLED even if the person dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System. For persons recently discharged from a DDSN residential service location, SLED must be contacted by the former DDSN residential provider if the death occurs within 30 days of the discharge date.

5. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means as soon as reasonably possible but, under no circumstances, to exceed two (2) hours following the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.

6. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

7. All deaths in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) and Community Residential Care Facilities (CRCF) must be reported in writing by the DDSN Regional Center/Provider designee to the Health Licensing Division of the South Carolina Department of Health and Environmental Control (DHEC) at the same time a report is made to DDSN.

8. An Administrative Review will be conducted for all deaths. **This review should never interfere with any outside investigation.** For ICF/IID and CRCF locations, the results of all Administrative Reviews must be submitted to DDSN and to DHEC, within five (5) calendar days of the death. For all other residential settings, the results of all Administrative Reviews must be submitted to DDSN within ten (10) business days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

Notification Procedures

For those persons living in a DDSN ~~sponsored~~ operated or contracted residential setting, the family/guardian or primary correspondent will be notified of the death by the method they have identified in the person's plan such as by phone, personal visit or by notifying their minister who would then notify the family. If the family has made no prior arrangements, the attending physician will inform the family of the death of their family member ~~as soon as possible after the death~~ per the physician's death notification policy. The provider representative will seek ~~P~~permission for an autopsy at that time as indicated by law. ~~The Case Manager will also contact the family to help with funeral and burial arrangements.~~ When gathering information on the death of a DDSN consumer, care must be taken to respect the feelings of survivors. The ~~staff person~~ provider representative should express condolences, indicate the importance of gathering key information for the benefit of other individuals with disabilities, and proceed to fill out the "Report of Death" ~~form~~ by retrieving information from ~~all appropriate sources~~ the participant and staff records. If family members are unwilling/unable to participate in filling out the ~~form~~ report, then the staff person should proceed with the form using information from other ~~sources~~ approved participant records.

Autopsy

An autopsy will be performed following the death of a person when requested by the coroner or SLED and should also be done when:

a) ~~d~~Death is an unexpected or unexplained outcome as determined by the attending physician and/or medical director, and/or Executive Director, or;

b) ~~r~~Requested by the family. (*Costs for an autopsy requested by the family, but not required by the Coroner or SLED, will be the financial responsibility of the family*).

If the circumstances of the death do not require an autopsy (i.e., not ordered by the Coroner's Office or SLED), but one is sought, the attending physician will seek permission from the next of kin or correspondent. If permission is denied, this objection will be honored, and the denial recorded in the chart by the requesting physician/medical director or ~~Executive Director~~ DDSN Regional Center/Provider designee.

Disposition of Remains

The remains of the deceased will be released according to the wishes of the person as specified in a pre-need document or to the parents or other responsible relative or guardian of record. If no responsible person is known or if such person refuses to accept custody of the remains, the ~~Facility Administrator/Executive Directors/CEOs or their~~ DDSN Regional Center/Provider designee will arrange for burial or other appropriate disposition of the remains.

If possible, persons should be buried in accordance with their documented preferences or, if none, in their home community. If no family member or relative can be located to help make arrangements for the burial in the home community, the ~~Facility Administrator/Executive Directors/CEOs~~ DDSN Regional Center/Provider can arrange for the burial at an appropriate community or church cemetery. In these cases, burials will be the financial responsibility of the DDSN Regional Center or ~~board/~~provider ~~responsible for~~ previously supporting the person after all other resources have been utilized.

Personal Funds

At the time of death, all funds conserved for the person are frozen, and no disbursements will be made without legal authority of the Probate Court. Should this pose a problem for families needing immediate access to the person's funds for funeral expenses, the ~~provider~~ DDSN Regional Center/Provider will co-operate with the family to assure the burial is handled in a reasonable manner in accordance with the family's wishes.

The ~~Facility Administrators/Executive Directors/CEOs or~~ DDSN Regional Center/Provider designee will file the Affidavit for Collection of Personal Property Pursuant to Small Estate Proceeding available on the judicial website http://www.judicial.state.sc.us/forms/ – quick links (Probate Court Form 420PC). The Probate Court will issue an order permitting payment to the proper persons.

~~B. DEATHS OF PERSONS AGE 18 AND ABOVE IN DDSN OPERATED HOMES OR THOSE HOMES CONTRACTED FOR OPERATION BY DDSN~~

~~Facility Administrators/Executive Directors/CEOs or their designee will report the death to the South Carolina Law Enforcement Division (SLED) immediately using SLED's toll-free number: 1-866-200-6066. In addition, the Initial Report of Death Form located in the Death Reporting function of the Incident Management System, must be completed as soon as possible, but no later than 24 hours, or the next business day.~~

~~1. A report must be made to DDSN and SLED even if the person dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System. For persons recently discharged from a DDSN residential service location, SLED must be contacted by the former DDSN residential provider if the death occurs within 30 days of the discharge date.~~

~~2. If the death was unexpected or suspicious in nature, the Facility Administrator/Executive Director/CEO or their designee must call the DDSN District Director or their designee and SLED immediately. Immediately means within two (2) hours of the death. The DDSN District Director will then notify the Associate State Director-Operations and the State Director. The Report of Death function on the Incident Management System must be submitted to DDSN as soon as possible, but no later than 24 hours, or the next business day. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.~~

~~3. All deaths in ICFs/IID and CRCFs must be reported in writing by the Facility Administrator/Executive Director/CEO or their designee to the Health Licensing Division of DHEC at the same time a report is made to DDSN.~~

~~4. The physician, Facility Administrator/Executive Director/CEO or their designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.~~

5. ~~An internal review by management will be conducted of all deaths. However, **the review should never interfere with the investigation of death conducted by SLED**. Results of all reviews must be submitted to DDSN within ten (10) working days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The Facility Administrator/Executive Director/CEO or their designee will submit the final report.~~

C. ~~DEATHS OF PERSONS OF ANY AGE OTHER THAN THOSE LIVING IN A RESIDENTIAL PROGRAM OPERATED BY OR CONTRACTED FOR OPERATION BY DDSN WHILE AT A DDSN REGIONAL CENTER OR PROVIDER LOCATION (E.G., DAY PROGRAM) OR WHILE UNDER THE SUPERVISION OF DDSN REGIONAL STAFF OR BOARD/PROVIDER STAFF PERSON (E.G., INDIVIDUAL REHABILITATON SUPPORTS)~~

1. ~~Facility Administrators/Executive Directors/CEOs or their designee will report the death to DDSN using the Death Reporting function of the Incident Management System as soon as possible, but no later than 24 hours, or the next business day.~~

2. ~~If the death was unexpected or suspicious in nature, the Facility Administrator/Executive Director/CEO or their designee must call the DDSN District Director or their designee immediately. Immediately means within two (2) hours of the death. The DDSN District Director will then notify the Associate Director-Operations and the State Director. The Report of Death function on the Incident Management System must be sent to DDSN as soon as possible, but no later than 24 hours, or the next business day. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.~~

3. ~~The physician, Facility Administrator/Executive Director/CEO or their designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.~~

4. ~~An internal review by management will be conducted of all deaths. However, **the review should never interfere with any outside investigation if applicable.** Results of all reviews must be documented within ten (10) business days in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The Facility Administrator/Executive Director/CEO or their designee will submit the final report.~~

B. Deaths of persons of any age, other than those living in a residential program operated by or contracted for operation by DDSN whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person (eg, respite, employment).

1. DDSN Regional Center/Provider designee will report the death to DDSN using the Death Reporting function of the Incident Management System within 24 hours.

2. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means as soon as reasonably possible but, under no circumstances, to exceed two (2) hours following the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.

3. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

4. The physician or DSDN Regional Center/Provider designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.

5. An Administrative Review will be conducted of all child deaths. **This review should never interfere with any outside investigation.** Results of all Administrative Reviews must be submitted to DDSN and to DHEC, as applicable, within ten (10) working days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

IV. Reporting the Death of Persons enrolled in a DDSN operated HCB Waiver who do not meet the criteria listed previously

In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons enrolled in a DDSN operated HCB Waiver. When the death that does not meet the criteria in A or B above, the Waiver Case Manager is responsible for reporting to DDSN.

1. Waiver Case Managers will report the death to DDSN using the Death Reporting function on the Incident Management System within 24 hours of their notification of the fatality.

2. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

3. An Administrative Review will be conducted for all deaths. **This review should never interfere with any outside investigation**. The Waiver Case Manager must complete the initial and final death reports as completely as possible, noting any suspected cause of death and whether an autopsy has been requested. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The Waiver Case Manager will submit the final report within ten (10) working days of the death.

V. ~~Quality Management~~ Mortality Reviews

~~All DDSN Regional Centers, DSN Boards and Contracted Service Providers must follow DDSN Directive 100-28-DD: Quality Assurance, to ensure continuous quality improvement in all services and supports provided to DDSN service recipients.~~ Providers are responsible for completing all required documentation to close out service authorizations, disenroll from Waiver services, and terminate billing. In addition, ~~P~~providers are expected to promptly comply with any requests for information from the Vulnerable Adult Fatality Committee or from the SLED Vulnerable Adult Investigations Unit. ~~In addition,~~ DDSN will participate in the Vulnerable Adult Fatalities Review Committee and the Children's Fatalities Review Committee to improve service quality and to develop and implement measures to prevent future deaths from similar causes from occurring if at all possible.

Through the DDSN Regional Center/Provider Risk Management Committee, a Mortality Review Process should evaluate information gathered during the reporting process to identify the following:

1. Immediate and secondary causes of death;

2. If the deaths were:

a. Expected due to a known terminal illness;
b. Associated with a known chronic illness;
c. A sudden, unexpected death;
d. Due to unknown cause
e. Due to an accident and, if so, the type of accident;
f. Due to self-inflicted injury or illness (e.g., suicide, serious self-injurious behavior);
g. Due to suspicious or unusual circumstances; and
h. Due to suspected or alleged neglect, abuse, or criminal activity.

3. Findings from any outside investigation (as available/applicable) such as SLED, law enforcement etc.

4. Any trends and/or patterns in the deaths reported.

5. Immediate and longer-term circumstances and events that contributed to or were associated with deaths.

6. Actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths.

~~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

Related Directives or Laws:

Child Protection Reform Act, S.C. Code Ann. § 20-7-480, et seq.
Omnibus Adult Protection Act, S.C. Code Ann. § 45-35-35, et seq.

~~100-28-DD: Quality Assurance and Management~~
200-02-DD: Financial Management of Personal Funds
200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs
Administrative Agency Standards

Main document changes and comments

Page 1: Commented [HC1] **Honey, Colleen** **9/13/2022 1:36:00 PM**

Shannon Childress – Charles Lea Center

It is our hope that you will take our comments seriously and apply changes, as necessary. Please understand that we also want all individuals receiving our services to be safe and free from harm however, imposing more requirements to Case Managers without fair compensation may result negatively as more Waiver Case Managers may resign from this service system altogether. It is our belief that by adding more duties to existing Case Managers, some things may get overlooked which in turn could result in unfair liability on behalf of the Case Manager. Case Management has always been a compliance driven position, but with the extra reporting that is suggested in your email, we are concerned that additional reporting requirements may take away the time that Case Managers need to fill service gaps, secure funding and secure appropriate equipment for the individuals served.

Thank you again for the opportunity to provide feedback.

Page 1: Commented [ML2R1] **Manos, Lori** **9/27/2022 10:26:00 AM**

DDSN Response: Reporting and analyzing the circumstances around deaths in the community is essential in assuring the health and welfare of all Home and Community Based Waiver participants. The Waiver Case Manager is the only logical person to complete the minimal reporting requirements because of their historical knowledge of the person and their ongoing relationship with the family.

Page 2: Commented [HC3] **Honey, Colleen** **9/14/2022 3:09:00 PM**

Laura Villeponteaux – Charleston DSN Board

The "Definitions" section is very helpful.

Page 2: Commented [ML4R3] **Manos, Lori** **9/27/2022 10:26:00 AM**

DDSN Response: Thank you

Page 3: Commented [HC5] **Honey, Colleen** **9/14/2022 3:11:00 PM**

Laura Villepointeaux – Charleston DSN Board

In reality when a person dies in a Provider's residential setting, usually EMS is called, and the responding EMTs notify the coroner, rather than the Provider.

Page 3: Commented [ML6R5] **Manos, Lori** **9/27/2022 10:29:00 AM**

DDSN Response: Language clarified.

Page 3: Commented [HC7] **Honey, Colleen** **9/13/2022 3:34:00 PM**

Heather Waddell – Aiken DSN Board

I would like for the section related to reporting death to be reviewed again because we have had several issues arise where we have someone whom we are providing supports for and they are under the care of hospice. Upon calling the Coroner's Office, we find that Hospice has already made that contact. I would recommend revising the policy to reflect that with the exceptions of someone being in the hospital or hospice, the coroner needs to be contacted. This would eliminate multiple agencies contacting the coroner's office and inundating their phones with calls regarding the same person who has passed away.

Page 3: Commented [ML8R7] **Manos, Lori** **9/27/2022 10:29:00 AM**

DDSN Response: Language clarified.

Page 5: Commented [HC9] **Honey, Colleen** **9/14/2022 3:13:00 PM**

Laura Villeponteaux – Charleston DSN Board

The new Section IV requirement for Case Managers to report and conduct an administrative review is very problematic. It could be extremely intrusive for a CM to contact and question the family of a community-residing individual upon their death. Further, these activities would not be billable activity and exceed the scope of CM's responsibilities. In the new fee-for-service environment, adding a non-billable activity to CM's responsibility is inappropriate. While it is understandable that DDSN wants to track relevant information about deaths of persons enrolled in HCB Waivers, we would suggest that this non-billable activity be conducted by someone at DDSN.

Page 5: Commented [ML10R9] **Manos, Lori** **9/27/2022 10:32:00 AM**

DDSN Response: Reporting and analyzing the circumstances around deaths in the community is essential in assuring the health and welfare of all Home and Community Based Waiver participants. The Waiver Case Manager is the only logical person to complete the minimal reporting requirements because of their historical knowledge of the person and their ongoing relationship with the family.

Page 6: Commented [HC11] **Honey, Colleen** **9/13/2022 1:33:00 PM**

Shannon Childress – Charles Lea Center

Case Managers are not always contacted by the family when an individual passes; however, in cases where they are contacted, if a family member makes contacts outside normal business hours (for example on Friday night), this call will be forwarded to an afterhours number. Requiring a Case Manager to report a death in DDSN's Incident Management System within 24 hours, would require the Case Manager to report this on the weekend and possibly by someone who is not familiar with the case or the person. Note: It is our assumption that DDSN intends on staffing someone on the weekends to accept the required report.

Page 6: Commented [ML12R11] **Manos, Lori** **9/27/2022 10:33:00 AM**

DDSN Response: Reporting and analyzing the circumstances around deaths in the community is essential in assuring the health and welfare of all Home and Community Based Waiver participants. The Waiver Case Manager is the only logical person to complete the minimal reporting requirements because of their historical knowledge of the person and their ongoing relationship with the family.

Page 6: Commented [HC13] **Honey, Colleen** **9/8/2022 3:32:00 PM**

Cindy Carter – Center for Developmental Services

The proposed IMS reporting activities for CMs in addition to closing/processing activities for deceased waiver participants represents additional work time that will not be reimbursed unless state funding could be requested following a person's death? This section represents case management activities that are or may be required following the death of a waiver participant. From the date of death forward, no case management activities can be billed to Medicaid but sometimes the responsibilities require a lot of a case manager's time that is unpaid.

Page 6: Commented [ML14R13] **Manos, Lori** **9/27/2022 10:32:00 AM**

DDSN Response: Reporting and analyzing the circumstances around deaths in the community is essential in assuring the health and welfare of all Home and Community Based Waiver participants. The Waiver Case Manager is the only logical person to complete the minimal reporting requirements because of their historical knowledge of the person and their ongoing relationship with the family.

Page 6: Commented [HC15] **Honey, Colleen** **9/13/2022 1:34:00 PM**

Shannon Childress – Charles Lea Center

Currently all Case Managers are required to contact the Dept. of Social Services if abuse and neglect is suspected. At the time a DSS report is made the case manager is required to report all DDSN services received. Asking a case manager to additionally complete an ANE report could result in confusion leading to an accidental omission of contacting DSS and/or conflicting presentation of information. **One report to DSS or SLED should remain a Case Manger's priority**. Adding more unnecessary steps to a Case Manager's responsibility will cause some confusion over what the priority should be. It is our recommendation that DDSN work more closely with the DSS and/or SLED to gather all of DDSN's requested information if quality assurance is the goal, as referenced above.

Page 6: Commented [ML16R15] **Manos, Lori** **9/27/2022 10:35:00 AM**

DSDN Response: The Waiver Case Manager's legal responsibilities to report to SLED/DSS are separate from their responsibilities to report under this directive.

Page 6: Commented [HC17] **Honey, Colleen** **9/13/2022 1:35:00 PM**

Shannon Childress – Charles Lea Center

Currently Case Managers are not asked to gather or report such critical information relating to a death. This task is completed by other state and governing authorities who are much more experienced to do so. Case Managers have been trained and are expected to coordinate and monitor services to support a disability. Case Managers are and have always been expected to provide information to law enforcement and DSS when requested. All other requests made by DDSN related to death reporting could be perceived as an interference to law enforcement's reporting process.

Page 6: Commented [ML18R17] **Manos, Lori** **9/27/2022 10:36:00 AM**

DDSN Response: Reporting and analyzing the circumstances around deaths in the community is essential in assuring the health and welfare of all Home and Community Based Waiver participants. The Waiver Case Manager is the only logical person to complete the minimal reporting requirements because of their historical knowledge of the person and their ongoing relationship with the family.

Page 6: Commented [HC19] **Honey, Colleen** **9/8/2022 3:32:00 PM**

Cindy Carter – Center for Developmental Services

The proposed IMS reporting activities for CMs in addition to closing/processing activities for deceased waiver participants represents additional work time that will not be reimbursed unless state funding could be requested following a person's death? This section represents case management activities that are or may be required following the death of a waiver participant. From the date of death forward, no case management activities can be billed to Medicaid but sometimes the responsibilities require a lot of a case manager's time that is unpaid.

Page 6: Commented [ML20R19] **Manos, Lori** **9/27/2022 10:36:00 AM**

DDSN Response: Reporting and analyzing the circumstances around deaths in the community is essential in assuring the health and welfare of all Home and Community Based Waiver participants. The Waiver Case Manager is the only logical person to complete the minimal reporting requirements because of their historical knowledge of the person and their ongoing relationship with the family.

Page 6: Commented [HC21] **Honey, Colleen** **9/8/2022 3:33:00 PM**

Cindy Carter – Center for Developmental Services

The proposed IMS reporting activities for CMs in addition to closing/processing activities for deceased waiver participants represents additional work time that will not be reimbursed unless state funding could be requested following a person's death? This section represents case management activities that are or may be required following the death of a waiver participant. From the date of death forward, no case management activities can be billed to Medicaid but sometimes the responsibilities require a lot of a case manager's time that is unpaid.

Page 6: Commented [ML22R21] **Manos, Lori** **9/27/2022 10:36:00 AM**

DDSN Response: Reporting and analyzing the circumstances around deaths in the community is essential in assuring the health and welfare of all Home and Community Based Waiver participants. The Waiver Case Manager is the only logical person to complete the minimal reporting requirements because of their historical knowledge of the person and their ongoing relationship with the family.

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Reference Number:	505-02-DD
Title of Document:	Death Reporting and Mortality Review Requirements
Date of Issue:	April 1, 1989
Date of Last Revision:	October 20, 2022 (**REVISED**)
Effective Date:	November 1, 2022
Applicability:	DDSN Regional Centers, DSN Boards, and Contracted Service Providers of Case Management, Day Services, and Residential Services

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I. Introduction

The purpose of this document is to establish procedures to be followed in the event of a death of individuals participating in a Department of Disabilities and Special Needs (DDSN) operated Home and Community Based (HCB) Waiver as well as individuals receiving DDSN contracted residential or day supports regardless of funding source.

Staff should always remain aware of the feelings and emotions of families whose loved one is critically ill or has just passed away. All contact with the family should be made in a sensitive and respectful manner. Direct Service Provider or Case Management staff who have worked closely with the critically ill or deceased person and family are important in assisting the family and are generally the primary contact for the family.

Should a person's death become imminent due to accident or serious illness, and the person is residing in a DDSN operated or contracted residence, the physician or the DDSN Regional Center/Provider designee should inform the parents/next-of-kin of the critical nature of the accident or serious illness. The residential staff or Case Manager, along with the physician will maintain contact with the family during the period the person remains in danger. If the family desires, a pastor

or other religious person of their choice will be located to minister to the needs of the person and the family.

II. Definitions

Allegation of Abuse, Neglect, or Exploitation (ANE) – A person has reason to believe that another person has been or is at risk for abuse, neglect, or exploitation.

Administrative Review – The final step of the incident management process that reviews the circumstances of the incident; weighs evidence of policy or procedural violations or employee misconduct, and creates corrective action plans. The Administrative Review is intended to mitigate risks and prevent future incidents, where possible.

Case Manager - A person selected by the participant to coordinate assessment, planning, care coordination, evaluation, and services to meet a service recipient's needs. The Case Manager provides advocacy and information about available resources to ensure choice, satisfaction, and quality.

Corrective Actions – Actions implemented to increase protection to persons from similar future incidents. Corrective actions can be implemented for a single person and/or related to an organizational change to prevent similar incidents to all persons served.

Critical Incident – A type of incident that has been determined to be a sufficiently serious indicator of risk that it requires an administrative review.

Expected Death (Natural Causes) – Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. This includes a death that is medically determined, based on a death certificate and supporting documentation, to have resulted solely from a diagnosed degenerative condition or a death that occurs as the result of an undiagnosed condition resulting from an explained condition, such as the aging process.

Unexpected Death – An unexpected death is primarily attributed to an external unexpected force acting upon the person. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unexpected.

Unexplained Death – A death in which the cause of death noted on a person's death certificate is not supported by documentation found in the person's medical history and other documentation.

Incident Management - The response to an event, intended to ensure the adequate, appropriate, and effective protection and promotion of the health, safety, and rights for all people served.

III. Reporting the Death of Persons Supported within DDSN Regional Centers or by DDSN Contracted Service Providers

In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons who reside in DDSN sponsored residential services, or whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person.

A. Deaths of Persons Receiving Residential Services in a Home Operated by or Contracted for Operation by DDSN

1. The physician or DDSN Regional Center/Provider ensures that the county coroner's office is immediately notified of all deaths unless the death occurred in a hospital or Hospice setting.

2. For deaths involving persons age 18 and above, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Vulnerable Adult Investigations Unit immediately using SLED's toll-free number: 1-866-200-6066.

3. For deaths involving persons age 17 and under, the DDSN Regional Center/Provider designee will report the death to the South Carolina Law Enforcement Division (SLED) Special Victims/Child Fatality Unit immediately using SLED's toll-free number: 1-866-200-6066. The death must also be reported to the SC DSS Out of Home Abuse and Neglect Investigation Unit (OHAN).

4. The Initial Report of Death Form located in the Death Reporting function of the Incident Management System, must be completed-within 24 hours. A report must be made to DDSN and SLED even if the person dies in a location other than his/her DDSN sponsored home (e.g., hospital). The report to DDSN must be submitted on the Incident Management System. For persons recently discharged from a DDSN residential service location, SLED must be contacted by the former DDSN residential provider if the death occurs within 30 days of the discharge date.

5. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means as soon as reasonably possible but, under no circumstances, to exceed two (2) hours following the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.

6. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

7. All deaths in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) and Community Residential Care Facilities (CRCF) must be reported in writing by the DDSN Regional Center/Provider designee to the Health Licensing Division of the South Carolina Department of Health and Environmental Control (DHEC) at the same time a report is made to DDSN.

8. An Administrative Review will be conducted for all deaths. **This review should never interfere with any outside investigation.** For ICF/IID and CRCF locations, the results of all Administrative Reviews must be submitted to DDSN and to DHEC, within five (5) calendar days of the death. For all other residential settings, the results of all Administrative Reviews must be submitted to DDSN within ten (10) business days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

Notification Procedures

For those persons living in a DDSN operated or contracted residential setting, the family/guardian or primary correspondent will be notified of the death by the method they have identified in the person's plan such as by phone, personal visit or by notifying their minister who would then notify the family. If the family has made no prior arrangements, the attending physician will inform the family of the death of their family member per the physician's death notification policy. The provider representative will seek permission for an autopsy at that time as indicated by law. When gathering information on the death of a DDSN consumer, care must be taken to respect the feelings of survivors. The provider representative should express condolences, indicate the importance of gathering key information for the benefit of other individuals with disabilities, and proceed to fill out the "Report of Death" by retrieving information from the participant and staff records. If family members are unwilling/unable to participate in filling out the report, then the staff person should proceed with the form using information from other approved participant records.

Autopsy

An autopsy will be performed following the death of a person when requested by the coroner or SLED and should also be done when:

a) Death is an unexpected or unexplained outcome as determined by the attending physician and/or medical director, and/or Executive Director, or;

b) Requested by the family. (*Costs for an autopsy requested by the family, but not required by the Coroner or SLED, will be the financial responsibility of the family*).

If the circumstances of the death do not require an autopsy (i.e., not ordered by the Coroner's Office or SLED), but one is sought, the attending physician will seek permission from the next of kin or correspondent. If permission is denied, this objection will be honored, and the denial recorded in the chart by the requesting physician/medical director or DDSN Regional Center/Provider designee.

Disposition of Remains

The remains of the deceased will be released according to the wishes of the person as specified in a pre-need document or to the parents or other responsible relative or guardian of record. If no responsible person is known or if such person refuses to accept custody of the remains, the DDSN Regional Center/Provider designee will arrange for burial or other appropriate disposition of the remains.

If possible, persons should be buried in accordance with their documented preferences or, if none, in their home community. If no family member or relative can be located to help make arrangements for the burial in the home community, the DDSN Regional Center/Provider can arrange for the burial at an appropriate community or church cemetery. In these cases, burials will be the financial responsibility of the DDSN Regional Center or provider previously supporting the person after all other resources have been utilized.

Personal Funds

At the time of death, all funds conserved for the person are frozen, and no disbursements will be made without legal authority of the Probate Court. Should this pose a problem for families needing immediate access to the person's funds for funeral expenses, the DDSN Regional Center/Provider will co-operate with the family to assure the burial is handled in a reasonable manner in accordance with the family's wishes.

The DDSN Regional Center/Provider designee will file the Affidavit for Collection of Personal Property Pursuant to Small Estate Proceeding available on the judicial website https://www.sccourts.org/forms/ (Probate Court Form 420ES). The Probate Court will issue an order permitting payment to the proper persons.

B. Deaths of persons of any age, other than those living in a residential program operated by or contracted for operation by DDSN whose death occurs at a DDSN Regional Center or provider location (e.g., day program) or while under the supervision of a DDSN Regional Center or board/provider staff person (e.g., respite, employment).

1. DDSN Regional Center/Provider designee will report the death to DDSN using the Death Reporting function of the Incident Management System within 24 hours.

2. If the death was unexpected or unexplained, the DDSN Regional Center/Provider designee must call the DDSN Associate State Director of Operations or their designee immediately. Immediately means as soon as reasonably possible but, under no circumstances, to exceed two (2) hours following the death. The Death Reporting function on the Incident Management System must be completed within 24 hours.

3. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

4. The physician or DSDN Regional Center/Provider designee shall notify the county coroner's office immediately of all deaths unless the death occurred in a hospital setting.

5. An Administrative Review will be conducted of all child deaths. **This review should never interfere with any outside investigation.** Results of all Administrative Reviews must be submitted to DDSN and to DHEC, as applicable, within ten (10) working days of the death. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The DDSN Regional Center/Provider designee will submit the final report.

IV. Reporting the Death of Persons enrolled in a DDSN operated HCB Waiver who do not meet the criteria listed previously

In order to provide quality assurance oversight, DDSN tracks relevant information on the deaths of all persons enrolled in a DDSN operated HCB Waiver. When the death that does not meet the criteria in A or B above, the Waiver Case Manager is responsible for reporting to DDSN.

1. Waiver Case Managers will report the death to DDSN using the Death Reporting function on the Incident Management System within 24 hours of their notification of the fatality.

2. If there is any reason to believe that abuse or neglect may have occurred, the provider will also need to complete a corresponding ANE Report on the Incident Management System.

3. An Administrative Review will be conducted for all deaths. **This review should never interfere with any outside investigation**. The Waiver Case Manager must complete the initial and final death reports as completely as possible, noting any suspected cause of death and whether an autopsy has been requested. The results of the review must be documented in the Report of Death-Final Report, located within the Death Reporting function of the Incident Management System. The Waiver Case Manager will submit the final report within ten (10) working days of the death.

V. Mortality Reviews

Providers are responsible for completing all required documentation to close out service authorizations, disenroll from Waiver services, and terminate billing. In addition, providers are expected to promptly comply with any requests for information from the Vulnerable Adult Fatality Committee or from the SLED Vulnerable Adult Investigations Unit. DDSN will participate in the Vulnerable Adult Fatalities Review Committee and the Children's Fatalities Review Committee to improve service quality and to develop and implement measures to prevent future deaths from similar causes from occurring if at all possible.

Through the DDSN Regional Center/Provider Risk Management Committee, a Mortality Review Process should evaluate information gathered during the reporting process to identify the following:

1. Immediate and secondary causes of death;

2. If the deaths were:

    a. Expected due to a known terminal illness;
    b. Associated with a known chronic illness;
    c. A sudden, unexpected death;
    d. Due to unknown cause;
    e. Due to an accident and, if so, the type of accident;
    f. Due to self-inflicted injury or illness (e.g., suicide, serious self-injurious behavior);
    g. Due to suspicious or unusual circumstances; and
    h. Due to suspected or alleged neglect, abuse, or criminal activity.
    3. Findings from any outside investigation (as available/applicable) such as SLED, law enforcement etc.

4. Any trends and/or patterns in the deaths reported.

5. Immediate and longer-term circumstances and events that contributed to or were associated with deaths.

6. Actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths.

Barry D. Malphrus Vice Chairman	Stephanie M. Rawlinson Chairman

Related Directives or Laws:

Child Protection Reform Act, S.C. Code Ann. § 20-7-480, et seq.
Omnibus Adult Protection Act, S.C. Code Ann. § 45-35-35, et seq.

200-02-DD: Financial Management of Personal Funds
200-12-DD: Management of Funds for Individuals Participating in Community Residential Programs
Administrative Agency Standards

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 ~~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.	
~~107~~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.	
~~108~~110	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~~
~~109~~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: ~~www.therapservices.net/southcarolina.~~ https://secure.therapservices.net/auth/login
~~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~~	"~~Employment/Day Services" includes Employment-Individual, Employment-Group, Day Activity, Career Preparation, Community Services and Support Center.~~

	~~Residential and Employment/Day service locations.~~	~~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.	

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 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	~~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.~~
206	All board meetings and minutes comply with the South Carolina's Freedom of Information Act. • Minutes, policies, and by-laws must be consistent with state and local laws (S.C. Code Ann. § 30-4-20).	~~Minutes, policies, and by-laws must be consistent with state and local laws (SC Code Ann. §44-20-378).~~

GOVERNING BOARD: DISABILITIES AND SPECIAL NEEDS (DSN) BOARD		
	STANDARD	~~**GUIDANCE**~~
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: 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. • 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/CEO 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.	
304	The governing body defines the expectations for the President/CEO's performance and at least annually evaluates and provides feedback regarding performance.	

~~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."~~
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 a relative of the Executive Director. • A supervisor from supervising an employee who is a relative.	

PERSONNEL ADMINISTRATION		
	STANDARD	~~**GUIDANCE**~~
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 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.	~~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.~~
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.~~

PERSONNEL ADMINISTRATION		
	STANDARD	~~**GUIDANCE**~~
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. c. Employee handbook must contain: • Discussion of the laws described in the written policies; • Rights of the employee 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,~~	

PERSONNEL ADMINISTRATION		
	STANDARD	~~**GUIDANCE**~~
	~~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."~~	

~~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, 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.	

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.	
610	The Agency shall submit a certified annual audit of its agency's financial statements as specified in DDSN Directive 275-04-DD: Procedures for Implementation of DDSN Provider Audit Policy, by September 30th of each year for the prior year, unless DDSN provides an extension. The Provider also shall submit a reconciliation of the cost reports to the audited financial statements.	

QUALITY/RISK MANAGEMENT	
701	The Agency has a Quality Management Plan to 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. • Roles and responsibilities of the staff persons related to the practice of quality management. The Agency shall revise the quality management plan every 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.
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.
704	The Agency uses solicited feedback to improve or expand services. The provider will track major areas of need identified as a result of the annual participant/family satisfaction surveys and actions planned and taken.
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 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.
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.
710	The Agency must follow reporting requirements and track/trend/analyze the use of restraints and/or other restrictive interventions on a quarterly basis by reviewing documentation of each restraint employed, by type, to include the staff implementing the restraint, the duration of the restraint, notification provided to the Human Rights Committee, and notification provided to the Behavior Supports provider. When planned restraints are included in the Behavior Support Plans, the provider ensures the Behavior Support Plans are submitted to DDSN for approval. When restrictive interventions are employed as a default action because other measures in the Behavior Support Plan were not effective, the restraint/restrictive intervention must be reported as a Critical Incident. Consumer/staff injury resulting from the use of restraints must be tracked and analyzed. Narrative information may also be analyzed in order to identify more specific trends with a continual emphasis on restraint reduction and elimination. If there are no restraints or restrictive interventions reported for the prior review period, the Agency must document their monitoring efforts to ensure unauthorized restraints were not implemented.

FOR INFORMATIONAL PURPOSES ONLY

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Reference Number:	275-05-DD
Title of Document:	General Duties of the South Carolina Department of Disabilities and Special Needs (DDSN) Internal Audit Division
Date of Issue:	February 14, 2002
~~Last Review:~~	~~November 19, 2020~~
Date of Last Revision:	~~November 19, 2020~~XXXX, 2022 (**REVISED**)
Effective Date:	~~April 16, 2017~~XXXX, 2022
Applicability:	DDSN Central Office, DDSN Regional Centers ~~and all providers of DDSN Sponsored Services including: Adult Companion Providers, Case Management Providers, Day Service Providers (i.e., career prep, day activity, community services, support center), Early Intervention Providers, Employment Services Providers, Financial Management Providers, HASCI Rehabilitation Support Providers, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Providers, Intake Providers, Residential Habilitation Providers and Respite Providers.~~ DDSN-Operated Community Settings, DSN Boards and Contracted Service Providers of all Service Programs

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Purpose and Mission

The purpose of the South Carolina Department of Disabilities and Special Needs (DDSN's) Internal ~~Auditing~~ Audit Division (IA) is to provide ~~an~~ independent, objective assurance and consulting ~~activity~~ services designed to add value and improve the agency's~~/service providers'~~ operations. The mission of internal audit is to enhance and protect organizational value by providing risk-based and objective assurance, advice, and insight. ~~It~~ IA helps ~~the organization~~DDSN accomplish ~~their~~ its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control~~, governance, and the implementation of best practices~~ processes.

Standards for the Professional Practice of Internal Auditing

IA will govern itself by adherence to the mandatory elements ~~to~~ of The Institute of Internal Auditors'(IIA) International Professional Practices Framework, including the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the *International Standards for the Professional Practice of Internal Auditing*, and the Definition of Internal Auditing. The Internal Audit Director will report periodically to senior management and the Finance and Audit Committee regarding the Internal Audit Division's conformance to the Code of Ethics and the *Standards*.

Authority

It is the policy of DDSN to establish and support an Internal Audit Division as an independent appraisal function to examine and evaluate DDSN and provider activities as a service to Executive Management and the DDSN Commission.

The State Director shall appoint the Director of Internal Audit, subject to the approval of the full DDSN Commission. The Director of Internal Audit shall be responsible for the day-to-day administration and operation of the Internal Audit Division, subject to policies, rules and regulations adopted by the DDSN Commission.

Subject to the approval of the State Director, the Director of Internal Audit shall prescribe the organizational structure and the personnel necessary to carry out the Internal Audit function.

The Director of Internal Audit reports administratively to the State Director and functionally to the Finance and ~~/~~Audit Committee Chair of the DDSN Commission.

~~An annual audit plan will be developed by the Director of Internal Audit and submitted for review to the State Director, reviewed and approved by the Finance/Audit Committee, with final approval by the DDSN Commission. If adjustments are necessary due to changes in needs or priorities of DDSN, the changes will be coordinated with affected personnel.~~

~~In carrying out their responsibilities, members of the Internal Audit Division will have full, free, and unrestricted access to all DDSN funded service provider organizations' activities, records (manual and electronic), property, and personnel, and to the Finance/Audit Committee of the Commission, as necessary.~~

The Director of Internal Audit will have unrestricted access to, and communicate and interact directly with, the Finance and Audit Committee, including in private meetings without management present.

To establish, maintain, and assure that DDSN IA has sufficient authority to fulfill its duties, the Finance and Audit Committee will:

- Approve the IA Division's ~~internal audit~~ charter;
- ~~Approve the Internal Audit Committee Charter;~~
- Approve the risk-based internal audit plan;
- Approve the ~~internal audit~~Internal Audit Division's budget and resource plan;
- Receive communications from the Director of Internal Audit on the Internal Audit

Commented [CC1]: Included in the SCDSN Finance Audit Committee Charter

Division's performance relative to ~~the~~ its plan and other matters;
- Approve decisions regarding the appointment and removal of the Director of Internal Audit;
- Approve the remuneration of the Director of Internal Audit; and
- Make appropriate inquiries of management and the Director of Internal Audit to determine whether there is inappropriate scope or resource limitations.

IA is authorized to:

- Have full, free, and unrestricted access to all functions, records, property, and personnel pertinent to carrying out any DDSN, DSN Board or Contracted Service Provider engagement, subject to accountability for confidentiality and safeguarding of records and information.
- Allocate resources, set frequencies, select subjects, determine scopes of work, apply techniques required to accomplish audit objectives, and issue reports.
- Obtain assistance from the necessary personnel of DDSN, as well as other specialized services from within or outside DDSN, in order to complete the engagement.

Independence and Objectivity

~~The DDSN Internal Audit Division is a staff function, and as such, does not have any responsibility or authority over areas that are being audited; therefore, any review or recommendation by Internal Audit will not in any way relieve the supervisor of the assigned responsibilities inherent with his/her position.~~

The Director of Internal Audit will ensure that the IA Division remains free from all conditions that threaten the ability of internal auditors to carry out their responsibilities in an unbiased manner, including matters of audit selection, scope, procedures, frequency, timing, and report content. If the Director of Internal Audit determines that independence or objectivity may be impaired in fact or appearance, the details of the impairment will be disclosed to ~~the~~ appropriate parties.

Internal auditors will maintain an unbiased mental attitude that allows them to perform engagements objectively and in such a manner that they believe in their work product, that no quality compromises are made, and that they do not subordinate their judgment on audit matters to others.

Internal Auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, Internal Auditors will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair their judgment, including:

- Assessing specific operations for which they had responsibility within the previous year.
- Performing any operational duties for DDSN or its contracted service providers.
- Initiating or approving transactions external to the Internal Audit Division.
- Directing the activities of any DDSN employee not employed by the Internal Audit Division, except to the extent that such employees have been appropriately assigned to auditing teams or to otherwise assist internal auditors.

Where the Internal Audit Director has or is expected to have roles and/or responsibilities that fall outside of internal auditing, safeguards will be established to limit impairments to independence or objectivity.

Internal Auditors will:

- Disclose any impairment of independence or objectivity, in fact or appearance, to appropriate parties.
- Exhibit professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined.
- Make balanced assessments of all available and relevant facts and circumstances.
- Take necessary precautions to avoid being unduly influenced by their own interests or by others in forming judgments.

The Director of Internal Audit will confirm to the Finance and Audit Committee, at least annually, the organizational independence of the Internal Audit Division.

The Director of Internal Audit will disclose to the Finance and Audit Committee any interference and related implications in determining the scope of internal auditing, performing work, and/or communicating results.

Scope of Internal Audit Activities

The scope of internal audit activities encompasses, but is not limited to, objective examinations of evidence for the purpose of providing independent assessments to the DDSN Commission and management on the adequacy and effectiveness of governance, risk management, and control processes for DDSN. Internal audit assessments include evaluating whether:

- Risks relating to the achievement of DDSN's strategic objectives are appropriately identified and managed.
- The actions of DDSN's commissioners, executive management, employees and contractors are in compliance with DDSN's directives, standards, policies, procedures and applicable laws and regulations.
- The results of operations or programs are consistent with established goals and objectives.
- Operations or programs are being carried out effectively and efficiently.
- Established processes and systems enable compliance with the directives, standards, policies, procedures, laws and regulations that could significantly impact DDSN.
- Information and the means used to identify, measure, analyze, classify and report such information are reliable and have integrity.
- Resources and assets are acquired economically, used efficiently, and protected adequately.

The Director of Internal Audit will report periodically to senior management and the Finance and Audit Committee regarding:

- The Internal Audit Division's purpose, authority, and responsibility.
- The Internal Audit Division's plan and performance relative to its plan.

- The Internal Audit Division's conformance with the IIA's Code of Ethics and *Standards*, and action plans to address any significant conformance issues.
- Significant risk exposures and control issues, including fraud risks, governance issues, and other matters requiring the attention of, or request by, the Finance and Audit Committee.
- Results of audit engagements or other activities.
- Resource requirements.
- Any response to risk by management that may be unacceptable to DDSN.

The Internal Audit Director also coordinates activities, where possible, and considers relying upon the work of other internal and external assurance and consulting service providers as needed. The Internal Audit Division may perform advisory and related client service activities, the nature and scope of which will be agreed with the client, provided the Internal Audit Division does not assume management responsibility.

Opportunities for improving the efficiency of governance, risk management, and control processes may be identified during engagements. These opportunities will be communicated to the appropriate level of management.

Responsibility

The Internal Audit Director has the responsibility to:

- Submit an annual risk-based internal audit plan to the State Director, Finance and Audit Committee, and DDSN Commission for review and approval.
- Communicate to the State Director and the Finance and Audit Committee the impact of resource limitations on the internal audit plan.
- Review and adjust the internal audit plan, as necessary, in response to changes in DDSN's priorities, risks, operations, programs, systems and controls.
- Communicate to the State Director and the Finance and Audit Committee any significant interim changes to the internal audit plan.
- Ensure each engagement of the internal audit plan is executed, including the establishment of objectives and scope, the assignment of appropriate and adequately supervised resources, the documentation of work programs and testing results, and the communication of engagement results with applicable conclusions and recommendations to appropriate parties.
- Follow up on engagement findings/observations and corrective actions, and report periodically to senior management and the Finance and Audit Committee any corrective actions not effectively implemented.
- Ensure the principles of integrity, objectivity, confidentiality, and competency are applied and upheld.
- Maintain a professional audit staff that collectively possesses or obtains the knowledge, skills, experience, professional certifications, and other competencies needed to meet the requirements of the internal audit charter.
- Ensure emerging trends and successful practices in internal auditing are considered.

- Establish and ensure adherence to policies and procedures designed to guide the Internal Audit Division.
- Ensure adherence to DDSN's relevant policies and procedures, unless such policies and procedures conflict with the internal audit charter. Any such conflicts will be resolved or otherwise communicated to senior management and the Finance and Audit Committee.
- Ensure conformance of the Internal Audit Division with the *Standards*, with the following qualification:
    - If the Internal Audit Division is prohibited by law or regulation from conformance with certain parts of the *Standards*, the Internal Audit Director will ensure appropriate disclosures and will ensure conformance with all other parts of the *Standards*.

~~The primary objective of the Internal Audit Division is to assist members of management in the effective discharge of their responsibilities by reviewing activities/programs and providing analyses, recommendations, and information regarding the activities/programs reviewed. The reviews are conducted to assure DDSN and its provider organizations comply with applicable State/Federal laws, standards, directives, policies, procedures and regulations. As such, the DDSN Internal Audit Division is concerned with all phases of DDSN and its provider organizations' operations. To this end, the Internal Audit Division will:~~

~~1) Determine the adequacy, efficiency, and effectiveness of systems of internal accounting and operating controls;~~

~~2) Determine the accomplishment of established goals and objectives;~~

~~3) Review and determine the reliability and integrity of financial information;~~

~~4) Determine the means of safeguarding assets and consumer funds;~~

~~5) Review and determine compliance with policies, procedures, laws, and regulations; and~~

~~6) Should Internal Audit discover a conflict of interest regarding any DDSN staff, the Audit Director will report such conflict to the Finance Audit Committee in Executive Session.~~

~~**Activities**~~

~~Specific internal audit responsibilities are as follows:~~

~~1. Perform scheduled audits of service provider organizations, DDSN Regional Centers, and DDSN Central Office for the effectiveness of operations and compliance with established standards and policies.~~

~~2. Perform special request audits in response to allegations/complaints/concerns of a financial or programmatic nature.~~

~~3. Provide consultation, technical assistance, and training to DDSN Divisions, DDSN Regional Centers and the service provider organizations.~~

4. Review, evaluate, and follow up on internal audit findings and recommendations with appropriate management staff.

5. Coordinate internal audit efforts with external auditors/reviewers.

6. Report to the DDSN Commission as requested to outline internal audit activities and review completed reports.

Audit Process/Steps

DDSN Internal audits will be conducted in accordance with this policy and with the procedures outlined in the DDSN *Audit Procedures Manual*. Generally, an audit of any activity or facility will consist of the following steps with the exception for a special audit (i.e., cash related, suspected fraud, etc.) which will be conducted on a no-notice or short notice basis.

1. When practical (i.e., time or type of audit), an engagement memo will be issued prior to a scheduled audit. The purpose of the engagement memo is to notify management of the area to be reviewed, describe the audit to be performed, and to request items needed at the onset of the review. If time does not permit, management will be notified by telephone and/or e-mail as soon as possible.

2. Preliminary planning consists of consideration being given to: any prior audit results (if applicable); internal controls; record keeping employed; documentary evidence required (i.e., required by policy, procedure, law, regulation, etc.); applicable policies and procedures; prior reviews by external and internal parties; and the type of report to be issued.

3. An audit program will be developed based on decisions reached during the preliminary planning. The program will be modified as dictated by discoveries made during the audit.

4. An entrance conference will be conducted between the auditor and management of the work unit(s) to be reviewed to discuss the nature of the audit, the areas to be audited, and the support required.

5. Fieldwork will consist of inquiry of appropriate personnel, observation of applicable activities, and examination of applicable records and documents. Fieldwork will depend on the type of audit being performed as well as the type of activity, operation, or program being reviewed.

6. The auditor will conduct an exit conference with management at the conclusion of the fieldwork to discuss the results of the audit. The exit conference should be a summary of concerns noted during the review that were communicated to auditee management throughout the engagement.

7. Findings will be documented after the completion of the fieldwork. These draft findings will be sent to the appropriate manager for the area being audited with a request that the findings be reviewed and corrective action plans be submitted to DDSN Internal Audit within 30 calendar days, or less, per DDSN Internal Audit's request.

~~**Reporting**~~

~~A draft report will be issued upon receipt of an acceptable corrective action plan; the draft will then be forwarded to the auditee for a final review for completeness and accuracy with follow-up to Internal Audit staff regarding any corrections/concerns detailed in the draft report.~~

~~Upon receiving the auditee's corrective action plan, Internal Audit staff will review actions to ensure satisfactory disposition of the audit findings and recommendations. If a corrective action plan is considered unsatisfactory, DDSN Internal Audit staff will hold further discussions to achieve acceptable disposition. If a mutually acceptable corrective action plan cannot be attained, an auditor's comment may be noted in the final report.~~

~~Once the draft report is accepted by both parties, a final report will be issued which incorporates the findings and submitted corrective action plans.~~

~~The results of formal audits and/or investigations will be reported to appropriate management based on the entity reviewed. In almost all cases (exceptions being criminal cases where DDSN Internal Audit staff is assisting law enforcement and is precluded from discussing the review based on the signing of non-disclosure statements), audit reports will be shared with the DDSN State Director, DDSN Commissioners, appropriate DDSN management levels, and in the case of provider organizations, the Executive Director and members of the organizations' governing board.~~

Commented [CC2]: To align DDSN IA Charter with IIA Model Internal Audit Activity Charter, remove Audit Process/Steps and Reporting from directive and include on DDSN website for Internal Audit Division.

Financial Sanctions

A financial sanction~~, by way of a contract withhold,~~ is only applicable to repeat findings as they relate to the health, safety and/or welfare of individuals being served.

The sanction will only apply when ~~a~~ follow-up ~~audit is~~procedures are conducted and ~~finds~~ the accepted corrective action from the initial audit was not implemented. The Provider will then be given notice and be allowed 90 days to implement the agreed upon corrective action. If in the subsequent visit (i.e., the third visit), the corrective action plan was not implemented, the Provider will receive a financial sanction in the amount of a minimum of $1,000 with a potential increase based on the discretion of the Finance and Audit Committee.

An appeals process will be available to any Provider who is assessed a financial sanction for repeat internal audit findings/observations as they relate to the health, safety, and/or welfare of individuals being served. The appeal shall be requested within 30 days of notice of the sanction. The Appeals Committee membership will include: two (2) DDSN staff members; two (2) community provider members from each provider association; and one (1) consumer or family member. Once appointed, the Appeals Committee shall decide among the membership who shall be named as chair. Once appointed, the members shall serve for two (2) years.

~~**Statement on Fraud**~~

~~Auditors should be alert to situations (i.e., observations, informants) or transactions that could indicate actual or potential fraud or abuse, and consider extending audit steps and procedures, as necessary, to determine the effect of fraud on the audit results. The Audit Director should be made aware as soon as the auditor discovers potential or suspected fraud.~~

~~Auditors should exercise due professional care in pursuing indications of suspected fraudulent activity so as to avoid mistaken accusations or alerting suspected individuals and to not interfere with potential investigations or legal proceedings. If an auditor suspects fraud, embezzlement, or other possible criminal conduct, this should be discussed with the Auditor-In-Charge before proceeding further. The Auditor-In-Charge will in turn initiate a conference with the DDSN Audit Director and any other parties deemed appropriate (i.e., DDSN General Counsel). Depending on the extent and severity of the suspected fraud, appropriate reporting to the responsible entity (i.e., local law enforcement, SLED, etc.) will take place, and fieldwork in the area may be discontinued temporarily.~~

~~If the findings from an audit give the auditor reason to believe that fraud may have occurred in the Medicaid program, under the Code of Federal Regulations, 42 CFR §455.15, then the case must be referred to the Medicaid Fraud Control Unit (MFCU) in the South Carolina State Attorney General's Office.~~

Commented [CC3]: To align DDSN IA Charter with IIA Model Internal Audit Activity Charter, remove Statement on Fraud from directive and include in DDSN Audit Procedures Manual.

Quality Assurance and Improvement Program

IA will maintain a quality assurance and improvement program that covers all aspects of the internal audit activity. The program will include an evaluation of the ~~internal audit activity's~~Internal Audit Division's conformance with the *Standards* and an evaluation of whether ~~the~~ Internal Auditors apply the IIA's Code of Ethics. The program will also assess the efficiency and effectiveness of the internal audit activity and ~~identifies~~ identify opportunities for improvement.

The Director of Internal Audit will communicate to senior management and the ~~Commission~~ Finance and Audit Committee on the internal audit activity's quality assurance and improvement program, including results of ongoing internal assessments~~,~~ and external assessments conducted at least once every five years by a qualified, independent assessor or assessment team from outside DDSN.

Barry D. Malphrus
Vice Chairman

~~Gary C. Lemel~~Stephanie M. Rawlinson
Chairman