South Carolina Department of Disabilities & Special Needs
Quality Management Bulletin
May 2022

Stability Surveys for Calendar Year 2021

The South Carolina Department of Disabilities & Special Needs (DDSN) will participate in the annual Staff Stability Survey as a part of the National Core Indicators (NCI) for calendar year 2021. DDSN has partnered with National Association of State Directors of Developmental Disabilities Services (NASDDDS) and Human Services Research Institute (HSRI) for the past several years to administer the National Core Indicators (NCI) survey. This survey has provided DDSN with data about the strengths and weaknesses of our system and valuable information about our direct support workers.

Increasing attention has been paid to the role that the Direct Support Professional (DSP) workforce plays in the provision of supports for adults aged 18 and over with intellectual and developmental disabilities (ID/DD) and the staffing challenges of the past year. The Staff Stability Survey will give us reliable measures for the average length of DSP employment, number of DSPs employed by various types of agencies, vacant positions, wages, benefits and recruitment and retention strategies. The data gathered through this survey is very important as DDSN and the provider network in South Carolina continue to make progress in educating stakeholders about our workforce and the need to increase hourly wages. There is also a special section this year to assess the impact of the public health emergency of staffing availability.

Executive Directors for each agency providing direct services to adults have received an email from NCI with instructions on how to complete this survey using their online data entry system. Results of the survey will only be reported in the aggregate and your organization will not be identified in any way. The survey should be completed by your Human Resources or Payroll offices and reflect DSPs who were on the payroll during any period between January 1, 2021, and December 31, 2021. *This survey must be completed by June 30, 2022.*

DDSN is aware of the many competing interests for staff time and resources. We appreciate your time and feedback as we participate in this statewide survey.

National Core Indicators (NCI) In-Person Surveys

The National Core Indicators Project (NCI®) is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The purpose of the program, which began in 1997, is to support NASDDDS member agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time, to compare results across states, and to establish national benchmarks.

DDSN will be participating in the National Core Indicators' In-Person Adult Surveys in 2022. DDSN is among 45 other states participating in this process Alliant staff will begin completing interviews in January 2022. In order for Alliant to conduct the in-person survey, a background survey must be completed prior to the visit from Alliant.

DDSN recognizes the thorough completion of the background survey can take time and there are many competing priorities. This year, as an incentive for participation, DDSN will reimburse providers for time spent completing valid surveys. The background surveys will be sent to the Case Management provider unless the person receives residential habilitation. In that case, the residential provider will receive the background survey. In either case, each provider staff will complete the surveys to the best of their abilities. Once all surveys are completed, the provider will submit an invoice to DDSN Quality Management for review and payment.

Each provider agency should expect to receive an approximate 5% sample for adults receiving at least one service in addition to case management. There will be maximum of 25 surveys for any one provider agency. The samples will be pulled and initial communications with providers will be sent in the coming weeks. Upon receipt of the provider sample, each organization will be asked to complete an initial interest survey by the deadline established. Participation interest responses will be required for each person in the sample.

If you have questions, please contact us at Qualitymanagement@ddsn.sc.gov.

Incident Management Reporting

Why does Reporting Matter?

- Federal Requirements for ICFs/IID and Medicaid Home & Community Based Services Waiver Requirements
- States must provide certain assurances to CMS to receive approval for an HCBS waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the service (42 CFR § 441.302). DDSN Directives state when determining whether a particular event should be reported, the best guidance is "when in doubt, then report."

Initial Reports:

- The HCBS waivers require that the service provider make an initial report of an incident within 24 hours or the next business day.
- ICF/IID and CRCF Regulations require reports within 24 hours.
- The initial report should include a brief description of the incident and provide sufficient details to ensure that any authorized reviewer would have a good understanding of the incident, parties involved, and outside medical or law enforcement intervention.
- When initial reports are late, there is a risk that providers were unable to implement safety plans to protect persons served by the agency. This could potentially result in providers continuing to place the health and well-being of individuals at risk of further events.

Administrative/ Management Reviews:

- The provider must then complete an internal review of the incident within 10 working days (5 calendar days for ICFs/IID and CRCFs).
- During the administrative review process, reviewers are permitted to interview witnesses and collect witness statements as long as they do not interfere with the investigation of an allegation of ANE conducted by a State investigative agency.
- As a result of delays in submitting results of the internal reviews, providers may have continued to place the health and well-being of developmentally disabled individuals at risk of further critical incidents, ANE incidents, or death. For example, a delay could result in a staff member remaining employed after that member, based on the results of the internal review, should have been received additional training, disciplinary action, or perhaps terminated.

Addendum to Administrative/Management Review Report:

- If the disposition of the Administrative/ Management Review changes, or if there is additional information after the Final Report (e.g., the results from external agency investigation/review are received, or if upon approval from DDSN the employee is reinstated prior to the completion of a state investigative agency's final report), the Addendum to Administrative/ Management Review Report must be completed and sent to the DDSN Quality Management within 24 hours or the next business day of the change.

The Internal Review Process*

Administrative Leave Without Pay- The first step after an allegation has been reported is to put the alleged perpetrator(s) on administrative leave without pay (ALWOP). This notification to the alleged perpetrator is given by a member of management. This action helps protects the integrity of the information you will review.

Gathering Supporting Documentation- This step includes any photographs (if applicable), T-Logs, GER's, witness statements, daybook entries, timesheets, MAR's, and anything else that would help to piece a puzzle together. You are trying to recreate a scene that you did not witness.

Interviews- Interviews are crucial in fact finding, but you have to be prepared. During your gathering of information, write down questions where you need clarification. Make a list of the people you wish to speak with. Start with the alleged victim and work through all potential witnesses. When talking to the people involved, try to include open ended questions, such as, "Tell me how you completed that task," or "Can you tell me what a day at work is like for you?" etc…
Don't forget to be an active and good listener. Engage in the conversation! Don't just ask questions and write down responses.

Presenting Findings- Remember you are presenting your findings in the review, but the reader has not been through this process with you. You have to be clear and not just assume that the reader is familiar with the people you are talking about. Try to give a brief background of the alleged victim, include their level of disability, their personality, whether a behavior support plan is in place (or pending development), verbal or other communication skills, if there has been a recent trauma, change in routine, and anything to assist the readers to have a picture of who they are. Next, you must present the facts as you found them. Remember there is a difference between fact and opinion.

Reaching a Conclusion- This is the culmination of your efforts: reviewing, talking, notes, research, summaries, etc. Reaching a conclusion can be difficult because your job is to only look at verifiable Policy and Procedure violations or evidence of misconduct. This does not necessarily mean there were no problems identified, just no violations. It is sometimes hard to separate the two. Only State Investigative Agencies (SLED, Law Enforcement, DSS, Attorney General's Office, or the Ombudsman's Office) can investigate and substantiate/un-substantiate abuse.

*Taken from SCHSPA Presentation: "*Using the Internal Administrative Review Process to Effect Change and Improve Supports*" T. Bradford, M. Carter, and A. Dalton, March 8, 2022

Questions to ask prior to submitting the report to DDSN may include any of the following:

- ✓ Does the report list all residents and staff who were present at the time of the incident and/or may have knowledge of the incident?
- ✓ Were statements collected from all staff with direct knowledge of the event?
- ✓ Was a statement collected from the person receiving services?
- ✓ Was the family notified of the incident?
- ✓ Were the appropriate state agencies informed of the allegations?
- ✓ Was a statement collected from other residents that may have witnessed the event?
- ✓ Is there a need to re-evaluate a Physical Management Plan?
- ✓ Did staff participate in required OJT and/or annual training?
- ✓ When were staff last trained on the ANE/CI Policy?
- ✓ When were staff last trained on Resident Rights and dignity/respect issues?
- ✓ When were staff last trained in Crisis Management?
- ✓ Are the Crisis Management techniques effective in redirecting the person's behavior?
- ✓ Was a GER appropriately completed?
- ✓ Date of last BSP revision:
- ✓ Date of last observation by the Psychologist/plan author:
- ✓ Have staff been trained in the use of the BSP?
- ✓ Is there a need to re-evaluate a Behavior Support Plan?
- ✓ Was the location staffed according to individual plans?
- ✓ Did a nurse assess the person or was the person sent for a medical evaluation?
- ✓ If the person has a 1:1 staff assigned, who provided training to ensure the staff understood their responsibilities?
- ✓ Date of last Management Team on-site review in the location (unannounced quarterly visit to the home):
- ✓ Were there any findings during the Management Team On-site Review to be addressed? If so, were those actions completed?

Monitor Hot Spot Issues

Injuries of Unknown Origin-
How often does this happen? What types of injuries?

ER Visits with no admission-
What happened? Are there patterns?

Behavior Supports and Crisis Management-
Are appropriate supports in place?

Use of the "Other" category-
Nearly all Critical Incident Types will fit into a defined category

Mortality Review-
Look at the coordination of care and prevention efforts.

Report Expectations

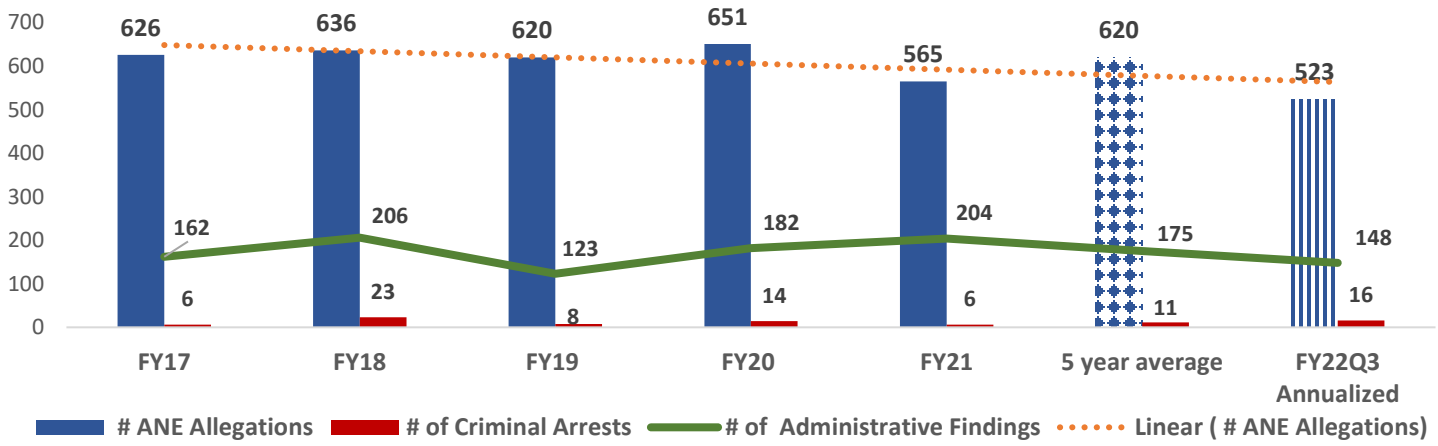
- **Timeliness of reporting!!**
  - Communication is key. Staff must report and get the process started. We all have competing priorities, but reports must be submitted on time.
- **Know the timeframes for your programs**
  - CRCF/ICF reporting timeframes are 5 calendar days, not business days!
- **Management actions vs. Disciplinary Action**
  - Personnel actions are not your management action. They are just the beginning of the process. What will your management team do in response to the allegation/event?

SCDDSN Incident Management Report 5-year trend data

for Community-Based Services *(Includes Residential & Day Service Settings) Thru 3/31/2022*

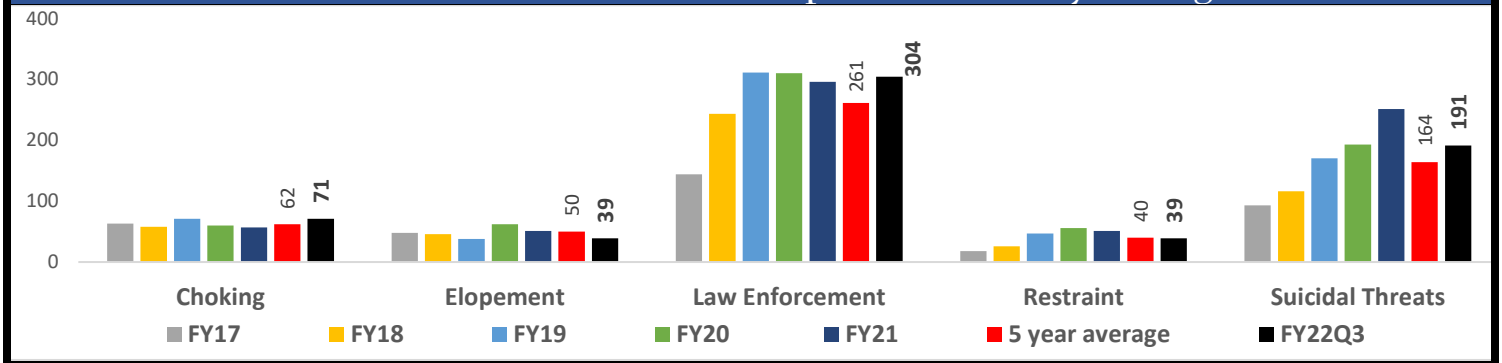
Allegations of Abuse, Neglect, Exploitation	FY17	FY18	FY19	FY20	FY21	5 YEAR Average	FY22 Annualized (Actual Q3)
# of Individual ANE Allegations	626	636	620	651	565	**620**	**523** (392)
# of ANE Incident Reports (One report may involve multiple allegations)	455	450	415	436	388	**429**	**505** (374)
Rate per 100	10.5	11.9	9.6	11.8	10.9	**10.9**	**9.3**
# ANE Allegations resulting in Criminal Arrest	6	23	8	14	7	**11**	**16** (12)
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	162	206	123	182	204	**175**	**148** (111)

ANE Allegations: Comparison to Arrest Data & Administrative Findings



Critical Incident Reporting	FY17	FY18	FY19	FY20	FY21	5 YEAR Average	FY22 Annualized (Actual Q3)
# Critical Incidents ***	918	1071	916	982	974	**972**	**1,247** (935)
Rate per 100	10.5	11.9	9.6	11.8	10.9	**10.9**	**15.4**
# Choking Events	63	58	71	65	57	**62**	**71** (53)
# Law Enforcement Calls	144	243	311	310	296	**261**	**304** (228)
# Suicidal Threats	93	116	170	193	251	**164**	**191** (143)
# Emergency Restraints or Restraints w/ Injury	18	26	47	56	51	**40**	**39** (29)

5 Year Critical Incident Trend Report- Community Settings



Note: Total CI Reporting numbers for FY17 have been adjusted for comparison due to a change in the criteria for reporting implemented in FY18. Major Medical events, hospitalizations related to general health care, and business/operational events are no longer reflected in this data.

****** Critical Incident totals exclude COVID-19 Reports.***

Death Reporting	FY17	FY18	FY19	FY20	FY21	5 YEAR Average	FY22 Annualized (Actual Q3)
# of Deaths Reported- Community Settings	78	73	78	86	130	**89**	**93** (70)
Rate per 100	1.7	1.6	1.6	1.9	2.8	**1.9**	**1.8**

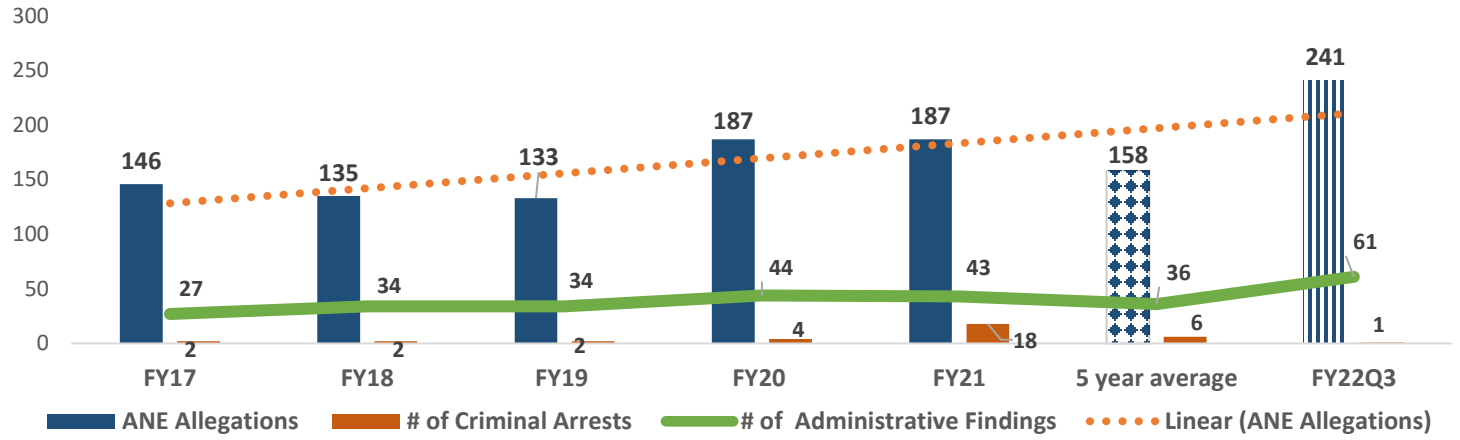
Report Date 5/6/22

SCDDSN Incident Management Report 5-year trend data

for Regional Centers *Thru 3/31/2022*

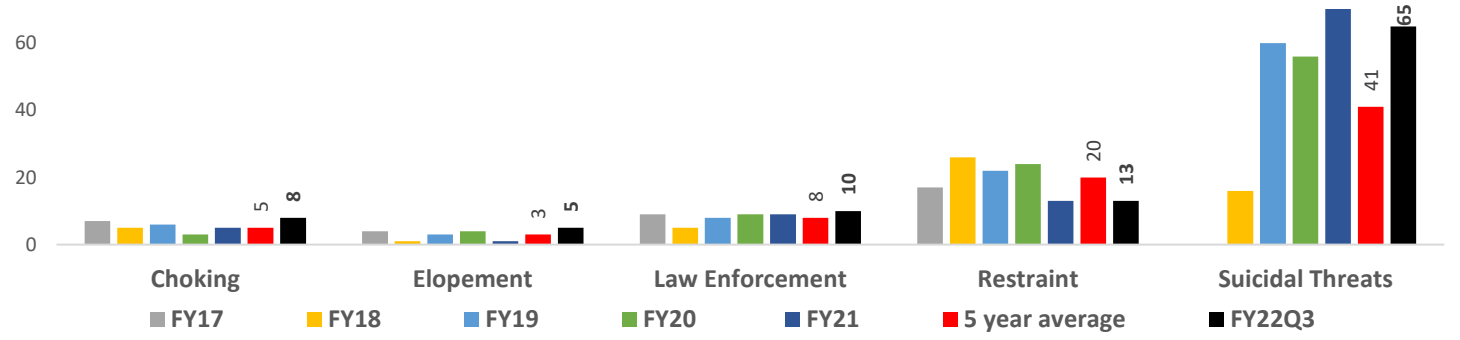
Allegations of Abuse, Neglect, & Exploitation	FY17	FY18	FY19	FY20	FY21	5 YEAR Average	FY22 Annualized (Actual Q3)
# of Individual ANE Allegations	146	135	139	187	187	**158**	**241** (181)
# of ANE Incident Reports (One report may involve multiple allegations)	104	97	102	136	138	**115**	**154** (116)
Rate per 100	17.1	19.2	20.9	28.9	27.9	**23.4**	**39.3**
# ANE Allegations resulting in Criminal Arrest	2	2	2	5	18	**5.6**	**1** (1)
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	27	34	34	44	43	**36**	**61** (46)

ANE Allegations: Comparison to Arrest Data & Administrative Findings



Critical Incident Reporting	FY17	FY18	FY19	FY20	FY21	5 YEAR Average	FY22 Annualized (Actual Q3)
# Critical Incidents ***	108	144	132	135	124	**129**	**132** (99)
Rate per 100	15.4	20.6	18.6	20.8	19.1	**18.9**	**21.5**
# Choking Events	7	5	6	3	5	**5**	**8** (6)
# Law Enforcement Calls	9	5	8	9	9	**8**	**20** (10)
# Suicidal Threats	0	16	60	56	73	**41**	**65** (49)
# Emergency Restraints or Restraints w/ Injury	17	26	22	24	13	**20**	**13** (10)

5 Year Critical Incident Trend Report- Regional Centers



Note: Total CI Reporting numbers for FY17 have been adjusted for comparison due to a change in the criteria for reporting implemented in FY18. Major Medical events, hospitalizations related to general health care, and business/operational events are no longer reflected in this data.

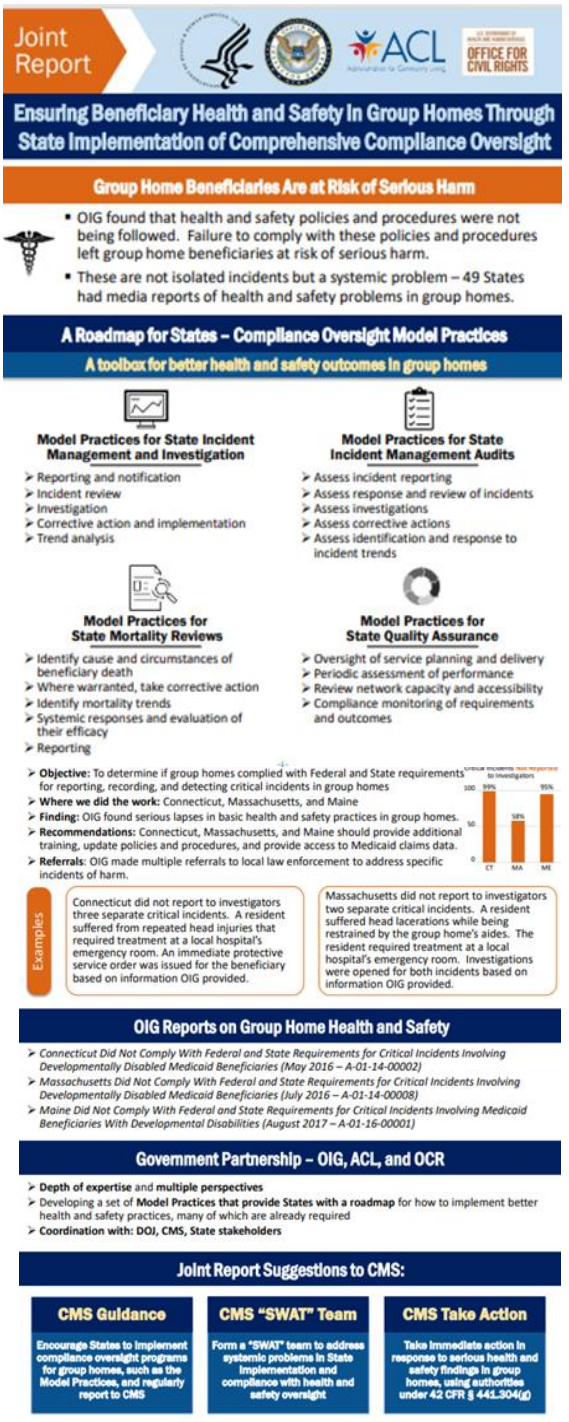
****** Critical Incident totals exclude COVID-19 Reports.***

Death Reporting	FY17	FY18	FY19	FY20	FY21	5 YEAR Average	FY22 Annualized (Actual Q3)
# of Deaths Reported - Regional Centers	24	27	33	22	48	**31**	**17** (13)
Rate per 100	3.4	3.8	4.6	3.4	7.0	**4.4**	**2.9**

Report Date 5/6/22

The Office of Inspector General Investigation in SC

- The OIG has performed audits in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors. Their objective was to determine whether South Carolina complied with Federal Medicaid waiver and State requirements for reporting and monitoring ANE Allegations, Death Reports, and Critical Incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.
- The OIG reviewed South Carolina's compliance with Intellectually Disabled and Related Disabilities (IDRD) waiver requirements for reporting and monitoring during our audit period of January 1, 2015, through June 30, 2017. This included over 7,000 adult ID/RD Waiver beneficiaries.
- SCDDSN and SCDHHS will work together to address findings cited in the report.



Related Reports from the Office of Inspector General

- California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (9/22/2021)
- Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (5/5/2021)
- New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (2/16/2021)
- Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (7/9/2020)
- Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities (3/27/2020)
- Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (1/17/2020)
- Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (6/11/2019)
- Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (8/9/2017)
- Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (7/13/2016)
- Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (5/25/2016)
- Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries (9/28/2015)

- Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight Joint Report* 1/17/2018 * *This report was jointly prepared by the Department of Health and Human Services, Office of Inspector General; the Administration for Community Living; and the Office for Civil Rights.*

Provider Level Risk Management Expectations

DDSN and its provider network have a responsibility to prevent, as much as possible, the occurrence of unfavorable events in the lives of people served. Examples of unfavorable events for people supported include the following: abuse, mistreatment, exploitation, critical incidents, accidents/ injuries, medication errors, preventable illnesses, preventable restraints, and preventable deaths. It is very important that service providers have reliable systems for reporting, analyzing, and following up on unfavorable events for people supported. Each of these systems should be governed by policies and procedures and have sufficient resources at their disposal to assure that corrective actions are undertaken to lessen the occurrence of unfavorable events in the future.

Definition of R*isk*[1]

Risk [noun]
1: possibility of loss or injury
2: someone or something that creates or suggests a hazard
3 a: the chance of loss
b: a person or thing that is a specified hazard to an insurer
c: an insurance hazard from a specified cause or source
4: the chance that an investment will lose value

At risk: in a state or condition marked by a high level of risk

Risk [verb]
1: to expose to hazard or danger
2: to incur the risk or danger

- Providers have a responsibility to monitor risk within their agencies.
- When unfavorable event data has been collected and obvious trends or patterns have been identified, it is important to have a strategy to analyze the data in a more in-depth fashion to identify as many additional trends or patterns as possible.
- As trends or patterns emerge, the agency staff can review further to develop training and prevention efforts.

"Risk." *Merriam-Webster.com Dictionary*, Merriam-Webster, https://www.merriam-webster.com/dictionary/risk.

Identifying trends in unfavorable events may be developed by focusing on three areas: Variables in the people supported; Staff Variables; and External Variables. By focusing methodically on the variables in these three areas, the provider may be able to identify trends or patterns between the unfavorable event and one variable or identify more complex patterns between the unfavorable event and multiple variables. After trends or patterns have been identified, then through training, policy/procedure changes, staffing changes, environmental changes, etc., the provider may be able to reduce the likelihood that that type of unfavorable event will occur in the future.

Variables Among People Supported:

- Age (e.g.; elderly; children)
- Gender
- Medical diagnoses
- Type of disability
- Level of disability
- Communication ability
- Kinds of injuries- (e.g.; fracture; bruise; fall; bed sore)
- Involvement or lack of involvement of medical specialists
- Cause of death- (e.g.; trauma; dehydration; bowel obstruction)
- Location of death- (e.g.; home; work; ER; while a hospital in-patient

Staff Variables

- Employee or Contractor
- Length of service- (e.g.; months; years)
- Level or types of training
- Age of employee
- Gender of employee
- Staffing ratio
- Shift and Day of week
- Regular staff or contract staff; "pulls" or overtime
- Number of hours worked/ on duty

External Variables

- Specific residence
- Specific day program
- Specific location within the building
- Family Involvement
- Environmental risks- (e.g.; slippery floors; stairs; playgrounds; swimming pools; busy street)
- Level/ type of home/ program- (e.g.; ICF/IID; CTH; SLP)
- Weather- (e.g.; dark; rainy; windy)
- Season of the year
- Provider
- Region of the state

As the agency becomes more and more familiar with any unfavorable event data it has collected, it can add other variables to this listing that may assist in understanding, and ultimately in preventing, as much as is humanly possible, unfavorable events for people supported by the agency. Each DDSN Regional Center, DSN board or contracted service provider will also utilize their respective risk managers and Risk Management Committees to regularly review all critical incidents for trends and to determine if the recommendations made in the final written reports were actually implemented and are in effect. The Provider's Risk Management Committee will also review documentation related to reporting trends including falls, choking events, sepsis, aspiration, and bowel obstruction. Trends for injuries and illness will be reviewed to determine appropriate individual and systemic responses.
The Provider Risk Management Committee will review this data at least quarterly.

A broad-based agency Risk Management program should fulfill the following purposes:

- **Improve the safety and quality of life for consumers and employees;**
- **Conserve financial resources**
- **Prevent litigation**
- **Maintain relationships of trust among stakeholders**

Admission/Discharge/Transfer Process

The Admission/Discharge/Transfer Form must be completed on the ADT Application by the residential services provider proposing to serve the individual. The form must be acknowledged by the individual's case manager, then approved by the appropriate DDSN staff prior to admission. The on-line system will notify the residential provider, the individual's case manager, and appropriate DDSN personnel throughout the process. In addition, there is a central email address, ADT@ddsn.sc.gov, for providers to submit any updates or corrections, once the ADT is in progress.

The ADT Form includes a proposed admission date. The case manager should have the actual move-in date and provide this date to DDSN via the ADT@ddsn.sc.gov email address. Submitting this date vis email will save everyone several phone calls to obtain the updated information regarding admission dates.

When a Residential Provider submits the ADT form, the Service Coordinator/Case Mgr. must acknowledge the submission. Some are stating that they aren't receiving the notifications to acknowledge the ADT's. The resident's current primary caseworker and their supervisor should receive Emails on Admission and Discharge forms. For Transfers, the sending provider's users with the role of adt.residential provider-administrator should receive the email. With staff changes, it is essential to make sure these duties are passed on to the new staff and communication amongst staff exists.

The ADT Coordinator will update and approve the ADT may be placed on hold.

An ADT may be placed on hold in the following situations:

1) The facility is at full capacity and no other ADT is submitted transferring or discharging someone out of that facility – no vacancy.
2) Waiting on Funding;
3) Waiver Enrollment;
4) Waiver slot request;
5) HRC Approval
6) SLP I Assessment not attached
7) Not on the Critical Needs List (CNL)
8) Other

All individuals that are discharged due to death or relocating out of the state of South Carolina must be closed out in CDSS and the Case Manager must complete this process.
Please have all Deaths closed out within a month of the individual's passing.

Please submit an email to ADT@ddsn.sc.gov with the actual move date for any person being admitted, or transferred in order to update STS/CDSS and SPM with the correct admission date. The ADT Coordinator will process the allowable Discharges using the Date of Proposed Action on the ADT to Discharge the individual. If there are any updates after the ADT is submitted, please email the details to ADT@ddsn.sc.gov.

Health & Sanitation Inspections

The South Carolina Department of Disabilities & Special Needs (DDSN) contracts with the State Fire Marshal's Office (OSFM), a division of SC Labor, Licensing, & Regulation, for Fire/Safety Inspections of CTH Is, CTH II, SLP IIs, and Day Programs. In 2019, the OSFM also began completing Health and Sanitation inspections for CTH Is and CTH IIs supporting persons under the age of 21. This change was beneficial to providers, as both inspections could be accomplished in a single visit and no additional fees were required.

As we move forward, the OSFM is further streamlining their efforts and will include the Health and Sanitation inspection as a part of all regularly scheduled CTH I and CTH II Fire/Safety inspections. This will facilitate a more efficient admission for persons under age 21. The Health and Sanitation Inspection includes basic operating expectations, so there is no negative impact to providers, other than the purchase of a refrigerator thermometer, if the current unit does not include a digital temperature display.

An Office of State Fire Marshal Informational Bulletin has been attached for provider reference.

Reporting Requirements for ICF/IID and CRCF Locations

SC DHEC has recently communicated to DDSN that CRCF programs and ICF/IID are inconsistently following incident reporting and notification deadlines as outlined in regulations. As such, facilities can expect to receive citations for non-compliances in this area. The regulations related to incident reports are 61-84: 601 for CRCF facilities and 61-13:701 for ICF/IID facilities. In addition, DDSN Directives 100-09-DD and 534-02-DD outline incident management requirements.

ICF/IID and CRCF facilities must follow regulatory requirements and use the deadlines below in order to remain compliant with SC DHEC regulations.

As DDSN directives 100-09-DD and 534-02-DD do not contain the exact language below, this memo serves as an addendum to directives 100-09-DD and 534-02-DD until such a time they are revised to include this guidance.

ICF/IID and CRCF Incident Report Entry and DHEC Notification Deadlines		
Provider Type	**Initial Report Due**	**Final Report with Review/Findings Due**
ICF/IID	24 Hours	Five (5) Calendar Days from the Incident
CRCF	24 Hours	Five (5) Calendar Days from the Incident

Training Offered through SC LLR

The Training Division of the South Carolina Department of Labor Licensing and Regulation's Office of Outreach and Training provides a variety of programs designed to reduce or eliminate safety and health hazards in general industry, construction and the public sector. These programs are presented by trained personnel at convenient locations around the state. Most courses last about 1-2 hours and use a variety of audio-visual aids. This service is provided free of charge! http://osha.llr.sc.gov/pdfs/CourseList.2.5.20.pdf

- Bloodborne Pathogens Confined Space – General Industry
- Electrical Safety Work Practices (General Industry)
- Emergency Action Plans/Means of Egress (Exits)
- Fall Protection (General Industry or Construction)
- Hazard Communication
- Hazard Recognition for Maintenance Personnel or Construction
- Heat Stress
- Office Safety
- OSHA Inspection Process
- OSHA Injury & Illness Record Keeping
- Personal Protective Equipment
- Power and Portable Hand Tools
- Respiratory Protection
- Storage of Flammable Liquids
- Violence in the Workplace
- Walking and Working Surfaces

Quick Guide to Developing Good Plans of Correction

South Carolina Department of Disabilities and Special Needs

Providers must submit an acceptable plan of correction (POC) for non-compliances identified during review/ monitoring activities. The POC is one of the most important parts of the review/monitoring process. Good POCs are the key to promoting the health, safety, and rights of people.This quick guide will help you produce effective plans.

Key Steps to Developing a Good Plan of Correction

How to use Key Steps to Analyze an Issue

Why is the standard important?	What Should You Do? Read the standard and ask yourself: Why does this standard exist? How does it protect people? *Example Standard-Hot water temperature in CTH sites:* a) *Shall be no less than 100 degrees F.* b) *Shall never be more than 120 degrees F in a home where an individual lives who is incapable of regulating watertemperature.* c) *Shall never be more than 130 degrees F.* **Answer**-This standard is important because it protects people from accidental scalding, which could lead to seriousinjury or death.
What happened?	Review the specific non-compliance to determine exactly what happened. **Answer**-The shower's water temperature in Individual #1's bathroom was 135°F.
Why did this happen?	Conduct an analysis to find out why the non-compliance occurred. **Answer**-The anti-scald protective device on the shower was malfunctioning.
What do we do right now?	Take necessary steps to correct the specific problem. Identify others who may be affected. **Answer**-The anti-scald protective device on the shower was repaired immediately. The water temperature was testedthree times and did not exceed 120°F.
How do we prevent this from happening again?	Make a plan to prevent the conditions that led to the non-compliance from happening again. **Answer**-All anti-scald protective devices will be checked for functionality upon installation and monthly thereafter.

Using the Key Step Answers to Develop a Good Plan of Correction

Do's

- **Be specific in your description of what was/will be done immediately.**
  Example: The anti-scald protective device on the shower was repaired immediately. The water temperature was tested three times and did not exceed 120°F.
- **Include actions to identify identical non-compliances elsewhere.**
  Example: All other anti-scald devices used in other homes were checked for functionality and were in good repair.
- **Be specific in your description of the actions that will be taken to prevent recurrence.**
  Example: All anti-scald protective devices will be checked for functionality upon installation and monthly thereafter.
- **Designate a person who is responsible for enacting the plan**.
  Example: Anti-scald devices will be checked by the Agency Maintenance Supervisor.
- **Include specific dates or time periods by which corrections were/will beaccomplished.**
  Example: July 20, 2018 - The anti-scald protective device on the shower was repaired immediately. The water temperature was tested three times and did not exceed 120°F.

Don'ts

- **Be vague in your description of what was/ will be done immediately.**
  Example: Water temperature was lowered.
- **Ignore the possibility of identical non-compliances elsewhere.**
  Example: Water temperature was lowered.
- **Be vague in your description of the actions that will be taken to prevent recurrence.**
  Example: Water temperature will be monitored.
- **Write a general statement that doesn't clearlyestablish who is responsible.**
  Example: Water temperature will be lowered and monitored.
- **Omit dates or timeframes for when corrections were/ will be accomplished**.
  Example: Water temperature will be monitored.

- *All other anti-scald devices used in other homes were checked and were in good repair.*
- *When new anti-scald protective devices are installed - Devices will be checked for functionality before any individual uses the sink.*
- *On the First Day of Every Month - All anti-scald protective devices will be checked for functionality monthly.*

What to Submit with your Plan of Correction?

DDSN takes steps to verify whether an acceptable plan of correction has been implemented as part of deciding on whether the non-compliances has been corrected or if additional steps are needed to resolve the issue(s). Submitting evidence of plan implementation along with the plan of correction can expedite the review process and may minimize the number of times staff return to the homes to verify compliance. The more evidence a setting submits, the easier it will be to determine compliance. Sometypes of evidence are very useful to determine compliance; other types are not useful at all.

Useful Evidence

Documentation produced by the provider.

- This evidence type includes updated policies, documentation of staff-specific training, updated assessments and support plans, maintenance logs, and anyother internal documents.

Documentation produced by an external source.

- This evidence typeis extremely reliable, as it is generated by impartial third parties.
  Examples include bills and invoices for equipment, materials, or labor; written statements or letters from professionals who participated in the plan's implementation (such as fire-safety experts or outside training sources); and documents confirming future appointments(such as medical appointments or on-site repair work).

Photographic and video evidence.

- Pictures and videos are goodsources of evidence that the setting has made repairs or improvements to the physical site and grounds.

Evidence that is not Useful

Statements of support from individuals, family members, or public officials.

- While feedback from the community may be valuable to thesetting, it does not serve as evidence of compliance.

Promises to comply.

- Written statements from the setting where apromise is made to comply with the regulation is not factual evidence.

The plan of correction alone.

- Some providers believe that submittinga plan to correct non-compliances is sufficient to demonstrate compliance. This is not the case. Following the plan leads to compliance, so evidence of following the plan is required.

Corrective Action Plan Tips

DDSN has received and reviewed thousands of plans of correction. DDSN recognizes that provider agencies are structured differently and manage operations in different ways. There is no "standard" plan of correction that's effective for all providers; whatworks for one provider may not always work for another provider. DDSN wants you to succeed, so don't hesitate to ask us for technical assistance with developing a plan or submitting evidence! You may ask for help at any time, but it's extremely beneficial toseek assistance before submitting your plans of correction for review. This will minimize ongoing back-and-forth correspondence and will lead to quicker POC approvals.

DDSN has identified several recurring elements in providers' plans of corrections that have shown to be ineffective to achieve andmaintain compliance. Consider the following when creating and implementing POCs.

Overreliance on Policy and Procedures for Corrective Action. Policies and procedures can be effective components of a plan of correction, but they shouldn't be the primary solution. In some cases, creating additional policies sets the provider up for failure, because they create additional (self-imposed) standards that must be adhered to above and beyond DDSN requirements. Specific actions are much more effective than written policies. If a new policy or procedure is necessary to prevent recurrence of non-compliance, make sure it fits into your existing policies and operations.

New Checklists, Forms, and "Tickler Files." Many providers elect to create new forms and tracking mechanisms to monitor ongoing compliance with a requirement. Creating additional document beyond DDSN requirements may result in unnecessary administrative burdens for the provider. Before creating new forms and tracking mechanisms, ask yourself: Are we really going to do this in the long term? Will itreally help? If additional documentation is required, make it as simple and as operationally feasible as possible. Whenever possible, incorporate forms and tracking systems into documents or systems that already exist.

Nonspecific Staff Trainings and Training Plans. Staff training is usually necessary to prevent recurrence ofa non-compliance, but such trainings must be targeted to the staff who need them. A plan reading "All staff will be trained" implies that every staff person will receive the same training, even if the training doesn't relate to their job duties. For example, non-compliances relating to record content may require staff training, but only for staff who manage records. Also, when training staff on a new requirement or procedure, it's a good idea to have a training specific to the topic as opposed to incorporating it into a regularly occurring staff meeting where other topics will be discussed.

Not Considering the Non-Compliances in Totality when Developing the Plan. Plans of correction almost always address each non-compliance individually, even when different non-compliances result from the same root cause. If multiple physical site non-compliances are found during an inspection, it's likely the result of operational gaps in physical site maintenance, so one long-term plan to prevent recurrence – such as hiring a physical plant manager or clarifying his duties – may be sufficient to prevent all types of physical site non-compliances in the future. This is especially important when non-compliances for failure tomeet individuals' needs are found for multiple individuals. While person-centered responses are very important, providers should always be mindful of potential systematic issues that could compromise
individuals' health and safety.

SOUTH CAROLINA STATE FIRE

OSFM
INFORMATIONAL BULLETIN

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

Objectives:

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

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

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

Procedures

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

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

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

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

III. Contents

A. Fire Safety

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

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

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

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

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

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

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

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

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

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

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

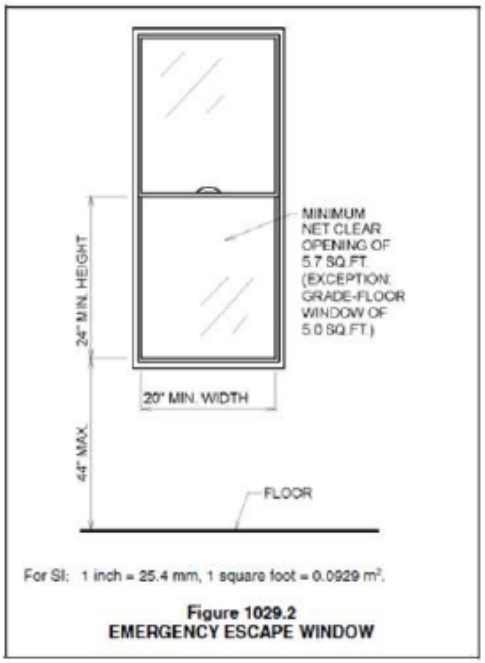


Figure 1029.2
EMERGENCY ESCAPE WINDOW

Equation: (Length x Width) ÷ 144

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

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

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

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

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

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

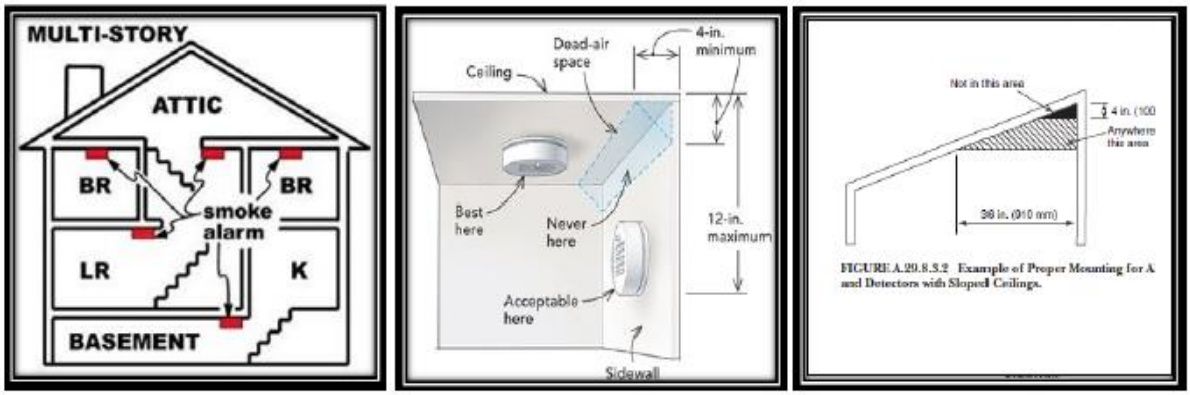


FIGURE A.29.8.5.2 Example of Proper Mounting for A and Detectors with Sloped Ceilings.

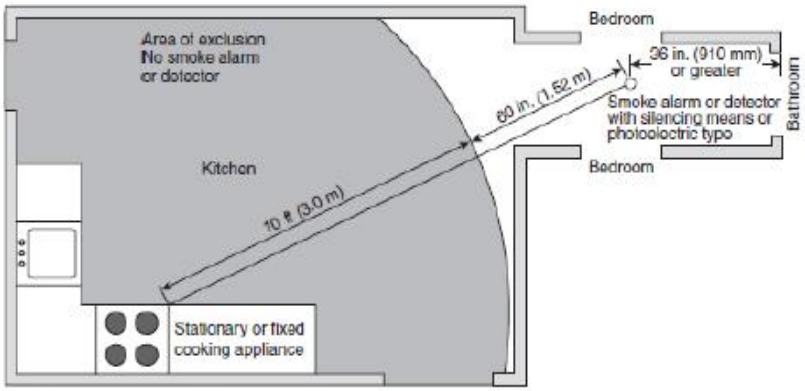


FIGURE A.29.8.3.4(4)(b) Example of Smoke Alarm or Smoke Detector Placement Between 10 ft (3.0 m) and 20 ft (6.1 m) Away in Hallway from Center of Stationary or Fixed Cooking Appliance.

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

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

   * Carbon monoxide alarms expire based on the manufacture's guidelines.
   **Bedrooms with fuel fired appliances or fireplaces shall also have carbon monoxide alarms.

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

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

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

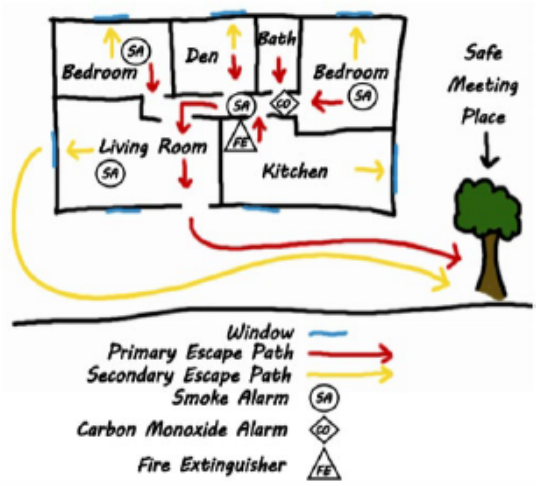
10. The dwelling shall be free of dangers that constitute an obvious fire hazard such as the following:

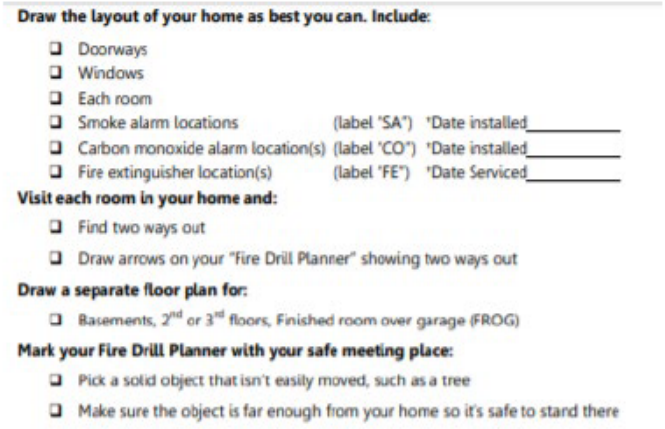
a. Hoarding conditions (contact supervisor).
b. Electrical Hazards, including using extension cords as permanent wiring.
c. Improperly installed/maintained dryer vent.
d. Storage of flammable liquids or gases.
e. Items considered a fire hazard by the Deputy's judgement (contact supervisor)

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

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

Foster Home Fire Drill Planner




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

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

Visit each room in your home and:

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

Draw a separate floor plan for:

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

Mark your Fire Drill Planner with your safe meeting place:

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

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

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

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

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

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

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

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

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

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

2. Public Water/Waste or Well Water Sample R.114-550.N.2 (OSFM not citing pending tests).
   a. Shall be negative for Coliform and E.coli.
   b. Positive samples will be handled by the Senior Deputy – Notification will be made to the caseworker and homeowner for disinfection procedures in accordance with SCDHEC.
      - DDSN providers perform annual tests. State Fire does not collect DDSN Well samples for testing.
3. Septic hazards that constitute a danger to health - R.114-550.L.3.a
   - CTH II - R.114-592.A.5.d
4. Pet Inoculations annual per SC Code of Laws §47-5-60. - R.114-550.N.3.b
   a. Pet Inoculations are required for Cats, Dogs, and Ferrets
      - CTH II - R.114-592.B.3.a
5. CTH II Fridge Temperatures maintained at or below 41 degrees Fahrenheit (5 degrees Celsius) per DDSN. Items in Freezer shall be maintained frozen, - R.61-25 3-501.12 (A).
   a. Refrigerators shall be equipped with ambient air temperature measuring devices. - R.61-25 4-204.112 (A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.

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

IV. Interpretation Contact

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