From: Linguard, Christie
Subject: Meeting Notice - The Commission of the SCDDSN - Commission Meeting - November 17, 2022
Date: Tuesday, November 15, 2022 3:02:27 PM
Attachments: November 17 2022 Commission Packet.pdf

Good Afternoon,

The South Carolina Commission on Disabilities and Special Needs will hold its regularly scheduled meeting in person on Thursday, November 17, 2022, at 10:00 a.m. in conference room 251 at the SC Department of Disabilities and Special Needs Central Administrative Office, 3440 Harden Street Extension, Columbia, SC. To access the live audio stream for the 10:00 a.m. meeting, please visit https://ddsn.sc.gov**.**

Please see the attached Commission Meeting packet.

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

Thank you.

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

A G E N D A

South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Conference Room 251 (TEAMS)
Columbia, South Carolina

November 17, 2022 **10:00 A.M.**

1. Call to Order *Chairman Stephanie Rawlinson*

2. Notice of Meeting Statement *Commissioner Robin Blackwood*

3. Welcome

4. Adoption of Agenda

5. Invocation *Commissioner David Thomas*

6. Approval of Commission Meeting Minutes
   1. Emergency Commission Meeting – November 9, 2022 **Pages 3-12**
   2. Special Called Commission Meeting/Listening Session – October 20, 2022 **Pages 13-14**
   3. Commission Meeting – October 20, 2022 **Pages 15-20**

7. Commissioners' Update *Commissioners*

8. Public Input

9. Programs and Services

   A. Level of Care Need Assessment Instrument for DDSN *EdMetric, LLC*
   Gerald Koocher, PhD – *Consulting Technical Advisor*
   Stanley Rabinowitz, PhD - *Senior Technical Advisor*

   B. Strategic Planning for DDSN *Sage Squirrel Consulting, LLC*
   Sheli Reynolds, PhD – *Senior Associate Director, UMKC Institute of Human Development, University Center in Excellence on Developmental Disabilities*
   Erika C. Robbins, M.A., PMP – *Owner/Partner*

10. Commission Committee Business

   A. Finance & Audit Committee *Committee Chair Robin Blackwood*

   1. Financial Approval & Threshold Report – Cooperative Grants **Pages 21-22**
   2. 275-05-DD: General Duties of DDSN Internal Audit **Pages 23 - 28**

   B. Policy Committee *Committee Chair Barry Malphrus*

   1. Administrative Agency Standard **Pages 29-39**
   2. Committee Update

11. Old Business:

A. Quarterly Incident Report **Pages 40-41** — *Ms. Ann Dalton*
B. Human Resources Update **Pages 42-45** — *Ms. Liz Lemmond*
C. Outreach Update — *Harley Davis, Ph.D.*

12. New Business:

Financial Update **Page 45** — *Mr. Quincy Swygert*

13. Director's Upate — *Michelle G. Fry, J.D., Ph.D.*

14. Next Regular Meeting – January 19, 2023

15. Adjournment

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

EMERGENCY COMMISSION MEETING MINUTES

November 9, 2022

The South Carolina Commission on Disabilities and Special Needs met on Wednesday, November 9, 2022, at 4:15 p.m. at the Department of Disabilities and Special Needs Central Office, 3440 Harden Street Extension, Columbia, South Carolina.

The following were in attendance:

COMMISSION
Present In-Person
Barry Malphrus – Vice Chairman
Robin Blackwood – Secretary
Gary Kocher, MD
Eddie Miller
Michelle Woodhead

Microsoft Teams
Stephanie Rawlinson – Chairman
David Thomas

DDSN Administrative Staff

Michelle Fry, State Director; Constance Holloway, General Counsel; Lori Manos, Interim Associate State Director of Policy; Janet Priest, Associate State Director of Operations; Courtney Crosby, Director of Internal Audit; Quincy Swygert, Chief Financial Officer; Harley Davis, Chief Administrative Officer; Ann Dalton, Director of Quality Management; Carolyn Benzon, Attorney; Preston Southern, Information Technology Division; and Christie Linguard, Administrative Coordinator.

Others Present

Attorney Micah Caskey, Counsel for Lutheran Services Carolinas; and Bethany Vause, Lutheran Services Carolinas.

Call to Order and Notice of Meeting Statement

Chairman Rawlinson called the meeting to order and Secretary Blackwood read a statement of announcement about the meeting that was distributed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Adoption of the Agenda

On a motion by Commissioner Malphrus, seconded by Commissioner Kocher and unanimously approved by the Commission members, the agenda was unanimously approved as presented. (Attachment A)

Chairman Rawlinson read a statement and a disclaimer stating the following: According to South Carolina laws and the Commission Bylaws along with the Policies of the agency, the Commission is not required to allow public input; however, for the purposes of information and transparency, this Commission chooses to offer this opportunity for important matters. The rules set forth are as follows: You must refrain from using personal attacks on any Commission member, individual, DDSN employee or any other persons connected to DDSN. If your presentation involves discussing individuals who are served by DDSN, please refrain from using identifying information such as names, birthdays, and Social Security numbers, etc. Each presenter will be allowed a sufficient amount of time for their presentation; however, if the presentation becomes redundant or excessive, then the presenter will be required to conclude their presentation within a few seconds. Commissioners were asked to please hold their questions until both presentations have concluded. Lastly, the Commission does reserve the right to terminate any presentation which does not adhere to the guidelines set forth.

Presentation regarding Lutheran Services Carolinas (LSC)

Attorney Micah Caskey addressed the Commission briefly by stating that he is unclear as to the nature of this meeting. He noted there has been a lack of communication with the agency. He asked for an opportunity to respond prior to any definitive decisions being made.

Ms. Dalton then addressed the Commission by stating the problems and concerns the agency has had with Lutheran Services Carolinas, especially in the past few months. (Attachment B)

Ms. Priest made the staff recommendation that the licenses issued to Lutheran Services Carolinas be revoked, which includes twenty-seven (27) CTHI licenses and eight (8) CTHII licenses.

Attorney Caskey asked if he could have three (3) more minutes to readdress the Commission, which was granted by the Commission. Attorney Caskey asked the Commission to look at the responses outlined before each Commissioner in detail. He highlighted the timeline for the Corrective Action Plan (CAP) and the responses received from the agency.

General Counsel, Ms. Holloway, addressed the Commission to briefly discuss the appeals rights outlined in the agency's Directive (167-01-DD), if the Commission takes an action today.

Dr. Fry clarified that this meeting is not an administrative hearing. That is an entirely different process. She also noted that after receiving the responses to the third CAP from LSC and the ability to reasonably design transition planning, staff brought their concerns to this Meeting out of concern for the health safety and well-being of those served.

Executive Session

At 5:05 PM, Commissioner Blackwood made a motion to enter into executive session to receive legal advice regarding a contractual matter: Lutheran Services Carolinas. The motion was seconded by Commissioner Woodhead and unanimously approved by the Commission.

Rise from Executive Session

At 5:52 PM, the Commission rose out of executive session. Chairman Rawlinson stated that no motions or actions taken during the executive session.

Commissioner David Thomas did not rejoin the meeting after the executive session.

Action Items Necessary from Executive Session

Commissioner Miller made a motion to accept staff's recommendation to revoke all licenses issued to Lutheran Services Carolinas, which includes eight (8) licenses for CTHIIs and twenty-seven (27) licenses for CTHIs. This motion was seconded by Commissioner Kocher and unanimously approved by the Commission.

A second motion was made by Commissioner Miller to terminate Lutheran Services Carolinas contract with the SC Department of Disabilities and Special Needs for the contract period of July 1, 2022 through June 30, 2023 based on Article 5, Sections B and C of the contract. This motion was seconded by Commissioner Woodhead and unanimously approved by the Commission.

Adjournment

On a motion by Commissioner Woodhead, seconded by Commissioner Miller and unanimously approved by the Commission, the meeting was adjourned at 5:55 PM.

Submitted by:	Approved by:
______________________________	______________________________
Christie D. Linguard Administrative Coordinator	Commissioner Robin Blackwood Secretary

Attachment A
DRAFT

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

EMERGENCY COMMISSION MEETING

AMENDED AGENDA

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

November 9, 2022 **4:15 P.M.**

1. Call to Order — *Chairman Stephanie Rawlinson*

2. Notice of Meeting Statement — *Commissioner Robin Blackwood*

3. Adoption of Agenda — *Chairman Stephanie Rawlinson*

4. Presentation regarding Lutheran Services Carolinas (LSC)
   a) *Micah Caskey, Counsel for LSC*
   b) *Ann Dalton and Janet Brock Priest*

5. Executive Session — *Chairman Stephanie Rawlinson*

   Legal advice regarding contractual matter: Lutheran Services Carolinas

6. Rise from Executive Session

7. Action Items Necessary from Executive Session

   Lutheran Services Carolinas

8. Adjournment

Remarks from Ann Dalton, DDSN Director of Quality Management
Emergency Commission Meeting: November 9, 2022

The Administrative Agency Standards provide a foundation for the DDSN Network of provider agencies. These standards articulate the basic expectations for all providers to ensure qualified, well-trained staff and appropriate policies and procedures are in place to ensure protections for people supported, including an environment that meets applicable laws, and a culture that promotes dignity and respect.

As a qualified provider entity, Lutheran Services Carolinas (LSC) submitted their credentials and provided evidentiary documentation to indicate they have the capacity to provide the designated services with qualified, well-trained staff and that those services will be delivered within the defined scope of their service area. In other words, LSC said they know how to provide Residential Habilitation when they were approved to be a provider. DDSN is available to provide technical assistance, but our agency does not expect to train a provider on how to do their job. When a provider submits their qualifications to deliver Residential Habilitation, they are attesting that they have what it takes to successfully deliver that service. Not only does that include an understanding of the Care, Skills Training, and Supervision, but also the nuances within the service delivery that requires appropriate assessment; development of a support plan including determining the need for a person's supervision, areas of training they need and desire; and opportunities to help the person to be supported in the least restrictive environment. Residential Habilitation is not assisted living and it is not custodial care. Residential Habilitation is an active service intended to continuously support the person and adapt to their needs.

DDSN's review of LSC over these past few months has revealed that staff are, in fact, not appropriately trained or supervised and they are not held accountable for violations of the agency's policies and procedures. The physical settings are cleaned up to get ready for an announced licensing inspection, but an impromptu "day-in-the-life" visit presents a much different picture.

Commissioners have received a packet of information that includes 5 attachments. They include the more formal correspondence with LSC related to our concerns over the past five months.

The unraveling that DDSN will present today began with a complaint a resident's mother made to their Case Manager on June 11. This person had increasingly difficult behaviors over a two-week period and ingested pieces of the vinyl flooring despite having a 1:1 staff assigned. Due to the increased behaviors, LSC began reaching out to DDSN in an effort to discharge the individual to a more restrictive placement. Through internal collaboration between DDSN Quality Management and Operations, we determined the situation required additional review and ad-hoc site visits were completed. Several discrepancies were then noted. Medication Administration Records (MARs) indicated vital psychotropic medications were not available for two of the residents for over 2 weeks. They were abruptly stopped when they were not delivered by the pharmacy. This is significant due to the likely impact on behavior, and also due to the need to titrate medications when there

is a medical need to reduce or increase dosages. In this case, the residents abruptly stopped, then later resumed their medications at the regular dosage. This included medications with clear warnings not to stop taking them, unless under the supervision of their physician.

Also noted:

- Medication Error Forms were completed, but there was no follow-up by LSC management to secure the medications.
- Further, there were discrepancies in the psychiatrist's orders and statement of Psychiatric Drug Review, versus the medications listed on the MAR.
- There was no documentation to support the very recognition of these concerns and their obvious policy violations by LSC staff.
- There was no acknowledgement by the physician's assistant or psychiatrist that the absence of prescribed medications could be the cause of the change in behavior.

DDSN has communicated their concerns about these issues multiple times to various levels of staff.

The observations and discrepancies in documentation discovered in June led to the initial Material Deficiencies letter on June 24. LSC responded to the concerns with general plans to address training and oversight which were to be completed by mid-August. LSC submitted an additional "improved" CAP on August 15, with a presumption that their freeze would be lifted at that time.

LSC effectively acknowledged their failure to review and remain current with DDSN Standards and Directives and train staff accordingly, but indicated their plan to take 45 days to complete their internal review and 90 days to inform and train staff on the DDSN requirements. Again, as a qualified provider, there was an expectation of compliance on Day 1.

<u>Generally speaking, the concerns related to LSC's service delivery was documented in site visits to multiple homes and can be summarized in three broad areas as follows:</u>

1. **Healthcare** – DDSN Residential Habilitation Standards ("Standards") require that each person receive coordinated and continuous health care services based on each person's health needs, condition, and desires. Additionally, the Standards require that the Residential Habilitation provider have procedures that specify the actions to be taken to assure that within 24 hours following a visit to a physician, Certified Nurse Practitioner, or Physician's Assistant all ordered treatments will be provided.
   The review revealed:
    - Failure to secure and/or administer ordered medications or treatments promptly or at all;
    - Failure to accurately and consistently document known health conditions or diagnoses; and
    - Failure to follow-up promptly or at all with physicians' recommendations to seek services from a specialist (e.g., Neurologist, Podiatrist) and failure to follow-up on recommendations made by medical professionals. For several people reviewed no evidence could be found to suggest that recommendations from a physician to seek services from a specialist occurred.
      For example:
        - Gastroenterologist for blood in stool
        - Gastroenterologist for PICA

- Pulmonologist for low oxygen saturation
- Neurologist following break through seizures and flat affect
- Podiatry following pitting edema
- Return to cardiologist following echocardiogram

- Failure to secure and/or administer ordered medications or treatments promptly or at all. No evidence could be found to suggest that medications were given as ordered.
  For example, medications were not given:
  - Approximately 119 times over 6 weeks (one person)
  - Approximately 50 times over 10 days (one person)
  - Approximately 48 times over 15 days (one person)
  - Approximately 82 times over 6 months (one person)
  - Medication for conjunctivitis (never given) (one person)
  - Supplemental oxygen that was never received (one person)

  *It should also be noted that no evidence was found to suggest that prescribers were contacted when medications were abruptly stopped and/or re-started, even when the drug label included warnings against abrupt stoppage.

- For several people reviewed no evidence could be found that recommendations from a physician following a visit were explored or implemented.
  For example:
  - Crowns recommended on teeth 18 and 19
  - Tooth 14 to be extracted due to decay when pain begins
  - Electric toothbrush to improve oral hygiene
  - Eyeglasses for full time wear
  - Prepared meals following complications of diabetes
  - Sample menus for diabetics

  *It should also be noted that on multiple occasions there was evidence of physician visits or Emergency Department visits but no written account of the visit or recommendations from it.

- Failure to accurately and consistently document known allergies and identify appropriate responses to an allergic reaction.
  For example:
  - Outside of chart = Ibuprofen **//** Plan = KNA **//** physician notes = Risperidal
  - Outside of chart = shellfish **//** Face sheet in chart = shrimp, cats, dogs **//** MAR = NKA
  - Outside of chart = aspirin, chocolate, white rice, sugar, Chinese food **//** Face sheet in chart = aspirin **//** Plan =aspirin, seasonal **//** Dietary section of plan = no food allergies **//** physical exam = NKA

LSC has arranged for the majority of their residents to receive healthcare from a physician's assistant that coordinates visits in a mobile unit that sets up in the parking lot of their administrative offices in Columbia. This arrangement does not promote community integration and is in conflict with the Home and Community Based Setting Regulation.

2. Medication Administration Errors - DDSN Residential Licensing Standards require that medications, including controlled substances and medical supplies, be managed in accordance with local, state and federal laws and regulations. The medications must be safely and accurately given. Orders for new medications and/or treatments be filled and given within 24 hours unless otherwise specified.
The review revealed the following:

- Documentation/listings of medications given/to be given were inaccurate or inconsistent. For example, the MAR did not list the same medications and dosage as the physician's orders. The primary care physician's listing of medications did not correspond to the psychiatrist's listing nor did either listing match the plan or the MAR.
- Prescriptions for medications and/ or treatments were not filled and given within 24 hours and when not completed, no reason was documented;
- Prescribed medications were not available, and therefore not given;
- Medication Administration Records (MARs) and controlled substance/drug records were inaccurately/inappropriately maintained;
- Documentation/listings of medications given/to be given were inaccurate or inconsistent.
- Medical supplies were not included on the MAR;
- General Event Reports were not created each time a medication administration error occurred; and
- Prescribers were not contacted when medications were abruptly stopped and/or re-started even when the drug label included warnings against abrupt stoppage.

DDSN raised serious concerns about the inaccuracies of the Psychotropic Medication Review documentation and failure of LSC staff to ensure consistency with the Medication Administration Record. Again, staff did not recognize problems created when a resident failed to receive medications for two weeks and staff did not recognize that different documents listed different medications for the same individual until DDSN brought the issue to their attention.

3. Residential Support Plans are the documents which are to delineate the specific care, supervision, and skills training to be provided to each person in order to ensure the person's health, safety and wellbeing. Residential Support Plans must be created based on the assessed needs of the person, be specific to the person, be current and accurate at all times, and be readily available to the staff who are expected to support the person.

Residential Support Plans were not thorough, complete, accurate, and/or readily available, for example:

- The name of some else appeared throughout the plan written for another person. For example, when reading "Jane's" plan, it states "Mary."
- Multiple, specific, identical statements were included in two plans for two housemates, but were not accurate for both and possibly not either.
- Residential Support Plans contained contradictory information or information that was contradictory to other information available about the person. For example:
  - Needs assistance with safe use of cleaning supplies and need no assistance.
  - Needs assistance to evacuate during emergency and needs no assistance

        - 30-minute supervision while awake and15-minute supervision is indicated as required
        - Line-of-sight supervision when dining and independent with dining
    - Information about the person for whom the plan was written was inaccurate or incomplete including, but not limited to, information about allergies, medications prescribed, medical diagnoses and conditions, and diets;
        - The supervision to be provided to those supported was often unclear, incomplete, or inconsistently reported;
    - Residential Support Plans were often not updated to reflect new interventions/supports needed by the person, not updated when interventions were not effective, and not monitored to ensure accuracy and effectiveness; and
    - The interventions in the Residential Support Plan or added to the Residential Support Plan were often not implemented.

When plans are not available for staff to review, it makes it difficult for staff to know how to interact with the person, what objectives they should be working on, of how to respond in certain situations. Basic details such as supervision needs and allergies were either inconsistent or missing from records available to staff on-site.

LSC submitted the second CAP response on August 15. Despite the efforts noted by LSC, DDSN has not found evidence that the CAP had been successfully implemented. A limited, on-site review on September 23, 2022, found many of the same critical issues from June and July continued in September. I can tell you that I have personally been on-site to a home and witnessed the deficiencies noted. While DDSN appreciates the review of service delivery LSC has completed thus far, it is still not clear how LSC has evaluated the processes in place that have led to the lapse in policy compliance. In total, LSC has submitted three Corrective Action Plan responses. Each has been thoroughly reviewed, but ultimately rejected by DDSN.

> *As Commissioners, imagine for a moment that you are in need of services. You are placed in a home with little to no stimulation. No artwork on the walls. There are only staff notices for chore lists, weekly menus, and a schedule for doctor's appointments and lab work. You do not have any place to go during the day. There are no work or volunteer opportunities. One of your roommates broke the TV a few weeks ago- you don't really know when and staff didn't make a report, so you have no TV to watch in your living room. You sit around all day. You are literally waiting for something to do. You have no toilet paper, soap, or paper towels in your bathroom and you have to ask staff to give you a snack because the food is locked in a cabinet. Your view of the outside world is mostly limited to van rides. Then, you are placed on a behavior support plan, or even prescribed medications because of your "behavior." This is the reality that I witnessed at two LSC homes.*

Based on the serious nature of these continued deficiencies, DDSN has lost confidence in LSC's abilities as a service provider.

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

SPECIAL CALLED COMMISSION MEETING/LISTENING SESSION MINUTES

October 20, 2022

The South Carolina Commission on Disabilities and Special Needs met on Thursday, October 20, 2022, at 1:00 p.m., at the Dorchester County Council Chamber, 500 North Main Street, Summerville, South Carolina.

The following were in attendance:

COMMISSION
Present In-Person
Stephanie Rawlinson – Chairman
Barry Malphrus – Vice Chairman
Robin Blackwood – Secretary
Gary Kocher, MD
Eddie Miller
Michelle Woodhead

Not Present
David Thomas

DDSN Administrative Staff

Michelle Fry, State Director; Constance Holloway, General Counsel; Lori Manos, Interim Associate State Director of Policy; Janet Priest, Associate State Director of Operations; Courtney Crosby, Director of Internal Audit; Mark Kaminer, Information Technology Manager; Preston Southern, Information Technology Division; Kimberly Cochran, Administrative Coordinator; and Christie Linguard, Administrative Coordinator.

Call to Order and Notice of Meeting Statement

Chairman Rawlinson called the meeting to order and Secretary Blackwood read a statement of announcement about the meeting that was distributed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Welcome

Chairman Rawlinson welcomed everyone and read the Guidelines of the Listening Session.

Adoption of the Agenda

On a motion by Commissioner Blackwood, seconded by Commissioner Kocher and unanimously approved by the Commission members, the agenda was approved as presented. (Attachment A)

Public Input

There was no public input.

Adjournment

On a motion by Commissioner Blackwood, seconded by Commissioner Malphrus and unanimously approved by the Commission, the meeting was adjourned at 9:44 a.m.

Submitted by:	Approved by:
______________________	______________________
Christie D. Linguard Administrative Coordinator	Commissioner Robin Blackwood Secretary

SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

MINUTES

October 20, 2022

The South Carolina Commission on Disabilities and Special Needs met on Thursday, October 20, 2022, at 10:00 a.m., at the Dorchester County Council Chamber, 500 North Main Street, Summerville, South Carolina.

The following were in attendance:

COMMISSION
Present In-Person
Stephanie Rawlinson – Chairman
Barry Malphrus – Vice Chairman
Robin Blackwood – Secretary
Gary Kocher, MD
Eddie Miller
David Thomas
Michelle Woodhead

DDSN Administrative Staff

Michelle Fry, State Director; Constance Holloway, General Counsel; Lori Manos, Interim Associate State Director of Policy; Janet Priest, Associate State Director of Operations; Courtney Crosby, Director of Internal Audit; Susan Davis, Director of Employment Services; Becky Peters, Director of Day Programs; Mark Kaminer, Information Technology Manager; Preston Southern, Information Technology Division; Kimberly Cochran, Administrative Coordinator; and Christie Linguard, Administrative Coordinator.

Notice of Meeting Statement

Chairman Rawlinson called the meeting to order and Secretary Blackwood read a statement of announcement about the meeting that was distributed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Welcome

Chairman Rawlinson began by thanking the Dorchester County Council for allowing the Commission to use their Chamber today. A special thank you was extended to Tracey Langley, Clerk to County Council. She also thanked Kimberly Cochran for organizing the meeting space and lunches; and Christie Linguard for her continued support to the Commission.

Adoption of the Agenda

Commissioner Thomas requested to add "Legislative Update" to the agenda. Commissioner Malphrus made a motion to approve the agenda as amended; this motion was seconded by Commissioner Kocher and unanimously approved by the Commission. (Attachment A)

Invocation

Commissioner Malphrus gave the invocation.

Approval of the September 15, 2022 Commission Meeting Minutes

Commissioner Blackwood made a motion to approve minutes from the Commission Meeting held on September 15, 2022; seconded by Commissioner Malphrus and unanimously approved by the Commission. (Attachment B)

Commissioners' Update

Commissioner Thomas attended the Pickens County 50th Anniversary Celebration. He had a wonderful time. He thanked everyone and was happy to attend.

Commissioner Kocher had a private meeting with a consumer whose son has Autism.

Due to technical difficulties, the Commission recessed for five (5) minutes. difficulties.

Commissioner Blackwood participated in the CanTalk event last week in Greenville, SC. The SC Thrive drummers performed.

Commissioner Woodhead informed everyone that she did a presentation on disability and inclusion to her employer's executive team. She excitedly reported that the feedback was great. Her employer will begin focusing on inclusion and highlight disabilities at least one (1) month next year.

Commissioner Malphrus thanked Mr. Jim Kilgallen and the wonderful things he does with the Day Program here in Charleston. He also thanked the Dorchester County Council for allowing the Commission to hold this meeting in their Chambers.

Chairman Rawlinson reminded everyone that there will be a Special Called Meeting at 1:00 PM to hold a listening session for the community. The community will have five (5) minutes to tell the Commission of what is going on

in their community or inform the Commissioners of any issues or concerns regarding disabilities.

National Disabilities Employment Awareness Month

Ms. Susan Davis briefed the Commission on the agency's initiatives to promote National Disabilities Employment Awareness this month. She referenced the newsletter given to each Commissioner and showed two consumer employee focused videos. (Attachment C)

Commission Committee Business

A. Finance and Audit Committee

The Finance and Audit Committee met on October 12, 2022.

Commissioner Blackwood submitted the following item for approval:

Financial Approval and Threshold Report – The contract for long-range strategic planning consulting was awarded to Sage Squirrel Consulting, LLC in the amount of $283,180 for a one (1) year period with four (4) renewals. Coming out of the Committee as a motion and second, the Commission unanimously approved the contract with Sage Squirrel Consulting, LLC. (Attachment D)

CPIP Project Status/Move Up on List – three (3) items were presented for approval to begin the process for an RFP: Pee Dee Center Mulberry and Pecan Roof Replacement; Pee Dee-Pecan Dorms Bathroom Renovations; and Midlands Walnut Bathroom Renovations. Coming out of the Committee as a motion and second, the Commission unanimously approved the three (3) aforementioned plan to seek solicitation for the three above mentioned projects. (Attachment E)

Sale of Landrum I and II – the agency will work with the Department of Administration and the State Fiscal Accountability Authority to complete the approval to put these two facilities (Landrum I and II) on state surplus. Coming out of the Committee as a motion and second, the Commission unanimously approved to move forward with the sale of these two (2) properties. (Attachment F)

B. Policy Committee

Commissioner Malphrus presented the following items to the Commission:

505-02-DD: Death Reporting and Mortality – Commissioner Malphrus noted that this policy will be effective on November 1, 2022. Coming out

of committee as a motion and a second, the Commission unanimously approved this policy as written. Commissioner Thomas asked if the Committee could review the directive regarding do not resuscitate (DNR) soon. (Attachment G)

Ms. Manos added that the Committee reviewed the Administrative Agency Standard at the last meeting and have posted it to the website for the 10-day public comment period. Directive 275-05-DD - General Duties of the Internal Audit Division was reviewed by the Committee. It was passed to Finance and Audit Committee, which reviewed and sent out for public comment.

C. Legislative Committee

Commissioner Thomas asked the Commission and staff to think about the pros and cons of making DDSN a cabinet agency versus continuing with the Commission. Both Commissioner Thomas and Chairman Rawlinson would like for the Commission to have an open work session in January wherein we will solicit providers' feedback as well.

Old Business

A. Special Called Meeting on Screening & Eligibility Process

Ms. Manos stated that the agency is currently in the process of updating the screening and eligibility process within the agency; therefore, she is requesting that the Commission amend their motion from the August meeting to allow for more time to streamline the processes. Commissioner Malphrus made a motion to extend the motion made in August 2022 from 60 days to February 2023; the motion was seconded by Commissioner Thomas and unanimously approved by the Commission. Discussion was held to possibly have a meeting aside from the monthly Commission meeting.

B. Internal Audit (IA) Update

Ms. Crosby noted that the 2021 Agreed Upon Procedures Report is almost complete. The division is working with the boards and contracted service providers to resolve any outstanding questions. The IA division is now receiving the 2022 Agreed Upon Procedures Reports.

The Audit Observation Tracking Report is updated and has been emailed to all Commissioners. This Report includes the results of follow-up procedures that were completed in the last quarter.

The Internal Audit Charter was revised. It is now out for external review. Once the 10-day public comment period is over, this directive will go back to the Finance and Audit Committee for approval, and finally to the full Commission.

New Business

A. Financial Update

Mr. Swygert presented the FY23 Spending Plan vs Actual Expenditures through September 30, 2022. The agency is under budgeted by .26%. Commissioner Blackwood made a motion to approve the document, seconded by Commissioner Malphrus and unanimously approved by the Commission. (Attachment H)

Mr. Swygert introduced himself and talked a little bit about his work experience and background in finance.

The FY24 Budget Request was submitted to the Executive Budget Office on Friday, September 23, 2022. The agency's first hearing on the budget will take place on Tuesday, October 25, 2022 at 2:00 PM. The DDSN team will have 15 minutes to present our $32 million budget.

As of yesterday, the agency has received 32 FY22 Cost Reports from the 40 Boards. The Finance team is working on the Reports as they are submitted in order to meet the Department of Health and Human Services (DHHS) deadline.

Director's Update

The agency has successfully completed their social media public relations campaign with the South Carolina State Fair (Fair) for their sensory friendly morning on October 13, 2022. More than 3,000 fairgoers attended the inaugural event, which was covered by Fox, ABC, NBS and CBS television media affiliations. Staff at the agency was on hand to greet families and pass out sensory friendly toys and informational brochures. Exceptional Citizens Day is today at the Fair.

The agency is a sponsor for the Able, SC Employer's Summit. DDSN is also now a partner with Accessibility Mornings at the South Carolina State Museum. Stephanie Turner, the agency's new Autism Division Director, attended the event and is working to develop some updated resources for families in need of the agency's services.

DDSN will also assist in sponsoring the SC American Association on Intellectual and Developmental Disabilities' Conference on October 26 – 28, 2022 in Myrtle Beach, SC. Dr. Fry, amongst other DDSN staff, is a presenter at this Conference.

The agency has procured Sage Squirrel, LLC to assist with our Strategic Planning needs.

Down Syndrome Awareness Month is coming to an end and we are looking forward to supporting SC Family Connections of the Midlands in their Buddy Walk on November 6, 2022 in Irmo, South Carolina. We will be hosting a booth and passing out informational material regarding the programs and services at DDSN.

Next Regular Meeting

November 17, 2022 @ 10:00 AM

Adjournment

On a motion by Commissioner Blackwood, seconded by Commissioner Kocher and unanimously approved by the commission, the meeting was adjourned at 12:41 P.M.

Chairman Rawlinson again noted that the Special Called Meeting/Listening Session will begin at 1:00 PM today. Depending on the number of participants, the Session may end early. Commissioner Blackwood added that anytime anyone has any questions for the Commission members, please contact them. Their contact information is on the agency's website. Chairman Rawlinson then reread the Guidelines for the Listening Session.

Submitted by:

____
Christie D. Linguard
Administrative Coordinator

Approved by:

____
Commissioner Robin Blackwood
Secretary

Monthly DDSN Staff Report - Financial Approval & Threshold Reporting for November, 2022.

The purpose of this monthly report is to ensure staff comprehensively reports on all Executive Limitation Policy (800-CP-03) financial transactions for approval and financial threshold reporting requirements. The Finance and Audit Committee will decide which items require presentation to the Commission for a formal vote, as well as which items need only be reported via this report to the Commission to ensure transparent reporting. After the Finance and Audit Committee's decisions, this report will highlight item wording in red to notify Commission that the items will not need a formal vote and highlight items in yellow to indicate that the item will require a formal Commission vote to approve.

I. **New Non-Service Contracts $200,000 or Greater**:

II. **Existing Service Contracts Increasing $200,000 or Greater (simple list if based on indiv. choice; detail summary if not)**:

III. **$200,000 or Greater Increase in Personnel Positions for a Program or Division**:

IV. **New CPIP or Re-Scoping of an Existing CPIP**:

V. **New Consulting Contract**:

VI. **New Federal Grant**:

VII. **Current Year Spending Plan Revisions:**

1) Request to increase threshold of Cooperative Training Grants from $400K to $1M in FY2023 Spending Plan. Also request that these grants be approved as multi-year grants.

(NOTE: In August of each year, a report of all prior FY non-service expenditures by vendor over $200,000 will be presented as a "post-payment" review. This will add visibility for expenditures from contracts originated in prior FYs and vendors with separate purchases aggregating over $200,000 in current FY.)

Provider Grants for shared/cooperative services for training and/or staffing

As the landscape for service provision evolves and the labor market changes, DDSN Providers are presented with the opportunity and challenge of rethinking approaches to staffing and training. DDSN staff seek approval for two (2) competitive grant programs designed to facilitate cooperative approaches to meet these needs. Research has shown that such cooperative models are often used in other sectors and states to effectively meet training and staffing needs.
Specifically, the goal of the shared staffing grant program will be to encourage the development of sharing of full-time staff hired either by the cooperative entity for common administrative functions which require professional staff but for which one provider, alone, may not have full-time work. Those administrative functions may include but not limited to accounting and human resources. Such a cooperative model would financially benefit all participating cooperative providers.

The aim of the shared training grant is to encourage and support staff training needs that are shared by Providers but are also not appropriate for DDSN to provide. When contracting with DDSN and/or enrolling with Medicaid, each provider asserts its ability to deliver the services in accordance with the applicable policies and standards for which it contracts/ enrolls. While DDSN has a role in training, DDSN cannot assume the responsibility for training newly hired staff that are required for service delivery. For some providers, especially small providers, the ability to train newly hired staff in key positions (e.g., Residential Services Director, QIDP, Day Services Director, etc.) is limited. Cooperative models are often used in other sectors and states to ensure the knowledge specific to the function or role is transferred from professional to professional. Cooperative training models can offer providers within the cooperative the opportunity to share knowledge, promising practices, and offer the opportunity to problem solve with other professionals.

DDSN is optimistic that these grant opportunities will encourage and support innovative and financially viable approaches to Providers' needs in these areas.

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

South Carolina
Department of Disabilities
and Special Needs

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

Reference Number:	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
Date of Last Revision:	November 17, 2022 (**REVISED**)
Effective Date:	November 17, 2022
Applicability:	DDSN Central Office, DDSN Regional Centers 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 Audit Division (IA) is to provide independent, objective assurance and consulting services designed to add value and improve the agency's operations. The mission of internal audit is to enhance and protect organizational value by providing risk-based and objective assurance, advice, and insight. IA helps DDSN accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control processes.

Standards for the Professional Practice of Internal Auditing

IA will govern itself by adherence to the mandatory elements 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.

The Director of Internal Audit will have unrestricted access to, and communicate and interact directly with, the Finance and Audit Committee and DDSN Commission, as necessary, 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 charter;
- Approve the risk-based internal audit plan;
- Approve the Internal Audit Division's budget and resource plan;
- Receive communications from the Director of Internal Audit on the Internal Audit Division's performance relative to 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 engagement, subject to accountability for confidentiality and safeguarding of records and information.
- Have full, free and unrestricted access to all functions, records, property, and personnel within the scope of DDSN services pertinent to carrying out any 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 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 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*.

Financial Sanctions

A financial sanction is only applicable to repeat internal audit findings/observations as they relate to the health, safety and/or welfare of individuals being served.

The sanction will only apply when follow-up procedures are conducted and 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.

Internal Audit is responsible for monitoring compliance with reporting deadlines established in DDSN directive 275-04-DD: Procedures for Implementation of DDSN Audit Policy for DSN Boards, and 275-06-DD: Procedures for Implementation of DDSN Audit Policy for Contracted Service Providers, and reporting the results of monitoring to the Finance Division for invoicing of financial sanctions, where required by policy.

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 Division's conformance with the *Standards* and an evaluation of whether Internal Auditors apply the IIA's Code of Ethics. The program will also assess the efficiency and effectiveness of the internal audit activity and identify opportunities for improvement.

The Director of Internal Audit will communicate to senior management and the 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	Stephanie M. Rawlinson Chairman

South Carolina Department
of
Disabilities and Special Needs

ADMINISTRATIVE AGENCY STANDARDS

Effective July 1, 2012

Effective July 17, 2015

Effective August 31, 2017

Effective January 1, 2023

INTRODUCTION

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

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

Values: Our Guiding Beliefs

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

Principles: Features of Services and Supports

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

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

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

<table>
<tr><th colspan="2">GOVERNING BOARD: DISABILITIES AND SPECIAL NEEDS (DSN) BOARD</th></tr>
<tr><th></th><th>STANDARD</th></tr>
<tr><td>201</td><td>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)</td></tr>
<tr><td>202</td><td>The membership of the BOD is representative of the community it serves.</td></tr>
<tr><td>203</td><td>The BOD is the governing body and determines the general direction for the Agency by establishing policies pertaining to the operation of the Agency. These policies are reviewed at least annually by the Executive Director and reaffirmed by the Board. The Board of Directors will review, approve and document the vote in the minutes and the spending limits, to include credit cards, of the Executive Director on an annual basis.

Polices include, but are not limited to:

• Agency structure.
• Personnel.
• Preventing and Reporting Abuse.
• Reporting Critical Incidents.
• Fiscal Accountability.
• Staff training and Development.
• Emergency Response/Disaster Preparedness.
• Program and Services.
• Code of Ethics.
• Records Retention Policy covering Individual Service Records and Official Agency business.</td></tr>
<tr><td>204</td><td>Training is provided to members of the BOD within 90 days of appointment to the Board and their participation is documented.</td></tr>
<tr><td>205</td><td>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.</td></tr>
<tr><td>206</td><td>All board meetings and minutes comply with the South Carolina's Freedom of Information Act.

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

• Minutes, policies, and by-laws must be consistent with state and local laws (S.C. Code Ann. § 30-4-20 (Supp. 2022)).</td></tr>
<tr><td>207</td><td>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.</td></tr>
<tr><td>208</td><td>The BOD defines the expectations for the Executive Director's performance and at least annually evaluates and provides feedback regarding performance.</td></tr>
</table>

GOVERNING BOARD/BODY: QUALIFIED PROVIDERS	
	STANDARD
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.
302	The governing body participates in the fiscal management of the Agency and approves the annual budget, reviews comprehensive financial reports at every meeting and reviews an annual audit report including a written management audit letter for SCDDSN contracted services. • Management audit letter comments are presented to the governing board by the external auditor or CPA.
303	The governing body: • Employs Executive leadership where at least one member has a bachelor's degree from an accredited college or university in a human services field of study and at least three (3) years' experience working with people who have disabilities with at least one (1) year of experience in supervision/administration, and • Delegates the authority for the day-to-day management of the Agency in accordance with written policy. **Does not apply to sole proprietor partnership**
304	The governing body defines the expectations for the President/CEO's performance and at least annually evaluates and provides feedback regarding performance. **Does not apply to sole proprietor partnership**
305	All board meetings and minutes related to DDSN contracted services comply with the South Carolina's Freedom of Information Act. • All boards must adopt consistent rules of procedure including a records retention policy for all official agency business wherein records are retained for at least six (6) years. Minutes, policies, and by-laws must be consistent with state and local laws (S.C. Code Ann. § 30-4-20 (Supp. 2022)). **Does not apply to sole proprietor partnership**

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

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

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

FISCAL MANAGEMENT	
	STANDARD
601	The Agency manages its fiscal affairs in accordance with generally accepted accounting principles (GAAP) and sound business principles.
602	The Agency's assets and resources are properly insured. To include, but not limited to: a. Fire and Causality; b. Liability; c. Vehicle; d. Bonding of officers, employees, and agents of the Agency who are authorized to handle or be responsible for the Agency's and/or service users' funds; e. Directors and Officer's insurance; f. Tort liability; and, g. Workers' Compensation.
603	Insurance types and amounts are reviewed and approved by the Governing Board/Body.
604	All contracts and agreements to provide services are reviewed annually for appropriateness by the Governing Board/Body.
605	When an Agency charges for DDSN Contracted Service Delivery, it has a fee schedule that has been approved in writing by the Governing Board/Body and by DDSN. The fee schedule is provided to the service users or their guardians upon request.
606	DSN Boards grant equal access to Individual Family Support Funds to all who are eligible.
607	The DSN Board shall provide DDSN copies of financial statements as of the end of each calendar quarter at a minimum. These financial statements shall include, but not be limited to, a statement of financial position and results of operations of fiscal year to date. The Provider shall present these financial statements to the DSN Board's Board of Directors.
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 for DSN Boards, 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	
	STANDARD
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 no less than every three (3) years. A comprehensive quality management plan should draw ideas, standards, and measures from multiple sources and align with the Mission, Vision, Values, Principles, and Priorities of DDSN. Providers are encouraged to seek consultation and accreditation from nationally recognized leaders in the field.
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 completing the administrative review must follow reporting requirements and track/trend/analyze Allegations of Abuse, Neglect or Exploitation on a quarterly basis using the following information: 1. The total number of allegations made; 2. The types of allegations, including a trend of when and where they were reported; 3. The number of substantiated allegations, as determined by local law enforcement, SLED, DSS, or the Attorney General's Office; 4. The number of Administrative Findings, as determined by verified Standard of Care allegations, through DSS or the State Long Term Care Ombudsman's Office or a Regional Ombudsman. A distinction should be made between allegations with known and unknown perpetrators and the types of violations cited (i.e., Administrative Oversight, Dignity & Respect, Supervision, etc.); 5. The number of initial reports submitted in compliance with policy; and 6. The number of final reports submitted in compliance with policy. Narrative information may also be analyzed in order to identify more specific trends.

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.

SCDDSN Incident Management Report 5-year trend data

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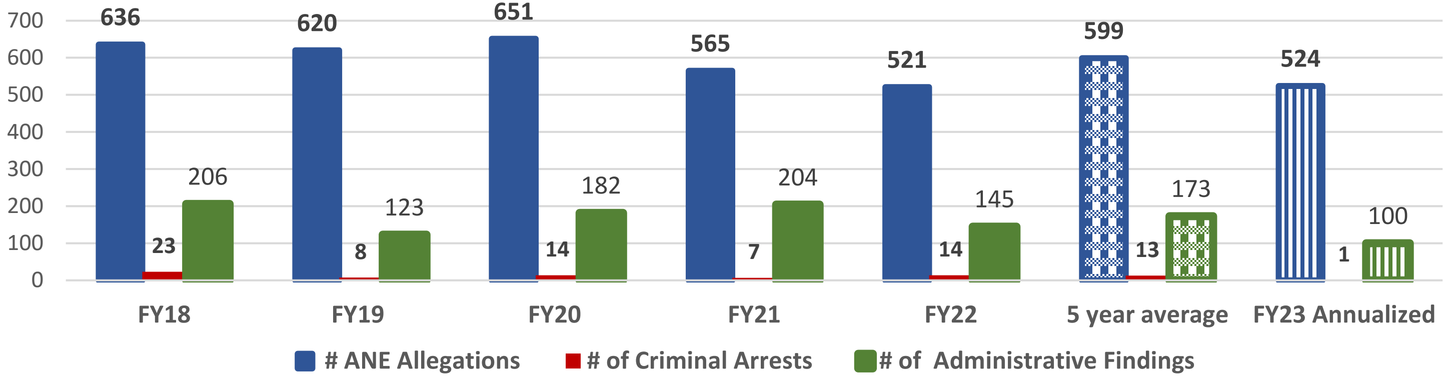
for Community-Based Services *(Includes Residential & Day Service Settings) Thru 9/30/2022*

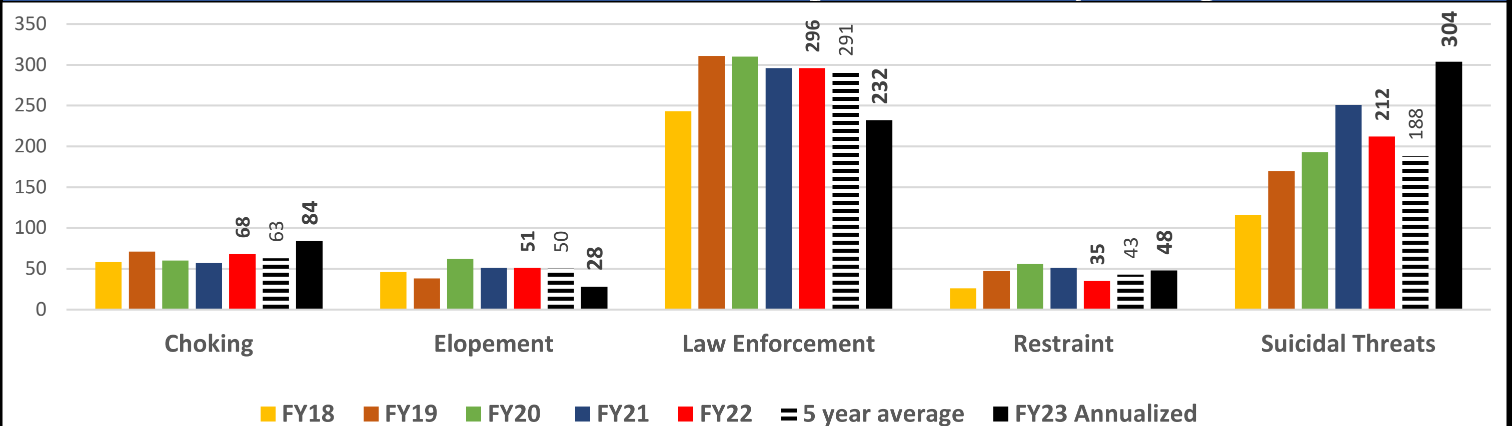
Allegations of Abuse, Neglect, Exploitation	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q1)
# of Individual ANE Allegations	636	620	651	565	521	**599**	524 (131)
# of ANE Incident Reports (One report may involve multiple allegations)	450	415	436	388	371	**412**	388 (97)
Rate per 100	11.9	9.6	11.8	10.9	9.3	**10.7**	9.3
# ANE Allegations resulting in Criminal Arrest	23	8	14	7	14	**13**	4 (1)
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	206	123	182	204	149	**173**	100 (25)

ANE Allegations: Comparison to Arrest Data & Administrative Findings



Critical Incident Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q1)
# Critical Incidents	1071	916	982	974	1245	**1037**	1220 (305)
Rate per 100	11.9	9.6	11.8	10.9	15.4	**11.9**	15.2
# Choking Events	58	71	65	57	68	**64**	84 (21)
# Law Enforcement Calls	243	311	310	296	296	**291**	232 (58)
# Suicidal Threats	116	170	193	251	212	**188**	304 (76)
# Emergency Restraints or Restraints w/ Injury	26	47	56	51	35	**43**	48 (12)

5 Year Critical Incident Trend Report- Community Settings



Death Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q1)
# of Deaths Reported- Community Settings	73	78	86	130	102	**94**	100 (25)
Rate per 100	1.6	1.6	1.9	2.8	2.2	**2.0**	2.2

Report Date: 11/8/2022

SCDDSN Incident Management Report 5-year trend data

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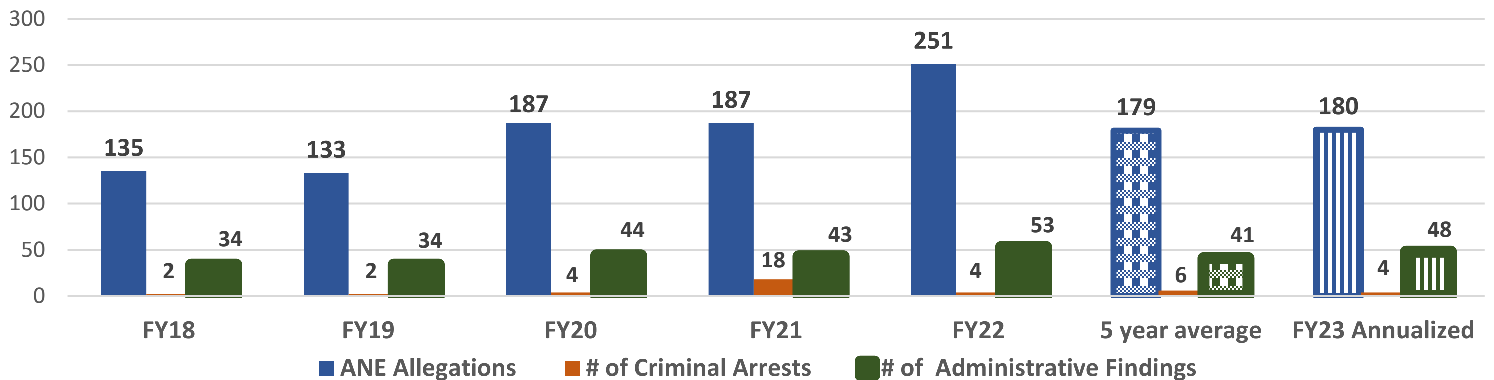
for Regional Centers *Thru 9/30/2022*

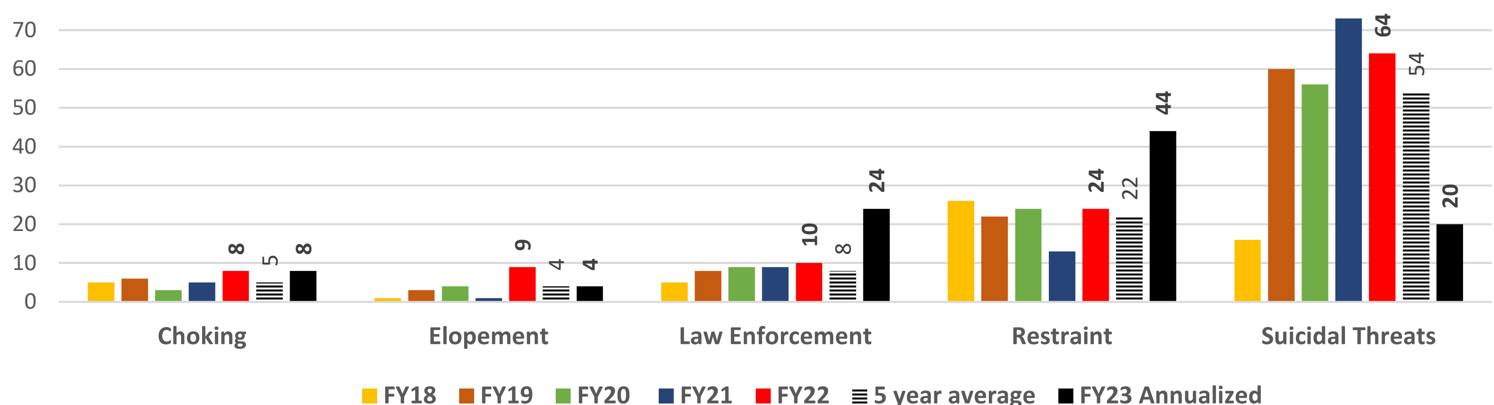
Allegations of Abuse, Neglect, & Exploitation	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q1)
# of Individual ANE Allegations	135	139	187	187	251	**179**	180 (45)
# of ANE Incident Reports (One report may involve multiple allegations)	97	102	136	138	165	**128**	152 (38)
Rate per 100	19.2	20.9	28.9	27.9	38.0	**27.0**	29.0
# ANE Allegations resulting in Criminal Arrest	2	2	5	19	4	**6**	4 (1)
# ANE Allegations with Administrative Findings from DSS or State Long-Term Care Ombudsman	34	34	44	43	53	**41**	48 (12)

ANE Allegations: Comparison to Arrest Data & Administrative Findings



Critical Incident Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q1)
# Critical Incidents	144	132	135	124	160	**139**	152 (38)
Rate per 100	20.6	18.6	20.8	19.1	24.2	**21.1**	24.1
# Choking Events	5	6	3	5	8	**5**	8 (2)
# Law Enforcement Calls	5	8	9	9	10	**8**	24 (6)
# Suicidal Threats	16	60	56	73	64	**54**	20 (5)
# Emergency Restraints or Restraints w/ Injury	26	22	24	13	24	**22**	44 (11)

5 Year Critical Incident Trend Report- Regional Centers



Death Reporting	FY18	FY19	FY20	FY21	FY22	5 YEAR Average	FY23 Annualized (Thru Q1)
# of Deaths Reported - Regional Centers	27	33	22	48	36	**33**	24 (6)
Rate per 100	3.8	4.6	3.4	7.0	**5.4**	**4.8**	4.0

Report Date: 11/8/2022

Comparative DSP Hiring Reports: October 2021 to October 2022
*data is reset on January 1 every year

October 2022 Monthly DSP Hiring Report -- ALL REGIONAL CENTERS					
Regional Center	Midlands	Whitten	Pee Dee/Saleeby	Coastal	Totals
Accepted Offer (yes/no)	7/0	16/0	8/0	14/22	45/22
FBI Check Passed (yes/no/no-show)	7/0/0	16/0/0	8/0/0	22/0/14	53/0/14
Drug Test Passed (yes/no/no-show)	4/3/0	14/2/0	8/0/0	17/3/16	43/8/16
PPD Test Passed (yes/no/no-show)	4/3/0	15/1/0	8/0/0	18/0/18	45/4/18
Started on-the-floor after training	4	13	8	11	36
Avg.Days Between Referral & Hire Package	13.4	8.1	20.7	8.2	10.8
Avg. Days Between Hire Package & Tr.Class	11.8	15.0	10.5	22.2	14.9
Total Prior Month Separations	6	14	5	6	31
Net Increase/(Decrease) for Month	-2	-1	3	5	5
Net Increase/(Decrease) for Calendar Yr.	-34	-4	23	15	0
Annualize Monthly Turnover *	78%	175%	52%	112%	104%
Vacant DSP FTEs **	126	151	124	105	506

October 2021 Monthly DSP Hiring Report -- ALL REGIONAL CENTERS					
Regional Center	Midlands	Whitten	Pee Dee/Saleeby	Coastal	Totals
Accepted Offer (yes/no)	3/0	14/1	14/0	14/0	39/2
FBI Check Passed (yes/no/no-show)	3/0/0	12/1/2	14/0/0	14/0/0	36/1/4
Drug Test Passed (yes/no/no-show)	3/0	9/1/5	14/0/0	14/0/0	34/2/5
PPD Test Passed (yes/no/no-show)	3/0	9/1/5	13/1/0	14/0/0	33/2/6
Started on-the-floor after training	3	9	13	14	39
Avg.Days Between Referral & Hire Package	12.0	13.6	15.2	6.5	11.8
Avg. Days Between Hire Package & Tr.Class	11.0	15.1	29.7	34.4	22.6
Total Prior Month Separations	7	12	10	11	40
Net Increase/(Decrease) for Month	-4	-3	3	3	-1
Net Increase/(Decrease) for Calendar Yr.	-53	-82	-79	17	-197
Annualize Monthly Turnover *	71%	148%	96%	125%	110%
Vacant DSP FTEs **	102	174	139	95	510

The report compares the month of October 2021 and October 2022.
Total average of days to process hires has decreased by (25%) in process time.
Total Separations:

- October 2021: 40 employees
- October 2022: 31 employees

October 2021 the agency had a net decrease of (197) DSP's.
October 2022 the agency has reached net change of (0) DSP's. This indicates that the agency is able to recruit and retain DSP staff at an equal rate than we are losing them (separations, terminations, etc).

Most recent DSP hiring data include the following for the month of November:

- Coastal Regional Center – 18 DSP's
- Midlands Regional Center – 2 DSP's and 3 RN's
- Pee/Saleeby – 8 DSP's
- Whitten – 21 DSP's; 1 RN; 2 LPN's

DDSN has been able to continue to recruit and retain DSP staff in 2022 at a higher rate as compared to 2021. The recruiting and retention efforts indicated below have assisted the agency with decreasing turnover. DDSN remains to have a high turnover rate. However, Calendar Year 2022 continues to improve with continued increased recruitment and retention, and increased compensation efforts.

DDSN implemented the Direct Support Professional Career Path Program, effective July 2. Currently, this effort has reported to assist with turnover in the regional centers.

In addition, Human Resources evaluated the Day Programs classification and compensation, which resulted in the elimination of multiple internal classifications of Direct Support. This effort assists with promoting consistency in posting and filling positions as it relates to Day Programs and Direct Support Personnel. Day Support staff were reclassified to Recreation Specialist I-II and Workforce Specialist I – II. In addition, compensation was evaluated and new hire rates were established which range from $33,280 – $35,360.

In addition, Human Resources conducted a compensation review for classifications in additional program areas located in the regional centers. Ultimately, evaluating the responsibilities of staff serving in support roles for the regional centers. This includes Consumer Supports, Housekeeping, Food Service, and Maintenance. This effort has been successful for the agency in recruitment and retention.

Central Office Postings

Central Office completed 62 hires during January 2022 – October 2022

- 23 New Hires (Not from another State Agency)
    - 6 Temporary staff
    - 17 Full Time
- 10 New Hires (Movement between State Agencies)
- 16 rehired Temps
- 13 Internal hire into new positions

Recruitment/Retention Initiatives:

- Career Projects social media (Twitter, Facebook, LinkedIn)
- Indeed
- Conducting Rapid Hire Events for all Regional Centers
- Attending Job/Career Fairs at all Regional Centers
- Collaboration with Technical Centers and ECPI College of Nursing
- Successful Weekend Warrior Program
- Continue to utilize the job Referral Reward program
- Continue to utilize the candidate Retention Bonus
- Continue to utilize the Nursing Recruitment and Retention Bonus
- Increased Nursing Rates (LPN - $48,000; RN - $62,000; Nurse Manager - $68,000)
- Performance/Merit-Base Increases for the Agency

Onboarding Redesign

- Human Resources continues to work on the development the On-Boarding Ambassador program for Central Office.
- The program is scheduled to begin January 2023.

Employee Performance Management (EPMS)

- 88% submission success for Central Office
- EPMS training was provided in Central Office in April 2022; and in the Regional Centers.
- HR completed a successful upload in SCEIS for EPMS evaluation on behalf of the agency.

Exit Interview Process

- Human Resources is working on an electronic Exit Interview Process. This is an effort to assist with electronically gathering data trends as it relates to retention, employee engagement and establishing future training initiatives.

United Way Campaign

- Human Resources is promoting the United Way Campaign during October – November 2022 on behalf of the agency.
- Efforts include selling/promotion of Bingo Cards and Pet Photo Contest.
- The goal for 2022 is $5000.00. The agency is at approximately 25% close to the goal. This does not include reoccurring donations.

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FY 23 Spending Plan VS Actual Expenditures - 10/31/2022

Category	Approved Spending Plan	Cash Expenditures YTD	SCDHHS Monthly "Wash" Expenditures with Revenue YTD *	Total Monthly Expenditures YTD	Remaining Spending Plan	Spending Plan Deviation with Actual
DDSN spending plan budget	$ 938,535,153	$ 104,563,889	$ 203,506,822	$ 308,070,711	$ 630,464,442	REASONABLE
Percent of total spending plan remaining	100.00%	11.14%	21.68%	32.82%	67.18%	
% of FY Remaining					66.67%	
Difference % - over (under) budgeted expenditures					-0.51%	

* In October 2022, providers billed & paid by SCDHHS an estimate of $203.5 million in services (waiver services + state plan services).

Methodology & Report Owner: DDSN Budget Division