THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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SC Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Edgar W. Dickson, Presiding Judge

Case No. 2010-CP-40-1095
Appellate Case No. 2015-000109

Protection and Advocacy for People with Disabilities, Inc., ... Appellant,

v.

Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, ... Respondents.

RECORD ON APPEAL

Reid T. Sherard Phillips L. McWilliams David C. Dill Nelson Mullins Riley & Scarborough LLP Post Office Box 10084 Greenville, SC 29603 (864) 250-2300 Anna Maria Darwin Protection and Advocacy for People with Disabilities, Inc. 545 N. Pleasantburg Drive, Suite 106 Greenville, South Carolina 29609 (864) 235-0273 Thornwell W. Simons 3710 Landmark Drive, Suite 208 Columbia, South Carolina 29204 (803) 782-0639 *Attorneys for Appellant*	William H. Davidson, II Kenneth P. Woodington Davidson & Lindemann, P.A. 1611 Devonshire Drive- Second Fl. Post Office Box 8568 Columbia, South Carolina 29202 (803) 806-8222 *Counsel for Respondents*

RECORD ON APPEAL
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Certificate of Counsel

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND
IN THE COURT OF COMMON PLEAS

JUDGMI IN A CIVIL CASE

CASE NUMBER: 2010CP4001095

Protection And Advocacy For People With Disabilities Inc

PLAINTIFF(S)

Beverly A H Buscemi

SC Department Of Disabilities & Special Needs

DEFENDANT(S)

Submitted by: _____	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other _____

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other _____

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other _____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

RICHLAND COUNTY FILED 2012 OCT -4 PM 4:03 JEANETTE W. McBRIDE C.C.P. & G.S.

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.
Additional Information for the Clerk : _____

INFORMATION FOR THE PUBLIC INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**

Circuit Court Judge _____ **Judge Code** _____ **Date** _____

For Clerk of Court Office Use Only

This judgment was entered on the _____ day of _____, 20 _____ and a copy mailed first class or placed in the appropriate attorney's box on this 4 October 2012 to attorneys of record or to parties (when appearing pro se) as follows:

Anna Maria Darwin
Jerrilea S Davison
Kenneth P. Woodington
Thornwell W Simons

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter _____

Clerk of Court Jeanette W. McBride

SCRCP Form 4C (10/2011)

SCANNED

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs, and The South Carolina Department of Disabilities and Special Needs and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	IN THE COURT OF COMMON PLEAS C.A. No. 2010-CP-40-1095 **ORDER**

RICHLAND COUNTY
FILED
2012 OCT -1 PM 12:48
JEANETTE W. McBRIDE
C.C.P. & G.S.

This matter came before the Court for hearing on August 2, 2011, on Cross Motions for Summary Judgment. Plaintiff appeared and was represented Anna Maria Darwin; Defendants appeared and were represented by Kenneth Woodington. This Court has reviewed proposed orders granting Summary Judgment for both parties.

Under South Carolina law, summary judgment is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law. See Rule 56(c) SCRCP; *Fleming v. Rose*, 350 S.C. 488, 567 S.E.2d 857, 860 (2002). Summary judgment is appropriate if the pleadings,

SCANNED

depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. When plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted. *Ellis v. Davidson*, 358 S.C. 509, 595 S.E.2d 817 (Ct. App. 2004). However, where a genuine issue as to *any* material fact exists, summary judgment should not be granted.

This Court takes notice that "determination of legislative intent is a matter of law." *Jones v. State Farm Mutual Auto Ins. Co.*, 364 S.C. 222,228, 612 S.E.2d 719, 722 (2005) (citing *City of Myrtle Beach v. Juel P. Corp.*, 344 S.C. 43, 543 S.E.2d 538 (2001)). There remains however issues of material fact presented to the Court in which reasonable minds could differ, and summary judgment is not proper. This Court concludes there is an issue of material fact and this matter should be tried.

Therefore, both Plaintiff's and all Defendants' Motions for Summary Judgment are hereby **denied.**

This Court's denial of the Motions for Summary Judgment is not intended to decide any factual issues in this present case.

AND IT IS SO ORDERED this 1 day of October, 2012

The Honorable L. Casey Manning
Presiding Judge
Fifth Judicial Circuit

Columbia, South Carolina

FORM 4

JUDGMENT IN A CIVIL CASE

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND
IN THE COURT OF COMMON PLEAS

CASE NUMBER: 2010CP4001095

Protection And Advocacy For People With Disabilities Inc

PLAINTIFF(S)

Beverly A H Buscemi

SC Department Of Disabilities & Special Needs

DEFENDANT(S)

Submitted by: _____

Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

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☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Other _____

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other _____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.

Additional Information for the Clerk : _____

INFORMATION FOR THE PUBLIC INDEX

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If applicable, describe the property, including tax map information and address, referenced in the order:

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Circuit Court Judge _____ **Judge Code** _____ **Date** _____

For Clerk of Court Office Use Only

This judgment was entered on the _____ day of _____, 20 _____ and a copy mailed first class or placed in the appropriate attorney's box on this 4 December 2012 to attorneys of record or to parties (when appearing pro se) as follows:

Anna Maria Darwin
Thornwell W Simons

Jerrilea S Davison

Kenneth P. Woodington

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter _____

Clerk of Court Jeanette W. McBride

SCRCP Form 4C (10/2011)

SCANNED

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND)
) Civil Action Number: 10-CP-40-1095

Protection and Advocacy for People with Disabilities, Inc.,

Plaintiff,

v.

Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission,

Defendants.

ORDER

2012 NOV 29 PM 3:37
C.C.P. & G.S.

Plaintiff in this action claims a right to review certain medical records of individuals during the course of statutorily-authorized inspections by Plaintiff of living conditions in facilities that house developmentally disabled persons. Defendants have denied that there is any statutory authority for plaintiff to review individual medical records in the absence of individualized complaints. Instead, Defendants argue, the statute that authorizes plaintiff to investigate living conditions limits the kind of records available for inspection to "plans of care." *S.C. Code Ann.* § 43-33-350(4), a term which they contend has a specific and more limited meaning in this context, preventing the extension of the term to personal medical records.

This case was tried before the Court, sitting without a jury, on October 3, 2012. The Plaintiff presented testimony from Gloria Prevost, Executive Director of Protection and

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Advocacy for People with Disabilities, Inc. ("P & A"). Plaintiff also presented testimony from Susan Perry and Kimberly Tissot, both of whom have conducted team advocacy inspections. Defendants presented testimony from Dr. Kathi Lacy, the Associate Director of Policy at the Department of Disabilities and Special Needs (DDSN), who is familiar with the use of the term "plans of care" in the context of DDSN facilities and services. By consent of the parties, the Court also considered the previously-filed Affidavits of Ms. Prevost and Dr. Lacy.

For the reasons set forth herein, the Court concludes that the Defendants' legal position is supported by the language of the pertinent statutes, especially as read in conjunction with related legal authorities, and by the interpretation of the statutes in practice. As a result, it is appropriate that this action be dismissed. While the Court appreciates the purpose and efforts of the Protection and Advocacy System, the Court and P & A are constrained by powers granted to P & A by S.C. Code Ann. § 44-33-300, et seq. Therefore, the Court finds that allowing P & A access to patients' medical records at Community Training Homes without the patients' or guardians' consents is overstepping the authority granted by the Legislature.

FACTS

A. Background.

The Plaintiff, Protection and Advocacy for People with Disabilities, Inc., is a corporation which has been given certain powers and duties under state law. *S.C. Code Ann.*, §§43-33-310, et seq. The existence of such an entity is a prerequisite to the State receiving certain federal funding. *See* 42 U.S.C. § 15043.

As detailed in the Complaint, the basic facts of this case are that Plaintiff has sought to review personal medical records in the course of conducting "team advocacy inspections" of living conditions in facilities in which developmentally disabled or handicapped persons reside.

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The power to conduct such investigations is conferred on the Plaintiff by *S.C. Code Ann.* § 43-33-350(4), which will be discussed below in detail.

In the course of seeking to inspect living conditions, Plaintiff additionally claims authority to review the medical records of the residents of the institutions, regardless of whether they were clients of Plaintiff, and regardless of whether specific complaints had been made by residents or persons acting on their behalf.[1] In particular, P & A has sought to review MARs (Medication Administration Records, or drug charts). Complaint, Par. 26. Those records contain details about which medications were administered to each patient, together with the times of administration of the medications.

DDSN declined to permit the examination of any records other than "plans of care," the only kind of record mentioned in the statute. Specifically, § 43-33-350(4) provides that in the course of a team advocacy inspection of living conditions, Plaintiff may review "the plans of care for individuals in a residential care facility and a community mental health center day program." (Emphasis added.) No other types of records are mentioned in that section. DDSN accordingly denied Plaintiff's request to review individual medical records without authorization from the DDSN consumers or their representatives. After several rounds of correspondence, attached to the Complaint, the parties' respective positions did not change. As a result, Plaintiff filed the present action. The question presented by this case involves a determination of whether the term "plans of care," as used in § 43-33-350(4), extends to the personal medical records of the individuals living in the facilities that are subject to inspections of living conditions by Plaintiff.

[1] Indeed, Ms. Prevost, Plaintiff's Executive Director, testified that P & A was seeking to review this personal medical information regardless of the wishes of the consumers of services or the representatives of such individuals.

B. **Statutory provisions pertaining to P & A.**

The powers and duties of the plaintiff organization are set forth in § 43-33-350. The specific power involved in the present case is the power to "conduct team advocacy inspections . . . to review living conditions" in facilities that provide residences to developmentally disabled persons. To put this specific grant of authority in context, a review of the general powers and duties of P & A, set forth in § 43-33-350, is appropriate. There are four powers in all. Only one, the one set forth in § 43-33-350(4), is involved in this action.

The first power is found in § 43-33-350(1). It provides that P & A "shall protect and advocate for the rights of all developmentally disabled persons . . . and for the rights of other handicapped persons by pursuing legal, administrative, and other appropriate remedies to insure the protection of the rights of these persons." This general grant of power does not specifically address the issues in the present claim.

The second power is found in § 43-33-350(2). It provides that P & A "may investigate complaints by or on behalf of any developmentally disabled or handicapped person." This power is related to specific complaints, and is not the same as the power involved here, which is the power to conduct general random inspections of facilities in the absence of such specific complaints.

The third power is found in § 43-33-350(3). It provides for the prioritization of the services that P & A provides to its clients. Specifically, it provides that P & A "may establish a priority for the delivery of protection and advocacy services according to the type, severity, and number of handicapping conditions of the person making a complaint or on whose behalf a complaint has been made." Obviously, this provision for internal prioritization by P & A itself is not related to the issues in this case.

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The fourth and final power conferred by state law is found in § 43-33-350(4). That subsection provides for the team advocacy inspections of facilities. Those inspections are the subject matter of this case. The subsection provides in its entirety as follows:

> [P & A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program. Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. The designee must meet criteria developed by the Joint Legislative Committee on Mental Health and Mental Retardation, after consultation with the system and the South Carolina Association of Residential Care Homes. The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Committee on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

(Emphases added.) As can be seen, the "team advocacy inspections" of "living conditions" contemplated by this subsection are general in nature, and not the result of particular complaints by or behalf of any particular person.

CONCLUSIONS OF LAW

1. **As a matter of law and administrative practice, the term "plan of care," in the context of Medicaid Waiver clients, refers to a specific document which sets forth the services to be provided to the client.**

As both sides have pointed out, S.C. Code Ann. § 44-33-350(4) was added in 1990 and subsequently amended in 1993 to include "plans of care" as part of what P & A is allowed to inspect at its unannounced team advocacy inspections. Because the term "plans of care" is not specifically defined by the statutes, it is appropriate for the Court to look to other sources and other uses of that term. The Court is most persuaded by the use of the term in Federal health care law, specifically 42 U.S.C. § 1395n(c)(1) (involving Medicaid waivers) and 42 C.F.R.

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§ 441.(b)(1)(i) and 42 C.F.R. § 441.351(f). As discussed more fully below, the term has been described by the Fourth Circuit in *Doe v. Kidd*, 2011 WL 1058542 (4th Cir. 2011) as involving something significantly less than all of a patient's medical records. The term is also used in South Carolina's Medicaid Waiver forms. Lacy Affidavit, Exhibits 1 and 2.

As set forth in Dr. Lacy's testimony and affidavit, a plan of care in this context is a document that is mandated by Medicaid law, which uses that precise term. It is prepared by the person's Service Coordinator. Affidavit of Kathi Lacy, Par. 3. As set forth in Par. 4 of the Lacy Affidavit, the Service Coordinator "conducts a formal, standardized assessment of the person's needs by gathering information from the person, family members, friends, service providers and medical care providers. The Service Coordinator then works with the person and the family to determine what services would best address the identified needs." The resulting document, i.e., the plan of care, "typically includes the medical and other services to be provided, their frequency, and the type of provider to furnish them." *Id.* The document that performs this function has had different working names from time to time, but those names have always referred to the plan of care. Lacy testimony and Lacy Affidavit, Par. 5. The document in which the recommendations are made is a form, Lacy Affidavit, Exhibit 1, and is the document generally referred to as the "plan of care." This meaning of the term is one that has had long usage. *Id.*, Par. 6. While Plaintiff claims that the term also applies to other documents, Plaintiff has not disputed any of these facts set forth in the Lacy affidavit, nor did Plaintiff provide any evidence to the contrary in any respect.

As set forth above and in the Lacy Affidavit, the term "plan of care" is used in the Medicaid waiver services context to refer to the specific document that contains the service plan for the individual. In addition to the factual information set forth in that affidavit, these specific

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documents are also specifically mentioned in the parts of the U.S. Code and Code of Federal Regulations that pertain to Medicaid waiver services. (It is undisputed that the Medicaid waiver program provides the funding for the vast majority of people who live in the facilities that P & A seeks to inspect. Complaint, Par. 49.) Specifically, 42 U.S.C. § 1395n(c)(1) provides:

> (1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.

(Emphasis added). To the same effect is 42 C.F.R. § 441.301(b)(1)(i), which provides as follows:

> (b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—
>
> (1) Provide that the services are furnished—
>
> (i) Under a written plan of care subject to approval by the Medicaid agency;

(Emphasis added.)

Another regulation, 42 C.F.R. § 441.351(f), while addressed only to waiver programs covering persons aged 65 and over, illustrates the kinds of information that are to be found in plans of care:

> **(f) Plan of care.** The request must provide that the home and community-based services described in § 440.181 of this subchapter, are furnished under a written plan of care based on an assessment of the individual's health and welfare needs and developed by qualified individuals for each recipient under the waiver. The qualifications of the individual or individuals who will be responsible for developing the individual plan of care must be described. Each plan of care must contain, at a minimum, the medical and other services to be provided, their frequency, and the

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type of provider to furnish them. Plans of care must be subject to the approval of the Medicaid agency.

(Emphasis added.)

The term is also used in South Carolina's Medicaid Waiver document, excerpts of which are attached as Exhibit 2 to the Lacy Affidavit. In that document, the plan of care is described in the same manner as in the Lacy Affidavit.

A typical illustration of the use of the term in South Carolina to mean this document is found the recent unreported case, *Doe v. Kidd,* 2011 WL 1058542 (4th Cir. 2011). There the Fourth Circuit described a plan of care as follows:

> DDSN approved a "plan of care" that was developed for Doe pursuant to 42 C.F.R. § 441.301(b) (hereinafter the "2003 plan"). J.A. 616–44. The 2003 plan included a regime of personal care, psychological evaluations, and other services to be provided in-home at the residence of Doe's mother. It also recommended that Doe "receive residential habilitation from a DDSN approved provider" within three months at a "setting located within the Columbia area to be chosen by her family."

2011 WL 1058542 at 2. *See also, e.g., McCrann v. Department of Health and Human Services,* 704 S.E.2d 899, 901 (N.C. App. 2011)(plan of care in the Medicaid wavier program is "a schedule of services to be provided to the program participant"); *Boatman v. Murphy*, 2010 WL 2178821, 1 (S.D.Ind. 2010)(case manager assesses the Medicaid waiver applicant's specific needs and creates a plan of care and cost comparison budget, which are submitted to the Division of Aging for review). These cases, the statutes and regulations, as well as longstanding administrative practice described in the Lacy Affidavit, make it clear that the reference to "plans of care" in § 43-33-350(4) is a reference to a term which has a very specific meaning in this

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context. Such plans of care do not include MARs and other individual medical records that serve functions other than those served by plans of care.[2]

2. The statute creating P & A makes it clear that P & A can review individual medical records only in limited instances, which do not include team advocacy inspections.

A review of the entire state statutory scheme creating P & A makes it clear that the General Assembly actually intended that P & A would not be permitted to review individual medical records in the course of facilities inspections relating only to living conditions. The 1993 amendment to § 44-33-350(4) was expressly "to provide for the review of the plans of care for individuals in a residential care facility and a community mental health center day program," which, as Defendant points out, is a rather limited expansion of P & A's authority and seemingly not meant as carte blanche to peruse medical records as the Plaintiff seeks. The Court therefore finds that, although the term was not defined in the statute by the Legislature, it nonetheless was meant to have a specific meaning and not an expansive, all-inclusive definition that would include any and all of the CTH patients' medical records.

Section 43-33-370(2) states that, upon receipt of a complaint pertaining to the treatment of a particular individual, P & A may "inspect and copy any documents . . . which bear upon the subject matter of the individual complaint, except for the individual medical, treatment or other personal records of other persons in the program or facility." (Emphases added.) Therefore, the

[2] Plaintiff argues that it has inspected another kind of facility, Community Residential Care Facilities (CRCF's) and has not been prevented by another agency, the Department of Mental Health, from reviewing medical records in that context. However, those facilities are mostly small, private, and probably unaware of which records they should produce and should not produce. In addition, as Ms. Prevost testified, Plaintiff was conducting those inspections as a contractor with the Department of Mental Health. In any event, that other context, which does not involve DDSN, is not before the Court, and cannot govern the present situation, where the matter is being contested.

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Court concludes that the language of § 44-33-350(4), when read in conjunction with the entire Act, and specifically, § 44-33-370(2), was not meant to give P & A access to all or even any of the CTH patients' medical records, absent a complaint filed by a specific patient or waiver by a patient or guardian. Instead, the General Assembly defined the records available to Plaintiff in a team advocacy inspection as only "plans of care," which has a specifically-intended, and rather restrictive (for the Plaintiff's purposes) meaning.

In other words, it is clear that P & A can only view medical records of a specific individual in response to a specific complaint by or on behalf of that individual. This section leaves no doubt that the General Assembly was aware of the need for privacy as to medical records on the part of disabled individuals.

Also, Section 43-33-400, discussed below, provides that in the context of agency cooperation with P & A, the agencies "shall permit [P & A] to inspect and copy any record or documents provided for in 43-33-370(2)." (Emphasis added). As shown above, those records are reviewable only in cases involving individual complaints, and only the records of the specific individual are permitted to be copied.

3. The common meaning of the term "plans of care" does not extend to the kinds of medical records sought by P & A.

Finally, it is clear from the plain meaning of the term that a "plan of care" is something different from a medical record, and specifically from a medication administration record. A "plan" is a document providing for guidance in the future. Thus, as typically defined in dictionaries, a "plan" is "a scheme or method of acting, doing, proceeding, making, etc., developed in advance."[3] (Emphasis added.)

[3] http://dictionary.reference.com/browse/plan

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In accordance with this definition of "plan" in general, a plan of care is a guidance document that sets forth what will be provided to the person. On the other hand, most medical records, and especially the medication administration records Plaintiff seeks, are not advance planning documents, but rather are documentation of something that occurred in the past, specifically, documentations of the previous administration of medications.

Presumably, by limiting the records reviewable by P & A in the course of a review of "living conditions," § 43-33-350(4), the General Assembly intended that P & A would be able to review plans of care in order to see whether the conditions in the facilities were responsive to the residents' plans of care. However, since the team advocacy inspections were to pertain only to living conditions, and not to each individual's specific situation, the line was drawn by the General Assembly at plans of care.[4] Plaintiff's claim of a right to review documentations of past events therefore fails to satisfy the most basic definition of what a "plan of care" might be.

The Court would also note that the record in this case contains a number of Team Advocacy Inspection reports relating to inspections that occurred before this action was filed. Those reports are typically around six pages long. They detail a number of matters that involve living conditions, such as resident privacy, fire hazard, maintenance, sanitation, housekeeping, food storage, accessibility, resident hygiene, clothing needs and resident safety. These reports demonstrate that even without access to personal medical records, P & A can still conduct thorough inspections of living conditions at the residences.

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[4] Of course, the General Assembly could always decide to expand the nature of the documents reviewable by P & A, but that policy decision is one for the legislature, and not this Court, which is faced with the clear language of the statute, as well as the undisputed practice under that language.

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4. Other arguments by Plaintiff based on the language of the statute in issue or unrelated statutes provide no support for Plaintiff's contentions.

Plaintiff makes several other unavailing arguments, some of which are based on the statute in question, and others of which are based on unrelated provisions of the Code. As discussed below, all are without merit.

a. Unannounced nature of the inspections.

Plaintiff's first argument concerns DDSN's suggestion, made prior to this litigation, that P & A could obtain medical records with the consent of residents or their guardians. P & A claims that this would conflict with the unannounced nature of the inspections. This is not necessarily true, but in any event, has nothing to do with the definition of the term "plans of care" found in § 43-33-350(4).

In correspondence that took place prior to the filing of this action, DDSN had suggested that P & A could review the residents' medical records, in addition to their plans of care, if consent from the residents or their guardians could be obtained. P & A now argues that to do so would make P & A's intent to conduct inspections known to the facilities, when the statute provides for unannounced visits. The Court finds this argument unpersuasive. A medical record waiver can be executed by a patient or his or her guardian at any time, perhaps most effectively upon intake to the facility, and kept on site with the patient's file. P & A would still be free to conduct unannounced inspections and at that time inspect any medical records for which disclosure has been waived. The Court feels that, absent any waiver, P & A is not entitled to access to patients' medical records at a Community Training Home.

In any event, this argument is merely addressed to an alternative approach that had been suggested by DDSN. Even if this approach were to have the effect of advising the facility in advance that an inspection of living conditions might be forthcoming, that result still cannot

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expand the meaning of the term "plans of care" beyond the clear meaning that the term has in this context, as DDSN has already argued. This entire argument is therefore simply beside the point.

b. Use of the term "including."

Plaintiff claims that when the statute provided for P & A to make "unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility," the term "including" suggests that other records might be reviewed as well.

The first problem with this argument is that it contradicts the well-settled rule that "to express or include one thing implies the exclusion of another," also known as "inclusio unius est exclusio alterius." *Nelson v. Ozmint*, 390 S.C. 432, 436-437, 702 S.E.2d 369, 371 (2010).[5] The fact that plans of care are referenced, but no other types of records, is a compelling indication that the General Assembly intended for only those records to be inspected. Secondly, and as Plaintiff itself points out, this language was inserted by Act No. 133 of 1993. Prior to that act, the statute provided for team advocacy inspections of living conditions, but did not reference plans of care. Act No. 133 added the language about plans of care. The title of the 1993 Act was

> AN ACT TO AMEND SECTION 43-33-350, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO THE POWERS AND DUTIES OF THE PROTECTION AND ADVOCACY SYSTEM FOR THE HANDICAPPED, INC., SO AS TO PROVIDE FOR THE REVIEW OF THE PLANS OF CARE FOR INDIVIDUALS IN A RESIDENTIAL CARE FACILITY AND A COMMUNITY MENTAL HEALTH CENTER DAY PROGRAM BY THE TEAM ADVOCACY

[5] Plaintiff references cases in which the presumption is reversed, but those involve situations where the word "including" modifies the term to be defined. In order for that rule to apply in the present case, the statute would have to say "records, including plans of care," but it does not say that. Instead, it says "living conditions . . . , including plans of care. . . ."

PROJECT'S COORDINATOR OR HIS DESIGNEE AND REQUIRE THE DESIGNEE TO MEET CERTAIN CRITERIA.

(Emphasis added.) The language added is shown below with underlining:

> [P & A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program. Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. The designee must meet criteria developed by the Joint Legislative Committee on Mental Health and Mental Retardation, after consultation with the system and the South Carolina Association of Residential Care Homes. The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Committee on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

In other words, the only additional information made reviewable by the 1993 amendment was the information in plans of care. To argue otherwise, as Plaintiff tries to do, is to argue exactly the opposite of what the General Assembly intended with this limited addition to the statute.

c. The term "living conditions."

Plaintiff claims that the provision of health and medication services is part of what is meant by "the living conditions of a residential facility." § 43-33-350(4). This is a broader definition of the term "living conditions" than the context indicates. In addition, even if Plaintiff's broad definition of "living conditions" were to be accepted, it still would not change the reference in the statute to the "plan of care," which is a very specific document in this context.

First of all, in common parlance, the term "living conditions" tends to refer to the physical surroundings in which a person lives, such as the sanitation of the residence and

whether it is adequately heated and cooled. *See, e.g., South Carolina Dept. of Social Services v. Sims,* 359 S.C. 601, 604, 598 S.E.2d 303, 305 (Ct. App. 2004), where the term was used to describe the physical aspects of a home; *Benjamin v. Housing Authority of Darlington County,* 198 S.C. 79, 15 S.E.2d 737, 739 (1941)(rural housing act would "provide sanitary homes and living conditions for farm families of low income"). Additionally, this connotation of physical surroundings is clearly the meaning intended in other similar provisions of the Code. These include, for instance, § 31-13-180, which deals with moderate to low income housing, and provides that "a serious shortage of sanitary and safe residential housing . . . will contribute to the creation and persistence of substandard living conditions."

Finally, even if the term "living conditions" extended as far as Plaintiff claims, which is surely not the case, this still would not change the very specific and limited meaning that the term "plans of care" carries in this context, as discussed above. As a result, any argument of Plaintiff based on the use of the term "living conditions" in the statute is unavailing.

d. The reference to "plans" of care.

Plaintiff also claims that the General Assembly must have intended more than one kind of document, because it used the plural term "plans of care." The short answer to this is that each facility has more than one resident, each of whom will have a plan of care, so it is completely appropriate to refer to those specific plans, one per resident, in the plural. This reference is clearly insufficient to overcome the specificity of the reference in other contexts, as discussed above. Moreover, it does not overcome the fact that the documents referenced in the statute are "plans," that is future-oriented, and not medical records, which document events in the past.

e. Use of similar phrases in other statutes.

Plaintiff also makes passing reference to the use of the term "plans of care" elsewhere in the Code, but suggests no reason why those references should overcome the specificity of the reference in § 43-33-350(4). Again, a "plan" is a document providing guidance for the future, while a medication administration record is a documentation of something that occurred in the past. In other words, the medication administration records are simply not the kinds of records that would be included in the most fundamental definition of a "plan." As the term "plan of care" is used in the references cited by Plaintiff, it is clear that it normally has this connotation of a document that contains plans for the future, not documentation of past events.[6]

5. Plaintiff's claims based on vague language in statutes pertaining to cooperation are insufficient to overcome the specific limitations on the kinds of documents that can be disclosed to Plaintiff.

Plaintiff's Second Cause of Action alleges that certain other language in state and federal statutes is a source for the authority it claims. First, Plaintiff cites § 43-33-400. That section, however, only provides as follows:

> All departments, officers, agencies and institutions of the State shall cooperate with the System in carrying out its duties. . . . Notwithstanding any other provision of law, any program or facility shall permit the System to inspect and copy any record or documents provided for in 43-33-370(2).

(Emphases added.) The first emphasized part of the statute, and the one on which Plaintiff relies, simply provides for cooperation with Plaintiff in its carrying out of the duties it already has. This provision is not the source of any duty not previously mentioned in the statute. In addition, the

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[6] The statutes and regulations cited by Plaintiff are all of the same nature as, for example, § 44-7-350 (DHEC licensure of Nursing Homes: an "agency placing a client in a community residential care facility shall develop an individual plan of care in cooperation with the provider") While the context is different from that in this case, the concept of an advance plan is the same.

sole reference to making records available is a reference back to § 43-33-370(2), which as seen above, provides only for disclosure in situations where individualized complaints are made.

In addition, Plaintiff cites 42 U.S.C. § 15043(a)(3)(b), which states that the State should provide to P & A, "to the extent that information is available, . . . "information about the adequacy of health care and other services . . . that individuals with developmental disabilities who are served through home and community based waivers (under Medicaid) receive..." This section does not suggest that the State is required to provide P & A with confidential medical information of DDSN clients. That information is authorized to be released only in the individualized circumstances set forth earlier in the statute, specifically in 42 U.S.C. § 15043(a)(2)(F) and –(J), both of which provide for the release of the records of individuals only when complaints are made relating to specific individuals. It is unreasonable to think that Congress would have provided elaborate limitations of the disclosure of such information in those two specific sections, only to then authorize virtually unlimited access in a later section that deals only with general reviews of adequacy of health care and other services.

CONCLUSION

For the foregoing reasons, the Court concludes that Plaintiff's claimed right to review medical records is without support in the pertinent statutes, and that as a result, this action should be, and is, dismissed with prejudice.

AND IT IS SO ORDERED.

Edgar W. Dickson
Presiding Judge

Orangeburg, South Carolina

November 20, 2012

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STATE OF SOUTH CAROLINA	)	**IN THE COURT OF COMMON PLEAS**
	)	
COUNTY OF RICHLAND	)	Civil Action Number: 10-CP-40-1095
	)	
Protection and Advocacy for People with Disabilities, Inc.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	**ORDER DENYING PLAINTIFF'S MOTION FOR RECONSIDERATION**
Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission,	)	
	)	
Defendants.	)	

By Order filed December 4, 2012, the Court dismissed this action. On December 17, 2012, Plaintiff served a Motion for Reconsideration. For the reasons set forth below, the motion is denied. with one exception as noted herein.

I. Plaintiff's claims concerning the language of the statute (Heading I of Plaintiff's motion).

Plaintiff initially contends that the Order ignores the plain meaning of the term "plans of care" as used in S.C. Code Ann. § 43-33-350(4). However, the Order did not rely solely on the use of the term "plan of care" in federal law, as Plaintiff seems to suggest (Motion at 2-3). The Court looked to federal law as an illustration of the use of a well-defined meaning of the term "plan of care" in a very similar, and often identical, context. Order 5-9. In addition, the Court

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addressed the plain meaning of the term "plan" at pp. 10-11 of the Order. Specifically, the Court noted that the term "plan" plainly connotes the idea of guidance for the future. The medication administration records (MARs) sought by Plaintiff in this case, as their descriptive title would suggest, are records that serve to document past occurrences, i.e., the administration of medications, and therefore fall outside the normal definition of what is meant by a "plan."

Plaintiff also argues that the Order did not make adequate reference to other state statutes and regulations. Motion at 3-4. In that part of the motion, Plaintiff reiterates its reference in prior filings to various state law provisions that mention the term "plan of care" in some fashion. The Order, however, noted (p. 16, n. 6) that those state law references were generally similar to § 43-33-350(4) in referencing an advance plan. In addition, Plaintiff does not cite to any particular definition of the term in any of those references that would support its arguments in this case.

Plaintiff notes (Motion at 4-5) that the Court's reference in the Order to Medicaid usages and authorities would not strictly apply to those situations in which team inspections would be conducted in facilities whose clients are not Medicaid Waiver clients. Again, however, Plaintiff misperceives the nature of the Court's reliance on Medicaid authorities, as already mentioned above. The Medicaid authorities simply provide a detailed illustration of the meaning of the term in contexts that are the same as that in the present case, regardless of whether or not a particular individual is a Medicaid Waiver client. It should also be noted that in its Complaint, Plaintiff asserted its belief that with respect to the types of residences whose inspection is sought in this action, "the great majority of people with developmental disabilities in CTHs are recipients of Medicaid services under the Medicaid Mental Retardation/Related Disabilities Waiver." Complaint, Par. 49.

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Plaintiff makes several other arguments (Motion at 5-7) regarding the interpretation of the statute. Most of these deal with the specific terms of the federal authorities referenced in the Order, and have already been discussed in the Order at pp. 5-9. Plaintiff also refers (Motion at 6) to an interrogatory response by Defendants, but as Defendants have pointed out, Defendants' Memorandum in Response to Plaintiffs' Motion for Summary Judgment at p. 7, n. 4, the language of the DDSN standard itself (as opposed to the interrogatory response) is that there must be "documentation that the physician's [or dentist's] recommendations are being followed" (emphasis added). The term "plan of care" is not actually used in that standard.

On pp. 7-8 of its motion, Plaintiff reasserts certain contentions about the use of the phrase "living conditions, including plans of care" in § 43-33-350(4). These contentions were considered and addressed at pp. 13-15 of the Order.

Finally, with respect to interpretation of the statute, Plaintiff puts forth its own unsupported allegation that medical care and treatment are so much a part of the "living conditions" of the residents of the facilities that a review of the residents' medical records must necessarily be a part of an inspection of their living conditions. The short answer to this is found at pp. 9-10 of the Order, in which the Court referenced the language of § 43-33-370(2). In that subsection, the General Assembly referenced "the individual medical, treatment or other personal records" of residents of inspected facilities, but only in order to exempt such records from review by P&A except where an individual complaint has occurred. In other words, the General Assembly was well aware of how to describe the kinds of records sought by Plaintiff in this case, but simply chose not to make such records available to Plaintiff in the course of conducting team inspections of living conditions at residential facilities.

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II. Plaintiff's claims concerning broad construction of the statute (Heading II of Plaintiff's motion).

Plaintiff next contends that its position on the definition of the term "plans of care" is supported by the presence of limitations on who can see team inspection reports. Motion at 10-11. However, the definition of the term "plans of care" is not, as a matter of simple logic, determined by who can view the defined documents. Moreover, "plans of care," as that term is used by DDSN, are sufficiently private documents in themselves to warrant the limitations on who may see them. This claim is accordingly not relevant to the issue before the Court.

III. Plaintiff's claims concerning the nature of medication administration records as constituting "plans of care." (Heading III of Plaintiff's motion).

In this section of its motion (Motion at 11), Plaintiff contends that a medication administration record is a "plan of care" in and of itself. Plaintiff claims that such records "set forth the medications each resident is to receive, the planned dosage and the time it is to be given, then it tracks staff's actual administration of the medication." *Id.*

A significant problem with this argument is that Plaintiff did not introduce any medication administration records into evidence. As a result, there is nothing in the record that would permit the Court to review the merits of this contention. Even if one or more MARs had been placed in evidence by Plaintiff, however, the contents of those documents would still not necessarily contain everything that Plaintiff claims such documents contain. Moreover, such documents would at most normally only provide evidence of compliance with certain doctors' orders. Neither the physicians' orders themselves nor the records showing the extent of compliance with the orders can fairly be said to meet the definition of a "plan of care" in this context, for the reasons already set forth in the Order.

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IV. Deference to P&A's construction of its enabling statute (Headings IV and V of Plaintiff's motion).

Plaintiff next argues that its own interpretation of the subsection in issue is entitled to deference as a construction by the agency charged with its administration. Plaintiff initially relies on *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). That reliance is misplaced, however, because *Chevron*-style deference is accorded only to regulations or other formally-adopted agency actions. *See, e.g., Christensen v. Harris County*, 529 U.S. 576, 587 (2000). Any agency action short of the described degree of formality does not receive such a high level of deference. *Id.* (no *Chevron* deference given to "interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law").

Plaintiff also claims that its interpretation of the statute is entitled to deference under the principle that such deference is given to construction of a statute by the agency charged with its administration, at least as long as the agency's construction is not contrary to the clear language of the statute. *See, e.g., State v. Sweat*, 379 S.C. 367, 374, 665 S.E.2d 645, 649 (Ct. App. 2008). However, as will be shown, that rule does not apply to an agency such as P&A, which is not charged with the administration of the statute in the sense used by courts in applying this rule of construction.

The rule of construction cited by Plaintiff is founded on the idea that the applicable legislative body (Congress or a state legislature) has delegated to the agency, either explicitly or implicitly, the authority to make policy. *See, e.g., Linemaster Switch Corp. v. U.S. E.P.A.*, 938 F.2d 1299, 1303 (D.C. Cir. 1991)("[b]efore we may defer to an agency's construction of a statute, we must find either explicit or implicit evidence of congressional intent to delegate interpretive authority"). This includes the filling in of gaps in the enabling legislation.

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There is no indication in P&A's enabling legislation, S.C. Code Ann. §§ 43-33-310, et seq., that the General Assembly intended to delegate such authority to P&A. Instead of serving as a policymaking or regulatory agency, P&A was created to serve investigative and advocacy functions to the extent authorized by statute. Those functions actually exclude the role of serving as a policymaker, because neither an investigator nor an advocate is empowered to legislate the proper subjects of their own activities. In an analogous context, it has been held, for example, that a "civil prosecutor typically lacks authority to issue substantive regulations to interpret a statute establishing liability." *Kelley v. E.P.A.*, 15 F.3d 1100, 1106 (D.C. Cir. 1994). Here, P&A, as an investigator, lacks authority to decide what the General Assembly intended for it to be able to investigate. That decision is one for the courts, and specifically, for the Court in the present case.

It is regularly held that no deference should be given to the views of agencies to which policymaking authority has not been delegated. *See also, e.g., Pittston Stevedoring Corp. v. Dellaventura,* 544 F.2d 35, 49 (2d Cir. 1976)(no deference to an adjudicatory agency that was "not a policy making but entirely an umpiring agency"); *State of Fla., Dept. of Ins. v. National Amusement Purchasing Group, Inc.*, 905 F.2d 361, 366 (5th Cir. 1990)(no deference where agency was "not charged with administering the Act, but merely has responsibility under the Act to report on its implementation"); *Air North America v. Department of Transp.*, 937 F.2d 1427 (9th Cir. 1991)(deference to agency's construction of the Administration Procedure Act inappropriate as Congress did not direct the Department to implement the Act).[1] The duties

[1] While no South Carolina case has been located which has had the need to address the issue for some kind of legislative delegation of authority to interpret, state courts have reached the same conclusion as the federal cases cited above. *See, e.g., Committee of Consumer Services v. Public Service Com'n of Utah,* 75 P.3d 481, 484 (Utah 2003)(no deference to agency construction "[u]nless the legislature has granted discretion to an agency to interpret statutory language").

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conferred on P&A simply are not the kinds of duties that carry with them the authority to make policy regarding the proper construction of P&A's enabling legislation.

In its Heading V, Plaintiff argues that DDSN had knowledge of Plaintiff's investigatory practices and should be "prevented, by estoppels or otherwise," from objecting to Plaintiff's efforts to review personal medical records. Motion at 13. This contention is not supported by the record. Plaintiff may have introduced evidence that it managed to inspect those records at a few facilities that serve DDSN clients, but there is nothing in the record to indicate that the DDSN Director or anyone with statewide authority at the agency was aware of such inspections. Indeed, the attachments to the Affidavit of Gloria Prevost indicate that DDSN's supervisory officials objected to P&A's plan to inspect individual medical records as part of team advocacy inspections as soon as those officials were made aware of P&A's plans. In fact, it was those objections by DDSN's highest-ranking officials that led to the filing of this lawsuit.

Plaintiff also argue that other agencies, such as the Department of Mental Health and perhaps DHEC, have permitted P&A to review the kinds of records sought to be reviewed in the present case. Motion at 12-13. However, Ms. Prevost testified that P&A was acting pursuant to contract with DMH, which means in effect that P&A was an agent of DMH. *See* Order at 9, n.2. As for DHEC, the evidence of what DHEC would permit to be inspected was limited, at best.[2] Plaintiff has certainly made no showing of the precise nature of the other agencies' interpretations, or that DDSN actually knew of these interpretations, even assuming that such interpretations would apply in the present context. Plaintiff likewise has not cited any legal authority to show why DDSN should be bound by a interpretation given a statute by other

[2] Plaintiff cites *DHEC vs. Bellwood Manor, Inc.*, 2010 WL 6782577 (S.C. Administrative Law Court 2010), but the issue of which records could be reviewed was not the subject of that case.

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agencies, probably in other contexts, and of which DDSN has not been shown to have been aware of. As a result, any claim based on alleged interpretations by other agencies is unmeritorious, both because of inadequate proof of the nature of the interpretations and DDSN's knowledge thereof, and also because no authority has been cited to support this claim as a matter of law.

V. Application of the Order to non-Medicaid settings (Heading VI of Plaintiff's motion).

Under Heading VI of its motion, Plaintiff asserts that some of the facilities that it inspects do not house persons who are Medicaid clients. Motion at 14. As noted above, however, the Order referred to Medicaid law and practice primarily for purposes of illustrating the meaning given to the term "plan of care." The Order did not hold that the Medicaid authorities were literally controlling, but only that given the clear meaning of the term in the Medicaid context, that same meaning should also apply in the present state law context as well. The Order additionally was based on the plain meaning of the term (Order at 10-11) and on other parts of the P&A statute itself (Order at 9-10). As a result, any concern that the Order might improperly extend Medicaid concepts to other contexts is misplaced.

VI. Effect of the Order on unannounced inspections (Heading VII of Plaintiff's motion).

In this part of its motion (pp. 14015), Plaintiff addresses the Order's discussion of a suggestion by DDSN that one way for P&A to review medical records would be to obtain prior consent from the residents or their representatives. As the Order points out, however,

> [T]his argument [by Plaintiff] is merely addressed to an alternative approach that had been suggested by DDSN. Even if this approach were to have the effect of advising the facility in advance that an inspection of living conditions might be forthcoming, that result still cannot expand the meaning of the term "plans of care" beyond the clear meaning that the term has in this context, as DDSN has

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already argued. This entire argument is therefore simply beside the point.

Order at 12-13. In other words, if the statute did not grant to P&A the right to review medical records, as opposed to plans of care, then team advocacy inspections of medical records would be blocked, not because of the refusal of consent, but because the statute did not permit such records to be reviewed in the course of an inspection, as the Order has held. There was no suggestion in the Order that the review by P&A of plans of care, as defined in the Order, could be blocked by the nonconsent of the client or the client's representatives.

VII. Alleged conflation of different parts of the P&A statute (Heading VIII of Plaintiff's motion).

In Plaintiff's Issue VIII, it is contended that the Order was in error by holding, according to Plaintiff, that "[l]imitations on P&A's authority to inspect records in one context do not apply in other legally distinct contexts; . . ." Motion at 16. As with several other arguments made by Plaintiff, this misperceives the nature of what was held in the Order. The Order held that § 43-33-370(2) placed substantial limitations on the ability of P&A to review individual medical records, permitting such review only in response to a specific complaint by or on behalf of an individual, and even then, P&A's document review was not to include "the individual medical, treatment or other personal records of other persons in the program or facility." §43-33-370(2)(emphasis added). In other words, given the clearly-expressed desire of the General Assembly to protect individual medical records of facility residents even in situations where complaints have been made, it is not reasonable to think that the General Assembly would have intended to permit unrestricted access by P&A to those same protected records in the course of an inspection that was not necessarily even made in response to a complaint.

This holding by the Court was an application of the very familiar principle that "In ascertaining the intent of the legislature, a court should not focus on any single section or

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provision but should consider the language of the statute as a whole." *Mid-State Auto Auction of Lexington, Inc. v. Altman*, 324 S.C. 65, 69, 476 S.E.2d 690, 692 (1996). Taking the statute as a whole, there can be no question that the General Assembly intended to make individual medical records available to P&A only in very limited circumstances, and not in the wholesale fashion for which P&A presently contends.

VIIII. Arguments pertaining to the trial record (Heading IX of Plaintiff's motion).

In this heading of its motion, Plaintiff cites two instances in which it contends that the Order went beyond the trial record. The first of the two is the following provision of the Order:

> The Court therefore finds that, although the term was not defined in the statute by the Legislature, it nonetheless was meant to have a specific meaning and not an expansive, all-inclusive definition that would include any and all of the CTH patients' medical records.

Order at 9. Plaintiff asserts that this holding constitutes a statement that Plaintiff was seeking "any and all of the CTH patients' medical records." Motion at 16. Actually, it does not constitute a statement about what Plaintiff was seeking at all. In the context of this case, this statement clearly meant that Plaintiff should not have access to any and all CTH patients' medical records at the facility.

Plaintiff's second and other argument about matters in the record is directed toward footnote 2 on p. 9 of the Order. That footnote provides as follows:

> Plaintiff argues that it has inspected another kind of facility, Community Residential Care Facilities (CRCF's) and has not been prevented by another agency, the Department of Mental Health, from reviewing medical records in that context. However, those facilities are mostly small, private, and probably unaware of which records they should produce and should not produce. In addition, as Ms. Prevost testified, Plaintiff was conducting those inspections as a contractor with the Department of Mental Health. In any event, that other context, which does not involve DDSN, is not before the Court, and cannot govern the present situation, where the matter is being contested.

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Plaintiff argues that the reference to certain CRCF's as "mostly small, private, and probably unaware of which records they should produce and should not produce" is unsupported by the record. The Court concludes that this language to which Plaintiff objects is not necessarily material, but in any event, the Court concludes that the footnote can properly be amended slightly to resolve this issue raised by Plaintiff. The Court is accordingly filing an Amended Order that differs from the original with the changes as shown below:

> Plaintiff argues that it has inspected another kind of facility, Community Residential Care Facilities (CRCF's) and has not been prevented by another agency, the Department of Mental Health, from reviewing medical records in that context. However, ~~those facilities are mostly small, private, and probably unaware of which records they should produce and should not produce. In addition,~~ as Ms. Prevost testified, Plaintiff was conducting those inspections as a contractor with the Department of Mental Health. In any event, that other context, which does not involve DDSN, is not before the Court, and cannot govern the present situation, where the matter is being contested.

IX. Public policy arguments (Heading X of Plaintiff's motion).

Finally, Plaintiff argues that the result reached in the Order is "contrary to South Carolina public policy, general principles of equity, and the needs of South Carolina citizens." Motion at 17. Plaintiff here asserts that having medical records subject to review is something that "helps ensure that South Carolina residents with disabilities are receiving appropriate care and living in safe environments." While no one would disagree with the worthiness of the broad goal quoted immediately above, Plaintiff does not recognize that those residents, like all other residents of the state, are entitled to have their medical records remain private, absent a clear expression of intent to the contrary by the General Assembly. That clear expression of intent is lacking in this case; indeed, the statute's plain meaning makes it very clear that the only records to be made available during team advocacy inspections would be plans of care, as that term is defined in the Order. Plaintiff's policy arguments are properly addressed to the General Assembly, which defines

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policy in this area, rather than to the courts, whose role is to effectuate the expressed intent of the legislature.

For the foregoing reasons, the Court concludes that Plaintiff's Motion for Reconsideration should be denied, except for striking the language referenced above. Accordingly, the Court will enter the Amended Order that deletes that language.

AND IT IS SO ORDERED.

Edgar W. Dickson
Presiding Judge

Orangeburg, South Carolina

December 5, 2014

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FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND
IN THE COURT OF COMMON PLEAS

JUDGME IN A CIVIL CASE

CASE NUMBER: 2010CP4001095

Protection And Advocacy For People With Disabilities Inc

PLAINTIFF(S)

Beverly A H Buscemi

SC Department Of Disabilities & Special Needs

DEFENDANT(S)

Submitted by: _____	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other _____

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other _____

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other _____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.

Additional Information for the Clerk : _____

INFORMATION FOR THE PUBLIC INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**

Circuit Court Judge _____ **Judge Code** _____ **Date** _____

For Clerk of Court Office Use Only

This judgment was entered on the _____ **day of** _____, **20** _____ and a copy mailed first class or placed in the appropriate attorney's box on this 17 December 2014 to attorneys of record or to parties (when appearing pro se) as follows:

Anna Maria Darwin
Jerrilea S Davison
Kenneth P. Woodington
Thornwell W Simons

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter _____

Clerk of Court Jeanette W. McBride

SCRCP Form 4C (10/2011)

SCANNED

STATE OF SOUTH CAROLINA **COUNTY OF RICHLAND**	**IN THE COURT OF COMMON PLEAS** Civil Action Number: 10-CP-40-1095
Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	**AMENDED ORDER**

RICHLAND COUNTY
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Plaintiff in this action claims a right to review certain medical records of individuals during the course of statutorily-authorized inspections by Plaintiff of living conditions in facilities that house developmentally disabled persons. Defendants have denied that there is any statutory authority for plaintiff to review individual medical records in the absence of individualized complaints. Instead, Defendants argue, the statute that authorizes plaintiff to investigate living conditions limits the kind of records available for inspection to "plans of care." *S.C. Code Ann.* § 43-33-350(4), a term which they contend has a specific and more limited meaning in this context, preventing the extension of the term to personal medical records.

This case was tried before the Court, sitting without a jury, on October 3, 2012. The Plaintiff presented testimony from Gloria Prevost, Executive Director of Protection and

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Advocacy for People with Disabilities, Inc. ("P & A"). Plaintiff also presented testimony from Susan Perry and Kimberly Tissot, both of whom have conducted team advocacy inspections. Defendants presented testimony from Dr. Kathi Lacy, the Associate Director of Policy at the Department of Disabilities and Special Needs (DDSN), who is familiar with the use of the term "plans of care" in the context of DDSN facilities and services. By consent of the parties, the Court also considered the previously-filed Affidavits of Ms. Prevost and Dr. Lacy.

For the reasons set forth herein, the Court concludes that the Defendants' legal position is supported by the language of the pertinent statutes, especially as read in conjunction with related legal authorities, and by the interpretation of the statutes in practice. As a result, it is appropriate that this action be dismissed. While the Court appreciates the purpose and efforts of the Protection and Advocacy System, the Court and P & A are constrained by powers granted to P & A by S.C. Code Ann. § 44-33-300, et seq. Therefore, the Court finds that allowing P & A access to patients' medical records at Community Training Homes without the patients' or guardians' consents is overstepping the authority granted by the Legislature.

FACTS

A. Background.

The Plaintiff, Protection and Advocacy for People with Disabilities, Inc., is a corporation which has been given certain powers and duties under state law. *S.C. Code Ann.*, §§43-33-310, et seq. The existence of such an entity is a prerequisite to the State receiving certain federal funding. *See* 42 U.S.C. § 15043.

As detailed in the Complaint, the basic facts of this case are that Plaintiff has sought to review personal medical records in the course of conducting "team advocacy inspections" of living conditions in facilities in which developmentally disabled or handicapped persons reside.

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The power to conduct such investigations is conferred on the Plaintiff by *S.C. Code Ann.* § 43-33-350(4), which will be discussed below in detail.

In the course of seeking to inspect living conditions, Plaintiff additionally claims authority to review the medical records of the residents of the institutions, regardless of whether they were clients of Plaintiff, and regardless of whether specific complaints had been made by residents or persons acting on their behalf.[1] In particular, P & A has sought to review MARs (Medication Administration Records, or drug charts). Complaint, Par. 26. Those records contain details about which medications were administered to each patient, together with the times of administration of the medications.

DDSN declined to permit the examination of any records other than "plans of care," the only kind of record mentioned in the statute. Specifically, § 43-33-350(4) provides that in the course of a team advocacy inspection of living conditions, Plaintiff may review "the plans of care for individuals in a residential care facility and a community mental health center day program." (Emphasis added.) No other types of records are mentioned in that section. DDSN accordingly denied Plaintiff's request to review individual medical records without authorization from the DDSN consumers or their representatives. After several rounds of correspondence, attached to the Complaint, the parties' respective positions did not change. As a result, Plaintiff filed the present action. The question presented by this case involves a determination of whether the term "plans of care," as used in § 43-33-350(4), extends to the personal medical records of the individuals living in the facilities that are subject to inspections of living conditions by Plaintiff.

[1] Indeed, Ms. Prevost, Plaintiff's Executive Director, testified that P & A was seeking to review this personal medical information regardless of the wishes of the consumers of services or the representatives of such individuals.

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B. Statutory provisions pertaining to P & A.

The powers and duties of the plaintiff organization are set forth in § 43-33-350. The specific power involved in the present case is the power to "conduct team advocacy inspections . . . to review living conditions" in facilities that provide residences to developmentally disabled persons. To put this specific grant of authority in context, a review of the general powers and duties of P & A, set forth in § 43-33-350, is appropriate. There are four powers in all. Only one, the one set forth in § 43-33-350(4), is involved in this action.

The first power is found in § 43-33-350(1). It provides that P & A "shall protect and advocate for the rights of all developmentally disabled persons . . . and for the rights of other handicapped persons by pursuing legal, administrative, and other appropriate remedies to insure the protection of the rights of these persons." This general grant of power does not specifically address the issues in the present claim.

The second power is found in § 43-33-350(2). It provides that P & A "may investigate complaints by or on behalf of any developmentally disabled or handicapped person." This power is related to specific complaints, and is not the same as the power involved here, which is the power to conduct general random inspections of facilities in the absence of such specific complaints.

The third power is found in § 43-33-350(3). It provides for the prioritization of the services that P & A provides to its clients. Specifically, it provides that P & A "may establish a priority for the delivery of protection and advocacy services according to the type, severity, and number of handicapping conditions of the person making a complaint or on whose behalf a complaint has been made." Obviously, this provision for internal prioritization by P & A itself is not related to the issues in this case.

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The fourth and final power conferred by state law is found in § 43-33-350(4). That subsection provides for the team advocacy inspections of facilities. Those inspections are the subject matter of this case. The subsection provides in its entirety as follows:

> [P & A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program. Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. The designee must meet criteria developed by the Joint Legislative Committee on Mental Health and Mental Retardation, after consultation with the system and the South Carolina Association of Residential Care Homes. The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Committee on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

(Emphases added.) As can be seen, the "team advocacy inspections" of "living conditions" contemplated by this subsection are general in nature, and not the result of particular complaints by or behalf of any particular person.

CONCLUSIONS OF LAW

1. **As a matter of law and administrative practice, the term "plan of care," in the context of Medicaid Waiver clients, refers to a specific document which sets forth the services to be provided to the client.**

As both sides have pointed out, S.C. Code Ann. § 44-33-350(4) was added in 1990 and subsequently amended in 1993 to include "plans of care" as part of what P & A is allowed to inspect at its unannounced team advocacy inspections. Because the term "plans of care" is not specifically defined by the statutes, it is appropriate for the Court to look to other sources and other uses of that term. The Court is most persuaded by the use of the term in Federal health care law, specifically 42 U.S.C. § 1395n(c)(1) (involving Medicaid waivers) and 42 C.F.R.

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§ 441.(b)(1)(i) and 42 C.F.R. § 441.351(i). As discussed more fully below, the term has been described by the Fourth Circuit in *Doe v. Kidd*, 2011 WL 1058542 (4th Cir. 2011) as involving something significantly less than all of a patient's medical records. The term is also used in South Carolina's Medicaid Waiver forms. Lacy Affidavit, Exhibits 1 and 2.

As set forth in Dr. Lacy's testimony and affidavit, a plan of care in this context is a document that is mandated by Medicaid law, which uses that precise term. It is prepared by the person's Service Coordinator. Affidavit of Kathi Lacy, Par. 3. As set forth in Par. 4 of the Lacy Affidavit, the Service Coordinator "conducts a formal, standardized assessment of the person's needs by gathering information from the person, family members, friends, service providers and medical care providers. The Service Coordinator then works with the person and the family to determine what services would best address the identified needs." The resulting document, i.e., the plan of care, "typically includes the medical and other services to be provided, their frequency, and the type of provider to furnish them." *Id.* The document that performs this function has had different working names from time to time, but those names have always referred to the plan of care. Lacy testimony and Lacy Affidavit, Par. 5. The document in which the recommendations are made is a form, Lacy Affidavit, Exhibit 1, and is the document generally referred to as the "plan of care." This meaning of the term is one that has had long usage. *Id.*, Par. 6. While Plaintiff claims that the term also applies to other documents, Plaintiff has not disputed any of these facts set forth in the Lacy affidavit, nor did Plaintiff provide any evidence to the contrary in any respect.

As set forth above and in the Lacy Affidavit, the term "plan of care" is used in the Medicaid waiver services context to refer to the specific document that contains the service plan for the individual. In addition to the factual information set forth in that affidavit, these specific

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documents are also specifically mentioned in the parts of the U.S. Code and Code of Federal Regulations that pertain to Medicaid waiver services. (It is undisputed that the Medicaid waiver program provides the funding for the vast majority of people who live in the facilities that P & A seeks to inspect. Complaint, Par. 49.) Specifically, 42 U.S.C. § 1395n(c)(1) provides:

> (1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.

(Emphasis added). To the same effect is 42 C.F.R. § 441.301(b)(1)(i), which provides as follows:

> (b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—
>
> (1) Provide that the services are furnished—
>
> (i) Under a written plan of care subject to approval by the Medicaid agency;

(Emphasis added.)

Another regulation, 42 C.F.R. § 441.351(f), while addressed only to waiver programs covering persons aged 65 and over, illustrates the kinds of information that are to be found in plans of care:

> **(f) Plan of care.** The request must provide that the home and community-based services described in § 440.181 of this subchapter, are furnished under a written plan of care based on an assessment of the individual's health and welfare needs and developed by qualified individuals for each recipient under the waiver. The qualifications of the individual or individuals who will be responsible for developing the individual plan of care must be described. Each plan of care must contain, at a minimum, the medical and other services to be provided, their frequency, and the

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> type of provider to furnish them. Plans of care must be subject to the approval of the Medicaid agency..

(Emphasis added.)

The term is also used in South Carolina's Medicaid Waiver document, excerpts of which are attached as Exhibit 2 to the Lacy Affidavit. In that document, the plan of care is described in the same manner as in the Lacy Affidavit.

A typical illustration of the use of the term in South Carolina to mean this document is found the recent unreported case, *Doe v. Kidd,* 2011 WL 1058542 (4th Cir. 2011). There the Fourth Circuit described a plan of care as follows:

> DDSN approved a "plan of care" that was developed for Doe pursuant to 42 C.F.R. § 441.301(b) (hereinafter the "2003 plan"). J.A. 616–44. The 2003 plan included a regime of personal care, psychological evaluations, and other services to be provided in-home at the residence of Doe's mother. It also recommended that Doe "receive residential habilitation from a DDSN approved provider" within three months at a "setting located within the Columbia area to be chosen by her family."

2011 WL 1058542 at 2. *See also, e.g., McCrann v. Department of Health and Human Services,* 704 S.E.2d 899, 901 (N.C. App. 2011)(plan of care in the Medicaid wavier program is "a schedule of services to be provided to the program participant"); *Boatman v. Murphy,* 2010 WL 2178821, 1 (S.D.Ind. 2010)(case manager assesses the Medicaid waiver applicant's specific needs and creates a plan of care and cost comparison budget, which are submitted to the Division of Aging for review). These cases, the statutes and regulations, as well as longstanding administrative practice described in the Lacy Affidavit, make it clear that the reference to "plans of care" in § 43-33-350(4) is a reference to a term which has a very specific meaning in this

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context. Such plans of care do not include MARs and other individual medical records that serve functions other than those served by plans of care.[2]

2. The statute creating P & A makes it clear that P & A can review individual medical records only in limited instances, which do not include team advocacy inspections.

A review of the entire state statutory scheme creating P & A makes it clear that the General Assembly actually intended that P & A would not be permitted to review individual medical records in the course of facilities inspections relating only to living conditions. The 1993 amendment to § 44-33-350(4) was expressly "to provide for the review of the plans of care for individuals in a residential care facility and a community mental health center day program," which, as Defendant points out, is a rather limited expansion of P & A's authority and seemingly not meant as carte blanche to peruse medical records as the Plaintiff seeks. The Court therefore finds that, although the term was not defined in the statute by the Legislature, it nonetheless was meant to have a specific meaning and not an expansive, all-inclusive definition that would include any and all of the CTH patients' medical records.

Section 43-33-370(2) states that, upon receipt of a complaint pertaining to the treatment of a particular individual, P & A may "inspect and copy any documents . . . which bear upon the subject matter of the individual complaint, except for the individual medical, treatment or other personal records of other persons in the program or facility." (Emphases added.) Therefore, the Court concludes that the language of § 44-33-350(4), when read in conjunction with the entire

[2] Plaintiff argues that it has inspected another kind of facility, Community Residential Care Facilities (CRCF's) and has not been prevented by another agency, the Department of Mental Health, from reviewing medical records in that context. However, as Ms. Prevost testified, Plaintiff was conducting those inspections as a contractor with the Department of Mental Health. In any event, that other context, which does not involve DDSN, is not before the Court, and cannot govern the present situation, where the matter is being contested.

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Act, and specifically, § 44-33-370(2), was not meant to give P & A access to all or even any of the CTH patients' medical records, absent a complaint filed by a specific patient or waiver by a patient or guardian. Instead, the General Assembly defined the records available to Plaintiff in a team advocacy inspection as only "plans of care," which has a specifically-intended, and rather restrictive (for the Plaintiff's purposes) meaning.

In other words, it is clear that P & A can only view medical records of a specific individual in response to a specific complaint by or on behalf of that individual. This section leaves no doubt that the General Assembly was aware of the need for privacy as to medical records on the part of disabled individuals.

Also, Section 43-33-400, discussed below, provides that in the context of agency cooperation with P & A, the agencies "shall permit [P & A] to inspect and copy any record or documents provided for in 43-33-370(2)." (Emphasis added). As shown above, those records are reviewable only in cases involving individual complaints, and only the records of the specific individual are permitted to be copied.

3. The common meaning of the term "plans of care" does not extend to the kinds of medical records sought by P & A.

Finally, it is clear from the plain meaning of the term that a "plan of care" is something different from a medical record, and specifically from a medication administration record. A "plan" is a document providing for guidance in the future. Thus, as typically defined in dictionaries, a "plan" is "a scheme or method of acting, doing, proceeding, making, etc., developed in advance."[3] (Emphasis added.)

[3] http://dictionary.reference.com/browse/plan

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In accordance with this definition of "plan" in general, a plan of care is a guidance document that sets forth what will be provided to the person. On the other hand, most medical records, and especially the medication administration records Plaintiff seeks, are not advance planning documents, but rather are documentation of something that occurred in the past, specifically, documentations of the previous administration of medications.

Presumably, by limiting the records reviewable by P & A in the course of a review of "living conditions," § 43-33-350(4), the General Assembly intended that P & A would be able to review plans of care in order to see whether the conditions in the facilities were responsive to the residents' plans of care. However, since the team advocacy inspections were to pertain only to living conditions, and not to each individual's specific situation, the line was drawn by the General Assembly at plans of care.[4] Plaintiff's claim of a right to review documentations of past events therefore fails to satisfy the most basic definition of what a "plan of care" might be.

The Court would also note that the record in this case contains a number of Team Advocacy Inspection reports relating to inspections that occurred before this action was filed. These reports are typically around six pages long. They detail a number of matters that involve living conditions, such as resident privacy, fire hazard, maintenance, sanitation, housekeeping, food storage, accessibility, resident hygiene, clothing needs and resident safety. These reports demonstrate that even without access to personal medical records, P & A can still conduct thorough inspections of living conditions at the residences.

[4] Of course, the General Assembly could always decide to expand the nature of the documents reviewable by P & A, but that policy decision is one for the legislature, and not this Court, which is faced with the clear language of the statute, as well as the undisputed practice under that language.

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4. Other arguments by Plaintiff based on the language of the statute in issue or unrelated statutes provide no support for Plaintiff's contentions.

Plaintiff makes several other unavailing arguments, some of which are based on the statute in question, and others of which are based on unrelated provisions of the Code. As discussed below, all are without merit.

a. Unannounced nature of the inspections.

Plaintiff's first argument concerns DDSN's suggestion, made prior to this litigation, that P & A could obtain medical records with the consent of residents or their guardians. P & A claims that this would conflict with the unannounced nature of the inspections. This is not necessarily true, but in any event, has nothing to do with the definition of the term "plans of care" found in § 43-33-350(4).

In correspondence that took place prior to the filing of this action, DDSN had suggested that P & A could review the residents' medical records, in addition to their plans of care, if consent from the residents or their guardians could be obtained. P & A now argues that to do so would make P & A's intent to conduct inspections known to the facilities, when the statute provides for unannounced visits. The Court finds this argument unpersuasive. A medical record waiver can be executed by a patient or his or her guardian at any time, perhaps most effectively upon intake to the facility, and kept on site with the patient's file. P & A would still be free to conduct unannounced inspections and at that time inspect any medical records for which disclosure has been waived. The Court feels that, absent any waiver, P & A is not entitled to access to patients' medical records at a Community Training Home.

In any event, this argument is merely addressed to an alternative approach that had been suggested by DDSN. Even if this approach were to have the effect of advising the facility in advance that an inspection of living conditions might be forthcoming, that result still cannot

expand the meaning of the term "plans of care" beyond the clear meaning that the term has in this context, as DDSN has already argued. This entire argument is therefore simply beside the point.

b. Use of the term "including."

Plaintiff claims that when the statute provided for P & A to make "unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility," the term "including" suggests that other records might be reviewed as well.

The first problem with this argument is that it contradicts the well-settled rule that "to express or include one thing implies the exclusion of another," also known as "inclusio unius est exclusio alterius." *Nelson v. Ozmint*, 390 S.C. 432, 436-437, 702 S.E.2d 369, 371 (2010).[5] The fact that plans of care are referenced, but no other types of records, is a compelling indication that the General Assembly intended for only those records to be inspected. Secondly, and as Plaintiff itself points out, this language was inserted by Act No. 133 of 1993. Prior to that act, the statute provided for team advocacy inspections of living conditions, but did not reference plans of care. Act No. 133 added the language about plans of care. The title of the 1993 Act was

> AN ACT TO AMEND SECTION 43-33-350, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO THE POWERS AND DUTIES OF THE PROTECTION AND ADVOCACY SYSTEM FOR THE HANDICAPPED, INC., SO AS TO PROVIDE FOR THE REVIEW OF THE PLANS OF CARE FOR INDIVIDUALS IN A RESIDENTIAL CARE FACILITY AND A COMMUNITY MENTAL HEALTH CENTER DAY PROGRAM BY THE TEAM ADVOCACY

[5] Plaintiff references cases in which the presumption is reversed, but those involve situations where the word "including" modifies the term to be defined. In order for that rule to apply in the present case, the statute would have to say "records, including plans of care," but it does not say that. Instead, it says "living conditions . . . , including plans of care. . . ."

PROJECT'S COORDINATOR OR HIS DESIGNEE AND REQUIRE THE DESIGNEE TO MEET CERTAIN CRITERIA.

(Emphasis added.) The language added is shown below with underlining:

> [P & A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program. Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. The designee must meet criteria developed by the Joint Legislative Committee on Mental Health and Mental Retardation, after consultation with the system and the South Carolina Association of Residential Care Homes. The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Committee on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

In other words, the only additional information made reviewable by the 1993 amendment was the information in plans of care. To argue otherwise, as Plaintiff tries to do, is to argue exactly the opposite of what the General Assembly intended with this limited addition to the statute.

c. The term "living conditions."

Plaintiff claims that the provision of health and medication services is part of what is meant by "the living conditions of a residential facility." § 43-33-350(4). This is a broader definition of the term "living conditions" than the context indicates. In addition, even if Plaintiff's broad definition of "living conditions" were to be accepted, it still would not change the reference in the statute to the "plan of care," which is a very specific document in this context.

First of all, in common parlance, the term "living conditions" tends to refer to the physical surroundings in which a person lives, such as the sanitation of the residence and

whether it is adequately heated and cooled. *See, e.g., South Carolina Dept. of Social Services v. Sims*, 359 S.C. 601, 604, 598 S.E.2d 303, 305 (Ct. App. 2004), where the term was used to describe the physical aspects of a home; *Benjamin v. Housing Authority of Darlington County*, 198 S.C. 79, 15 S.E.2d 737, 739 (1941)(rural housing act would "provide sanitary homes and living conditions for farm families of low income"). Additionally, this connotation of physical surroundings is clearly the meaning intended in other similar provisions of the Code. These include, for instance, § 31-13-180, which deals with moderate to low income housing, and provides that "a serious shortage of sanitary and safe residential housing . . . will contribute to the creation and persistence of substandard living conditions."

Finally, even if the term "living conditions" extended as far as Plaintiff claims, which is surely not the case, this still would not change the very specific and limited meaning that the term "plans of care" carries in this context, as discussed above. As a result, any argument of Plaintiff based on the use of the term "living conditions" in the statute is unavailing.

d. The reference to "plans" of care.

Plaintiff also claims that the General Assembly must have intended more than one kind of document, because it used the plural term "plans of care." The short answer to this is that each facility has more than one resident, each of whom will have a plan of care, so it is completely appropriate to refer to those specific plans, one per resident, in the plural. This reference is clearly insufficient to overcome the specificity of the reference in other contexts, as discussed above. Moreover, it does not overcome the fact that the documents referenced in the statute are "plans," that is future-oriented, and not medical records, which document events in the past.

e. Use of similar phrases in other statutes.

Plaintiff also makes passing reference to the use of the term "plans of care" elsewhere in the Code, but suggests no reason why those references should overcome the specificity of the reference in § 43-33-350(4). Again, a "plan" is a document providing guidance for the future, while a medication administration record is a documentation of something that occurred in the past. In other words, the medication administration records are simply not the kinds of records that would be included in the most fundamental definition of a "plan." As the term "plan of care" is used in the references cited by Plaintiff, it is clear that it normally has this connotation of a document that contains plans for the future, not documentation of past events.[6]

5. Plaintiff's claims based on vague language in statutes pertaining to cooperation are insufficient to overcome the specific limitations on the kinds of documents that can be disclosed to Plaintiff.

Plaintiff's Second Cause of Action alleges that certain other language in state and federal statutes is a source for the authority it claims. First, Plaintiff cites § 43-33-400. That section, however, only provides as follows:

> All departments, officers, agencies and institutions of the State shall cooperate with the System in carrying out its duties. . . . Notwithstanding any other provision of law, any program or facility shall permit the System to inspect and copy any record or documents provided for in 43-33-370(2).

(Emphases added.) The first emphasized part of the statute, and the one on which Plaintiff relies, simply provides for cooperation with Plaintiff in its carrying out of the duties it already has. This provision is not the source of any duty not previously mentioned in the statute. In addition, the

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[6] The statutes and regulations cited by Plaintiff are all of the same nature as, for example, § 44-7-350 (DHEC licensure of Nursing Homes: an "agency placing a client in a community residential care facility shall develop an individual plan of care in cooperation with the provider") While the context is different from that in this case, the concept of an advance plan is the same.

sole reference to making records available is a reference back to § 43-33-370(2), which as seen above, provides only for disclosure in situations where individualized complaints are made.

In addition, Plaintiff cites 42 U.S.C. § 15043(a)(3)(b), which states that the State should provide to P & A, "to the extent that information is available, . . . "information about the adequacy of health care and other services . . . that individuals with developmental disabilities who are served through home and community based waivers (under Medicaid) receive..." This section does not suggest that the State is required to provide P & A with confidential medical information of DDSN clients. That information is authorized to be released only in the individualized circumstances set forth earlier in the statute, specifically in 42 U.S.C. § 15043(a)(2)(F) and –(J), both of which provide for the release of the records of individuals only when complaints are made relating to specific individuals. It is unreasonable to think that Congress would have provided elaborate limitations of the disclosure of such information in those two specific sections, only to then authorize virtually unlimited access in a later section that deals only with general reviews of adequacy of health care and other services.

CONCLUSION

For the foregoing reasons, the Court concludes that Plaintiff's claimed right to review medical records is without support in the pertinent statutes, and that as a result, this action should be, and is, dismissed with prejudice.

AND IT IS SO ORDERED.

Edgar W. Dickson
Presiding Judge

Orangeburg, South Carolina

December 5, 2014

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STATE OF SOUTH CAROLINA	**IN THE COURT OF COMMON PLEAS**
COUNTY OF RICHLAND	
Protection and Advocacy for People with Disabilities, Inc.,	
PLAINTIFF,	**DOCKET NO.:**
vs.	**COMPLAINT**
Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs,	**NON-JURY TRIAL REQUESTED**
and	
The South Carolina Department of Disabilities and Special Needs	
and	
Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission,	
DEFENDANTS.	

RICHLAND COUNTY
FILED
2010 FEB 15 PM 4:15
JEANETTE W. GRIDE
C.C.P. & G.S.

Complaint for Declaratory Judgment and Injunctive Relief

INTRODUCTION

COMES NOW Plaintiff, Protection and Advocacy for People with Disabilities, Inc. (P&A) and files this action for declaratory and injunctive relief on the grounds

that Defendants have not permitted Plaintiff to complete state-authorized inspections of facilities where people with intellectual disabilities live. In support of its prayer for relief, Plaintiff alleges as follows:

PRELIMINARY STATEMENT

P&A brings this action for the purpose of ending Defendants' refusal to permit P&A to complete inspections of facilities that provide residence and supportive services to people served by the Department of Disabilities and Special Needs (DDSN). DDSN operates Community Training Homes (CTHs) directly and through local Disabilities and Special Needs Boards (DSN Boards) and other contractors. An essential component of those services for which CTHs receive compensation is ensuring that residents take their medication as prescribed and that they receive medical care as necessary. DDSN's order that its contractors prohibit P&A from reviewing documents that may contain health information is preventing P&A from providing the independent oversight of CTHs required by law. P&A seeks to perform inspections of these homes as part of its Team Advocacy Program authorized by S.C. Code Ann. § 43-33-350 (Supp.2009).

P&A has been conducting Team Advocacy inspections of community residential care facilities (CRCFs) across the state since 1986 and, to date, has conducted over 1000 inspections of CRCFs.[1] Like CRCFs, CTHs provide food, housing and care, including oversight of medication administration, to people who are unable to live independently. Residents of CTHs typically require a higher level of care than residents of CRCFs. Almost all residents of CTHs take a number of medications which must be administered

[1] See No Place To Call Home: How South Carolina Has Failed Residents of Community Residential Care Facilities, issued by P&A July 21, 2009; http://www.pandasc.org/crcfreport.pdf.

correctly. Over the years, Team Advocacy inspections of CRCFs have revealed life-threatening medication errors and Team Advocacy inspection reports have provided information critical to maintaining resident health and safety. By refusing to allow P&A to complete its inspections, Defendants have effectively prevented P&A from ensuring that people living in CTHs have the same protection as those living in CRCFs. Monitoring of these facilities will prevent injury to some of the most vulnerable people in South Carolina.

JURISDICTION AND VENUE

1.

This court has jurisdiction to declare rights, status, and other legal relations and to grant injunctive and other relief pursuant to the South Carolina Uniform Declaratory Judgment Act, S.C. Code Ann. § 15-53-10 to 53-140 (Supp. 2009), by ordering Defendants to provide full access to the homes and records, including but not limited to medication administration records (MARs), of people with developmental disabilities when Plaintiff is performing Team Advocacy inspections.

2.

Venue for this action is appropriate in the Court of Common Pleas of Richland County since DDSN's main office is located in Richland County.

PARTIES

3.

Plaintiff P&A is a non-profit corporation designated by the State of South

Carolina to serve as the federally mandated Protection and Advocacy System for South Carolina. S.C. Code Ann. § 43-33-310 to 33-400 (1976).[2] P&A is vested with the power to advocate for all individuals with developmental and other disabilities within South Carolina. P&A is authorized to enforce the civil rights of people with disabilities and is specifically charged with protecting and advocating for the rights of people with developmental disabilities. Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001-15045 (2003); S.C. Code Ann. § 43-33-10 to 33-400 (1976).[3] P&A also has the authority to investigate allegations of abuse and of neglect concerning people with developmental disabilities.

4.

P&A's Team Advocacy program has the following authority:

> It may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program.

S.C. Code Ann. § 43-33-350(4) (Supp.2009)

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[2] P&A is mandated to protect and advocate for people with disabilities under the federal laws listed below: Protection and Advocacy for Individuals with Mental Illness, *42 U.S.C.A. §§ 10801-10807, 10821-10827;* Protection and Advocacy for Individuals with Developmental Disabilities, *42 USC §§ 15041-15045*; Protection and Advocacy for Individual Rights, *29 USC § 794e;* Protection and Advocacy for Assistive Technology, *29 U.S.C.A. § 3004*; Protection and Advocacy for Traumatic Brain Injury *42 USC § 300d-53*; Protection and Advocacy for Voting Access, *42 USC §§ 15461-15462*; and Protection and Advocacy for Beneficiaries of Social Security, *42 U.S.C.A. § 1320b-21.*

[3] "A Protection and Advocacy System may exercise its authority under State law where the authority exceeds the authority required by the Developmental Disabilities Assistance and Bill of Rights Act, as amended. However, State law must not diminish the required authority of the Protection and Advocacy System." 45 C.F.R. § 1386.21(f)

5.

Defendant DDSN is the state agency that has "authority over all of the state's services and programs for the treatment and training of persons with mental retardation[4] and related disabilities, autism, traumatic brain injury and spinal cord injury." S.C. Code Ann. § 44-20-240. DDSN directly licenses day programs and community-based housing for adults with disabilities and oversees their funding. *See* S.C. DDSN Directive 104-01-DD (Oct 1, 2009 Revision). http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/104-01-D(Revised%20100109)%20with%20memo.pdf. DDSN contracts with local DSN Boards, created by S.C. Code Ann. § 44-20-375 (2002), and private providers to provide services to individuals eligible for DDSN services.

6.

Defendant Beverly A. H. Buscemi, Ph.D. is the State Director of DDSN.

7.

Defendants Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight are Members of the DDSN Commission, the governing body of DDSN, and are charged with the statutory duty to determine the policy and promulgate regulations governing the operation of the department [SCDDSN] and the employment of professional staff and personnel. S.C. Code Ann. § 44-20-220 (2002).

[4] The term "mentally retarded" is no longer considered to be accurate or appropriate, and is generally not used by P&A. However, the term is still pervasive in the law and in regulations.

LEGAL BACKGROUND

8.

"Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program." S.C. Code Ann. § 43-33-350(4) (Supp 2009). Team Advocacy inspections are an essential part of South Carolina's legislative plan to protect individuals with disabilities. By providing independent, third-party oversight of the facilities that serve and house these citizens, Team Advocacy inspections help ensure that South Carolina residents with disabilities are receiving appropriate care and living in safe environments.

9.

In 1993, P&A's enabling legislation was amended to add S.C. Code Ann. § 43-33-350 (4) (Supp 2009), which specifically enumerates access to plans of care as part of the Team Advocacy inspector's authority to review "living conditions." S.C. Code Ann. § 43-33-350(4).

10.

South Carolina law states the following:

> All departments, officers, agencies and institutions of the State shall cooperate with the System in carrying out its duties. Notwithstanding any other provision of law, all departments, officers, agencies and institutions of the State may, on the behalf of a developmentally disabled or handicapped person, request the System to provide protection and advocacy services. Notwithstanding any other provision of law, any program or facility shall permit the System to inspect and copy any record or documents provided for in 43-33-370(2).

S.C. Code Ann. § 43-33-400 (1976).

11.

P&A has, over the past year, attempted to conduct Team Advocacy inspections of CTHs licensed by DDSN.

12.

CTHs are community-based residences for individuals with developmental disabilities. Most are directly administered by local DSN boards and certain private providers, in accordance with standards established by DDSN. *See* generally, DDSN Directive # 104-01-DD (Oct. 1, 2009 Revision); Title of Document: SCDDSN Certification & Licensure of Residential & Day Facilities; included as Attachment A.

13.

Upon information and belief, almost all residents of CTHs take a number of medications which must be administered correctly.

14.

On or about June 11, 2009, P&A notified DDSN via letter that P&A would shortly begin inspections in CTHs.[5] *See* Attachment B.

15.

After some initial discussion between P&A and DDSN concerning how the program would work, reporting procedures, and what the inspections would involve, on August 31, 2009, Eugene A. Laurent, Ph.D., then the acting state director for DDSN, sent a letter to P&A's executive director, Gloria Prevost. *See* Attachment C. In the letter, Dr. Laurent stated that DDSN interpreted the term "plan of care" in the Team Advocacy statute to

[5] In late 2007, P&A originally notified DDSN of its intent to expand its Team Advocacy inspection program into CTHs. At that time DDSN did not raise objections to P&A's access to records. However, due to other issues, P&A did not begin CTH inspections until 2009.

refer only to a specific DDSN document known as the "residential treatment/support plan." DDSN asserted that Plaintiff's Team Advocacy authority does not cover, "any protected health information (PHI), including the medical records, the medication administration record, or any other record protected under HIPAA," excepting only the specific "residential treatment/support plan."

16.

Other references to "plans of care" in state law are consistent with a plain meaning that a written plan that details whatever care, medical or otherwise, a particular individual is receiving is a plan of care. *See* S.C. Code Ann. § 44-81-40 (2002) (Bill of Rights for Residents of Long-Term Care Facilities); S.C. Code Ann. § 44-113-20 (12) (2002) (Provider Self-Referral Act of 1993); S.C. Code Ann. § 44-7-350 (2002) (Creation and monitoring of plan of care by agency placing individual in community residential care facility); S.C. Code Ann. § 40-33-44 (Supp.2009) (Exceptions to supervision requirements for licensed practical nurses); S.C. Code Ann. § 43-35-10 (Supp.2009) (Omnibus Adult Protection Act Definitions); S.C. Code Ann. § 40-36-290 (2001) (Responsibilities and duties of occupational therapists); S.C. Code Ann. §§ 63-13-80 (Supp.2008) (Investigation and inspections of child care facilities), 63-13-420 (Supp.2008) (Licensure requirements for private childcare centers and group childcare homes) and 63-13-620 (Supp.2008) (Licensure for public childcare centers and group childcare homes); S. C. Code Ann.§ 40-45-280(c) (2001) (Physical therapy records); S.C. Code Ann.§ 59-63-80 (Supp.2009) (Development of policies governing individual health care plans for students with special health care needs).

17.

Similarly, the regulations of several other South Carolina agencies also refer to "plans of care" in varying contexts, often including medical care as an aspect of the plan. *See, e.g.*, DHEC Regulation 24 A S.C. Code Ann. Regs 61-13 E(3)(a) (Supp. 2009), "Standards for Licensing Habilitation Centers For The Mentally Retarded or Persons With Related Conditions[,]" (implying the "plans of care" could include medical information suitable for review by a nurse); DHEC Regulation 25 S.C. Code Ann. Regs 61-78, 704 (Supp. 2009), "Standards for Licensing Hospices", § 704 (plans of care to be approved by a physician); DHHS Regulation 27 S.C. Code Ann. Regs 126-314 (1976), "Nursing Facility Services[,]" (Medicaid nursing services to be provided according to a written plan of care supervised by a physician). While none of these are directly controlling (Reg. 61-13, for example, is directed toward habilitation centers), they illustrate that the phrase "plan(s) of care" is used consistently with the above–stated plain meaning.

18.

DDSN has only a few regulations promulgated pursuant to the Administrative Procedures Act,[6] S.C. Code Ann. § 1-23-10 to 23-680 (Supp. 2009). Instead, DDSN issues "directives" and standards, many of which contain references to "plans" that relate to "care" in different contexts.

19.

Upon information and belief, DDSN has in the past maintained several different types of "plans" which governed service recipients' care, treatment, and living

[6] http://www.scstatehouse.gov/coderegs/c0.88.htm

conditions. The names, definitions, and contents of these directives and policies have frequently changed. DDSN does not archive prior directives on its website.

20.

Upon information and belief, at some point subsequent to the completion of the Legislative Audit Council's 2006 audit of DDSN (*See* http://www.lac.sc.gov/Reports/2008/DDSN.htm), DDSN changed its system of "plans" further. Residents living in non-institutional settings—and only those residents—had their "single plan" replaced with a group of separate plans for each need of the resident. Such service recipients now have separate plans that cover day program services, behavior support, and residential habilitation (the "residential treatment/support plan"). Upon information and belief this change applies to residents of CTHs.

21.

Currently, DDSN "directive" # 104-01-DD (Oct.1, 2009 Revision), "SCDDSN Certification and Licensure of Residential & Day Facilities," provides the framework through which DDSN contracts with the South Carolina Department of Health and Environmental Control (DHEC) to certify and license CTH facilities. *See*: http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/104-01-DD(Revised%20100109)%20with%20memo.pdf). The current actual standards are subsidiary documents titled, respectively, "Residential Habilitation Standards" (July 2009 revision) and "Residential Licensing Standards" (July 2009 Revision). *See*: http://ddsn.sc.gov/providers/qualitymgmt/Documents/2009ResHabStan.pdf and http://ddsn.sc.gov/providers/qualitymgmt/Documents/ResLicStds.pdf).

22.

The "Residential Habilitation Standards (RH)" require that several "plans" which relate to "care" be developed. RH4.5 requires that a "residential plan" be developed within 30 days of admission and every 365 days thereafter; RH4.6 states this plan must include "the type and frequency of care to be provided," along with descriptions of "supervision," "functional skills training," and "any other supports/intervention" that are provided as well. "Care" is defined as, "assistance with or completion of tasks that cannot be completed by the person and about which the person is not being taught (including but not limited to regulation of water temperature, fire evacuation needs, etc.)." Residential Habilitation Standards 4.5 and 4.6 (July 2009), http://ddsn.sc.gov/providers/qualitymgmt/Documents/2009ResHabStan.pdf.

23.

DDSN's internal "directive" #167-06-DD (May 1, 2008 Revision), "Confidentiality of Personal Information," states "information from the record will be available without the individual's written consent . . . to those with a legitimate need to see the information[,]" and allows release of information "as required by law." *See*: http://ddsn.sc.gov/Documents/aboutddsn/ddsndirectives/currentdirectives/167-06-DD.pdf.

24.

On September 16 and 17, 2009, P&A attempted to conduct Team Advocacy inspections of CTHs. The local DSN Boards operating these CTHs refused to let the P&A Team Advocacy inspector review records, which might have contained health information, without the residents' written consent or the written consent of the residents'

legal guardians. Upon information and belief, these local boards refused P&A access to the records based on the direction of DDSN.

25.

On October 22, 2009, P&A attempted to conduct an inspection of another CTH, operated by a private provider. This provider also refused to allow P&A's Team Advocacy inspector to review records, which might contain health information, without the residents' written consent or the written consent of the residents' legal guardians.

26.

As part of the Team Advocacy review of living conditions, the P&A staff member who is the Team Advocacy inspector has attempted to review records which may contain health information, such as the MARs, of CTH residents. This review is necessary because the records reflect any health care provided to the residents under the guidance of staff and the staff's assistance in administering therapies, medications and special diets which may be prescribed for individual residents. Inspection of MARs is especially critical because the MARs frequently present the only up-to-date, comprehensive plan for or record of the daily administration of each individual's medications.

27.

Defendant Buscemi has continued Dr. Laurent's policies regarding P&A's access to resident records.

28.

DDSN has a duty to cooperate with P&A in the performance of P&A's statutory duties. S.C. Code Ann. § 43-33-400 (1976).

FOR A FIRST CAUSE OF ACTION

29.

The allegations of all preceding paragraphs are incorporated as if repeated verbatim herein.

30.

Under S.C. Code Ann. § 43-33-310 (1976), P&A is the designated protection and advocacy system for South Carolina.

31.

Under S.C. Code Ann. § 43-33-350(4) (Supp. 2009), the designated protection and advocacy system for South Carolina has the power to conduct Team Advocacy inspections of facilities providing residence to individuals with developmental or other disabilities.

32.

Team Advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program.

33.

The relevant South Carolina Code section does not explicitly define "plans of care." S.C. Code Ann. § 43-33-350(4) (1976). The plain language of the Code indicates the Team Advocacy inspector has access to all "plans," *plural*, that relate to "care," of whatever kind, for the stated residents.

34.

In late 2007, P&A informed DDSN that P&A staff and volunteers would be performing Team Advocacy inspections of certain DDSN facilities. *See* Attachment D.

35.

When P&A notified DDSN in 2009 that it was going to begin inspections of CTHs, Defendants then asserted that P&A could not review records of residents of CTHs without prior written consent of the residents or the legal guardians based upon Defendants' interpretation of the Team Advocacy provision and the Health Insurance Portability and Accountability Act (HIPAA). Pub. L. No. 104-191, 110 Stat. 1936 (1996). *See* Attachment E.

36.

Upon information and belief, Defendants have forbidden the operators of CTHs to release records that may contain health information, including MARs, to Team Advocacy inspectors without the consent of the individual or legal guardian. *See* Attachment F.

37.

Upon information and belief, Defendants' interpretation of the term "plans of care" in S.C. Code Ann. § 43-33-350(4) (1976) is that it refers only to a single narrowly defined document, the "residential treatment/support plan" and that P&A's Team Access authority is limited to review of that single document. Defendants have provided P&A with no support for this claim in statute or regulation at either the federal or state level.

38.

Upon information and belief, CTH residents are typically eligible for Intermediate Care Facility/Mental Retardation (ICF/MR) level of care, and many of them require daily medications in order to function in the residential setting of a CTH. Residents of CTHs must meet this level of care to qualify for services under the Mental Retardation/Related Disabilities Medicaid waiver. This level of care is similar to that required of a nursing home but adjusted for people with intellectual disabilities. For these individuals, medication administration is a necessary and critical part of their daily life, and as integral a part of their "living conditions" as their food or clothing.

39.

DDSN's "Residential Licensing Standards" for Community Training Homes[7] require safety measures such as regular fire inspections, a first aid kit, and that "medications must be safely and accurately given."

40.

Upon information and belief, DDSN, the DSN County Boards and private providers which operate CTHs are "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA). Pub. L. No. 104-191, 110 Stat. 1936 (1996). Under 45 C.F.R. § 164.512(a)(1) (2002), "a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law."

41.

The Federal Department of Health and Human Services has issued guidance which indicates that covered entities may release protected health information to state

[7] July 2009 Revision., http://ddsn.sc.gov/providers/qualitymgmt/Documents/ResLicStds.pdf; DDSN Residential Habilitation Standards

Protection and Advocacy systems when another federal, state or other law mandates such disclosures, consistent with the requirements in such law. http://www.hhs.gov/hipaafaq/permitted/require/909.html *See* Attachment G. As stated above, state law authorizes P&A to conduct Team Advocacy inspections.

42.

The same laws which authorize Team Advocacy inspections and P&A's many other activities also place stringent confidentiality requirements upon P&A, particularly in areas where P&A operates without the individual consent of a person with a disability. *See* S.C. Code Ann. § 43-33-350(4) (Supp. 2009); S.C. Code Ann. § 43-33-380 (1976); 45 C.F.R. § 1386.21(i); 45 C.F.R. § 1386.22(e).

43.

Even after being informed of the above, Defendants are violating South Carolina law by continuing to order its CTH providers to refuse Plaintiff access to resident records which may contain health information without prior written consent, thus preventing P&A from performing Team Advocacy inspections under S.C. Code Ann. § 43-33-350(4) (Supp. 2009).

44.

Unlike prior DDSN plans that governed resident care, none of the "plans" which DDSN has offered to make available during Team Advocacy inspections contain medication information. The MAR is an example of a document, used in CTHs that should be reviewed as part of P&A's inspection since it does offer evidence of the adequacy of living conditions and care and treatment of residents in CTHs.

45.

Defendants continue to deprive P&A of its right to fully review living conditions, including records and "plans of care" under S.C. Code Ann. § 43-33-350(4) (Supp. 2009).

46.

Due to their violations of the laws cited herein, Defendants are liable and Plaintiff is entitled to declaratory and injunctive relief as set forth in the prayer for relief.

FOR A SECOND CAUSE OF ACTION

47.

The allegations of all preceding paragraphs are incorporated as if repeated verbatim herein.

48.

DDSN has a duty to cooperate with Plaintiff under State and Federal law. Under state law this duty is found at S.C. Code Ann. § 43-33-400 (1976). The federal requirement is at 42 U.S.C. § 15043(a)(3)(b) (2003):

> The State shall provide . . . information about the adequacy of health care and other services, supports, and assistance that individuals with developmental disabilities who are served through home and community-based waivers (authorized under section 1396n (c) of this title) receive to the designated State Protection and Advocacy system.

42 U.S.C. § 15043(a)(3)(b) (2003) [referring to Medicaid, 42 U.S.C. 1396n(C)].

49.

Upon information and belief, the great majority of people with developmental disabilities in CTHs are recipients of Medicaid services under the Medicaid Mental Retardation/Related Disabilities Waiver.

50

By ordering its CTH providers to refuse to provide to Team Advocacy records which relate to residents' living conditions, including plans of care, that may contain health information, DDSN is failing to "cooperate with the System in carrying out its duties" and failing to provide "information about the adequacy of health care and other services, supports, and assistance that individuals with developmental disabilities who are served through home and community-based waivers (authorized under section 1396n (c) of this title) receive," as required by S.C. Code Ann. § 43-33-400 (1976) and 42 U.S.C. § 15043(a)(3)(b) (2003).

51.

Due to their violations of the laws cited herein, Defendants are liable and Plaintiff is entitled to declaratory and injunctive relief as set forth in the prayer for relief.

EQUITY

52.

The allegations of all preceding paragraphs are incorporated as if repeated verbatim herein.

53.

Because of the actions of Defendants P&A has been, and will continue to be, unable to perform complete inspections of the facilities although authorized to do so under South Carolina law.

54.

Authorization of Team Advocacy inspections in the South Carolina P&A enabling statute is designed to allow P&A to review the living conditions, including records and plans of care, of individuals with disabilities who live in facilities such as CTHs. S.C. Code Ann. § 43-33-350(4). Such inspections are an essential part of South Carolina's legislative plan to protect individuals with disabilities. By providing independent, third-party oversight of the facilities that serve and house these citizens, Team Advocacy inspections help ensure that South Carolina residents with disabilities are receiving appropriate care and living in safe environments. This demonstrates our state's policy to ensure that people with disabilities are protected and that they have an advocate in P&A.

55.

The actions of Defendants have deprived P&A of its ability to perform inspections of these residential facilities and to advocate for, and protect, the residents who live there.

56.

P&A notified DDSN, Dr. Buscemi, and, through them, the Commissioners via letters and telephone calls that they were in violation of South Carolina law and the basis for P&A's position. Despite this information Defendants continue to block P&A's attempts to perform full inspections of the living conditions and plans of care of residents of CTHs and refuse to cooperate with P&A in its efforts to fulfill its duties under the law.

57.

P&A has been injured by DDSN's refusal to permit P&A's statutorily authorized Team Advocacy program to protect residents by completing effective inspections of these facilities through review of all of the resident records, including MARs and other

documents which might contain health information. Likewise, the residents of CTHs are injured because P&A cannot carry out its mandate to inspect living conditions and review plans of care.

58.

Unless restrained by this Court Defendants will continue to block P&A's attempts to perform full inspections of the living conditions and plans of care of residents of CTHs and refuse to cooperate with P&A in its efforts to fulfill its duties under the law in spite of P&A's legal authority under S.C. Code Ann. § 43-33-350(4) and the requirements of S.C. Code Ann. § 43-33-400.

59.

P&A has no adequate remedy at law for this continuing violation of the law.

60.

DDSN should therefore be enjoined from refusing:

A. to cooperate with P&A;

B. to recognize that P&A's Team Advocacy inspector has the right to review living conditions and plans of care and to communicate such information to its providers, and

C. to ensure that P&A's Team Advocacy inspector is allowed to review resident records, including those containing health information, and plans of care such as the MARs.

61.

Due to their violations of the law cited herein, Defendants are liable and P&A is entitled to declaratory and injunctive relief as set forth in the prayer for relief.

PRAYER FOR RELIEF

WHEREFORE, P&A prays this Court for an Order:

A. Assuming jurisdiction of P&A's claims;

B. Declaring that the actions of Defendants have been in violation of state law;

C. Requiring that DDSN and its contractors cooperate with P&A as required under South Carolina law;

D. Requiring Defendants recognize P&A's Team Advocacy inspector has the right to review living conditions and plans of care and to communicate such information to its providers;

E. Declaring that Defendant DDSN is required to allow P&A access to the information and records, including but not limited to MARs and other health care records, of residents in CTHs so that P&A can perform its inspections;

F. Enjoining DDSN from interfering with P&A in the performance of its duties under the law;

G. Requiring DDSN to promptly direct all local DSN boards and other CTH providers to allow Team Advocacy inspectors access to all records which may provide information concerning living conditions and which may also be considered within the

plain meaning of the phrase "plans of care," including but not limited to residents' MAR records; and

H. Awarding P&A attorney fees and costs pursuant to S.C. Code Ann. § 15-77-300 (2005) and any other relief which the Court may deem just and proper.

Dated this 16 day of February, 2010.

Respectfully submitted,

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

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ATTORNEYS FOR PLAINTIFF

Reference Number:	104-01-DD
Title of Document:	SCDDSN Certification & Licensure of Residential & Day Facilities
Date of Issue:	October 21, 1988
Effective Date:	October 21, 1988
Last Review Date:	October 1, 2009 **Revised**
Date of Last Revision:	October 1, 2009
Applicability:	South Carolina Department of Disabilities and Special Needs (SCDDSN) and Contracted Providers of Residential, Day, and Respite Facilities (Excluding Family-Arranged Respite) and Recreational Camps.

PURPOSE:

To identify authority and guidance for the South Carolina Department of Disabilities and Special Needs (SCDDSN) to contract with the South Carolina Department of Health and Environmental Control (SCDHEC) to certify and/or license residential and day facilities.

AUTHORITY:

South Carolina Code Annotated §44-20-710 (Supp 2008), authorizes SCDDSN to license or contract for licensure day facilities for adults. Facilities may be licensed as: Residential or Day Camps; Adult Activity Centers; Work Activity Centers; Sheltered Workshops and Unclassified Programs.

South Carolina Code Annotated §44-7-260 (Supp 2008), authorizes SCDDSN to sponsor, certify, or license community-based housing for adults or contract for these functions.

South Carolina Code Ann §44-7-110 (Supp 2008), 44-20-10 (Supp 2008), and 44-21-10 (Supp 2008), grants SCDDSN authority to license or contract the licensure function for respite facilities for children and/or adults

Since 1985 DDSN has maintained a Memorandum of Agreement (MOA) with the Department of Social Services (DSS), which grants DDSN authority to license Community Training Homes for children. The MOA is in accordance with provisions of South Carolina Code Annotated §44-20-1000 (Supp 2008). DDSN standards meet Child Foster Care Regulation 27 SC Regs. 114-550 (Supp 2008) for homes licensed as a CTH I or Child Group Home Regulation 27 SC Regs 114-590 (Supp 2008) for homes licensed as a CTH II as approved annually by DSS. Please note: DSS defines a child as a person under the age of twenty-one and any movement of these children within DDSN Residential Services must be coordinated through the District Offices and the Quality Management Division.

South Carolina Law grants the South Carolina Department of Health and Environmental Control (SCDHEC) the authority to license Community Residential Care Facilities (CRCF) for adults and Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

GENERAL:

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

1. Qualified by SCDDSN;
2. Compliant with applicable federal, state and local laws;
3. Compliant with all applicable SCDDSN policies, procedures, and standards and,
4. Issued a license or certification by SCDDSN or SCDHEC.

Facilities shall only provide the type of service that is identified on the certificate or license, and shall serve no more than the maximum number of people identified on the certificate and/or license.

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

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

SUPPORT MODELS LICENSED/CERTIFIED BY SCDDSN OR ITS CONTRACTOR:

I. Residential:

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

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

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

B. Community Training Home II (CTH II):

A homelike environment in the community where no more than four (4) people live. Care, supervision and skills training are provided by qualified and trained staff in accordance with the resident's service plan.

C. Supervised Living Program I (SLP I):

Supports are provided by qualified and trained staff to adults who require occasional support. Staff are available by telephone 24 hours a day, seven (7) days a week. Staff are available by telephone 24 hours a day, seven (7) days a week to provide assistance as needed.

D. Supervised Living Program II (SLP II):

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

SCDDSN's contracted provider agencies may provide additional residential options, including Community Residential Care Facilities (CRCF) and Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR). These facilities are licensed by SCDHEC.

II. Respite:

Services may be provided in the person's home, other residence selected by the person/family, or a facility licensed/certified by SCDDSN or its contractor.

III. Day:

A. Adult Activity Center:

A goal oriented program of developmental, prevocational services designed to develop, maintain, increase or maximize an individuals functioning in activities of daily living, physical growth, emotional stability, socialization, communication, and vocational skills.

B. Sheltered Workshop:

A work program whose purpose is to assist participants to achieve their potential through the use of individual work goals, remunerative employment, supportive services in a controlled environment. The workshop will maintain a certificate with the United States Department of Labor, which designates it as a "regular work program".

C. Work Activity Center:

A workshop having an identifiable program designed to provide therapeutic activities for mentally retarded workers whose physical or mental impairment is so severe as to interfere with normal productive capacity. Work or production is not the main purpose of the program; however, the development of work skills is its main purpose. The program must have a certificate from the United States Department of Labor designating it as a Work Activity Program when applicable.

D. Unclassified Program:

A program that provides a beneficial service and observes appropriate standards to safeguard the health and safety of clients, staff and the public. This would include non-work related day supports.

IV. Recreational Camp:

A. Day:

A program of recreational activities with an emphasis on outdoor and camping activities that utilize trained leadership and the natural or man-made outdoor surroundings to contribute to the camper's mental, physical, and social growth.

Services are provided for less than twenty-four hours a day to adults and/or children.

B. Residential:

A program of recreation activities with an emphasis on outdoor and camping activities that utilize trained leadership and natural or man-made outdoor surroundings to contribute to the camper's mental, physical and social growth.

Services are provided for four (4) or more consecutive twenty-four hour periods of camp programming at one or more campsites to adults and/or children.

SCHEDULE FOR REVIEWS

Licensing/Certification reviews will be conducted as follows:

SETTING	FREQUENCY
Community Training Home I Serving adults (18 years and older)	A 33% sample of every provider's homes every year.
Community Training Home I Serving children (17 years and younger)	Annually
Community Training Home II Serving adults (21 years and older)	A 33% sample of every provider's homes every year.
Community Training Home II Serving children (20 years and younger)	Annually
Supervised Living Program I	A 33% sample of every provider's homes every year.
Supervised Living Program II	A 33% sample of every provider's homes every year.
Respite Facility	A 33% sample of every provider's homes every year.
Adult Activity Center	Annually
Sheltered Workshop	Annually
Work Activity Center	Annually

SETTING	FREQUENCY
Unclassified Program	Annually
Recreational Day Camp	Annually
Recreational Residential Camp	Annually

APPLICATION PROCESS:

A. For A New Facility:

To initiate licensing/certification reviews of new facilities, all sections of the SCDDSN Licensing/Certification Application must be completed no later than 60 days prior to the opening of the facility. The projected opening date of the facility must be noted. SCDDSN must approve all new facilities prior to licensure by DDSN or its contractor.

B. To Update Existing Application:

A SCDDSN Licensing/Certification Application must be completed when/if any information contained in the previously submitted application changes. The provider must insure that the application information is current at all times.

C. For A Residential Facility Serving Children:

A completed SCDDSN Licensing/Certification Application must be submitted no later than 60 days prior to the expiration of the certification.

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

FIRE SAFETY INSPECTIONS:

Fire Safety Inspections, when required, must be made by a Fire Marshal employed by the State Fire Marshal's office. Fees for this service are pre-paid by SCDDSN but inspections must be requested. Requests should only be made via the Internet following these steps:

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

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

FINDINGS / PLANS OF CORRECTION / RE-VISIT

Staff from SC DHEC will make an on-site review of the physical plant and records, then compare their finding with the requirements as set forth in standards, policies, and procedures. As a result of these activities, a report will be issued to the provider agency. In most cases, a report will be provided to the agency on-site. In all cases, a report will be provided within 30 days.

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

- Class 1 Deficiency – The person's physical, emotional, and financial well being is in immediate jeopardy. Immediate correction is required.

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

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

Upon receipt of the report, the Provider will have fifteen days to submit a written plan of correction (POC). The Plan of Correction should not only address the individual deficiency cited, but should also include a systemic response to ensure correction across the agency. If the provider does not agree with the content of the report, reconsideration may be requested. The provider may request reconsideration of the deficiencies by submitting, in writing, the standard, policy, or procedure cited; the finding related to the standard, policy, or procedure; the nature of their disagreement with the finding; and any documentation to support their position. The provider is allowed one reconsideration request per survey cycle. The provider would submit the request of citation reconsideration with their plan of correction (i.e. within 15 days of receiving the licensing report). Requests for reconsideration should be submitted to:

SCDDSN
PO Box 4706
Columbia, SC 29240
Attention: Director, Mental Retardation Division

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

The reconsideration will be completed within 30 days of receiving the request. Based on the results of the reconsideration, if needed, a new report will be issued. A POC for all deficiencies must be submitted to SCDDSN within 15 days of the reconsideration decision.

FOLLOW-UP

All deficiencies cited in a licensing report will require a follow-up review. A provider may have two follow-up reviews for annual surveys. The deficiency Class (I, II, III) dictates the number of follow-up reviews completed and/or sanctions imposed. (See Sanctions) All timeframes identified above apply to these follow-up surveys. All citations identified on the reports will be individually reviewed to determine the type of follow up needed (i.e. documentation request or onsite review). All Class I citations will be resolved onsite at the time of the review. Each Class II or Class III citation will be reviewed individually to determine the most appropriate method for follow-up.

SC DHEC will contact the provider agency and discuss the follow-up process, as it relates to their review. Contact will be made within 90 days of the approved Plan of Correction. Citation determinations will be identified as follows:

1. Need documentation review
2. Need onsite review

Results of the Follow-up Review will include the following:

1. Corrected - Based on submitted documentation (in lieu of site visit)
2. Corrected – Based on successful implementation of the Plan of Correction and/ or systemic review
3. Not Corrected – The Plan of Correction was not implemented successfully
4. Not Corrected – Acceptable Progress. The Plan of Correction has been implemented and acceptable progress made. Individual and systemic remediation are expected.

A review of all standards/indicators will take place during the annual review process. Any findings of repeat/recurring citations and the use of documentation for citation correction will be discussed at the exit meeting and a report will be sent to the provider within 30 days. The citation determinations and results will be formatted in the same manner as indicated above. A written plan of correction will be submitted by the provider in response to the follow-up review.

SANCTIONS:

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

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

- Sanction 2 – Depending on the level or quantity of deficiencies, any of the following sanctions may be issued: 1) ongoing site monitoring, 2) technical assistance, 3) the issuance of a provisional license/ certificate with a shortened expiration date, 4) the license/certificate capacity of the program may be reduced, 5) financial payments for that program may be held in a reserve account, 6) financial payments may be reduced, or 7) the license/certificate may be denied, suspended, revoked, or rescinded. For example, if there are several or fewer deficiencies across licensed facilities with no repeated findings, options 1 or 2 may be used. If multiple deficiencies are discovered across licensed facilities and systemic problems that exist are not resolved after option 1 through 6 have been issued, then option 7 will be issued.

APPEALS:

The imposition of the specific sanction that involves denial, suspension or revocation of a license may be appealed. Departmental Directive 167-01-DD governs these appeals.

EXCEPTIONS:

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

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

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

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

Kathi Lacy, Ph.D.
Associate State Director, Policy
Originator

Eugene A. Laurent, Ph.D.
State Director
Approved

ATTACHMENTS:

Request for Exception Form
Application to Operate Residential, Day Facility, or Camp

MEMORANDUM

TO: Official Distribution

FROM: Ann Dalton
Director, Quality Management Division

DATE: October 9, 2009

RE: Revision of 104-01-DD

A technical amendment has been made to Departmental Directive 104-01-DD, *SCDDSN Certification & Licensure of Residential & Day Facilities*. This amendment changes the due date requirements for a Plan of Correction from 30 days to 15 days after receipt of the licensing report. This change has been made in order to keep the licensure survey process and plans of correction consistent among all programs surveyed by SC DHEC. In extenuating circumstances, additional time may be approved for submission of the plan of correction. Requests for an extension should be submitted to the DDSN Quality Management Division.

If you have any questions, please contact me at (803) 898-9813 or adalton@ddsn.sc.gov.

Attachment

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection & Advocacy System for South Carolina

June 11, 2009

Eugene A. Laurent, Ph.D.
Interim State Director
South Carolina Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, South Carolina 29240

Dear Dr. Laurent:

Sometime ago, Protection and Advocacy for People with Disabilities, Inc., (P&A) informed DDSN that P&A would be expanding its successful Team Advocacy Program to include inspections of housing in the community for people with intellectual (and related) disabilities.

Under this expansion of our Team Advocacy program, staff and volunteers will make unannounced visits to community-based residential facilities. The first visits will be to Community Training Homes (CTH II). We are now ready to begin inspections under this program. These initial inspections will be made using only P&A staff members. Eventually, we will recruit, train and utilize volunteers to assist in these inspections.

During their visits the Team will review records and speak with staff and residents. As with Community Residential Care Facilities (CRCFs), Team Advocacy will provide a report and an opportunity to respond to each facility. The reports will also be submitted to DDSN, the Ombudsman, local DSN boards, other facility operators as applicable and, as required by statute, DMH and DHEC. Enclosed for your information are copies of the tools which we plan to use during these inspections.

CENTRAL OFFICE
SUITE 208
3710 LANDMARK DRIVE
COLUMBIA, SC 29204
(803) 782-0639
(Voice and TTY)
FAX (803) 790-1946

PIEDMONT OFFICE
SUITE 106
545 N. Pleasantburg Drive
GREENVILLE, SC 29607
(864) 235-0273
1-800-758-5212
(Voice and TTY)
FAX (864) 233-7962

INFORMATION AND REFERRAL
Toll Free:
1-866-275-7273
(Voice)
or
1-866-232-4525
(TTY)
Email:
info@protectionandadvocacy-sc.org

PEE DEE OFFICE
2137 B HOFFMEYER ROAD
FLORENCE, SC 29501
(843) 662-0752
1-800-868-0752
(Voice and TTY)
FAX (845) 662-0786

LOW COUNTRY OFFICE
1569 SAM RITTENBERG BLVD.
CHARLESTON, SC 29407
(843) 763-8571
1-800-743-2553
(Voice and TTY)
FAX (843) 571-0880

Since its inception Team Advocacy has worked to improve the quality of life for South Carolinians with disabilities. We are looking forward to increasing the number of South Carolinians benefiting from this important program. We request that you advise local boards and other contractors of the expansion of our Team Advocacy activity.

Please contact me at 803 217-6713 or prevost@protectionandadvocacy-sc.org if you have any questions about Team Advocacy.

Very truly yours,

Gloria M. Prevost
Executive Director

Cc: Anna Maria Darwin, Esq
SC DDSN Commissioners

ATTACHMENT C

Eugene A. Laurent, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department OF Disabilities AND Special Needs

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

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Deborah C. McPherson

August 31, 2009

Ms. Gloria Prevost
Executive Director
Protection & Advocacy for People with Disabilities
3710 Landmark Drive, Suite 208
Columbia, SC 29204

RE: P&A Team Advocacy DD Project

Dear Ms. Prevost:

The Agency's attorney, Ms. Tana Vanderbilt and your attorney, Ms. Anna Marie Darwin, have been in discussions since July 1, 2009, regarding the law pertaining to team advocacy inspections.

S.C. Code Ann. §43-33-350(4) gives P&A the provision to make unannounced visits to review the living conditions of residential facilities, and specifically states "including plans of care for individuals in a residential care facility." The disagreement between our attorneys is over the interpretation of "plans of care." While we appreciate P&A's efforts to conduct inspections in community training homes, our obligation is to ensure that the rights of our consumers are protected.

Due to the regulations of the Health Insurance Portability and Accountability Act (HIPAA), P&A must get a signed HIPAA authorization from all CTH II residents, their legal guardian or parent if a minor, before reviewing any Protected Health Information (PHI), including the medical records, the medication administration record or any other record protected under HIPAA except for the residential treatment/support plan as required by state law.

We have informed our contracted providers of our position for CTH II staff to release only the residential treatment/support plan, which we consider the same as the plan of care, to the P&A team advocacy coordinator. If the coordinator obtains a signed HIPAA authorization to disclose health information from the consumer, his/her legal guardian, or parent if a minor, then the P&A advocacy coordinator can review medical documents specifically listed on the authorization.

Thank you again for your efforts in inspecting the living conditions of CTH IIs. We pledge our cooperation with P&A in carrying out these inspections.

Sincerely,

Eugene A. Laurent, Ph.D.
State Director
EAL/cch

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

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

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

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

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection & Advocacy System for South Carolina

November 30, 2007

Stanley J. Butkus, Ph.D.
Director
South Carolina Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240

Dear Dr. Butkus:

Protection and Advocacy for People with Disabilities, Inc., (P&A) is expanding its successful Team Advocacy Program to include inspections of housing in the community for people with intellectual disabilities.

Since 1990 Team Advocacy has been inspecting Community Residential Care Facilities (CRCFs) to determine whether individuals who reside in those settings receive the services they need, including medical care, transportation, employment opportunities, and recreation. Team Advocacy staff and volunteers work closely with the Department of Mental Health, the Department of Health and Environmental Control, and the Long Term Care Ombudsman in the Lieutenant Governor's Office on Aging.

Team Advocacy is established by South Carolina law, S.C. Code § 43-33-350(4), which provides:

> (4) It [P&A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program.... The system shall prepare a report based on the inspection which must be submitted to the...South Carolina Department of Health and Environmental Control, and State Department of Mental Health (material omitted).

Federal regulations implementing the Developmental Disabilities Assistance and Bill of Rights Act also authorize P&A access to residents for monitoring individual rights and safety, 45 C.F.R. §§ 1386.22(g) and (h)

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1569 SAM RITTENBERG BLVD.
CHARLESTON, SC 29407
(843) 763-8571
1-800-743-2553
(Voice and TTY)
FAX (843) 571-0880

Under this expansion of our Team Advocacy program, staff and volunteers will make unannounced visits to community-based residential facilities. P&A anticipates that the first visits will be to Community Training Homes. As you may know, we have asked Ms. Vanderbilt for a list of community facilities operated by or under the authority of DDSN but she has, to date, refused to provide this information to us. As the protection and advocacy system for South Carolina we are entitled to this information. We have informed Ms. Vanderbilt that, if necessary, we will take appropriate action to uphold our position as the P&A. Additionally, P&A intends to fulfill its statutorily-mandated role of inspecting and monitoring facilities serving individuals with disabilities.

During their visits the Team will review records and speak with staff and residents. As with CRCFs, Team Advocacy will provide a report and an opportunity to respond to each facility. The reports will also be submitted to DDSN, the Ombudsman, local DSN boards, other facility operators as applicable and, as required by statute, DMH and DHEC.

Since its inception Team Advocacy has worked to improve the quality of life for South Carolinians with disabilities. We are looking forward to increasing the number of South Carolinians benefiting from this important program. We request that you advise local boards and other contractors of the expansion of our Team Advocacy activity.

Please contact me at 803 217-6713 or prevost@protectionandadvocacy-sc.org if you have any questions about Team Advocacy.

Very truly yours,

Gloria M. Prevost

Gloria M. Prevost
Executive Director

Cc: J. David Almeida
Anna Maria Darwin, Esq.
SC DDSN Commissioners

AUG 14 2009
P & A Region 1

Eugene A. Laurent, Ph.D.
State Director
Robert W. Barfield
Deputy State Director
Administration
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA
Department
OF
Disabilities
AND
Special Needs

3440 Harden Street Ext (29203)
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Toll Free: 888/DSN-INFO
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August 12, 2009

Ms. Anna Maria Darwin, Esq.
Protection and Advocacy, Inc.
545 N. Pleasantburg Drive, Suite 106
Greenville, SC 29607

RE: Team Advocacy

Dear Anna Marie:

Thank you for your response to our proposed notice dated July 24, 2009. DDSN supports P&A's efforts to review living conditions and give DDSN feedback.

It is the opinion of DDSN that inspection of living conditions is similar to a home study to assess the physical surroundings. The Agency disagrees that would involve the review of medical records. S.C. Code §43-33-350(4) is specific as to plans of care and not an example of what is to be reviewed. The Agency understands that P&A has been doing similar inspections in CRCF's; however, there is no oversight body for these residences.

DDSN has a federally certified quality assessment organization that reviews plans of care and does direct observation of the Agency's contract providers of CTH IIs. DHEC, which as of August 2, 2009, will be doing the licensing inspections of the CTH IIs as well.

The DD Act that you cite and the website state that medical records can be provided to P&A under certain circumstances. 42USCA1504.3 (9)(2) I & J refer to access to records when the person with a disability is a client of the system or when P&A is conducting an investigation based on a report of abuse. There is no provision for access to medical records for the Team Advocacy inspections. If access to the medical records is to be granted, a release must be given by the person whose records are to be reviewed.

The goal of DDSN is to protect the rights of persons with disabilities. Therefore, when applicable, plans of correction may be done if the Team Advocacy inspections raise concerns not already identified by one of the other systems of quality monitoring.

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

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

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

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

If you have any questions, please feel free to contact me at 898-9683 or by email at tvanderbilt@ddsn.sc.gov.

Sincerely,

Tana Vanderbilt

Tana Vanderbilt
General Counsel

TV/cch

Eugene A. Laurent, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department OF Disabilities AND Special Needs

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Website: www.ddsn.sc.gov

September 28, 2009

Ms. Anna Maria Darwin, Esq.
Protection and Advocacy, Inc.
545 N. Pleasantburg Drive, Suite 106
Greenville, SC 29607

RE: Team Advocacy

Dear Anna Maria:

On behalf of Dr. Laurent and the Agency, I want to assure you that the South Carolina Department of Disabilities and Special Needs (SCDDSN) is cooperating fully with Protection and Advocacy (P&A) and allowing the Team Advocacy Inspections to go forward in the CTH II homes. I do want to point out that SCDDSN does not supervise the daily operations of the CTHs, except in those few situations where SCDDSN directly operates the CTHs.

Dr. Laurent finds it strange that the Agency is having to protect the privacy rights of our consumers, when that job should be one that P&A performs. The Agency, as previously stated, understands that if P&A were conducting an investigation based upon a report of abuse or neglect, the federal statute allows P&A access to protected health information.

As has been suggested by a member of the SCDDSN Commission, signing the release provided to you by email on July 1, 2009, would be the best way to settle this issue. SCDDSN will facilitate in anyway necessary having the releases executed.

If P&A is still unwilling to have the releases signed, the Agency is going to seek an opinion from the Office of the Attorney General as to the release of the protected healthcare information during the Team Advocacy Inspections.

If you have any further questions, please feel free to contact me at (803) 898-9683 or by email at tvanderbilt@ddsn.sc.gov.

Sincerely,

Tana Vanderbilt

Tana Vanderbilt
General Counsel
TV/cch
cc: Dr. Eugene A. Laurent, State Director-SCDDSN
Ms. Gloria Prevost, Director-S.C. Protection and Advocacy

P & A Region 1
SEP 29 2009
RECEIVED

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

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

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

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

Anna Maria

The agency has received inquiries about the Team Advocacy project and this is the information that we will be sharing with them and I would like your input if there is anything else you would like to include.

Re: P & A Team Advocacy Project

The S.C. Code Ann §43-33-350(4) refers to Team Advocacy inspections as unannounced visits to review the living conditions and reviewing plans of care. DDSN's position on the plan of care is that is refers only to the residential treatment/support plan. No other records, including the medication administration record, treatment notes, logs, and the like may be reviewed. Further the law stipulates that only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of the plans of care. You may assume that P & A will adhere to this requirement upon entering the home.

Second, due to laws protecting health information of all Americans, i.e., Protected Health Information (PHI) and Health Insurance Portability and Accountability Act (HIPAA), P & A must get a signed HIPAA authorization from all CTH II residents, their legal guardian, or parent if a minor, when reviewing the plans of care (i.e., residential treatment/support plan). A sample HIPAA authorization is attached. Note that it only covers what the state and federal codes allow P & A to review. If a resident et al. does not sign a written release, then P & A cannot review his/her residential treatment/support plan.

Third, the Federal Law under which Protection and Advocacy Programs are established permits such programs to investigate alleged abuse when there is reason to believe that abuse has occurred or when there is a complaint concerning a specific facility. So unless they announce either of the two situations upon arrival at a CTH II home, they are limited to inspections to "review the living conditions" of a CTH II home and the residential treatmentsupport plan.

SC Code §43-33-350(4) does not require the facility to produce a plan of correction.

ATTACHMENT G

U.S. Department of Health & Human Services

May a covered entity disclose protected health information to a Protection and Advocacy system where the disclosure is required by law?

Answer:

Yes. The Privacy Rule permits a covered entity to disclose protected health information (PHI) without the authorization of the individual to a state-designated Protection and Advocacy (P&A) system to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law. 45 CFR 164.512(a). The Developmental Disabilities Assistance and Bill of Rights Act (DD Act) provides for each state to designate a public or private entity as the Protection and Advocacy system to protect and advocate for the rights of individuals with developmental disabilities, including investigating incidents of abuse or neglect. The P&A designated pursuant to the DD Act is also the Protection and Advocacy system for purposes of the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act) and is empowered to protect and advocate for the rights of individuals with mental illness. These statutes and their implementing regulations require that access to records be provided to P&As under certain circumstances. See the DD Act at 42 USCA 15043(a)(2)(I) and (J) and the PAIMI Act at 42 USCA 10805(a)(4), and their implementing regulations at 45 CFR 1386.22 and 42 CFR 51.41, respectively. Thus, a covered entity may disclose PHI as required by the DD and PAIMI Acts to P&As requesting access to such records in carrying out their protection and advocacy functions under these Acts. Similarly, covered entities may disclose PHI to P&As where another federal, state or other law mandates such disclosures, consistent with the requirements in such law. Where disclosures are required by law, the Privacy Rule's minimum necessary standard does not apply, since the law requiring the disclosure will establish the limits on what should be disclosed. Moreover, with respect to required by law disclosures, a covered entity cannot use the Privacy Rule as a reason not to comply with its other legal obligations.

Section 164.512(a)(2) provides that in making a "required by law" disclosure about adult abuse, neglect or domestic violence (section 164.512(c)), for judicial or administrative proceedings (section 164.512(e)), or for law enforcement purposes (section 164.512(f)), covered entities must also comply with any additional privacy requirements in these provisions that apply. However, none of the additional procedural protections in sections 164.512(c), (e) and (f) apply to the type of "required by law" disclosures to P&As under the provisions of the DD and PAIMI Acts discussed here.

Date Created: 06/10/2005
Last Updated: 08/08/2005

STATE OF SOUTH CAROLINA	**IN THE COURT OF COMMON PLEAS**
COUNTY OF RICHLAND	Civil Action Number: 10-CP-40-1095
Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	**Answer** **(All Defendants)**

The Defendants Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, that is, all Defendants, answering the Complaint herein, would allege and show the following:

FOR A FIRST DEFENSE

1. Defendants deny each and every allegation of the Complaint not hereinafter specifically admitted, qualified, or explained.

2. The initial portions of the Complaint, styled "Introduction" and "Preliminary Statement" are primarily argumentative and descriptive. As such, this verbiage requires neither admission nor denial. Insofar as either the "Introduction" or the "Preliminary Statement" attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

3. Paragraphs 1 and 2 are either merely descriptive of this action or they set forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

4. Answering Paragraph 3, Defendants admit that Plaintiff P&A is a private, non-profit corporation established pursuant to federal and state law. The remaining allegations of Paragraph 3 set forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

5. Paragraph 4 sets forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

6. Paragraph 5 sets forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

7. Paragraph 6 is admitted.

8. Answering Paragraph 7, it is admitted that all of the individuals therein listed are presently DDSN Commissioners. The remainder of Paragraph 7 sets forth legal conclusions

which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

9. Paragraphs 8 through 10 set forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

10. Paragraph 11 is admitted on information and belief.

11. Paragraph 12 is admitted.

12. Answering Paragraph 13, Defendants would allege that that paragraph contains too much generalization to be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

13. Answering Paragraphs 14 and 15, Defendants would refer the Court to the letters referenced therein for the best evidence of their contents. Except as expressly admitted, the allegations of those paragraphs are denied.

14. Paragraphs 16 and 17 set forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

15. Answering Paragraph 18, Defendants would refer the Court to the regulations, directives and standards therein referenced for the best evidence of their contents. Except as expressly admitted, the allegations of Paragraph 18 are denied.

16. Answering Paragraph 19, Defendants would refer the Court to the documents referenced therein for the best evidence of their contents. Except as expressly admitted, the allegations of Paragraph 19 are denied.

17. Answering Paragraph 20, Defendants would allege that DDSN did not change its system of plans in response to any audit. Since 1991, DDSN has always required a residential plan for those people receiving residential habilitation services as approved by the federal and state Medicaid programs. Each service has always required its own service plan. Plans of various kinds are prepared for residents of CTHs as appropriate and as required, but it is denied that DDSN is required to disclose to P & A, in the course of a team advocacy inspection, any "plan" other than the residential plan referenced herein. Any remaining allegations of Paragraph 20 are denied.

18. Answering Paragraphs 21 through 23, Defendants would refer the Court to the documents referenced therein for the best evidence of their contents. Except as expressly admitted, the allegations of those paragraphs are denied.

19. Paragraphs 24 and 25 are admitted.

20. The first sentence of Paragraph 26 is admitted on information and belief. The remainder of Paragraph 26 is denied.

21. Paragraph 27 is admitted to the extent that it references the kinds of records to which DDSN has denied access by P & A.

22. Paragraph 28 sets forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

23. Answering Paragraph 29, Defendants reiterate and reallege each and every paragraph and affirmative defense of this Answer as if set forth herein.

24. Paragraphs 30 and 31 set forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

25. Paragraph 32 is simply a statement of what Plaintiff believes to be the proper scope of a Team Advocacy inspection. As such, it in effect sets forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

26. Paragraph 33 sets forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

27. Answering Paragraph 34, Defendants would refer the Court to the document referenced therein for the best evidence of its contents. Except as expressly admitted, the allegations of Paragraph 34 are denied.

28. Answering Paragraph 35, Defendants would refer the Court to the document referenced therein for the best evidence of its contents. Except as expressly admitted, the allegations of Paragraph 35 are denied.

29. Answering Paragraph 36, Defendants would refer the Court to the document referenced therein for the best evidence of its contents. Except as expressly admitted, the allegations of Paragraph 36 are denied.

30. The first sentence of Paragraph 37 is admitted. The remainder of Paragraph 37 is denied.

31. Answering Paragraph 38, Defendants would allege that that paragraph contains too much generalization to be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

32. Answering Paragraph 39, Defendants would refer the Court to the document referenced therein for the best evidence of its contents. Except as expressly admitted, the allegations of Paragraph 39 are denied.

33. Paragraph 40 sets forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

34. Answering Paragraphs 41 and 42, Defendants would refer the Court to the documents referenced therein for the best evidence of their contents. Except as expressly admitted, the allegations of Paragraphs 41 and 42 are denied.

35. Paragraph 43 is denied.

36. The first sentence of Paragraph 44 is admitted on information and belief. The second sentence of Paragraph 44 is denied.

37. Paragraphs 45 and 46 are denied.

38. Answering Paragraph 47, Defendants reiterate and reallege each and every paragraph and affirmative defense of this Answer as if set forth herein.

39. Paragraph 48 sets forth legal conclusions which can neither be admitted or denied. Insofar as such allegations attempt to establish liability on the part of Defendants, Defendants would deny same and demand strict proof thereof.

40. Paragraph 49 is admitted on information and belief.

41. Paragraphs 50 and 51 are denied.

42. Answering Paragraph 52, Defendants reiterate and reallege each and every paragraph and affirmative defense of this Answer as if set forth herein.

43. Paragraphs 53 through 55 are denied.

44. Answering the first sentence of Paragraph 56, it is admitted that P & A communicated its view of the law to some of the Defendants, but it is denied that P & A's view of the law is correct. The remainder of Paragraph 56 is denied.

45. Paragraphs 57 through 60 are denied.

46. The remainder of the Complaint, including the prayer for relief, is denied.

FOR A SECOND DEFENSE

47. The Complaint fails to state facts sufficient to constitute a cause of action.

FOR A THIRD DEFENSE

48. The individual Defendants should be dismissed, because their presence in this action is not necessary to obtain complete relief.

FOR A FOURTH DEFENSE

49. On information and belief, some or all Plaintiffs lack standing to bring some or all of the claims set forth in the Complaint.

WHEREFORE, having fully answered the Complaint, Defendants respectfully pray that this action be dismissed with prejudice in its entirety, for the costs of this action, and for such other and further relief as the Court may deem appropriate.

[Signature block appears on following page]

DAVIDSON & LINDEMANN, P.A.

By: _____

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ATTORNEYS FOR DEFENDANTS

Columbia, South Carolina

March 16, 2010

STATE OF SOUTH CAROLINA	)	
	)	COURT OF COMMON PLEAS
County of Richland	)	2010-CP-40-1095
	)	
	)	
PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.	)	
	)	
PLAINTIFF,	)	
	)	
vs.	)	TRANSCRIPT OF RECORD
	)	
BEVERLY A.H. BUSCEMI, Ph.d., IN HER OFFICIAL CAPACITY AS STATE DIRECTOR, SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS,	)	
	)	
DEFENDANT,	)	

October 3, 2012
Columbia, South Carolina

BEFORE:

THE HONORABLE EDGAR W. DICKSON, JUDGE.

APPEARANCES:

ANNA MARIA DARWIN, ESQ.
THORNWELL SIMMONS, ESQ.
Attorneys for the Plaintiff

KENNETH WOODINGTON, ESQ.
Attorney for the Defendant

KAREN AMBROZIAK
Official Court Reporter

C O N T E N T S

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THE COURT: This is file 2010-CP-40-1095. The case is styled Protection and Advocacy for People with Disabilities, Inc. vs. -- and if I mess up pronunciation, Beverly Buschemi?

THE WITNESS: Buscemi.

THE COURT: Thank you.

PhD in Her Official Capacity as the Director of the South Carolina Department of Social Needs -- Disabilities and Special Needs, and the South Carolina Department of Disability and Special Needs and a number of other named people as defendants.

All right. And let me see. Ms. Darwin, you represent the plaintiff.

MS. DARWIN: That's correct, Your Honor.

THE COURT: And Mr. Woodington, you represent the defendant?

MR. WOODINGTON: Yes.

THE COURT: All the defendants?

MR. WOODINGTON: All the defendants. I might add at the very beginning we're taking the position they don't need all these defendants if an injunction for relief should be in order but both -- one is enough.

THE COURT: Okay. Which one?

MR. WOODINGTON: Probably agency.

THE COURT: Okay.

MR. WOODINGTON: Since there's no damages sought.

THE COURT: Okay. All right. And Ms. Darwin, in rendering my decision today, is it all right if I just name the Department, just the agency?

MS. DARWIN: Yes, Your Honor.

THE COURT: Okay. Otherwise, all other defendants will show up on judgment rolls and things like that. So I just figured it might be better to do that, but that's all right with you.

So when I do the order, it will just refer to South Carolina Department of Disabilities and Special Needs.

Okay. Ms. Darwin, let me hear from you, please, ma'am.

MS. DARWIN: May it please the Court.

THE COURT: Yes, ma'am.

MS. DARWIN: I'm Ann Marie Darwin along with my associate, Thornwell Simmons. We represent Protection and Advocacy for People with Disabilities. We will call it P & A for short.

As you know, Your Honor, we have referred to the South Carolina code section as establishing P & A as the protection and Advocacy System for the State of South Carolina. Part of that provision allows us to do team advocacy inspections in facilities that provide residence to people with intellectual disabilities and other

disabilities.

Those inspections are unannounced visits to the facility to review living conditions, including plans of care. It's that particular provision of the South Carolina statute which is in question today.

The whole purpose of the P & A is to protect and advocate for people with disabilities and to try to protect them from abuse and neglect. That's why we're P & A. We protect and we advocate.

If you look at the South Carolina statute, if you look at the federal laws that require South Carolina to designate a P & A to beginning with, again the focus is to protect the health, safety, wellbeing of people with disabilities in this state.

The team advocacy provision takes that further and says in addition to your duty of the general protection and advocacy in investigating abuse and neglect, instead of setting priorities, we want you to do inspections where people with disabilities live and receive services.

In 1986, P & A began the team advocacy inspection program, and we've been doing it ever since. The main focus of that program has been in community residential care facilities but the provision does not limit us to those types of facilities.

The defendants have not argued over our ability to go

into community training homes which are the homes that they have licensed and that we're concerned with in this case.

The dispute is over some of the things that we do in our inspections. Can we do as much as we think that we can do. We, obviously, think we can go in, do an inspection, and we have been doing inspections.

We look at documents. We look at records concerning people with disabilities, the people who reside in that facility to determine whether or not they are receiving the care and treatment and services that they are supposed to be receiving from the operators of those facilities.

So in order to do that, we look at any records concerning the consumer that are kept in the home. We look at the financial records tracking where their money goes to when it comes into the facility, if they're getting money for their personal needs accounts to spend. Are they getting taken to their doctor appointments?

Have they had a physical when they were admitted to the home as is sometimes required. Do we have certain conditions? Are they on a special diet? We also look at the administration of medications?

The vast majority of people who live in these types of facilities have more than one condition. To be in a community training home, you have to at least qualify for

a high level of care.

It's not a nursing home level of care. It could be an intermediate care facility for people with intellectual disabilities. It means that you need help. You need help on a day-to-day basis with certain things.

Usually, part of what you need help with is taking medication, overseeing the medication, making sure that you get back and forth to your doctor's appointments and that you see the doctor and that your medical care is taken care of.

So what we do as part of our inspection is to ensure that these people are receiving quality care and services including medical care and that the drugs that they're being given on a day-to-day basis are tracked, recorded, and that they're being given the proper day-to-day dosages.

THE COURT: Can I ask you a question about that?

MS. DARWIN: Yes, sir.

THE COURT: If you are planning to track and record the proper dosages of medicines, do you have someone on your staff trained as a pharmacist to produce those?

MS. DARWIN: We don't have a pharmacy trained person. What we do basically is each facility is required to keep a medications administrations record. What we do is we reviewed those for a certain number of clients in each

home.

These facilities are only about four people at most. They're a bit large as a four-person home. So we would go in and look at certain files in that home, look at those MARs and compare what's written on the MAR, the dosage and the frequency and have they been signing off each time that they have given it and comparing it to the prescriptions to make sure it's up to date and make sure it's being given as prescribed.

THE COURT: Okay.

MS. DARWIN: It's the same thing that we do in the CRCF facility.

THE COURT: Okay.

MS. DARWIN: We track those. We note if there is a discrepancy. If there's a problem with a prescription or if it's unclear if the MAR has not been marked, anything we are concerned about, we bring it to the attention of the staff members there that day.

Then what happens at the end of our inspection report is we come back to the office. We might file a complaint with the agency that has the licensing authority over these particular types of the homes, and then we file a report within a certain number of business days with that agency with the other agencies that have concerns about these homes like an ombudsman.

The statute requires us to send a copy of the report to the Department of Mental Health. That's in the law. We also would send it out to the Attorney General. It the might be the regional ombudsman who is in that area, and the Department of Health and Human Services as most of these people are on Medicaid, and Medicaid is paying for their services.

Of course, it would go to DDSN, so they can take -- use our report to enforce their standards. We also send a copy of the report back to the operator so they can respond to us to DDSN so they know what we found.

A few years ago we expanded the team advocacy program into community training homes. We notified DDSN that we were going to do this. There was a delay.

A few years later we sent a notice that said, "Hey, we've got a person. They trained as required, and we're ready to launch these inspections." We started inspecting.

They had concerns over the review primarily of the documents of the consumers and whether or not that was a violation of the rights of those individuals. We couldn't resolve that issue.

They instructed the operators not to let us see those documents as it stood, and we went out, did a few more inspections.

Every operator said, "No. We're not going to let you look at the documents unless you get prior written permission from the individuals involved. So at this point in time, we have discontinued that part of the program."

Again, everything goes back to that team advocacies but to perform the State of inspections and to review these records. It's an integral part of the services of these homes that they need -- that the people in these homes receive assistance with activities of daily living including medical care and the taking of medication.

We would not be able to do a full inspection without having access to the information about the care and treatment they received. It is the same type of inspection or very similar to what we do in the CRCF.

Defendants have been receiving copies of our CRCF reports for years. The only person, the only entity that has mounted any legal objection to this type of access or something similar is Bellwood Manor, the case I referred to in your office, DHEC vs. Bellwood Manor, which is a CRCF, and that particular case was decided in favor of enforcing the DHEC fine against Bellwood Manor, but there are a couple of things in that case that really stand out.

One is the judge in that case, administrative law judge, is to ensure that those persons are being protected

and cared for to ensure that this right -- that their rights are being respected in the facilities on their quality of life and living conditions within these facilities and to protect them from abuse and neglect.

Another quote, as an organization authorized by statute to serve to protect the health and welfare and rights of disabled and handicapped persons in South Carolina, P & A's authority to conduct team advocacy inspections should be liberally construed.

THE COURT: All right.

MS. DARWIN: But based upon all of these things, the arguments we submitted earlier and all the briefs, we do believe that we ought to be able to go into these homes and submit those reports back to the appropriate people.

Thank you, Your Honor.

THE COURT: Yes, ma'am. Thank you.

Mr. Woodington?

MR. WOODINGTON: May it please the Court. I'll try to keep it relatively short as promised. I think the last statement the made is a true statement. They believe they're entitled to see the medical records and so forth.

Unfortunately, it's our position that the statute of the General Assembly didn't think that. Really, the remedy in this is with the General Assembly. It's not with the courts.

You know, we've thrown Medicare and Medicaid law around a bit in our brief which you've seen and had from the summary adjustment motions that were filed. That scares people to death, including me a little bit, that you cite such a law such as that.

This is a very simple question, and it's a simple question of interpretation of South Carolina law. The specific phase is -- I mean, this simple issue is whether the normal meaning of the term plan which describes what's going to happen in the future may also be applied to records, quote unquote which describe what has happened in the past.

They say very candidly what they want is MAR's Medication Administration Records. That's not a plan. That's a record. In the brief -- and forgive me for using this analogy again, but in baseball terms, the plan is the starting lineup. That's who's going to go out on the field.

The MAR and other medical records. They document what happened in the past. There is nothing in the term plan of care given its normal calm and ordinary meaning that even remotely suggest that it might include a record of something that happened in the past.

Indeed, the General Assembly knew how to deal with medical records because in the very same statute -- and

we'll discuss this a little bit -- it's 43-33-372, and it says that if somebody -- if some specific individual or person acting on behalf of such individual complains and files a complaints with the -- with the P & A, P & A can go into that facility and look at -- quote, inspect and copy any documents, record, files, books, charts or other writings which bear on the subject matter of the individual complaint of a specific individual goes and complains.

THE COURT: Do you mind giving me that statute again?

MR. WOODINGTON: I'm sorry. I didn't really expect you to look it up while I was talking but it's 43-33-370(2).

THE COURT: Okay. You might have to provide that with me because --

MR. WOODINGTON: Oh.

THE COURT: I'm with you.

MR. WOODINGTON: I'll tell you what.

THE COURT: I've got it.

MR. WOODINGTON: I have a highlighted version or at least an underlined version. I'll give opposing counsel the same thing.

MS. DARWIN: We have unmarked versions, too.

THE COURT: I've got it.

MR. WOODINGTON: I'd like a marked version if I can.

THE COURT: I've got it, sir. I was looking.

MR. WOODINGTON: It's two. It's down there.

THE COURT: Yes. I have got it.

MR. WOODINGTON: About halfway down.

What it says, of course, is that if you look at individual charts and so forth of the person on whose behalf the complaint has been filed, and then it goes on to say that except for the individual medical et cetera records of other persons in the program.

So it seems to me that not only is -- is -- are these medical records not included with any immediate plans of care, they are actually excluded later on down the road.

We have 2500 people in these facilities all total across the State, CTH2s, in these community care, community treatment homes, basically group homes with three or four people, as Ms. Darwin said.

DDSN and apparently the General Assembly, as well, is very concerned with having P & A or really anybody that is not specifically authorized by the statute coming in and pouring over the private medical records of 2500 individuals without very clear statutory instructions from the General Assembly which we submit is lacking in this case.

They are allowed to look at living conditions. The statute says living conditions. Living conditions they do

look at. They have a stack of reports they did in 2009, 2010. I don't think they've done any since then, but inspected some CTH2s.

You will see that they did a lot of inspections of living conditions, the size of the rooms, the heat and air conditioning, the quality of the food, so forth.

To not be able to see a medical record does not strip P & A of all ability to inspect living conditions. Quite to the contrary, from the records there.

So basically, that's our position. They have what the General Assembly has given them, the remedies with the General Assembly. We're here because Judge Manning denied summary judgment to both sides and even thought both sides submit there is no general issue of fact.

Our one witness, Kathy Lacey, the Associate Director of DDSN is with me, will discuss some of the fine details of it. I hope with some illustrative value in this case.

THE COURT: All right. Thank you, sir. All right.

Ms. Darwin, are you prepared to call your first witness?

MS. DARWIN: Yes, Your Honor. Gloria Prevost.

GLORIA PREVOST, after being duly sworn, testified as follows:

THE CLERK: State your full name for the record and please spell your last.

THE WITNESS: My name is Gloria McCain Prevost.
THE CLERK: Spell your last name, please.
(There was no response).
Spell your last, please.
(There was no response).
THE COURT: Ms. Prevost, would you spell your last name for me?
THE WITNESS: P-R-E-V-O-S-T.
THE COURT: Thank you. All right.
Your witness, Ms. Darwin.
MS. DARWIN: Thank you, Your Honor.

DIRECT EXAMINATION:

BY MS. DARWIN:

Q Ms. Prevost, would you tell us quickly about your educational background?

A Yes. I have a Masters in social work from Tulane University.

Q And you are currently the Executive Director of Protection and Advocacy; is that correct?

A That is correct. I began employment as Executive Director of P & A in 1997.

Q Would you please give us a short summary of your background before you came to P & A?

A Sure. I've worked in -- this is my fourth state. I've worked in advocacy organizations doing oversight.

I've also worked within at least the State Department of Mental Health, and at that time was called mental retardation. We now use the term intellectual disabilities.

In that state, I worked both directly as the director of social work within an institutions which provided services primarily to individuals with mental illness but also people with dual diagnoses including intellectual disabilities.

Then when I left the institutional work, I worked in a state office in charge of human rights for that state department which covered mental health, mentally disabilities and substance abuse.

Q Skipping over to P & A and your job here, what is the purpose of Protection and Advocacy for People with Disabilities?

A Protection and Advocacy -- as you may know, there is a P & A in every state and territory. There are 57 offices, and the goal, I think as we went into earlier, is to protect and advocate with people for all disabilities, including intellectual and developmental disabilities, to respond to complaints, to set priorities as to how we -- what things we focus on so we can be the most effective. In our state, we have the additional responsibility for the Team Advocacy Project.

Q In working on protection and advocacy issues, how do you protect people from abuse and neglect? What kind of efforts do you make as the P & A?

A As a P & A, we go into facilities. We respond to calls from family members of people who live in these facilities.

We go out and we see what the living conditions are including food, actually where people sleep, the medication review, the -- whether or not the medicines that are prescribed are what's in the storage compartment are being given, what the records show, and we review various internal and external documents relating to the facility and the individual care.

Q Talking about the Team Advocacy Program in particular, how long has it been operational to your knowledge?

A Since 1986 and that was by state statute.

Q Tell us a little about the team ad inspections and the program.

A Okay. The team advocacy inspections, there is a staff member and employee called a team advocate that person works with a trained people and other people at P & A train.

There's always at least a team advocate and a volunteer that goes into facilities. The team advocate

has the responsibility and authority to actually talk and look at records and -- including medical records in -- since 1986. The volunteer and --

MR. WOODINGTON: Your Honor, I am going to object to a characterization like that. That seems to be what this case is all about.

THE COURT: I understand. She was stating her opinion, Mr. Woodington. I'm not going to take that as my decision.

MR. WOODINGTON: Okay.

THE COURT: But I thank you for pointing that out.

MS. DARWIN: Thank you, Your Honor.

THE WITNESS: Thank you. May I continue?

THE COURT: Yes. Yes, ma'am.

THE WITNESS: Okay. The team advocate, I've gone in as a volunteer. I've never been the employee of Team Advocacy. I've gone in as a volunteer on visits.

In my role as volunteer and in the other volunteers, as I upstairs, look at the conditions, the closets, the sleeping arrangements, talking with the residents to see what it's like for them, are they getting the care that they want, would they prefer to live there, or would they rather live somewhere else?

Q Do the volunteers review any records at the facility?

A No. The team advocate does the record review.

Q What happens at the end of the inspection?
A At the end of the inspection, the team advocate makes a decision as to whether there is an issue, but I mean, I even write the term, the result, if there is imminent danger.

In the case of imminent danger, there is an immediate report to the appropriate state agency, particularly DHEC, perhaps LLR.

If there's not an imminent danger issue, there is a full report that he was sent to multiple state agencies, and it would include -- do you want me to go over the list?

BY MS. DARWIN:
Q Yes, please.
A It would include DHEC and licensing the facility, LLR which is the license administrator and the owner. DDSN gets a report. Department of Mental Health gets a report, the Ombudsman gets a report.

The Attorney General receives a report because of the possibility of Medicaid fraud. Health and Human Services because of the financial responsibility through Medicaid, and I may be leaving something out, but that's a pretty good overview.
Q Now, the reports, do they actually contain the names of any of the residents or specific confidential

information?
A No. These are general reports that are -- you know, provide overview of the situation within the facility.
Q At some point in time P & A made a determination to expand the Team Advocacy Training homes which are within the developmental disability or intellectual disability program; is that correct?
A That is correct.
Q How did that come about?
A After -- there was a law change that had to do with looking at abuse and neglect particularly in facilities operated and contracted with the Department of Disabilities and Special Needs.

Following that, we looked at -- there were several things that led us to go into this direction. One is we looked at the reports of the State Law Enforcement. We felt the community training homes, there seemed to be issues there just as there were with community residential care facilities.
Q Let me stop you real quick right there. I need to understand. When you say there were reports to South Carolina Law Enforcement, you're talking about SLED?
A I'm talking about SLED.
Q What kind of reports are you talking about?
A SLED gets all the reports of abuse and neglect in

facilities operated or contracted with the Departments of Mental Health and Disabilities and Special Needs. They do -- at facilities and they do a numerical report with numbers.

Q And they share that information with P & A?

A Yes, as well, as DDSN and many other organizations. So there was -- this was one issue. We also -- as we -- as I talked about earlier, we receive complaints, and we receive complaints throughout the years from family members who were concerned about the care of their relative within the community training homes.

So we felt that focused primarily or solely on CRCFs. We really needed to expand the CTHs. We notified DDSN, I believe in 2007, that we were going to expand the Team Advocacy project into the community training homes, and at that time we had a meeting, I believe, with Dr. Butkus who was then the director of DDSN. I think Dr. Lacy was involved and some other individuals.

Q Okay. And during that meeting, they were notified of our intention or P & A's intention to expand the program. Is that what you're saying?

A That is correct.

Q Okay. At some point in time, another notice was sent out to DDSN; is that right?

A Yes. We went through a time in 2008. We were -- we

hired an individual that we thought could bridge the gap to be trained to do the two positions, and we have two people, but they would both do CRCFs and CTHs.

We had a person on staff a short period of time, and she resigned. Some time within the next year, there were some major financial cutbacks of state government. We received state appropriations.

We lost that state appropriations, so we went through a restructuring reorganization, and then in 2009, we were ready to really start with the inspections of the CTHs, and we sent a letter at that time to DDSN saying we are ready to begin this.

Q All right. Some time after the 2009 notification, did you receive information back from DDSN about concerns they have?

A Yes. We received a letter. I believe the initial letter was from the interim director, Dr. Rhett, and it was something along the lines very similar to what's been talked about in court, questioning our authority to look at medical records.

Q May I approach the witness?

A You may.

(WHEREUPON, Plaintiff's Exhibit No. 1 were marked for identification only.)

BY MS. DARWIN:

Q I'm handing you what's been marked as Plaintiff's Exhibit No. 1. Take a few minutes and look at that document.

A Uh-huh.

Q Do you recognize it?

A I do.

Q Tell us what it is.

A Basically it's a letter dated August 31st, 2009 to me from Dr. Larrett. It said there had been discussions between Ms. Darwin and Ms. Vanderbilt, the DDSN attorney regarding the law pertaining to team advocacy inspections and that we have quoted the statute which gives us the provision to make unannounced visits to review living conditions of residential facilities and specifically stating including plans of care.

The disagreement between two attorneys is over the interpretation of plans of care, and it went on to say that due to the regulations of the Health Insurance Portability Accountability Act, HIPAA, the opinion of DDSN is P & A must get a signed HIPAA authorization form all residents if a minor before reviewing any protected health information including medical records, medication administrations record and other records protected under HIPAA.

They went on to say that they had informed their contracted providers about this issue, and they were to release only the residential treatment support plan which they considered the same as the plan of care.

The coordinator obtains a signed HIPAA authorization to disclose how the information -- to consider or legal guardian or parent, then the P & A advocacy coordinator could review documents specifically listed on the authorization.

THE COURT: Thank you, ma'am.

MS. DARWIN: I'd like to submit this in evidence as Plaintiff's Exhibit No. 1 if there are no objections.

THE COURT: All right. Plaintiff's No. 1 is in evidence without objection.

MS. DARWIN: Thank you, Your Honor.

THE COURT: Okay.

(WHEREUPON, Plaintiff's Exhibit No. 1 was admitted into evidence.)

BY MS. DARWIN:

Q This was one of the communications from DDSN expressing their concerns over the team advocacy inspections and community training homes. P & A at this point in time had been going out and actually inspecting those homes; correct?

A That is correct.

Q Do you remember off the top of your head how many inspections had already been done at this point?
A I do not. I think it was a limited number, but I'm not sure of the exact number, no.
Q And do you know what happened after this particular letter was received, the terms of the inspections themselves?
A Yes. Our team advocate was told that they could not see records, medical records.
Q So we attempted -- or P & A attempted to conduct further inspections?
A P & A attempted to conduct further inspections and were denied access to medical information.
Q Let's talk a little bit about the records that are reviewed. Do you have an understanding of the types of records that might be reviewed in a community training home?
A There would be --
Q Assuming that we have the authority.
MR. WOODINGTON: Excuse me. I know what you just said, Your Honor, and I assume this is just her opinion and not legal testimony.
THE COURT: I'm going to let -- it was just her opinion. It's my opinion that this is just to give me some background into what they want rather than what --

MS. DARWIN: That's really the crux of this, Your Honor, just to talk about -- I could have phased it more eloquently, but basically, I would like the witness to -- if she has an understanding about the types of records that we have might find or that we would hope to find in those homes, then I'd like to put that on the record.

THE COURT: I understand this is just what you'd like to see as a result of this. This is not -- it's not binding the court in any way.

MR. WOODINGTON: Okay. As stated just then, that's fine.

THE COURT: Okay. Thank you, sir.

MR. WOODINGTON: By the Court and Ms. Darwin.

THE COURT: All right. Ms. Darwin, continue.

THE WITNESS: Okay.

BY MS. DARWIN:

Q So let's talk about the types of records that we would hope to look about in these homes concerning medical care and medical administration?

A In my understanding, my opinion, what we would like to see would be something to really say whether or not the residence or the facility is getting what they should be getting, and it could be are the meals what is proposed. If someone has a medical situation such as diabetes, how that is being tracked and how the meals for that

individual are individualized and personalized.

If there are problems with whether the person has, say, medication for any kind of behavioral problems, what's happening and to track with the records that there's some awareness on the part of the people who assumed responsibility, that is the operators to intervene and make sure that services whether we're talking about food, medicine, or any kind of services are followed so that the person is protected and is safe from any kind of neglectful situations.

We would want to look at the -- I believe it's called the MAR, the Medication Administration Record, which gives us those things. We also -- I know from time to time one of the issues has been seeing that medications in the medicine cabinet is outdated. I mean, they're beyond the use by date.

We look at that to make sure that the medicine is still, you know, timely and is safe for use. What's in the medical safe chart matches what's in writing matches reality.

Q Do you expect that our team advocates will find the full doctor's file in any of these homes?

A No. I would be extraordinarily surprised if that were available in a community training home or a CRCF.

Q So is the focus of concern in reviewing these records

the performance of the staff in terms of the oversight of medical care and the provision of medication to the residence of these homes?

A Yes. As I understand it, the responsibility would be that the operator signs onto when they send money to keep someone in these facilities is that they will provide oversight of all the aspects of care.

Q Do you have any particular confidentiality concerns as the P & A?

A As the P & A we are extraordinarily aware of confidentiality issues, and we certainly do not bridge confidentiality of individual clients or collective clients.

Q All right. Do you -- are you aware of any provisions that limit what P & A can do with information obtained under the Team Advocacy Inspection program?

A I mean, other than keeping confidential and that our reports would be written in such a manner that would protect the individual confidentiality.

Q Does P & A routinely release the names of any residents of the facilities that P & A has inspected?

A No, not at all. In fact, we go to great lengths. We did a report in 2009 which is a broad-base report of our findings in the last few years in community residential care facilities.

We are extraordinarily cautious in that report to make sure that nothing would lead to information of individuals.

Q Are there any -- outside of the South Carolina laws, are there any statutes, federal or state, which would impact the ability of P & A to view its confidential information?

A As I understand, it's part of our federal requirement that we protect the confidentiality of our clients.

MS. DARWIN: Thank you. No further questions at this time.

THE COURT: Mr. Woodington?

MS. DARWIN: Please answer any questions of Mr. Woodington.

THE COURT: Mr. Woodington, your witness.

MR. WOODINGTON: I have just a few questions, Your Honor.

THE COURT: All right.

CROSS-EXAMINATION:

BY MR. WOODINGTON:

Q Ms. Prevost, is it your understanding that P & A started Team Advocacy inspections in 1986?

A That is correct.

Q And the statute, I think, was actually amended to allow inspections on living conditions such as we're

talking about here today in 1990 and again in 1993; is that right?

A I'm sorry, I don't know the answer to that.

Q Okay. But you never actually did inspect any CTH2s? At least -- let me clarify. It's CTH 1s and 2s, and there are other facilities that are run by DDSN such as supervised living programs, et cetera. Are you familiar with all those?

A I am.

Q You've only attempted to inspect CTH2s, right, correct, community training --

A Correct. That is my understanding in 2000--- I guess '09, that was where we focused. I could be off, but I think that's correct.

Q That's my understanding from the filings of the attorneys, and that only started in 2009, I believe.

A Correct.

Q So that's -- you know, if it I'm right about the statute being '90 or '93 or above that's 16 to 19 years after you first had the authority to inspect such a place as the CTH2s, correct?

A Well, from '86 to...

Q Or even '86, regardless, it was close to -- somewhere in the vicinity of two decades, give or take.

A Right.

Q Before it went to CTH2, and what did you inspect before, was it CRCFs?
A Community residential care facilities, CRCFs, correct.
Q Okay. And CRCFs are basically under an entirely different licensing scheme with than CTH2. Do you agree?
A That is correct, but I understand there's some times when CRCFs are redesignated by the state agencies and vice versa.
Q When you inspected some of these CRCFs, you did so for the Department of Mental Health, correct?
A We had been under contract with the Department of Mental Health since, I believe 1994, to inspect CRCFs.
Q Is that what all of your CRCF inspections have been pursuant to?
A The great majority, but I don't believe every single one.
Q Would you agree -- I mean, I could pull the contract out because I have the most recent version here, but basically is it true that you're acting as sort of a designee of the Department of Mental Health to go to these CRCFs to see what you could find?
A The contract calls for X number of inspections. If we have reason to go beyond that number on our own, we can also do that, and for a while, we also got money from --

and this was only for a couple of years from the Department of Health and Human Service because they were concerned about the use of Medicaid money in facilities. They supported our going in and -- along with Mental Health inspected the full review that I talked about earlier.

Q But again, your -- when you do the Department of Mental Health, you're sort of acting within the Department of Mental Health?

A We are certainly under contract with them to do inspections to protect the Department of Mental Health clients along other clients at the CRCFs.

Q Right. Okay. Have you been to the General Assembly in the last three or four or five years since you first ran into some opposition from DDSN about the particular records we discussed here today that passed the General Assembly?

A We have not.

Q You have not. Okay. And you had done, I think -- I think I have maybe 12 or 15 that I think your side is going to put in eventually CTH2 inspections in 2009 and 2010, correct?

A I do not know the number.

Q Okay. Have you seen the reports themselves?

A Part of them. I don't see every single report, but I

did see particularly when there was a controversy, I saw those reports.

Q Okay. Now, and do you know what kind of -- I may have already asked you this, and I apologize, Bellwood. Bellwood was not a DDSN facility, was it?

A No, it was not. It was a CRCF.

Q Okay. Would you agree that just under normal medical record law such as this, you could -- P & A could go to a residence of a CTH2 and obtain consent from that person or its representative to look at that person's medical records? You could do that, could you not?

A We could. One of the reasons team advocacy has been so effective and I think recognized by Health and Human Services, the Department of Mental Health, is the fact that the inspections are unannounced.

Q Well, let me explore that just a little bit because if -- if you -- say if you have a developmentally disabled person and you know who their guardian is, if you were to ask their guardian for permission to see their records, get a letter from their guardian or something, couldn't you still walk into the facility, the CTH2, say, "We're here for an unannounced inspection, and by the way, here is the consent of the guardian of so and so to see their medical records," how would that destroy the unannounced equality of --

A That would involve the assumption that there had not been the sharing of information, and we asked for the release prior to our visit.

Q Well, you're saying that the guardian was not willing to share the information?

A I don't know. I mean, they may have or may not want to. No, I don't mean show the assumption -- you would have to assume that the guardian -- if our guardian -- and this was just me, if our guardian, someone asked me for a release to look at my daughter's record --

Q Uh-huh.

A -- my inclination might be to call the facility and say, "I signed the release. I want to know this is happening." Some people would do that, so I'm not sure about that. That would be issue.

I think also it's just the fact that, again, my belief, we have the authority to see the records without a release.

Q And whether the parent or guardian wants you to view the records or not. That's your position?

A Yeah. We're the Protection and Advocacy system. We have a role to step in. Many, many other people in P & A facilities do not have parents and guardians. Many of them are alone and isolated, which is why the Team Advocacy is so important.

Q Do you know how many -- and I know -- if you're not familiar with them, I'll ask somebody else. Do you know how many CTH inspections you did in 2010?
A I do not.
Q Would you agree that there were some?
A Yes. But I do not know the number.
Q Okay. Have there been any in 2011 or 2012 to your knowledge?
A Not to my knowledge.
Q Okay. Let me find that real quick.
(Pause).
If you were to find the case of -- if you were to do a Team Advocacy inspection, okay, and let's assume without the medical records at this point, if you were to find a serious situation there, you're obligated to report that to certain state agencies and others?
A Correct.
Q Isn't P & A's position that you have the ability to report that to -- say -- you, obviously, can report it to the guardian if there is one, correct?
A I'm sorry, the last?
Q Obviously, you can report it to the guardian, if there is guardian, correct, that you found some problems with the individual?
A I don't know that that has come up, no.

Q Okay. Are you able -- are you authorized to report it to counsel, to some private lawyer, so they can sue on behalf of that individual?
A We've not used Team Advocacy for that purpose. We used it for the overall review, and then if we think there's someone that is in danger, we've gone through state agencies and held them accountable.
Q You have not gone to --
A Not to my knowledge.
Q Not to your knowledge?
A There are other people who have been in the position of actually doing the reporting. I have never done the reporting, and I think they might could answer that later today.
Q Okay. And the statute provides to two different types of persons. One is a team advocate.
A Right.
Q The other is a volunteer or the designee?
A Correct.
Q And you agree the statute says the designee can see even the plan of care as we defined it?
A Correct.
Q If they go through certain procedures set by the joint legislative committee on mental health, et cetera?
A It's a little problematic since there's not a --

MS. DARWIN: I'm going to object, Your Honor, to -- more to the form of the question because I got a little confused hearing it, but also he said to the plans of care as we define it. That was part of his question as I understood it. So if we could --

MR. WOODINGTON: Well, to the support plan. Is there a similar plan --

MS. DARWIN: The plan is not --

THE COURT: The residential support plan is one that you believe?

MR. WOODINGTON: Correct.

THE COURT: You'll just use it that way. Again, I'm just letting her state what she would like. So he is just questioning her about that.

MR. WOODINGTON: To be a little more clear about what I was talking about, the designee can only see that -- can only see the documents -- let me put it this way to make it even simpler: The documents that DDSN presently allows team advocacy people to see, if they care to come and see it, okay, they had -- the reports indicate that they have seen certain documents without objection from DDSN.

THE COURT: I'm familiar with that.

BY MR. WOODINGTON:

Q You're familiar with that, some of these CTH reports.

A Some documents. Is that what you're saying, just not

medical documents?
Q Correct.
A Right. Where you lost me was a question about the joint legislative audit committee.
Q Okay. I'm going to read you this. Only the coordinator -- and I'm reading from 43-33-350(4) which is the very statute that's at issue in this case. Down in the middle it says, "Only the coordinator or the Team Advocacy project or the coordinator's designee is authorized to perform reviews of plans of care"?
A Right.
Q And then it goes on to say the designee must meet criterion developed by the joint legislative committee on mental health and mental retardation after certain things have taken place. Has there ever -- are there such criteria in existence to your knowledge?
A By the time I moved to the State of South Carolina, that joint committee that longer existed.
Q So there's no criteria that you know of?
A Not to my knowledge.
Q Okay. All right. Thank you, Ms. Prevost.
A Thank you.
THE COURT: Anything on redirect?
MS. DARWIN: Yes, Your Honor.

REDIRECT EXAMINATION:

BY MS. DARWIN:

Q First of all, Ms. Prevost, if you were going out into a community training home, how would you know beforehand whether or not there was a guardian for each individual who lived in that home?

A Well, I wouldn't. I wouldn't have a list of the residents if I went out as part of a team inspection.

Q Assuming that P & A were required to get prior permission from the actual residents of the home or their guardians before looking at medical records for the purposes of a Team Advocacy inspection, what would happen if a guardian or an individual said, "No. I'm not going to sign your form and give you permission"?

A If we were being held to that, we would have a problem, and we wouldn't be able to do a complete inspection.

Q Going back to the discussion about the designee and what the designee looks at -- the provision, the Team Advocacy provision, that opposing counsel just went over with you, do you know who the designee is for this team ad?

A Historically -- as far as I know, since I've been there, the designee is the team advocate. I mean, we have a person who is designated by us as the team advocate, and that is the designee.

We don't use other people because we've been very cautious to be consistent in the quality of our reports, and we want a well-trained person as the team advocate. Then they're supported by trained volunteers, but the -- basically, the team advocate is responsible for the quality of the inspections and the -- you know, and, we believe responsibility of the training of the volunteers and the volunteer management.

MS. DARWIN: Thank you. No further questions.

THE COURT: Anything on recross?

MR. WOODINGTON: Your Honor, let me clear up one thing, but I want to make clear on that last set of questions.

RECROSS-EXAMINATION:

BY MR. WOODINGTON:

Q The statute refers to two different people, the coordinator or the team advocacy project and the coordinator's designee. Who is the coordinator of the Team Advocacy project?

A My response is in practice since I've been with P & A, it is one person is the team advocate which would be filling the coordinator, slash, designee position. We have don't have two or three people doing these jobs.

Q Is there an employee that is -- tell me the title of the employee.

A Team Advocate.
Q Team Advocate?
A Uh-huh.
Q Is there still one right now?
A Yes.
Q Who is the person?
A We have at this point -- we have Brenda Burnett is in that position.
Q Okay.
A And she just began maybe a month ago, three weeks ago.

MS. DARWIN: If I could interject real quick and clarify, we actually have two people doing the actual job because one person is retiring. So we are in a training position.

Susan Perry is here today. She has been the official Team Ad person. She is called an advocate, and I think this is the first time that you are hearing this. We can clarify this appropriately, Your Honor, but basically, Ms. Perry has been doing that about a month-and-a-half, and Brenda Burnett who is a former P & A person is undergoing training at this point.

She is officially called a Team Advocate, and has done, I think, three inspections since she came in to be trained.

THE COURT: Okay.

MR. WOODINGTON: I don't want to get confused, Your Honor. I can put this more on the record.

Is there somebody in position as the coordinator or the Team Advocate?

MS. DARWIN: Actually, I am the coordinator in the sense that I am the team leader, and I supervise directly all of the team advocates. What they do -- and obviously, Gloria is also involved on day-to-day basis, as well, so that's how we manage Team Advocacy.

MR. WOODINGTON: Well, Your Honor, I'm not slipping from examination to argument here, but if somebody else other than the coordinator, who Ms. Darwin just said is herself, is even looking at the plans of care that they can look at --

MS. DARWIN: Well, it says right here, Your Honor, that it can be the coordinator who -- basically, you can consider that person either me or the Team Ad staff or the designee. The designee is the team advocate.

So either the Team Advocate is kind of semantics. We're not required to have two separate positions, I don't believe. We have is one team advocate. That person is responsible for making sure, for actually performing the inspection, making it -- getting it done and reviewing those records herself.

It's usually a woman. The volunteer doesn't review the records. The volunteer assists with other parts of the inspection, and the Team Advocate comes back and then takes all the notes from the volunteer and their notes, and they write up the report. I usually review most of the reports, if not all of them, and then they are sent out.

THE COURT: And Mr. Woodington, what else do you want to argue about thus far?

MR. WOODINGTON: Well, the -- the designee is supposed to meet criteria developed -- it's supposed to be criteria that doesn't exist.

THE COURT: Correct.

MR. WOODINGTON: I'm wondering if we have a case of controversy here if we don't have somebody who is really authorized to look at this material.

MS. DARWIN: I don't think you can assume that there is no authorization here just because of that because again, at one point in time, that joint legislative committee -- also, we have training materials. We train every Team Advocate.

Most of our Team Advocates in the past have had certain backgrounds. Susan is kind of an exception. She has been with P & A for 23 years, and she is not a social worker. But a lot of our team advocates have Master of

social work degrees.

THE COURT: All right. We can come back to this, but the testimony is that this group, this joint legislative committee never developed any criteria. That is a correct statement; is that correct?

MS. DARWIN: We're not sure.

THE WITNESS: Not to our knowledge.

THE COURT: Well, y'all are the agency.

MS. DARWIN: We are the agency.

THE COURT: Designated to know that.

MS. DARWIN: I can tell you right now. I've been at P & A since 2001. That committee was gone by the time I started. We can perhaps dig through the records and find some of the original things.

I'm not sure if anybody is aware of any criteria ever developed by the committee. The committee doesn't exist. We've got training manuals. We provide on-site training.

We shared that information with DDSN originally and would be happy to do that again, and actually, one of the things that we have done in the past is we have had the person who supervised the contract, Vicki Mcgahee from the Department of Mental Health trained the advocate. We're certainly happy to have --

THE COURT: No. I don't need to go into that, but I want to confirm --

MS. DARWIN: As far as we know, we don't know the criteria ever developed and what happened to them.

THE COURT: Okay.

MS. DARWIN: And we have been operating the program all this time as it is.

THE COURT: Okay.

MR. WOODINGTON: Your Honor, first of all, I just want to make that clear for the record because it seems like the statute says you either have the coordinator who can -- who can perform such things or the designee.

The designee can only do it with the criteria that may not exist. That's my first point. My second point is for practical purposes, I assume you're not going to rule from the bench. We can leave the record open.

THE COURT: I don't believe I need that. If you decided as part of your position --

MR. WOODINGTON: Okay.

THE COURT: -- that you want that, I think I can still make a decision based on where y'all have been going the past two years.

MR. WOODINGTON: Okay. That's fine.

THE COURT: I'll let you think about it. At the end of the hearing, you want to go into -- delve into this issue, I'll be glad to let you delve into the issue, but I don't believe this is an issue you can fight about for two

years.

MR. WOODINGTON: It's not. It goes to whether we have somebody in court who is actually -- it's a case in controversy who is actually entitled to raise some of these points if they don't have it, but I -- you know --

MS. DARWIN: Your Honor --

MR. WOODINGTON: -- let me think about that a little bit.

MS. DARWIN: I can argue this, Your Honor, but I really think, you know, we've been doing this since 1986. There is a specific person who arranges the inspections, who goes out, performs them, comes back in and writes the report. Whether you call them the coordinator or the designee, I don't believe is important. It's a specific person that they trained.

THE COURT: Okay. All right. So we're through with this witness?

MR. WOODINGTON: Yes.

THE COURT: Okay. All right. You may step down.

THE WITNESS: Thank you.

THE COURT: I appreciates it. Next witness? I guess it would be your witness?

MR. SIMMONS: Your Honor, I'll have a thick stack of inspection reports from about 12 different inspection that is we did at CTHs. I would like to submit all of them as

one exhibit. I think just in the interest of time, it would be a lot quicker to do it that way. It's our business records.

THE COURT: All right. Has Mr. Woodington had an opportunity to look at them all?

MR. SIMMONS: Yes.

THE COURT: And these are just being placed in the record to show that you attempted do these inspections, and you weren't able to see the medical records?

MR. SIMMONS: Well, six of them showed that we did -- about six, I'd have to count, show that we did so many inspections and initially the directors let us look at the records on site, and then the letter that we showed earlier went out.

After that there are six or so reports that showed we tried to do full inspections, but they didn't let us look at the medical records.

THE COURT: Okay.

MR. SIMMONS: On such and such dates.

THE COURT: Okay. So the only thing this is telling me is that at one point we had five or six people that would let you look that the medical records per these inspections, and then after the letter went out saying that you couldn't do it, they stopped it?

MR. SIMMONS: That's the main thing.

THE COURT: Okay. Well, what's the unmain thing?

MR. SIMMONS: The other -- the other -- the other main thing --

THE COURT: Okay. The other main thing.

MR. SIMMONS: -- is that they show what goes into our inspections. They show the professional nature of these inspections. They show all the different parts of living conditions that we look at when we go into these facilities, and all the different parts that go into an inspection.

THE COURT: Okay. It's just a sample for me to see what depth you go to?

MR. SIMMONS: Yes.

THE COURT: Okay.

MR. WOODINGTON: Not only do I not have an objection, Your Honor, I encourage the court to look at these, sift through them, see that they were about to do a five-page inspection without seeing the medical records.

THE COURT: May they be introduced without objection then?

MR. WOODINGTON: Without objection except if this wouldn't be type technical to the truth of the matter asserted unless some place was dirty or something like that.

THE COURT: Right. I -- it's for the purposes of me

seeing what they do.

MR. WOODINGTON: Right. In fact, they weren't dirty.

THE COURT: I'm going to have them -- may have had just Plaintiff's Exhibit 2, and we'll just note. So you have them all.

MR. SIMMONS: It's multiple copies?

THE COURT: If you can handle those to the court reporter. She was going to mark that as Plaintiff's Exhibit 2, and that will be -- those are 12 reports, Mr. Simmons.

MR. SIMMONS: It is one, two, three, four, five, six, seven, eight, nine, ten, 11 reports, three copies of each stapled, if that's okay.

We could do these as 12 separate exhibits.

THE COURT: If you'll provide a copy to me and then the other copy to Mr. Woodington.

MR. SIMMONS: Okay.

MR. WOODINGTON: I do have copies except my secretary printed them out. I'll stack them. All right. Thank you, sir.

THE COURT: Let me go over what I have been given copies of to make sure that I have everything.

(WHEREUPON, Plaintiff's Exhibit No. 2 was marked for identification and received into evidence.)

MR. SIMMONS: Your Honor, I'd like to call our next

witness.

THE COURT: Okay.

MR. SIMMONS: Susan, Susan Perry.

THE COURT: Okay.

(WHEREUPON, a bench conference was held)

SUSAN PERRY, after being duly sworn, testified as follows:

THE CLERK: Please have a seat there, ma'am. Speak into the microphone. State your full name for the record and please spell your last.

THE WITNESS: Susan Perry, P-E-R-R-Y.

Your witness, Mr. Simmons.

DIRECT EXAMINATION:

BY MR. SIMMONS:

Q Ms. Perry, where are you currently employed?

A I'm employed with Protection and Advocacy for People with Disabilities.

Q How long have you worked there?

A Twenty-three years.

Q Before you came to P & A, what did you do?

A I worked with the -- I'm from Florence. I worked with Florence County, what then was called the Mental Retardation Board. It's now called Florence County Disabilities and Special Needs Board.

Q And what did you do in that position?

A I was the supervisor over all of the programs from the early intervention program to all the of the work shops and the preschool programs.

Q How did you come to work for P & A?

A I have a daughter that has an intellectual disability. She will be 40 years old in December, and when we found out that she was going to have some significant delay in her development, I didn't know how to help her.

I didn't know what to do, who to turn to, or how to go about getting services for her. So my background had been in accounting. I was currently working for an accounting firm in Florence.

I started trying to find out where I could go and what I could do. I was able to get in with the Disability Board. Unfortunately, while I was there, I felt that my hands were tied a lot in trying to advocate for my daughter, and I had an opportunity to come and work for Protection and Advocacy. It was a fit.

Q So how many years total have you been advocating for people with disabilities?

A Thirty-seven years.

Q Is your child a DDSN client currently?

A Yes, she is.

Q Okay. While you've been at P & A, what have you

done? What may you have done? That may be a bit overbroad since we're talking about 37 years. Let's talk about the present. What do you currently do at P & A?

A I am currently working with the Team Advocacy project, and I have been in that position for the last approximately 18 months.

Q What's your job title?

A I'm not really sure now. I think I'm still the Team Advocate.

Q Okay. So when did you take over that position when you started?

A It was in April, I think of last year.

Q Have you done inspections of CTH facilities?

A Yes.

Q I'd like to read off some dates. Did you inspect CTH facilities on June 15th, 2009, April 19th, 2010, May 10th, 2010, May 18th, 2010, and May 19th, 2010?

A I would recognize them better by the name of the facility, I'm sorry.

THE COURT: Mr. Simmons, I don't mean to interrupt your examination. Are these the ones that went in?

MR. SIMMONS: Yes.

THE COURT: All right. These are the inspections you've already done. These are already in evidence. If you want to move on.

THE WITNESS: I was involved in five.
BY MR. SIMMONS:
Q Okay. Were you allowed to inspect medical records in those?
A No, I was not.
Q Do you also inspect CRCF facilities?
A Yes, I do.
Q Could you tell me about the process of performing those inspections? What do you do when you show up at the door?
A When I show up at the door, okay.
THE COURT: Just so I can have some clarification. These are the inspections of the ones that are at issue here, the CTH2s?
MR. SIMMONS: I was going to start with the CRCF inspections, go over that briefly, and show how that's similar.
THE COURT: I don't -- okay.
MR. WOODINGTON: Your Honor, I...
MS. DARWIN: Actually, Your Honor.
MR. WOODINGTON: We're talking about CTHs here, not CRCFs.
MS. DARWIN: Actually, I think what we can do is ask her, first of all, does she remember how she performed CTH inspection and have her go through that process if she can

remember it. If there's something different from the first CRCF's inspection, we can ask her that afterwards.

THE COURT: To me, the issue is the inspections of the CTH2s; is that correct? That's where we bogged down here?

MR. SIMMONS: It is largely --

MS. DARWIN: The procedures are virtually the same. The only difference would be that they were in one setting or another, or the CTHs are almost always smaller.

THE COURT: Okay. Why don't we just go with the CTH2s, okay. If you want to jump to those questions. Then I will understand that the other ones are essentially the same.

BY MR. SIMMONS:

Q Okay. Let's go with that process then. Just tell me about the process that you go through the when you inspect a CTH?

A Okay. It's been a little while, but basically, it's the same thing. We announce who we are when we go to the door, I myself and a volunteer. The volunteer goes with me through what I call the walk through of the facility.

During that time, if we have not already secured a roster from whoever the staff is in charge, we will see if there are any of the residence there that are willing to be interviewed.

Most of the time, the people there are willing to talk to us, and we develop a list. That -- and that mainly consists of our sample list for that day.

After we do the walk through and we have a list for sample, the volunteer will go with her list, and I have the same list. She will go over her list, and she will begin to conduct resident interviews.

At that time being the team advocate, I will go to whatever area where the records are where the medication charts are, where the medication is stored and begin doing my records reviews.

Q To the extent that you're allowed to?

A Yes.

Q Okay. Can you tell me about what an MAR is?

A It's a -- it's a document that shows the names of medications and the -- it should have the same information on the MAR for the medication.

It should have when that medication is supposed to be administered, and there are -- there is a section over to the left where that information is, the description and how it's supposed to be taken and then over on the right-hand portion of that page, there are a lot of little boxes. And those little boxes when a staff gives the medication, they would initial in that little box based on the day of the week or, you know, the time of the day,

what, you know, is broken down into times of day. In a CTH, the staff are not nurses that administer the medications.

Q So is it basically the chart that tells the staff when to administer medications and what is administered and so forth?

A That's correct.

Q Okay. And let me see. What number?

(Pause).

Okay. Now, I -- I do need to circle back to some questions on CRCFs because I want to ask about the process of doing medications reviews, and obviously, we haven't been able to do any of those.

THE COURT: Okay. You just want to say this is what you want to do?

MR. SIMMONS: No. I want to --

THE COURT: You want to do this for CRCF?

MR. SIMMONS: I want to talk about the sort of things we do when we do the CRCF inspections.

THE COURT: Okay.

MR. WOODINGTON: I object to the relevance of it.

THE COURT: Right. Okay. I'll let you go through. Noting your objection so it will hopefully be preserved in case you need that.

MR. WOODINGTON: I tell you what, any such questions

about MARs and so forth, CRCFs -- I'm using acronyms here, I just want a standing objection to any such discussions throughout this hearing with opposing counsel.

MS. DARWIN: That's fine.

THE COURT: Okay. Mr. Simmons.

BY MR. SIMMONS:

Q That's fine. At the CRCFs you inspected, did you look at medical records?

A Now, you are referring to -- you said CRCFs?

Q CRCFs, yes. Was that the policy before you began, as well, to the best of your knowledge?

A To the best of my knowledge it was.

Q Did your inspections find medication errors?

A Yes.

Q About how often?

A It is difficult to say. It's unusual that we don't find medication errors, but depending on what our sample is, it's possible that we do find some sort of error in the medication that's not being given as it's instructed to give, it's not in stock, the medication is expired, it's given at the wrong time of day. There's confusion about how many tablets the person is supposed to take versus another time of the day. We do find a considerable amount of medication errors.

Q Is there anywhere else to look for medication errors

other than the MAR for --

A Not to my knowledge.

Q Okay. Are there any other -- you've already gone over how you thought -- do you announce -- for any inspections you do, CRCFs or CTHs --

A No.

Q -- do you announce inspections in advance for any inspection you conduct?

A No, not even my volunteer knows until just a few days before we go.

Q Why is that important?

A It's important because we don't want -- we want to be able to see what's going on at that facility as it would be run on a day-to-day basis. We don't want people putting out the Sunday china on a Wednesday. We want to see what it really looks like and what it's like for the individuals that are living there on a daily basis.

Q Even going in without warning as you do, do you find doctored records or records that have been altered in the CRCF inspections, obviously?

A Yes, I have.

Q Okay. Can you tell us about some instances where you found...

MR. WOODINGTON: Your Honor, I know I have an objection to this, but this is getting even farther

afield.

THE COURT: Yeah, I agree. She stated she has seen some of them altered. I'll take notice of that under your continuing objection to the relevancy of this continuing line of relevance.

BY MR. SIMMONS:

Q When you find problems at a CTH or CRCF, what do you do?

MR. WOODINGTON: I'm going to object to the form of the question. It's kind of compound, one or the other.

THE COURT: Do you treat problems differently each time, Mr. Simmons?

MS. DARWIN: Why don't you ask that?

BY MR. SIMMONS:

Q Is there any difference in how you treat problems?

A No.

Q So when you find a problem, what do you do about it?

A We want to know -- depending on what the issue is, we would notify the appropriate authority of any findings that we have.

Q Okay. Do you -- at the close of your inspection, do you prepare a report?

A We do. I do.

Q Are those the reports that we've already -- I guess you'll need to verify.

A I think four of those are mine, four of the ones I did.
Q What agencies get those reports?
A I think Gloria Prevost pretty much clarified that. DHEC, LLR, Department of Disabilities and Special Needs. I'm kind of like her. It's a pretty extensive list.
Q But DDSN does get those?
A Yes, three individuals at DDSN gets those reports.
Q But I can circle back. Earlier we talked some about your child. What's your child's name?
A My daughter's name is Candy.
Q Okay. What is she diagnosed with?
A She is diagnosed with intellectual disabilities.
Q And what's her -- how well does she function?
A Candy functions, I think, fairly well considering the severity of her disability. She is nonverbal, but she does have a brief number, about 30 signs that she knows. She is socially active. I think that's most important thing for her, rather than having a job, and she lives in a community training home in Florence.
Q That was going to be my next question. She does live --
A Yes.
Q -- in a community training home?
A Yes.

Q Are you familiar with her care?
A Oh yes, her dad and I are very involved.
Q Okay. What sorts of care does the staff at that CTH provide for her?
A They essentially --
MR. WOODINGTON: Your Honor, I kind of want to -- I know we're talking about human beings here, but this is not the point of it.
THE COURT: Tell me where we're going.
Ms. Perry, it's not that I'm not interested. The issue before me is an interpretation of the statute, and so I'm just trying to find out why I'm getting that.
MR. SIMMONS: The statute says living conditions including plans of care. I want her to talk about her daughter's living conditions at the facility and what that means and what -- what the different types of care that go into her living condition -- daughter's living conditions as an example of many other individuals statewide who live in this type of facility.
THE COURT: And that's supposed help me to decide the term living conditions?
MS. DARWIN: I'm sorry. The point of this particular testimony is that Ms. Perry's daughter is living at a CTH that would be subject to an inspection by a different team advocate.

If we were performing those functions today, or those inspections today, and we would expect to find certain things. She is getting certain care there, and it does involve medication and doctor's appointments.

We have parents who are very involved in her day-to-day life and see her frequently, but they still have issues and problems at CTHs.

MR. SIMMONS: And that --

MS. DARWIN: That would be addressed that might be discovered by a team advocacy inspection reported to the appropriate authorities.

MR. SIMMONS: But many people, unlike Ms. Perry's daughter, do not have involved parents and do not have active families and don't have any other way of finding problems with care. Unless somebody like us goes out and does an inspection, those problems might not get caught.

THE COURT: Okay.

MR. WOODINGTON: Your Honor, I would say it would make fine testimony in front of a legislative committee looking at how to change the statute that needs changed, but it doesn't belong in this case. I object to the basis of relevance.

THE COURT: I -- and -- Mr. Simmons, I've got copies of the reports that show what you go into, what the reports go into. That's come in without objection.

I do not see the relevance of continuing with testimony about her daughter in specific terms. I will note your proffer of what she -- of what you intended to get out of her so that I have that, but otherwise, I -- you can go with her testimony with anything else regarding the -- your basing inspections.

MR. SIMMONS: As long as that's noted for the record, then no further questions.

THE COURT: Okay. Your witness.

(There was no response).

Your witness.

MR. WOODINGTON: Oh, I'll be very short, Your Honor.

THE COURT: Okay.

CROSS-EXAMINATION:

BY MR. WOODINGTON:

Q Ms. Perry, I just have a couple of questions for you. Mr. Simmons called your attention to about five inspection reports in which you had participated in the inspections of, I believe; is that correct?

A That is correct.

Q And you would agree with me that each one of these is somewhere between five to seven pages long, correct?

A Yes, sir.

Q And in each case, they reflect that you went through the particular home, CTH2 home, looked at all the

bedrooms, looked at the place; is that correct?
A Yes, sir.
Q And you found some things. In some you found very little to complain about or have exceptions about, and some you found such things as expired foods and expired medications or maintenance problems or accessibility problems and so forth, correct?
A Yes, sir.
Q That was not necessary for you to look at medical records. You were able to observe of those as living conditions at the CTH2; is that correct?
A I was able to look at those things without looking at medical records.
Q One other question, and that is you had said that policy at CRCFs was that P & A could look at medical records at CRCFs. These were not -- two, I should say. Those were not DDSN's CRCFs inspections; is that correct?
A Sir, I never said anything about policy.
Q Your lawyer asked you about that pursuant to policy that you were looking at MARs and certain community care?
A I'm sorry, I didn't catch the word policy.
Q Okay.
A It's our procedure that we do.
Q But you wouldn't -- obviously, you would not know whose policy allowed you to inspect MARs and other

facilities?

A I am aware of our legislative authority.

Q Are you -- what your contention the legislative authority is.

A Yes.

MR. WOODINGTON: Thank you. That's all I have.

THE COURT: Mr. Simmons, anything on redirect?

MR. SIMMONS: No further questions, Your Honor.

THE COURT: Okay. Before you step down, Ms. Perry, I've got a couple of questions for you. When you -- when you were being -- in your direct examination, you indicated that you did residential interviews if they were willing to be interviewed; is that correct?

THE WITNESS: Yes, sir.

THE COURT: If they were unwilling, do you --

THE WITNESS: No, sir. We have to have their permission to go in their. We have to have their permission to talk to us. It's all volunteer --

THE COURT: Okay.

THE WITNESS: -- whether they, you know -- if they don't want to talk to us, we have no authority to say that we will.

THE COURT: Shortly after that, your attorney on direct was going over the MARs. When you do a CTH inspection, you can see the chart, the MAR?

THE WITNESS: I have not seen other people's charts. I only can speak of my daughter's --

THE COURT: Okay.

THE WITNESS: -- in a CTH2.

THE COURT: So when you go to a CTH, you do not get to see the MAR?

THE WITNESS: Not all the inspections I conducted as the team advocate for that inspection. We were not allowed to look at the medication MARs.

THE COURT: Okay. All right. Thank you, ma'am. All right. You may step down. I appreciate it.

MR. WOODINGTON: Your Honor, can I clarify one last -- I think neither one of us contests that in '09 some CTH2s would allow P & A to look at the MARs before this became all controversy.

MS. DARWIN: That's exactly -- yes, before -- I think at some point in time, DDSN sent an instruction or whatever you want to call it out to the operator saying unless P & A walks in with prior written permission, don't show certain things. From that point forward, operators would not let us look at certain documents.

THE COURT: And that's reason I'm here today.

MS. DARWIN: Yes, that's correct.

THE COURT: Okay. I'm with you.

MR. WOODINGTON: All right.

THE COURT: Thank you. Mr. Simmons or Ms. Darwin, any other witnesses for the plaintiff?

MS. DARWIN: Can we have just a second?

THE COURT: Sure.

(Pause.)

And Ms. Darwin, Mr. Woodington, could I see you just a second?

MS. DARWIN: Sure.

(Whereupon, there was a bench conference.)

THE COURT: We'll take a break now and come back at one. Thank you. We'll be in recess until one. Thanks.

MR. WOODINGTON: Thank you.

MR. SIMMONS: Thanks.

(WHEREUPON, a lunch break was taken.)

THE COURT: All right. Ms. Darwin or Mr. Simmons.

MS. DARWIN: I'll clarify real quick. We're only going to call one more witness unless something happens, so we cut out one. I think we're ready.

THE COURT: You're ready. Oh, okay.

MR. SIMMONS: Your Honor, I'd like to call Kimberly, Tissot, Tissot, T on the end.

KIMBERLY TISSOT, after being duly sworn, testified as follows:

THE CLERK: Please have a seat here, ma'am. Speak into the microphone. State your full name for the record

and spell your last.

THE WITNESS: My name is Kimberly Tissot, and that's T-I-S-S-O-T.

THE BAILIFF: You don't have to get quite on top of it.

THE WITNESS: Sorry.

THE COURT: All right. Your witness.

DIRECT EXAMINATION:

BY MR. SIMMONS:

Q Ms. Tissot, what is your educational background?

A I have a Masters of social work from the University of South Carolina.

Q Where are you currently employed?

A With the Disability Action Center.

Q What is your job title there?

A Executive director.

Q And before that, where did you work?

A At Protection and Advocacy for People with Disabilities.

Q What did you do there?

A I was a team advocacy advocate.

Q What were the dates for you being team advocate?

A I began in May of 2007 and left in April of 2010.

Q Okay. And in that capacity, you conducted inspections of a number of different facilities?

A That's correct.
Q About how many facilities did you independent?
A Approximately 250.
Q Okay. Were -- and out of all those facilities you inspected, those were mostly CRCFs, correct?
A That's correct.
Q Right. How many of those were under contract with the Department of Mental Health?
A The majority of them.
Q The majority?
A I don't have that number.
Q But did you inspect facilities that were outside the Department of Mental Health?
A Yes. I inspected a few DDSN CRCFs, as well as community training homes, too.
Q Do you remember how many DDSN CRCFs you inspected?
A Approximately six or seven.
Q Six or seven. Did you follow the same procedure at those facilities and inspect the medical records that you did at other facilities?
A Yes.
Q When you performed those inspections, did you follow -- we've talked a lot today about the procedures that the team advocate follows. Did you generally follow the same procedures we heard about earlier today?

A Yes.
Q Okay. Did you interview residents?
A Yes.
Q Did you ask for their permission to interview them?
A No.
Q No. But if a resident told you they didn't want to speak to you, what would you do?
A I would just document that.
Q And similarly when you toured the facilities, did you ask the resident permission to go into their rooms?
A I did not.
Q You did not. You just went ahead and did the inspection?
A I did.
Q So when you did your inspections with DDSN CRCFs and you expected them to provide the medical record at those facilities?
A Yes, they did.
Q And did you prepare -- when you concluded those inspections, did you prepared the same types of documents and reports that you prepared for all your other inspections?
A Yes, I did.
Q Did you send those out to all the same originations and state agencies including DDSN?

A They did.
Q So they had notice that you were doing those and didn't object?
A Yes; that's correct.
Q Okay. And did you also inspect CTH facilities?
A I did.
Q Do you remember how many?
A Probably the majority of them that were inspected was done by me.
Q And at those facilities, did they let you inspect the medical records?
A In the beginning they did.
Q In the beginning they did, but then later they didn't?
A That's correct.

MR. SIMMONS: I think that's all the questions I have.

THE COURT: Thank you, Mr. Simmons.

Mr. Woodington?

CROSS-EXAMINATION:

BY MR. WOODINGTON:

Q Ms. Tissot, so what were the dates that you examined, went to the DDSN CRCFs? Do you recall?
A Probably approximately between 2008 to 2010.
Q Were the -- do you know whether any of those

operators of the CRCFs were aware of DDSN's policy expressed to P & A in '09 about review of medical records?
A They were not aware.
MR. WOODINGTON: They were not aware. Okay. That's all I have.
THE COURT: All right. Anything on that issue, Mr. Simmons?
MR. SIMMONS: Nothing further.
THE COURT: All right. You may step down. Thank you, ma'am.
THE WITNESS: Thank you.
THE COURT: It was my understanding no other witnesses for the plaintiff; is that correct?
MS. DARWIN: That's correct.
THE COURT: Okay. All right. Mr. Woodington, is the defendant ready?
MR. WOODINGTON: The defendant is ready. I suppose for the record I could or should make a motion for a directed verdict on the grounds that nothing that has come out that has changed the legal position on our brief previously submitted to you.
THE COURT: Okay.
MR. WOODINGTON: There is no issue here.
THE COURT: I appreciate you making the motion for the record. I am denying it for the record.

MR. WOODINGTON: I understand.

THE COURT: I understand. So now do you want to go ahead and call whoever?

MR. WOODINGTON: I'd call Dr. Lacy.

THE COURT: Okay. Thank you, sir.

THE BAILIFF: Place your left hand on the Bible. Raids your right hand.

KATHI LACY, after being duly sworn, testified as follows:

THE CLERK: Please have a seat, ma'am. State your full name for the record. Please spell your last.

THE WITNESS: Kathi Lacy, L-A-C-Y.

THE COURT: Your witness.

DIRECT EXAMINATION:

BY MR. WOODINGTON:

Q For purposes, it's K-A-T-H-I, correct?

A Correct.

Q What's your present occupation?

A The Associate State director for Policy at the Department of Disability and Special Needs.

Q And could you give us your -- a brief bit of educational background, college and postgraduate?

A I have bachelor of science in nursing. I have a Masters in health administration and a PhD in public health.

Q In what?
A Public health.
Q Okay. How about describing your employment history with DDSN starting with the earliest date.
A I was hired in 1988 as the Medicaid coordinator and then was promoted to the director for the division with persons with intellectual disabilities and then my current job.
Q What are your responsibilities and duties in your present job?
A Responsible for developing the policies of which our providers follow including service standards and directives, things of that nature.
Q Okay. Are you familiar with the types of residences as -- well, all residences that are available for developmentally disabled people in South Carolina?
A Yes.
Q When I say developmentally disabled, that includes specifically intellectually disabled including formerly known as retarded. Can you tell me those?
A That's correct.
Q What others?
A Well, intellectual disability is the alternative name to mental retardation. That's the term for developmental disability.

Q Right. Okay. Are you familiar with the procedures that are in place for providing services to individuals who live in such placements as CTH2s?
A Yes.
Q Okay. And I think we've had that acronym defined in here before, but could you tell us what CTH stands for?
A Community Training Home.
Q Okay. Are you also familiar with the forms and documents that are used in the assessment process and so forth of the people in the CTH2s?
A Yes.
Q Okay. How about just describe -- you've heard a little bit of description of those in the record already. Can you describe what a CTH2 is for the Court's benefit?
A Sure. It's a home-like setting. We don't call them facilities. We call them people's homes that live in neighborhoods where typically people live in, three or four persons that are unrelated get 24-hour supervision, personal care and training.
Q Would it be -- and, Your Honor, if I go -- if I get too far out, just stop me. I'm just trying to provide some background here.
THE COURT: Okay.
BY MR. WOODINGTON:
Q Would a typical CTH2 be a three bedroom home in a

neighborhood?
A Yes.
Q Okay. And how many people are in CTH2s in South Carolina total, roughly?
A About 24 -- 2,500.
Q Okay. And the maximum is what again?
A Four.
Q Okay. Is there a minimum?
A No.
Q Okay. How many in the most -- how many people are in most CTs?
A The majority have four people --
Q Okay.
A -- living in there.
Q Okay. What's -- what's DDSN's role with respect to the operation of CTH2s?
A Well, we have a request for proposal, an RFP, that's with the Material's Management Office with the Budget and Control Board to solicit providers to become qualified to serve people in those.

If they're approved through a process, then that becomes the contract. So everything in that RFP that they've responded to becomes the contract, so we have a contractual relationship with providers who operate community training homes.

Q Can providers be both governmental and private?
A Yes.
Q Who are some examples of the governmental providers?
A In this area, we have -- let's say the Richland Lexington County Disabilities and Special Needs Board, Charleston County Disabilities and Special Needs Board.
Q The RFP is, correct me if I'm wrong, about 55 pages long, somewhere along that line?
A Yes.
Q Does it have a pendency also?
A Yes.
Q Okay. And so that's the -- that's the document that governs by which DDSN governs its relationship with a CTH2 provider?
A Correct.
Q Okay. Are all the residents of these places adults or most or what?
A The majority are. We do have some children between the ages of 18 and 21 years of age.
Q Okay.
A And then there are also a few homes that serve children under the age of 18.
Q Well, for the adult -- for the majority which would be the adult -- the place that houses adults, how does Medicaid fit into the picture?

A Well, DDSN has to apply in concert with the Medicaid agency, Health and Human Services, to operate a home and community based waiver. It's an alternative to institutional care, and people have the right to choose where they receive their care. So it's a document that's approved by the federal Medicaid agency.
Q And the waiver of the Medicaid home and community based waiver program has been around since about when?
A 1991.
Q Okay. Were you at DDSN at that time?
A Yes.
Q And did you -- were you involved in the Medicaid waiver administration at that time?
A Yes. I wrote the waiver document.
Q You wrote the waiver document?
A Yes.
Q Okay. Do you still write the waiver document?
A No.
Q Okay. Again, by way of background, can you just describe to the court how the home and community based services work in comparison to say institutionalization?
A Sure. Well, there's -- the intermediate care facility with persons for intellectual disability has been around for more than 30 years. The regulations around that have not changed for 30 years.

Q Let me stop you there. An intermediate care facility is an institution --
A Correct.
Q Like a nursing home, center, something like that?
A Correct.
Q Okay. Okay. Keep going.
A And so the law changed in the '80s giving people with disabilities the alternative to choose home and community based services as opposed to institutional care. So the federal government allowed people to write these waivers to serve people that made that choice.
Q And CTH2s are, correct me if I'm wrong, one area of -- one area of community based housing?
A It's called residential rehabilitation, and that can be provided in a variety of environments.
Q And just very briefly, could you just list one or two other ones just for background information?
A Supported living services, supervised living, and community residential care facilities.
Q And that would be in homes, apartments or -- the person's home, I should say, apartments or other homes?
A Right.
Q Okay. Could you just briefly describe the assessment and the planning process that goes into the fact that a CTH2 resident is in a CTH2, if that makes any sense?

A Yeah. The way that folks generally get to these homes is they are living at home with their families with all the informal caregiving for years and years.

There becomes a time when the primary caregiver is no longer able to take care of their family member with a disability, and their health and safety is in great jeopardy. So DDSN intervenes and finds appropriate places for these folks to move to.

Q Is that sometimes at the parent's request or all the time at the parent's request?

A It's not all the time. Sometimes there's situations where there is neglect going on in the home. It could be that the individual is hurting himself or the parent. So sometimes it's mostly the result of the parents needing additional support.

Q Okay. I'm going to show you this document -- did you get a copy of that -- and ask you to describe it briefly.

A Briefly, this is --

Q Just for identification more than anything else.

A All right. This is a service coordination and useful assessment. This is a document that's required to be completed at least on an annual basis by a service coordinator.

Q Okay. I would introduce this, Your Honor, as the Defendant's Exhibit 1.

THE COURT: All right.

Ms. Darwin, do you object?

MS. DARWIN: No objection.

THE COURT: Okay. Defendant's 1 is in evidence without objection.

(WHEREUPON, Defendant's Exhibit No. 1 was marked for identification only and entered into evidence.)

MR. WOODINGTON: By the way, Your Honor, to interrupt this for just a second. I don't know if we have formally done this or not, I would like to move into evidence everything that has been submitted on behalf of defendants in the summary judgment motions and attachments.

THE COURT: The documents that I mentioned at the very beginning.

MR. WOODINGTON: Correct.

MS. DARWIN: That's right. The plaintiffs would also want the same thing done.

THE COURT: Okay. Well, they are formerly in evidence, I thought.

MR. WOODINGTON: Well, I wanted to make sure.

THE COURT: Just to clarify on the record, all those documents that I mentioned earlier are in the record. I believe we're going to just double check to make sure I have everything.

MR. WOODINGTON: Right, right.

THE COURT: Everything will be in the record.
BY MR. WOODINGTON:
Q The reason I ask that at this point is your affidavit previously was submitted in 2011, had a document attached to that which was called a single plan. Do you recall that?
A I do.
Q And what's the relationship of Exhibit 1 right here to that single plan?
A It replaced the single plan.
Q Okay. When did that happen? I see down at the bottom that was revised February 1st, '12?
A I think there was a previous addition but very similar to this.
Q Okay. Does this serve the same function as the single plan?
A It does.
Q Okay. And what is that function?
A It's to do a formalized, standardized assessment of a person's needs for support.
Q Okay. Not to -- not to prolong it, but can you just flip through it and give a couple of examples of what is in -- let me do this: Let me start at the back. Four or five pages from the back, there is a document that says support plan, okay.

A Okay.

MR. WOODINGTON: Your Honor, are you with me?

THE COURT: I've got it.

BY MR. WOODINGTON:

Q Okay.

How about describing the support plan first?

A All right. Well, the information that gets into the support plan comes from the needs assessment.

Q Which was the prior part of this same document?

A Correct.

Q Okay. So --

A So anything that has been identified as a need and the person with the disability for their family would like for the service coordinator to address that need, it goes into the support plan.

Q Okay. Now then, the needs of -- tell me -- tell me the function of the first part of this document, service coordination and annual assessment?

A All right. It's looking at a person's health related needs, physical, dental, health related, diet.

Q Okay. Who performs this? Who does this?

A Service coordinator.

Q And in consultation with whom?

A With the family, the person with disability, people that know them well. They ask for information from the

person who attends a day program so they get it from a variety of sources.
Q And it includes medical sources sometimes, does it not?
A It does.
Q And then they get -- once the service coordination annual assessment, all 18 or 20 pages of it is filled out, then what happens?
A Then the plan is completed.
Q And that's the support plan?
A The support plan, correct.
Q In the case of a CTH2 resident, is it normally the case that one of these would have been in existence?
A It's required.
Q Before they got into a CTH2?
A More than likely, yes.
Q And the reason would be that they were already receiving DDSN services at home?
A Correct, they were receiving services in the home.
Q Okay. So to use the situation you described a few minutes ago, the person gets to the home but they can't stay home, is the person normally reassessed with one or more of these documents before they enter the CTH2?
A Yes, it's updated.
Q Okay. I think you said it's updated every year

thereafter, correct?
A Correct.
Q Okay. Let's -- let's look at the -- the pages aren't numbered but go to D which is about three pages in, unless you would like to stop.
A Yeah. This is an on electronic format, so looking at it paper wise may seem a little awkward.
Q All right. Okay.
THE COURT: Is D current resources?
MR. WOODINGTON: No. I'm sorry. It's the back part.
THE COURT: Oh, the back part?
MR. WOODINGTON: Yes.
THE WITNESS: I was with you.
MR. WOODINGTON: This is the support plan as opposed to the assessment.
THE WITNESS: Okay.
THE COURT: Needs and services?
MR. WOODINGTON: Needs and services.
THE COURT: Okay.
BY MR. WOODINGTON:
Q As you said, this is -- this is a paper copy of something that is now no longer done on paper; is that correct?
A That's correct.
Q So this D section here, I see the first question is

number so and so. What does this person need?
A Right.
Q Would there be a separate number and paragraph of this kind for each letter and need that person has?
A Yes.
Q Electronically again. You just don't do these anymore. This is just --
A Correct.
Q Okay. So -- so just tell me how that might be filled out. How many needs would an average CTH2 resident have, if there is such a thing?
A You know, probably three up to 12, something like that.
Q Okay. So just describe how this would be filled out for...
A So if a person has a need for help with personal care such as bathing, dressing, feeding, toileting, then that would be identified as a need, and the service coordinator and family and person would determine the best way to address that need.
Q And is that the thing that you just said addressed by these later blank service, slash, interventions to address the need, the date it was provided, who provided and it so forth?
A Correct.

Q Okay. And then the last page, tell me what the last page does?
A The meeting attendees?
Q Uh-huh.
A These are all the people that contributed to helping the service coordinator understand the person with disability better, and then that person participated in the assessment and plan development.
Q Okay. So again just to make the point clear, this document, the second part of this document, the support plan -- well, actually is the first part of this document?
A Yes.
Q The second part in particular, there would be as many section Ds as there are needs for that person?
A That's right.
Q Okay. And this, of course, is called the support plan at the present, correct?
A Yes.
Q And what are some other names for that document in practice?
A Plan and care, single plan had been named, we referred to before.
Q Okay. I'm going to quote you something from a case. This is in a brief that we have already filed, so it's a called Doe v. Kidd about a year-and-a-half old. The

fourth circuit federal court described the plan as follows and it said quote, DDSN approved a quote plan of care that was developed for Doe pursuant to a federal regulation. It says the 2003 plan in that case involved a -- included a regime of personal care, psychological evaluations and other services to be provided.

Now, the fourth circuit was talking about a quote plan of care in 2003. If the court had been addressing something that was done in 2012, would it be talking about this support plan?

A Yes.

Q Okay. Now, that's the next and probably last document I'll hand you just to identify is this.

A All right. This is the application that DDSN in concert with the Department of Health and Human Services submitted to the federal Medicare/Medicaid agencies for approval of our home and community based waiver.

Q And this is the thing you used to write but don't do anymore?

A Correct.

Q Actually, the full plan is online. It's about 200-some pages long, right?

A That's correct.

MR. WOODINGTON: I offer this as Defendant's 2, Defendant's Exhibit 2, Your Honor.

THE COURT: Any objection, Ms. Darwin?

MS. DARWIN: No objection.

THE COURT: Okay. Defendant's 2 is in evidence without objection.

(WHEREUPON, Defendant's Exhibit No. 2 was marked for identification and received into evidence.)

BY MR. WOODINGTON:

Q How about turn to section six? This is about two pages in. The pages are not numbered, but there is a section about six, seven pages in.

A Okay.

Q Got it?

A Additional requirements?

Q Yep.

Are you there, Your Honor?

THE COURT: Yes, sir.

BY MR. WOODINGTON:

Q Okay. 6(A), could you just read the first sentence of that?

A Service plan in accordance with 42 CFR 441-300.

Q Et cetera.

A Okay. A participant service plan of care is developed for each participant employing the procedures in appendix D. All?

MR. WOODINGTON: That's it.

THE COURT: Okay.

MR. WOODINGTON: Read one more sentence.

THE WITNESS: All?

BY MR. WOODINGTON:

Q How does that description and the waiver plan relate to our Exhibit 1 there?

A That's what it's referring to.

Q What's the it's referring to?

A Uh-huh.

Q Okay. Have -- I'm going to use the term in this document service plan that also says plan parenthesis of care, service plan.

Have these plans ever, to your knowledge, included medication administration records in them?

A No.

Q Have they involved physician's charts as a part of the plan?

A No.

Q Have they involved other medical information to your knowledge that involved documentation of past events?

A No.

Q Okay. Let me shift a little bit to a different area for just a moment and ask you about quality improvement in the Department of Disabilities and Special Needs. Can you describe how DDSN examinations its facilities or those --

those types of facilities to see how things are going, specifically CTH2s?

A Sure. We have a contract with a quality improvement organization that is designated as such by the Medicare and Medicaid to do quality assurance reviews for all types of people in particular people with intellectual disabilities.

So each year every provider that is serving a person with disabilities has an annual review. That review is a random valid sample of whether participants -- and there is a whole list that are put into a report and submitted to the provider.

The provider is required to submit a plan of correction and then the quality improvement organization goes and makes sure those things were done.

Q Does the quality improvement -- do they have the right to examine the medical records of the individuals in the homes?

A Yes, they do.

Q And can you explain the rationale for that?

A It's through the RFP process to submit an RFP to do our quality assurance reviews, and there is a business agreement within that contract.

Q And while HIPAA really isn't involved in this case, that's a partnership concept?

A Correct, we're required to protect people's personal health information.

MR. WOODINGTON: Okay. Your Honor, bear with me just a second.

THE COURT: Okay.

MR. WOODINGTON: Let me see if I can...

I try to be brief maybe to a fault, but that's all I have for this witness.

THE COURT: Thank you.

Ms. Darwin?

MS. DARWIN: Just a second, Your Honor.

THE COURT: Okay. Take your time.

(Pause.)

CROSS-EXAMINATION:

BY MS. DARWIN:

Q Dr. Lacy, at one point in time did DHEC perform certain functions directed towards CTHs on behalf of the Department of Disabilities and Special Needs?

A Well, DHEC is the licensing entity. So they -- we had a contract with DHEC to do licensing inspections which is different from the quality assurance review that I just referred to.

Q Is DHEC -- DHEC is nothing longer doing the licensing, are they?

A We have a new contract through Alliance (phonetic)

which is the quality improvement organization that is certified by the federal Medicaid agency to do that now.

Q But basically, DHEC is no longer involved in the licensing of CTHs?

A That's correct.

Q The licensing authorities for CTH is DDSN ultimately, isn't it?

A Yes.

Q Do you know whether or not DHEC has sent any inspectors to CTHs in South Carolina within the past year?

A Yes, they have. They completed their final review June 30th.

Q Just a second, Your Honor. I think --

THE COURT: Go ahead.

MS. DARWIN: -- I might be done, but I want to make sure.

BY MS. DARWIN:

Q Going back to, I believe, it was Defendant's Exhibit No. 2 which is actually two documents. I think they're together so we're referring to them as number one, that's the assessment and support plan, correct?

A Correct, yeah. They are -- they are actually connected electronically so that when an assessment is done and there is a need identified, you can't complete the plan without addressing that.

Q These documents don't reflect what occurs on a day-to-day basis at a CTH, though, do they?

A No.

MS. DARWIN: Thank you. That's all.

THE COURT: Anything on those issues, Mr. Woodington?

MR. WOODINGTON: Your Honor, only because I'm not sure I asked the question, if I have might have a little indulgence on this.

THE COURT: Okay.

MR. WOODINGTON: The question I have is whether quality assurance was in place at DDSN for these homes back in '93 when the statute was last -- was amended.

THE WITNESS: In 1993, DDSN was doing the quality assurance review of our contract providers, and we changed that in 1998, I believe.

We wanted it arm's lengths from doing the reviews ourselves, so we hired or contracted with the company that was specialized in this area.

MR. WOODINGTON: Okay. That's all I have.

THE COURT: Anything on that issue?

MS. DARWIN: Nothing, Your Honor.

THE COURT: Dr. Lacy, thank you.

You may call your next witness.

MR. WOODINGTON: That's it, Your Honor.

THE COURT: Okay. Any -- anybody you want to recall?

MS. DARWIN: No, Your Honor.

THE COURT: Okay. All right.

MR. WOODINGTON: Your Honor, I'd like to say one thing, if I can. The Court appreciates you abandoning that until this -- you take that up if you need to with another judge.

All right. Thank you all.

THE COURT: Mr. Simmons, I'm going to let you get together with Mr. Evans make sure we have everything.

Thank you all.

(There was an off-the-record discussion.)

MR. WOODINGTON: I have it.

MS. DARWIN: The only thing I was going to say, obviously, he can make a motion that at this point he should win. I would say we have that same motion, just for the record.

THE COURT: That's correct.

MS. DARWIN: Just for the record.

THE COURT: Okay. All right. Okay. You come on back just so we can talk for a minutes.

MS. DARWIN: Okay.

THE COURT: You can come on back here.

(Whereupon, the proceedings were concluded.)

P's #1

Attachment D

Eugene A. Laurent, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

COMMISSION
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August 31, 2009

Ms. Gloria Prevost
Executive Director
Protection & Advocacy for People with Disabilities
3710 Landmark Drive, Suite 208
Columbia, SC 29204

RE: P&A Team Advocacy DD Project

Dear Ms. Prevost:

The Agency's attorney, Ms. Tana Vanderbilt and your attorney, Ms. Anna Marie Darwin, have been in discussions since July 1, 2009, regarding the law pertaining to team advocacy inspections.

S.C. Code Ann. §43-33-350(4) gives P&A the provision to make unannounced visits to review the living conditions of residential facilities, and specifically states "including plans of care for individuals in a residential care facility." The disagreement between our attorneys is over the interpretation of "plans of care." While we appreciate P&A's efforts to conduct inspections in community training homes, our obligation is to ensure that the rights of our consumers are protected.

Due to the regulations of the Health Insurance Portability and Accountability Act (HIPAA), P&A must get a signed HIPAA authorization from all CTH II residents, their legal guardian or parent if a minor, before reviewing any Protected Health Information (PHI), including the medical records, the medication administration record or any other record protected under HIPAA except for the residential treatment/support plan as required by state law.

We have informed our contracted providers of our position for CTH II staff to release only the residential treatment/support plan, which we consider the same as the plan of care, to the P&A team advocacy coordinator. If the coordinator obtains a signed HIPAA authorization to disclose health information from the consumer, his/her legal guardian, or parent if a minor, then the P&A advocacy coordinator can review medical documents specifically listed on the authorization.

Thank you again for your efforts in inspecting the living conditions of CTH IIs. We pledge our cooperation with P&A in carrying out these inspections.

Sincerely,

Eugene A. Laurent, Ph.D.
State Director
EAL/cch

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

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

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

Team Advocacy DD Inspection for April 19, 2010
Arrowood CTH II, Columbia, South Carolina

Team Advocacy DD Project Report for Susan Perry, Kimberly Tissot, and Phyllis Ross

Facility Information

Arrowood CTH II is located at 720 Arrowood Road, Columbia, SC in Richland County. The home is operated by the Babcock Center, Inc. The home is licensed for four beds and was occupied by male residents. At the time of Team DD's visit, all beds were occupied. The home is a brick structure in a residential neighborhood. Team DD entered the home at 4:07 p.m. and departed the home at 6:48 p.m. The house manager, Janice Briggs, was not present during Team's visit. However, Ms. Briggs was available via telephone. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the home, reviewing residents' records, observations made while at the home, and interviews conducted with residents. The report addresses concerns Team DD found relating to the following:

- Expired foods
- Following caloric diet
- Maintenance
- Resident Rights
- Resident Equipment

In addition to the above concerns, the residents reported needing the following:

- Medical appointments
- Equipment

Home Tour

It was near shift change when Team DD arrived. One of the residents was home with one first shift staff. At 4:58 p.m., the other three residents arrived by a small bus from their individual day

programs. The home appeared homelike. The floors were hardwood except in the kitchen area where it was tiled. The front entrance had a wide and accessible doorway. Additionally, the foyer and hall were wide and accessible for wheelchairs (three residents used wheelchairs; one resident used a walker). The front sitting area had a comfortable couch, love seat, and chair. Team DD noted that there were pictures of residents displayed in the living room. The den area had a fireplace with gas logs, TV, a sofa, love seat, and chair. The furniture was attractive and comfortable. Team DD also noted that the home had a Nintendo Wii for the residents' use. All of the furniture appeared to be in good condition. There were Easter decorations on a bulletin board in the dining room. There was a large glassed porch off the den with a comfortable table and chairs for the residents use. Attached to the back of the home were a double carport and an area to park the home's bus. The bus appeared to comfortably accommodate four wheelchairs, two passengers and a driver.

The home had two bathrooms. One large bathroom had a standard size bathtub. The staff stated that the residents did not use that bathroom for bathing. The second bathroom was large and accessible with a lift and bathing table. Team DD did not enter the second bathroom as it was in use during the visit. There were four bedrooms. Bedroom #1 was on the backside of the home and had a door that exited to an accessible ramp at the far end of the home. The bedroom was personally decorated, attractive, neat, and had a double bed. There was a standing table in the bedroom to allow the resident time out of his wheelchair. Bedroom #2 was on the front of the home. This bedroom had an older hospital bed in the room. Bedroom #3, had a double bed and recliner in the bedroom. There were personal items in the room. Bedroom #4 had an older hospital bed in the room. There was a large TV, personal pictures, and a mirror mounted at an accessible level.

Infection Control, Sanitation and Health/Safety

The home appeared to be clean and well ventilated. The windows were open on the day of inspection. The home water temperature was within range when tested at 105.3°F. The home was free of obvious fire hazards. Team DD noted that the fire extinguisher was accessible and last inspected April 1, 2010. The smoke detectors were in the hall and each of the bedrooms. A first aid kit was located in the kitchen cabinet. The first aid kit was not complete. The first aid kit contained gloves, one 5X5 gauze, small scissors, tweezers, and tape. There was a flashlight in the home. The home had proper

lighting. The temperature was comfortable and free of insect infestation.

There were emergency exit routes posted on the wall. The home had a written evacuation plan that noted residents would relocate to other Babcock buildings should there be an emergency evacuation. The home had an adequate supply of food on hand.

The following exceptions were noted:

- The refrigerator contained expired mayonnaise dated 12-19-09 and one gallon of milk dated 4-18-10. Additionally, there was a package of cooked hamburger meat and bologna that were open with no labels. There was another package of cooked hamburger meat that was wrapped in foil, stored in a grocery bag in the back of the refrigerator with no date or label.

- The cabinet over the washer and dryer was unlocked. The unlocked cabinet contained furniture polish, disinfectant, glass cleaner, and antibacterial hand soap.

- A picture frame in the laundry room had broken glass.

- One of the staff members (Samuel Dreher) was assisting a resident in the bathroom. The resident was left in the bathroom alone for a significant amount of time. The resident was confined in the bathroom due to his immobility. Team DD had concerns regarding the resident's safety since he was left alone for a significant amount of time. The staff member did not appear to be respectful of the resident's privacy as the staff left the door open and invited Team DD members into the bathroom. From the hallway, Team DD saw that the resident was lying on a blue bathing table/lift. The staff then stated that the resident was having a bowel movement. When they realized what was happening, Team DD refused to enter the bathroom in order to respect the resident's privacy. The resident remained in the bathroom alone during the entire tour and meal observation. The resident did not eat dinner with his housemates during Team DD's visit. The resident was still in the bathroom when Team DD departed.

- Bedroom #1- the closet door was detached from its frame causing the closet doors to be wobbly.

- Bedroom #2- the closet doors (2) were detached at the floor. Additionally, the resident's wheelchair was in disrepair. The wheelchair's leg supports were worn and had been repaired with duct tape. The duct tape was detaching from the frame leaving a sticky residue. The left arm on the wheelchair was torn. See pictures at the end of this report.

Medication Storage & Administration

The medications were not reviewed due to DDSN's position that consent is required for P&A to review records.

Residents' Records and Access to Healthcare

Two resident records were reviewed and both residents who were present were interviewed. The residents' medical records were not reviewed due to DDSN's position that consent is required for P&A to review records.

- Both resident records noted whether the residents had a health care power of attorney or other advance directive. Neither resident had advance directives.

- Both residents' records reviewed contained current resident support plans.

- One of the two resident's records reviewed contained a behavioral support plan.

- One of the two resident's records reviewed contained documentation of the resident's diet. One of the residents was noted to have a 1300 calorie diet. The second resident's records did not contain the resident's diet.

- Both residents' records reviewed noted incident reports filed over the past year.

- Both residents' records noted that they attended a day program/workshop.

When interviewed, the residents stated that the home transports them to local doctor appointments. When asked if they needed any medical appointments, resident A reported needing an eye and dental exam. Neither of the residents stated that they have any problems getting transportation to medical appointments.

Residents' Clothing, Hygiene, Supplies, & Special Equipment

Both residents interviewed stated they like their bedrooms; one resident stated he liked his bedroom because it was built just for him. Both residents stated they could stay home from their day program if they were not feeling well. Both of the residents had their own personal bedrooms. Both residents reported that staff changed their sheets for them every week. Team DD noted that the residents had clean bath and bed linens and that their rooms were clean and decorated with personal items.

The residents interviewed by Team DD stated that they had enough clothes; one resident reported having too many clothes. Both residents stated that the staff assists them with washing their clothes as needed. The residents interviewed appeared to be wearing their own clothing and shoes which were well fitted and free of holes, stains, or tears. Both of the residents had several seasonal outfits of clothing available to them.

Both residents interviewed appeared to be clean and neatly groomed with clean faces, hair and clothes. When asked how often the residents took a shower or bath, one reported bathing every day, the second resident stated bathing three to four times a week. The residents reported they received clean bath towels each time they bathed. Both residents stated they have enough hot water to bathe comfortably. Team DD noted that there were toilet tissue and personal hygiene items available to the residents.

Spending Allowances

Team DD noted that both residents handle their weekly allowances independently. When interviewed, one of the residents reported spending most of his allowance at church while the second resident stated he purchased food and snacks from the store.

Meal Observation

Team DD observed the snack and dinner. For snack, two of the residents received a sweet roll; the other two residents did not receive a snack. The posted dinner was oven-fried chicken, rice, gravy, baby

green limas, applesauce, water, and sugar free tea. The menu posted reflected a variety of foods. The residents were served chicken, gravy on rice, lima beans, and a mixed fruit cup. The meal served looked appetizing, smelled good, and was served at the appropriate temperature. Second helpings were not available in the kitchen. Condiments were not on the table. The residents had time to eat their meal safely. One resident, not in Team DD's sample, received assistance from staff with feeding. Team DD noted one resident, not in Team DD sample, had not come to the dining room to eat because he was left in the bathroom during dinner. Team DD noted there was a portion of food left in the kitchen for that resident.

When interviewed, one of the residents mentioned he ate what they gave him; the other resident stated he does have choice in the foods he eats. One resident reported that he does have the opportunity to go with staff to the grocery store, the other resident stated he did not. When asked if the resident could get a second helping if they wanted, one stated he could receive a second helping, the other resident stated he could not receive a second helping (this individual was prescribed a 1300 calorie diet). Both residents stated they could ask for something different if they don't like what was being served. Neither resident reported any food restrictions by their doctor. When asked about foods they would like to have that they currently are not being served, neither of the residents mentioned any specific foods. Both residents reported they received enough food.

The following exception was noted:

- Team DD noted one resident in the sample was ordered on a 1300-calorie diet per day. The resident received the same or larger portions than others at the evening meal. When staff was questioned about the diet, the male staff present was aware that the resident was on a 1300 calorie diet.

Resident Interviews

Team DD interviewed two residents. Both residents interviewed stated they liked the home where they live. Both residents reported that staff was nice to them and treated them with respect. One resident even reported that one of the staff members (Cassandra) needed a raise. Both residents stated they know what their rights are and they have someone they can talk to when needed. Both residents reported they have never been locked out of the home or in a room. The residents interviewed stated they are given choices. Both

residents reported that they do not have any problems with house rules. When asked what they would change about the home, neither resident had any suggestions.

The residents interviewed were asked about activities they did in and outside of the home. Both residents stated they attend day programs outside of the home. One resident reported that he enjoys attending church and has friends there. One resident stated that he likes to go shopping and out to eat while the other resident stated that he has the staff shop for him. Both of the residents stated they have choices of activities they would like to do. One resident mentioned that he goes on over night visits with his family.

Team Advocacy DD Inspection for April 19, 2010
Arrowood CTH II, Columbia, South Carolina

Team Advocacy DD Inspection for April 19, 2010
Arrowood CTH II, Columbia, South Carolina

Team Advocacy DD Inspection for April 19, 2010
Arrowood CTH II, Columbia, South Carolina

Team Advocacy DD Project Inspection for September 17, 2009
Brewer Street CTH II, Cheraw, South Carolina

Facility Information

Brewer Street CTH II is located at 108 Brewer Street, Cheraw, South Carolina in Chesterfield County. The home is operated by the Chester County DDSN Board. The home is licensed for 4 beds and at the time of Team DD's visit had a full house. The home was occupied by female residents. The home is a house in a neighborhood. Team DD members entered the home at 4:08 pm and exited the home at 5:59 pm. The house manager, Keisha Adams was not present during Team DD's inspection. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, medications, medication administration records (MARs), observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Resident safety
- Resident rights
- Housekeeping
- Maintenance
- Food storage

In addition to the above concerns, the residents mentioned needing the following:

- Medical examinations
- Winter coat

Home Tour

When Team DD arrived, the staff member was getting ready to take the residents to dinner. The staff member reported that she had just given the residents a snack. Team DD received permission from the residents to talk with them and inspect the home prior to them going to dinner. The home appeared to be homelike. The inside of the home had attractive and comfortable furniture for the residents' use. The living room area was shared with an office area. The living room had comfortable and attractive furniture and a television which the residents appeared to be enjoying. The home was cheerfully decorated with appropriate seasonal decorations. The facility had four bedrooms; each bedroom had one bed. Additionally, the facility had two bathrooms. The residents' bedrooms where individually decorated. The residents' bedrooms were tidy. The home also had a carport with chairs and a table which the residents appeared to enjoy. Additionally, the back yard had a large gazebo with comfortable seating which one of the residents proudly mentioned purchasing. The residents appeared to be able to access all areas of the home. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The facility appeared to be clean and well-ventilated. The residence water temperature was noted to be within range when tested at 103.6°F. Team DD also noted that the fire extinguisher was accessible and was last inspected 9/1/2009. The staff members had certification in CPR and First Aid. A complete first aid kit was located in the bathroom/medication area. The residence was maintained at a comfortable temperature and was free of insect infestation. The residence had an adequate supply of food on hand.

The following exceptions were noted:

- The bed frames in bedrooms #3 and #4 were loose and wobbly.
- Bedroom #2 had a musky and foul odor. Additionally, the flashlight in the bedroom was inoperable.
- Bedroom #4 was without an overhead light cover/shield.
- The hall bathroom was without toilet paper.
- In the refrigerator, there was a package of white turkey lunch meat that had a sell by date of August 11, 2009. The meat had a foul odor.

Medication Storage & Administration

The medications were not reviewed due to DDSN's position that consent is required for P&A to review records. The CTH Coordinator, Sonja Gordon would allow Team DD to review the medication and records with verbal consent. However, Team DD refused to get verbal consent to review the medications and records due to P&A's position on the access authority.

Residents' Records and Access to Healthcare

The residents' healthcare records were not reviewed because of DDSN's position on allowing P&A to review records without consent. Team DD did review two of the residents' support plans and behavioral support plans.

- Both of the residents' records reviewed contained current resident support plans.
- Both of the residents' records reviewed contained a behavioral support plan.
- Both residents' records noted the residents' diets. Resident A was noted to have an 1800 calorie, low fat, low sodium, and low cholesterol diet. Resident B diet was noted to have an 1800 calorie diet.
- Neither of the resident records reviewed noted that there were any incident reports filed over the past year. However, the staff reported that incident reports are stored in the medical records at the main office.

- Both of the residents' records noted that the resident attended a workshop. Both residents were noted to attend The CHESCO Workshop.

When interviewed, one of the residents stated they are transported to local doctor appointments by the home; the second resident did not answer this question. When asked if the residents needed any medical appointments, Resident A reported needing an eye examination and Resident B reported needing an eye and dental examination.

Residents' Clothing; Hygiene Supplies, & Special Equipment

Both of the residents interviewed stated they like their bedroom at the facility; one resident reported liking his bedroom because her bedroom was "peaceful". Both of the residents reported they were able to take a nap as they wish. Neither of the residents had roommates. When asked how frequently their sheets were changed, both residents reported having their sheets changed "every Saturday." Both residents reported they change their own sheets. Team DD observed that the residents had clean bath and bed linens and that their bedrooms were clean and decorated with personal items.

When asked if they had enough clothing, one of the residents stated they did have enough clothing. When asked how frequently their clothes were washed, one resident stated her clothes were washed "every night" and one resident stated her clothes were washed "every other day." The residents interviewed appeared to be wearing their own clothing and shoes which were well-fitted and free of holes, stains, or tears. Both of the residents interviewed appeared to have at least seven seasonal outfits of clothing.

Both residents interviewed appeared to be clean and neatly groomed with clean faces, hair, and clothes. When asked how often the residents took a shower or bath, both residents stated bathing daily. Both residents stated there was enough hot water for them to shower comfortably and that they were able to get in and out of the shower at ease. Residents reported they received a clean bath towel every time they bathed and that they had enough toilet paper which was kept in the bathrooms.

The following exceptions were noted:

- Resident B reported needing a winter coat. Team DD noted that the resident did not have a winter coat.
- Team DD observed that Resident B didn't have any shampoo.

Spending allowances:

When interviewed, one of the two residents stated they received a weekly allowance. One of the residents mentioned using her allowance to purchase meals out. When asked if they had anyone hold onto their money for them, one of the residents mentioned staff members.

The following exception was noted.

- Resident B reported that the staff holds onto her money for her. The resident reported it "hurts her feelings" when the staff holds her money.

Meal Observation

Team DD did not observe a meal as the residents were planning to eat dinner out the day of Team DD's visit. Team noted the staff reported that residents were served a snack prior to Team's arrival. The staff reported the residents received cake for the snack.

Team DD noted that the dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents. When interviewed, both residents reported having a choice to what foods they are served. Both residents reported that staff members take food requests prior to going to the grocery store. Both residents reported going to the grocery store with staff members. When asked if there were any foods their doctors told them they should avoid, one resident mentioned they were supposed to have low calorie foods; the second resident reported having a "diabetic" diet. Both residents stated that their food was served at the right temperatures. When asked if their were any foods they would like to have that they currently aren't being served, one resident mentioned fried chicken; the second resident also mentioned fried chicken as well as collards and corn bread.

The following exception was noted:

- Team DD asked the staff about residents diet restrictions. The staff stated she was unaware of the residents' special diets.

Resident Interviews

Team DD members interviewed two residents. When asked if they liked living at the home, one resident stated she "loves it" and the second resident stated that the home is "not that good." When asked if the staff treated them with respect, one resident stated they did. One of the two residents reported that staff was nice to them. When asked if they knew their rights, one resident said yes and was able to give examples; the second resident stated that they would like to vote. One of the two residents reported that they felt safe at the facility. When asked whom they spoke to if they had a problem, one resident mentioned a staff member at the house and the second resident mentioned a staff member at the workshop. The residents interviewed stated they were never locked out of the home or in certain rooms. One resident mentioned wanting to move independently.

The residents interviewed were asked about activities they did in and outside of the home. When asked if they worked, both residents reported attending a workshop. One of the residents reported getting paid for her work; the second resident stated her paycheck gets sent to the house manager. Both residents reported they liked attending the workshop; one of the two residents mentioned she "loves it." When asked about activities the residents did in the community, both residents mentioned attending church, going out to eat and one resident mentioned going shopping. Both residents mentioned that they get to go to the places that they choose. One of the two residents reported going places with other people besides the other residents from the home. One of the residents reported visiting her friends. Neither of the residents reported going on vacation. One of the two residents reported attending a self-advocacy group.

The residents were also asked about activities they did in the home. One resident reported watching television and cleaning; the second resident did not report any activities in the home. When asked what activities they would like to do, one resident mentioned enjoying cook outs.

One of the residents mentioned that she had family members visit her at the home. When asked where the telephone they used was located, both residents mentioned the telephone in the living room. When asked if the home had any pets, neither of the residents mentioned any pets.

The following exceptions were noted:

- When asked what happened if they did not follow the facility's rules, one resident stated they would have to sit in her bedroom. The second resident mentioned she would be "kicked, slapped, and spanked."

- Resident A reported that the staff "yells sometimes."

- During the interview with Resident A, she reported that "I want to talk but I'm afraid to say something". The resident then proceeded to report that the staff leaves her alone on Friday nights. The resident reported that the staff returns at 7:00 am the next day.

- Resident A reported that her eyeglasses were broken by a staff member (Latonya Robinson). The resident stated that the staff member said that she fed her eyeglasses to a "snake".

- Resident A reported that the staff member, "Shannon is hateful". The resident could not provide examples of hateful behavior.

- Resident A reported that she did not have any privacy to use the telephone.

Team Advocacy DD Inspection for May 10, 2010
Cheryl Drive CTH II, Columbia, SC

Team Advocacy DD Project Report by Susan Perry, Phyllis Ross, and Stacy Arnold

Facility Information:

Cheryl Drive CTH II is located at 1821 Cheryl Drive, Columbia, SC in Richland County. United Cerebral Palsy (UCP) operates the home. The home is licensed for four beds. On the day of the inspection, all beds were occupied with male residents. The home is a brick structure in a residential neighborhood. Team DD entered the home at 3:55 p.m. and left the home at 7:30 p.m. The lead staff, Kathy Smith, was not present during the inspection. Jennifer Jennings and Rinaul "Coco" Gillespie, Community Living Coaches (CLC), were present during the inspection.

Overview:

This report contains information gathered from touring the home, reviewing residents' records, observations made while at the home, interviews conducted with residents, and conversations with the staff and individuals living in the home. This report addresses concerns Team DD found relating to the following:

- Expired food
- Accessibility
- Maintenance
- Resident equipment
- Staff interaction with residents
- Proper storage of chemicals

In addition to the above concerns, the residents reported needing the following:

- Longer bed for one individual

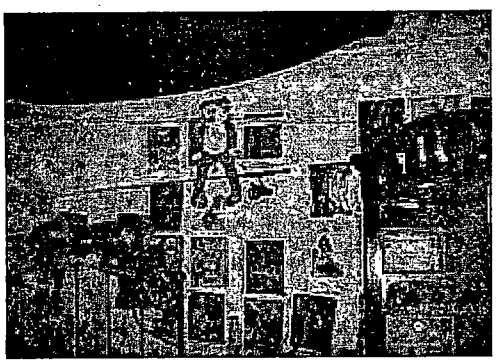
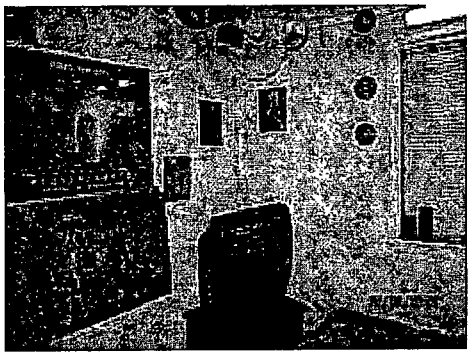
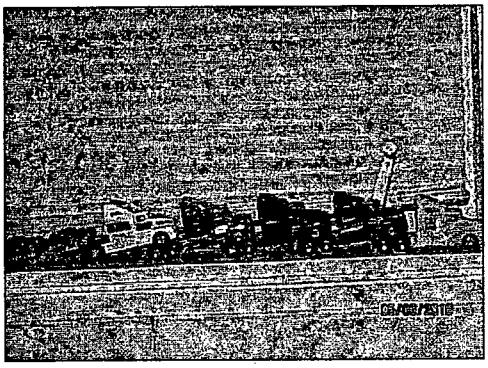
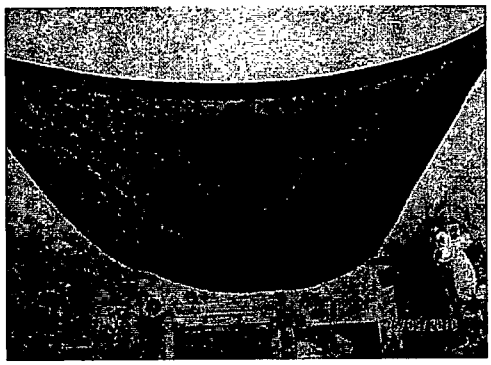
Home Tour:

Team DD arrived at the same time as a second shift CLC staff. One individual was sitting outside under the carport, two individuals were in their rooms, and one with sign out privileges was out of the home. The home appeared comfortable. The floors were hardwood and vinyl. The front entrance area had slate tiles. The

entrance to the front door had several steps with a handrail. The door was wide and the entrance, hall, and living areas were all wheelchair accessible. There was a solid wooden ramp in the carport area leading to the mudroom and kitchen. There was a grill in the backyard. Another solid ramp was in the back yard leading to the glass-enclosed back porch. From the back porch, a cement ramp provided accessibility to the den. There was a solid ramp leading from the dining room down to a sunken living room.

- Living room had a cloth sofa and love seat, coffee table and an end table. The staff had a desk, file cabinet, and bulletin board behind the desk in the living room. This was the only room with carpet on the floor. The carpet was stained and dirty. Draperies where hanging at the large front window.
- Dining room had a nice large wooden table and six chairs. Matching draperies were hanging at the large dining room window. A mural was on one wall in the dining room.
- Mudroom had a refrigerator, washer and dryer. There was a small dinette table between the mudroom and kitchen. The kitchen had a large counter. All of this area was open, without doors.
- Den had a leather type sofa and love seat, two end tables, and a television on a console. There was a brick fireplace and built-in shelves. A glass-enclosed Florida room was on the opposite side of sliding glass doors in the den.
- There were two tiled bathrooms. One large bathroom in the center hall was renovated to accommodate a lift and roll-in shower. A smaller bathroom in one of the individual's rooms had a bathtub with a shower, sink and cabinet, toilet, and built-in linen closet. The door and bathroom did not allow wheelchair access; however, two of the individuals were able to use the bathroom.
- There were four bedrooms.
  - Bedroom #1 in the front of the home had a single hospital bed with a green waterproof mattress. The room was personalized with a television and displayed several pieces of the individual's artwork and many stuffed animals. The closet and chest were well organized and had easy access.
  - Bedroom #2 in the front corner of the home had a double bed. There was a vanity and table with a television. The room was personalized with the individual's favorite college emblems and family pictures.
  - Bedroom #3 in the back corner of the home had a double bed. The second bathroom was located off of this bedroom. The room reflected the individual's preference to be untidy. Team DD noted the need for the room to be painted.
  - Bedroom #4 in the back of the home had a single bed, and television that was connected to the resident's stereo for stereo surround sound. This individual had a vast collection of 18 wheeler trucks, posters on the walls, a black light, many CDs hanging from the ceiling and a black

drapery with each of the four corners pinned to the ceiling making a parachute. This room was very personalized.

Infection Control, Sanitation and Health/Safety:

The home was well ventilated. However, when Team DD arrived, it was very hot inside the home. Team DD asked if the air conditioner was working. Staff checked the thermostat and found the heat had been left on from the cooler night before. Team DD noted the fire extinguisher was accessible and last inspected April 18, 2010. In addition, the home was equipped with a built-in fire alarm and ceiling water sprinkler system. There were evacuation devices hanging outside of the bedrooms for easy access. The first aid kit was organized and complete. Team DD saw no sign of insect infestation. Emergency exit routes were posted in the hall. The home had a written evacuation plan, which was contingent on decisions by administrators. The main evacuation plan was to evacuate to the Columbiana Mall. The home water temperature was 116° in the smaller bathroom sink.

The following exceptions were noted:

- The home could be cleaner.

- Refrigerator contained yogurt dated April 27, 2010, which was out of date. There was an uncovered container of corn; staff covered it with tin foil.
- There was a walker with a broken seat, a mattress and box springs, and a curtain rod stored on the back porch.
- An unlocked hall closet contained washing detergent and bleach.
- Bathroom door in the center bathroom had a hole approximately 5X5 inch in the front of the door. There was also a doorknob size hole in the lower middle portion of the back of the bathroom door. The door was hollow.
- Bedroom #3: Team DD could not open the left closet door because of miscellaneous items falling from stacked positions. The right side door of the closet did not open because a piece of furniture was positioned directly in front of the right door.

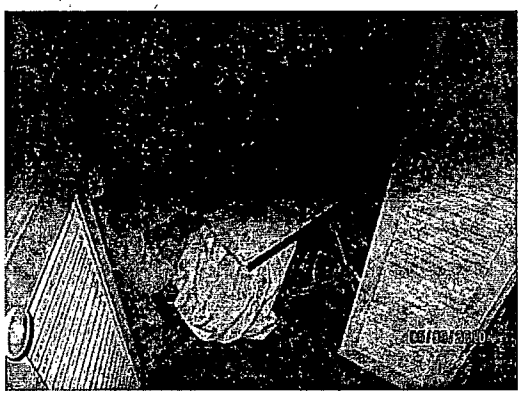


Figure 1- Left side of double closet does not completely open.

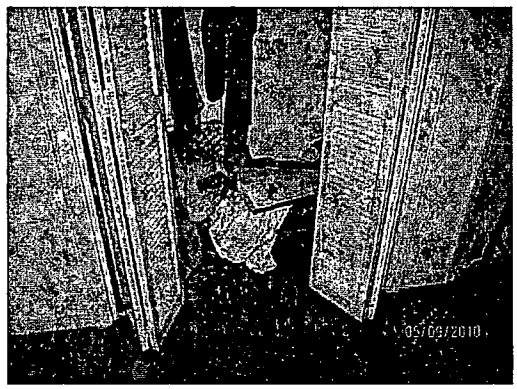


Figure 2- Same view.

Figure 3 - The right side of the double closet is blocked by the desk.

Team Advocacy DD Inspection for May 10, 2010
Cheryl Drive CTH II, Columbia, SC

Medication Storage & Administration:

- The medications were not reviewed due to DDSN's position that consent is required for P&A to review records.

Residents' Records and Access to Healthcare:

Two individuals' records were reviewed and both residents were present and were interviewed. The individuals' medical records were not reviewed due to DDSN's position that consent is required for P&A to review records.

- Neither of the individuals' records had a health care power of attorney or other advance directive.
- Both individuals' records contained a current resident support plan. Neither individual had a Behavioral Support Plan.
- Individual A had a special diet in his plan.
- Team DD reviewed an incident report for individual A. There were no other incident reports at the home.
- Both individuals attend UCP Day Habilitation.

During the interview, both individuals stated that the home transports them to local doctor appointments. When asked if they needed any medical appointments, individual A reported needing an eye exam. Individual B reported needing an eye and dental exam. Neither individual stated they have any problem getting transportation to medical appointments.

NOTE according to the records:

- Individual A's last dental appointment was December 9, 2008
- Individual B's last dental appointment was March 10, 2009.

Resident's Clothing, Hygiene, Supplies, & Special Equipment:

Individual A currently has a single hospital bed. He stated he needs a longer bed in order for him to fully stretch out at night. He stated he does not feel safe in the bed when staff doesn't remember to put up the side rails; he is concerned he will fall. Individual B stated he loves his room. Both individuals reported they can stay home if they are not feeling well. Both have individual rooms. Individual A reported

his sheets are changed everyday, while individual B reported they are changed when needed. Team DD noted that both individuals had clean bath and bed linens. Individual A's room was neat. Team DD noted staff assists Individual A. Individual B's room was disheveled, which reflects his lifestyle; he is more independent of staff.

Both individuals interviewed stated they had enough clothes. Both reported that they receive assistance from staff as needed to wash their clothes. Both individuals appeared to be wearing their own clothes and shoes, which were well-fitted and free of holes, stains, or tears. Both individuals had several seasonal outfits of clothing available to them.

Both individuals reported taking daily baths. They receive clean towels each time they bathe. Both appeared to be clean and well groomed to their preference. Both individuals stated there was sufficient hot water for bathing. Team DD noted that toilet tissue and personal hygiene items were available to the individuals.

Spending Allowances:

Team DD noted that Individual B handles his personal weekly funds while Individual A stated the house manager keeps his money.

- The Individual Support Plan for Individual A states he handles his personal funds.
- Team DD noted that both individuals have opted to use the UCP Consumer Trust Fund instead of a personal checking account.

Meal Observation:

Team DD did not observe snacks offered during the inspection. Team DD did observe the dinner meal. The posted dinner menu was Grilled chicken and corn. The menu posted listed a variety of foods. Three individuals were served grilled chicken, bread, corn, and yogurt. Individual A was served a large portion of lasagna, bread, corn, and yogurt. The meal looked appetizing, smelled good, and was served at an appropriate temperature. Individuals stated that there are second servings of food sometimes. Condiments were not on the table, but individuals knew where they were and could get them. Three individuals ate at the kitchen table while Individual A ate with the staff at the dining room table. When interviewed, Individual A stated that he can request different food if he doesn't like what is offered.

- Team DD noted the staff ate at the same time as the individuals. Team DD noted one staff ate the same lasagna meal as individual A. (Staff reported they are not allowed to leave the CTH II to get dinner.)

Individual B reported he makes a list of what he wants when the staff goes to the grocery store. Both individuals interviewed stated they received enough to eat. Individual A is on a chopped diet of ¼-inch pieces. Staff assisted Individual A with eating. When asked if there was anything they wanted that was not being served, Individual A stated, "Fried pork chops, they have baked pork chops."

Resident Interviews:

Team DD interviewed two individuals. When asked if they like where they lived, Individual A stated that he likes where he lives, but one individual is very loud and keeps him awake. Individual B stated that he "loves it." Both individuals reported that staff are nice to them and treat them with respect.

- Individual A stated that when he asks Erica to move his legs, she says, "You can do it yourself". Individual A stated that Erica gets a "little attitude" with him. He reported Coco and Jennifer help him; he does not want to lose them as staff.

Both individuals know they have rights. Both reported they have never been locked out of the home or in a room. Individual B reported he had been locked in his room at home before he moved to Cheryl Drive CTH II. Both individuals are given choices. When asked what they would change about the home, Individual A stated he wanted one individual to be quiet, Individual B stated he wanted a wider desk.

The individuals interviewed were asked about activities they did in and outside of the home. Both stated they have UCP Day Habilitation at the home. Both individuals stated they have choices of activities they would like to do. Both stated they go to the grocery stores, parks, and out to eat.

Team DD noted interaction between two individuals and one of the staff. The individuals and staff were making silly comments, poking each other on the arm and shoulder. The individuals were excessively teasing staff and all three were loud enough to be heard at the opposite end of the house. It was noted that the individuals feel comfortable with the staff and enjoy their company; however, staff should remain in control of the situation and set boundaries.

Team Advocacy DD Project Inspection for June 24, 2009
Godbold Street CTH II, Marion, South Carolina

Facility Information

Godbold Street CTH II is located at 402 East Godbold Street, Marion, South Carolina in Marion County. The home is operated by the Marion-Dillon DDSN Board. The home is licensed for 4 beds and at the time of Team DD's visit had a full house. The home was occupied by female residents. The home is a brick house on the corner of a busy street. Team DD members entered the home at 5:10 pm and exited the facility at 7:38 pm. The house manager, Ella James was not present during Team DD's inspection. However, the house manager was available via telephone. The exit interview was conducted with one of the two staff members. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, medications, medication administration records (MARs), observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Resident Rights
- Maintenance
- Flashlight batteries
- First Aid kit
- Medication
- Resident reported needing medical appointments.

Home Tour

When Team DD arrived, three of the residents were watching television and one resident was resting in his/her bedroom. The staff members were preparing dinner. The home appeared to be homelike. The inside of the home had attractive and comfortable furniture for the residents' use. The home had two living room areas. One of the living room areas appeared to be a formal living room and one of the living rooms appeared to be the common area. Both living rooms had comfortable and attractive furniture; the common living room included a television which the residents appeared to be enjoying. The home was cheerfully decorated with appropriate seasonal decorations. Team DD noted two bathrooms in the home. The home had four bedrooms with one bed in each. The residents' bedrooms included furniture of their choice, stuffed animals, curios, and individualized bed spreads. The residents' bedrooms were tidy. The residents appeared to be able to access all areas of the home. The entryways did not feature a ramp however none of the residents required a wheelchair. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The facility appeared to be clean and well-ventilated. The residence water temperature was noted to be within range when tested at 104.2°F. Team DD also noted that the fire extinguisher was accessible and was last inspected June of 2009. Additionally, smoke detectors were noted in each of the four bedrooms; however, the label attached to the detectors indicated that the batteries were last changed 1/7/2008. The home was properly lighted. The residence was maintained at a comfortable temperature and was free of insect infestation. The staff had documentation of training in first aid and CPR which was noted to be current.

There were emergency exit routes posted on the walls. The home had a written evacuation plan which noted that residents would relocate to the local Marion-Dillon County DDSN workshop in the event of an emergency evacuation. The residence had a substantial supply of food on hand.

The following exceptions were noted.

- The first aid kit was stored in disarray. The first aid kit was stored on the top shelf of a bookcase. The first aid kit's storage unit was not appropriately locked or closed. The items were not neatly stored and there were several packages of "sterile gauzes" opened and unsealed.

- The flashlights batteries appeared to need replacing in bedroom #1 and #3; the flashlights were dim.

- One of the bathrooms was without toilet paper. Additionally, underneath the bathroom sink appeared to have significant moisture damage; the wood underneath the cabinet appeared rotten. The bathroom also had a strong odor of mold.

- Bedroom #4- there was plastic covering the lampshade.

Medication Storage & Administration

Medications were stored in a locked closet near the front door. The medication area was free of loose pills or spills. One of the residents whose records were reviewed was prescribed controlled medications.

The following exception was noted.

- Resident A was prescribed Diazepam 5mg "Take one tablet by mouth every morning and take two tablets by mouth at bedtime." The MAR listed the medication as "Valium 5mg p.o. 9 a.m." The MAR was last initialed on 6/23/2009. Additionally, the count sheet was not accurate. Team noted there were two count sheets; one count sheet was accurate. The inaccurate count sheet noted there were 24 tablets remaining when the blister package contained 22 tablets.

Residents' Records and Access to Healthcare

Two resident records were reviewed and one of the residents agreed to be interviewed. One resident was not interviewed because they refused to be interviewed.

- Neither resident records contained documentation of a physical examination within the past year. However, the residential manager faxed the current physical exams to DD Team members.
- Neither resident records contained documentation of other medical examinations.
- Both of the resident records noted whether the residents had a health care power of attorney or other advance directive. Neither resident had any advance directives.
- Neither of the resident records reviewed noted the resident had received a tuberculin (TB) skin test or chest x ray. However, the residential manager faxed the residents' immunization records to DD Team members. Resident A's record noted that the resident had a TB test two months prior to admission and Resident B's record noted that the resident had a TB test two months prior to admission.
- Both of the residents' records reviewed contained current resident support plans.
- Both of the two residents' records reviewed contained a behavioral support plan.
- Both residents' records noted the residents' diets. Resident A was noted to have a "diabetic diet" and Resident B was noted to have a *regular* diet.
- Both of the resident records reviewed noted that there were incident reports filed over the past year.
- Both residents' records noted that the residents attended a workshop.

When interviewed, the one resident who was interviewed stated they are transported to local doctor appointments by the facility. Resident A reported needing a podiatry and psychiatrist appointment. The one resident who was interviewed stated that they did not have any problems getting transportation to medical appointments.

Residents' Clothing, Hygiene Supplies, & Special Equipment

The resident interviewed stated that they did not like their bedroom at the facility because they want to go home. The resident reported they were able to take a nap as they wish. The resident did not have a roommate. When asked how frequently their sheets were changed, the resident stated "on Fridays". The resident reported that staff members changed their sheets for them. Team DD observed that the resident had clean bath and bed linens and that her bedroom was clean and decorated with personal items.

When asked if they had enough clothing, the resident stated she did have enough clothing. When asked how frequently her clothes were washed, the resident stated her clothes were washed daily. The resident interviewed appeared to be wearing her own clothing and shoes

which were well-fitted and free of holes, stains, or tears. The resident interviewed appeared to have at least seven seasonal outfits of clothing appropriately stored in her dressers and closets.

The resident interviewed appeared to be clean and neatly groomed with clean face, hair, and clothes. When asked how often the resident took a shower or bath, the resident reported bathing "every morning." The resident stated there was enough hot water for her to shower comfortably and that she was able to get in and out of the shower at ease. The resident reported she received a clean bath towel "everyday." The resident reported that extra toilet paper was not stored in the bathroom; the resident reported that the home did not have extra toilet paper.

The following exceptions were noted.

- The resident who was interviewed reported not being able to stay home from the workshop when she is not feeling well.
- The resident reported wanting "dress clothes and shorts."

Spending allowances:

Both of the resident records contained information about the residents spending allowances. When interviewed, the resident stated she received a weekly allowance. The resident reported that she uses her money to go out to eat. When asked if she had anyone hold onto her money for her, the resident mentioned the staff.

Meal Observation

Team DD did not observe the dinner meal. The staff was preparing the meal during Team's visit. The posted meal was parmesan chicken, rice and gravy, fried or stewed squash, biscuit, fruit cocktail, iced tea, fruit punch, or water. Team DD asked the staff what residents with diabetes had for dessert and the staff mentioned fruit cocktail. The menu posted reflected a variety of foods. Team DD noted that the dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents.

When interviewed, the resident reported not having a choice to what foods she is served. The resident reported that the staff members do not take food requests prior to going to the grocery store and that she doesn't go to the grocery store with staff members. When asked if there were any foods her doctors told them she should avoid, the resident mentioned she was supposed to have diabetic foods. When asked about diet accommodations, the resident did not mention any. The resident interviewed stated that she received enough food. When asked if the resident's food was served at the appropriate temperature, the resident did not answer this question. The resident mentioned that if she didn't like what was being served that the staff would make her a peanut butter and jelly sandwich. When asked if there were any foods she would like to have that she currently isn't being served, the resident mentioned wanting shrimp.

Resident Interviews

Team DD members interviewed one resident. The resident interviewed stated she didn't like living at the home because she wants to live with her family members. When asked if she knew her rights, the resident said yes and was able to give examples. When asked whom she

spoke to if she had a problem, the resident mentioned the house manager. When asked what happened if they did not follow the facility's rules, the resident stated they would get written up. The resident reported not being locked outside the facility. When asked what she would change about the facility the resident mentioned wanting to "go out more." The one resident who was interviewed reported wanting to move.

The resident interviewed was asked about activities she did in and outside of the home. When asked if she worked, the resident reported attending an "adult daycare." The resident reported that she liked attending the "adult daycare." When asked about activities the resident did in the community, the resident reported going to church, going to the "Dollar Store", going out to eat at Hardees and Burger King, as well as going to Florence. The resident mentioned that they get to go to the places that they choose. The resident also reported going places with other people besides the other residents from the home. The resident reported having friends but that she didn't get to visit with her friends. The resident reported that she likes spending the night with her family. The resident reported that she has attended a self-advocacy group but that she didn't enjoy it.

The resident was also asked about activities she did in the home. The resident reported playing BINGO. When asked what activities she would like to do, the resident didn't mention any. When asked where the telephone they used was located, the resident mentioned a telephone in the office and kitchen. When asked if the home had any pets, the resident did not mention any.

The following exceptions were noted.

- The resident interviewed reported that the staff was not nice to them and did not treat her with respect. The resident could not give any examples of the staff's behavior. Additionally, the resident reported not feeling safe at night because staff slept.

- When asked if she was ever locked in rooms, the resident interviewed stated that the staff holds her bedroom door closed.

- The resident reported not having choices in what they want to do at the home. The resident stated that the home won't give her anything diabetic.

Team Advocacy DD Project Inspection for September 16, 2009
Kalmia Forest CTH II, Aiken, South Carolina

Facility Information

Kalmia Forest CTH II is located at 109 Kalmia Forest Drive, Aiken, South Carolina in Aiken County. The home is operated by Tri-Development Center of Aiken County, Inc. The home is licensed for 4 beds and at the time of Team DD's visit had a full house. The home was occupied by male residents. The home is a brick house in a neighborhood. Team DD members entered the home at 4:35 pm and exited the home at 6:43 pm. The Executive Director, Ralph Courtney arrived to the home shortly after Team DD's arrival. The exit interview was conducted with Mr. Courtney and two other staff members. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, medications, medication administration records (MARs), observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Fire hazards
- Maintenance
- Resident Rights

In addition to the above concerns, residents reported needing the following:

- Dental examination
- Clothing

Home Tour

When Team DD arrived, the residents were watching television. The home appeared to be homelike. The inside of the home had attractive and comfortable furniture for the residents' use. The living room area had comfortable-looking furniture and a television which one of the residents appeared to be enjoying. Team DD noted that all four of the residents' photographs were displayed on the fire place mantle. The home had a formal living room area with comfortable looking furniture and a computer for the residents use. The home was cheerfully decorated with appropriate seasonal decorations. The home had four bedrooms with one bed in each. The residents' bedrooms included furniture of their choice, stuffed animals, photographs, curios and individualized bed spreads. The residents' bedrooms were tidy. The home also had a back patio that overlooks the backyard. Team DD noted that one of the residents proudly mentioned mowing the home's lawn. The residents appeared to be able to access all areas of the home. The home did not have any ramps. However, none of the residents appeared to require a ramp. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The facility appeared to be clean and well-ventilated. The home's water temperature was noted to be within range when tested at 112.8°F. Team DD noted that the fire extinguisher was accessible and was last inspected 9/11/2009. Additionally, smoke detectors were noted in each of the four bedrooms. A complete first aid kit was located in the kitchen. Team DD noted that the house was equipped with operable flashlights. The residence was maintained at a comfortable temperature and was free of insect infestation.

There were emergency exit routes posted on the walls. The home had a written emergency evacuation plan which noted that residents would relocate to the Orangeburg County DDSN Board in the event of an emergency evacuation. The residence had an adequate supply of food on hand.

The following exceptions were noted:

- The formal living room had a lamp with plastic covering the lampshades.
- The hall bathroom's overhead light was dim. Team DD also noted that the commode's tank was without a cover.
- The couch in the living room was torn. Two of the lamps in the living room had plastic covering the lamp shade.
- There was a broken plastic lawn chair on the patio. Team DD noted that the chair had broken and sharp edges.

Medication Storage & Administration

The medications were not reviewed due to DDSN's position that consent is required for P&A to review records. Mr. Courtney would allow Team DD to review the medication and records with verbal consent. However, Team DD refused to get verbal consent to review the medications and records due to P&A's position on the access authority.

Residents' Records and Access to Healthcare

The residents' healthcare records were not reviewed because of DDSN's position on allowing P&A to review records without consent. Team DD did review two of the residents' support plans and behavioral support plans.

- Both of the residents' records reviewed contained current resident support plans.
- One of the two residents' records reviewed contained a behavioral support plan.
- One of the two residents' records noted the residents' diets. Resident A was noted to have a "regular" diet. Resident B diet was not noted in the records that Team DD reviewed.

- Neither of the resident records reviewed noted that there were any incident reports filed over the past year.

- One of the two residents' records noted that the resident attended a workshop.

When interviewed, residents stated they are transported to local doctor appointments by the home. Resident B reported needing a dental examination. Neither of the residents stated they have any problems getting transportation to medical appointments.

Residents' Clothing, Hygiene Supplies, & Special Equipment

Both of the residents interviewed stated they like their bedroom at the home; one resident reported liking his bedroom because of the television and his pictures. Both of the residents reported they were able to take a nap as they wish. One of the two residents reported being allowed to stay home from his workshop if he isn't feeling well. Neither of the residents had roommates. When asked how frequently their sheets were changed, both of the residents stated their sheets were changed weekly. Both residents reported they changed their own sheets. Team DD observed that the residents had clean bath and bed linens and that their bedrooms were clean and decorated with personal items.

When asked if they had enough clothing, both residents stated they did have enough clothing. When asked how frequently their clothes were washed, one resident stated his clothes were washed every Wednesday; the second resident did not know how often his clothes were washed. The residents interviewed appeared to be wearing their own clothing and shoes which were well-fitted and free of holes, stains, or tears. Both of the residents interviewed appeared to have at least seven seasonal outfits of clothing appropriately stored in their dressers and closets.

Both residents interviewed appeared to be clean and neatly groomed with clean faces, hair, and clothes. When asked how often the residents took a shower or bath, both residents stated bathing daily. Both residents stated there was enough hot water for them to shower comfortably and that they were able to get in and out of the shower at ease. One resident reported that he receives a clean bath towel as needed and one resident did not answer this question. Both residents reported having enough toilet paper which was kept in the bathrooms.

The following exceptions were noted:

- Resident A reported not being allowed to stay home for the day if he was sick.

- Both Residents A and B reported needing more shirts.

- Resident A reported needing a raincoat.

- Resident B reported needing new work shoes.

Spending allowances:

Both residents were noted to receive a personal needs allowance. When interviewed, both of the residents stated they received a weekly allowance. The residents reported spending their money to go out to eat and to purchase DVDs. When asked if they had anyone hold onto their money for them, one resident stated that "sometimes" the staff holds on to his money for him and the second resident reported that the staff holds onto his money for him.

Meal Observation

Team DD did not observe the dinner meal. The staff member was preparing the meal during Team DD's visit. Team DD asked the staff what residents with diabetes had for dessert and the staff member mentioned that the residents would be served fruits and sugar free items. The dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents.

When interviewed, both of the residents reported having a choice to what foods they are served. Both residents reported that staff members take food requests prior to going to the grocery store. Additionally, both of the residents reported going to the grocery store with staff members. When asked if there were any foods their doctors told them they should avoid, both residents reported they are supposed to stay away from fried foods. Additionally, one of the residents reported that they were allergic to nut products. Both of the residents reported that the home accommodates their diets. One of the two residents stated that their food was served at the right temperatures; one resident stated that they did not know if his food was served at the right temperatures. One of the two residents reported that they can get second helpings upon request; one resident stated they did not know if he could get second helpings. When asked if there were any foods they would like to have that they currently aren't being served, one resident mentioned wanting butterbeans and turnip greens.

Resident Interviews

Team DD members interviewed two residents. Both residents interviewed stated they liked living at the facility. Both residents reported that the staff members were nice to them and treated them with respect. When asked if they knew their rights, one resident said "yes but I have some doubt"; the second resident stated they did know his rights. Both residents reported that they felt safe at the facility. When asked whom they spoke to if they had a problem, one resident mentioned the house manager and the second resident mentioned the staff. When asked what happened if they did not follow the home's rules, one resident stated they would "tell somebody" and one resident stated they would get written up. The residents interviewed stated they were never locked out of the home or in certain rooms. Neither of the residents reported wanting to move.

The residents interviewed were asked about activities they did in and outside of the home. When asked if they worked, both residents reported having jobs cutting grass. Both residents reported getting paid for their work. One resident reported he liked attending the workshop, saying "its okay" and one resident reported not wanting to go to a workshop. When asked about activities the residents did in the community, one resident reported attending church; both residents reported going shopping at Wal-Mart; both

residents reported going out to eat at a Chinese restaurant; both residents mentioned going to parks; and one resident mentioned going bowling. One of the two resident mentioned that he gets to go to the places that he chooses. Both of the residents reported being allowed to visit their friends outside of the home. When asked if they went on vacation, one of the residents reported he was going on vacation soon for a bowling tournament. Both residents reported "sometimes" attending a self-advocacy group.

The residents were also asked about activities they did in the home. One resident reported they enjoyed watching television and being on the computer. The second resident reported he enjoyed watching television. When asked what activities they would like to do, one resident mentioned wanting to go to football games. When asked if they had any visitors, one of the residents mentioned that they had family members visit them at the home; the second resident stated that his girlfriend calls him at the home. When asked where the telephone they used was located, one resident mentioned that he had his own phone and the second resident mentioned using the phone in the kitchen. When asked if the home had any pets, one resident mentioned a cat (Note: Team DD verified that the cat had up-to-date vaccinations).

The following exceptions were noted:

- Resident A reported not being allowed to choose the restaurants when going out to eat.
- Resident B reported not being able to go places with the people he chooses.

Team Advocacy DD Project Inspection for July 29, 2009
Laurens Street CTH II, Joanna, South Carolina

Facility Information

Lauren's Street CTH II is located at 417 Laurens Street, Joanna, South Carolina in Laurens County. The home is operated by the Laurens County DDSN Board. The home is licensed for 4 beds and at the time of Team DD's visit had a full house. The home was occupied by female residents. The home is a brick house in a neighborhood. Team DD members entered the home at 4:25 pm and exited the facility at 6:20 pm. The house manager, Teresa Anderson was not present during Team DD's inspection. However, Ms. Anderson was available via telephone. The exit interview was conducted with one of the two staff members. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, medications, medication administration records (MARs), observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Fire hazards
- Staff training
- Medication storage
- Resident reported needing clothing
- Financial
- Meal observation

Home Tour

When Team DD arrived, the residents had just returned from their workshop. The residents arrived to the home in the home's van. The residents were served a snack which consisted of peanut butter crackers and water. The home appeared to be homelike. The inside of the home had attractive and comfortable furniture for the residents' use. The living room area had comfortable and attractive furniture, a television which one of the residents appeared to be enjoying, several live plants, and photographs of the residents hanging from the wall. The home had wide hallways which were accessible. Team DD noted three bathrooms in the facility; one of the bathrooms was for staff members. The residents' bathrooms were connected to each bedroom. Both bathrooms were accessible with roll-in showers. The home was cheerfully decorated with appropriate seasonal decorations. The home had four bedrooms with one bed in each bedroom. The residents' bedrooms included furniture of their choice, stuffed animals, curios, and individualized bed spreads. The residents' bedrooms were tidy. The rear exterior of the home had a patio with four rocking chairs. The residents appeared to be able to access all areas of the home. The garage and back entryways were leveled and accessible. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The facility appeared to be clean and well-ventilated. The residence water temperature was noted to be within range when tested at 113.3°F. The home was free of obvious fire hazards. Team DD also noted that the fire extinguishers were accessible and was last inspected July/2009. A complete first aid kit was located in the office area. The home was also equipped with an operable flashlight in each bedroom. The home was properly lighted. The residence was maintained at a comfortable temperature and was free of insect infestation.

There were emergency exit routes posted on the walls. The home had a written evacuation plan which noted that residents would relocate to Furguson CTH II or a local hotel in the event of an emergency evacuation. The residence had a substantial supply of food on hand.

The following exceptions were noted.

- The rear patio was noted to have several cigarette butts on the ground. The patio did not have a place to properly discard the cigarette butts and ashes. Team DD noted that one of the residents smoked cigarettes.

- The staff appeared to have last been trained in CPR on 4/4/2007.

Medication Storage & Administration

Medications were stored in a locked filing cabinet in the office area. The medication area was free of loose pills or spills. Neither of the residents whose records were reviewed was prescribed controlled medications. The medication administration record (MAR) was accurate and current.

The following exception was noted.

- The insulin lock box in the refrigerator had a broken lock. Therefore, the lockbox was not locked.

Residents' Records and Access to Healthcare

Two resident records were reviewed and both residents who were present agreed to be interviewed.

- Both resident records contained documentation of a physical examination within the past year.

- Both resident records contained documentation of other medical examinations such as dental appointments, vision appointments, urology appointments, pelvic examinations, and mammograms.

- Both of the resident records noted whether the residents had a health care power of attorney or other advance directive. Resident A was noted to have a power of attorney and Resident B was noted to have a guardianship.

- Both of the resident records reviewed noted the resident had received an annual tuberculin skin test.

- Both of the residents' records reviewed contained current resident support plans.
- Both of the residents' records reviewed contained a behavioral support plan.
- Both residents' records noted the residents' diets. Resident A was noted to have a 1500 calorie diet (staff are to chop all meats, hard vegetables, and fruit into dime sized pieces. Use regular knife to chop food) and Resident B was noted to have a low carbohydrate diet and a diabetic diet.
- Both of the resident records reviewed noted that there were several incident reports filed over the past year.
- Both residents' records noted that the residents attended a workshop.

When interviewed, one resident stated they are transported to local doctor appointments by the staff; one resident did not answer this question. None of the residents reported needing any medical examinations. Neither of the residents stated that they have any problems getting transportation to medical appointments.

Residents' Clothing, Hygiene Supplies, & Special Equipment

Both of the residents interviewed stated they like their bedroom at the home. Both of the residents reported they were able to take a nap as they wish. One of the two residents reported being allowed to stay home from their workshop if they aren't feeling well. Neither of the residents had roommates. When asked how frequently their sheets were changed, both residents stated "Saturdays". One of the residents reported that staff members changed their sheets for them; the second resident stated that they changed their own sheets. Team DD observed that the residents had clean bath and bed linens and that their bedrooms were clean and decorated with personal items such as photographs and stuffed animals.

When asked if they had enough clothing, one of the residents stated they did have enough clothing. When asked how frequently their clothes were washed, one resident stated her clothes were washed on Thursdays and one resident did not answer this question. The residents interviewed appeared to be wearing their own clothing and shoes which were well-fitted and free of holes, stains, or tears. Both of the residents interviewed appeared to have at least seven seasonal outfits of clothing appropriately stored in their dressers and closets.

Both residents interviewed appeared to be clean and neatly groomed with clean faces, hair, and clothes. When asked how often the residents took a shower or bath, one resident stated "two times a day" and one resident stated that she bathes daily. Both residents stated there was enough hot water for them to shower comfortably and that they were able to get in and out of the shower at ease. Residents reported they received a clean bath towel every time they bathed and that they had enough toilet paper which was kept in the bathrooms.

The following exception was noted.

- One of the residents reported not being able to stay home from their workshop when they aren't feeling well.

- Resident A reported needing pajamas, socks, bras, soap, and shampoo.

Spending allowances:

Team DD noted that the records contained documentation regarding the residents spending allowances. When interviewed, both of the residents stated they received a weekly allowance. The residents reported spending their money on crossword puzzles and one resident showed Team DD members her bottle of orange soda in the refrigerator. When asked if they had anyone hold onto their money for them, one resident mentioned the staff.

The following exception was noted.

- Resident A reported receiving $7 weekly. However, the resident's records noted she received $14 weekly.

Meal Observation

Team DD observed the dinner meal. The posted meal was turkey sandwiches, mixed vegetables, cinnamon apples, and water. Team DD asked the staff what residents with diabetes had for dessert and the staff member sugar free pudding. The menu posted reflected a variety of foods. The residents were served the posted meal. The meal served looked appetizing, smelled good, and was served at the appropriate temperature. Second helpings were not available in the kitchen. Appropriate condiments were not available for the residents at the tables. The residents were afforded enough time to safely eat. The dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents.

When interviewed, both residents reported that staff members take food requests prior to going to the grocery store. Neither resident reported going to the grocery store with staff members. One of the two residents mentioned liking the choice in foods that they eat. When asked if there were supposed to have a diabetic diet. Both residents stated that their food was served at the right temperatures. One resident mentioned that they can get a snack upon request. When asked if there were any foods they would like to have that they currently aren't being served, neither of the residents mentioned any.

The following exception was noted.

- Team DD noted that Resident A's food was not chopped up. As noted above, the resident's records required staff to chop all meats, hard vegetables, and fruit into dime sized pieces.

Resident Interviews

Team DD members interviewed two residents. One of the residents interviewed stated they liked living at the facility. The second resident stated that one of their housemates "gets on my nerves." One of the two residents stated that the staff was nice to them; one resident stated that they didn't like a staff member because the staff member wakes her up too early. Both

residents reported that the staff treated them with respect. When asked if they knew their rights, one resident stated they did and one resident did not answer this question. Both residents reported that they felt safe at the facility. When asked whom they spoke to if they had a problem, one resident mentioned the staff and one resident did not answer this question. When asked what happened if they did not follow the facility's rules, one resident stated they would "get it trouble I guess" and one resident did not answer this question. The residents interviewed stated they were never locked out of the home or in certain rooms. Both residents reported wanting to move.

The residents interviewed were asked about activities they did in and outside of the home. When asked if they worked, both residents mentioned attending a workshop. Both residents reported getting paid for their work. Both residents reported they liked attending the workshop. However, one resident mentioned wanting to work outside of the workshop. When asked about activities the residents did in the community, one resident reported going shopping at Wal-Mart and going out to eat; one resident reported going shopping, out to eat, and to parks. Both residents mentioned that they get to go to the places that they choose. Neither of the residents reported going places with other people besides the other residents from the home. One of the residents reported going on vacation at her family's house. One of the two residents reported that she spends the night off with family members. Neither resident reported attending a self-advocacy group. When asked if there were any activities they would like to do, one resident mentioned wanting to go to the beach and Disney World.

The residents were also asked about activities they did in the home. Both residents reported watching television. Additionally, one resident reported working on crossword puzzles at home. One of the residents mentioned that they had family members visit them at the home; the second resident stated that the staff members take them to her parent's home in Columbia. When asked where the telephone they used was located, one resident mentioned the telephone in the office and one resident did not answer this question. When asked if the home had any pets, one resident mentioned a stray cat outside.

Team Advocacy DD Inspection for May 19, 2010
Linsbury Circle CTH II, Columbia, SC

Team Advocacy DD Project Report by Susan Perry; inspection by Susan Perry & Phyllis Ross

Facility Information:

Linsbury Circle CTH II is located at 330 Linsbury Circle, Columbia, SC in Richland County. Burton Center operates the home. The home is licensed for four beds. On the day of inspection, all beds were occupied with male residents. The home is a brick structure in a nice residential neighborhood. Team DD entered the home at 3:50 p.m. and left the home at 7:40 p.m. The residents were not at the home when Team DD arrived but came in at 4:08 p.m. James Barton, staff, was present during the entire inspection. Linda Gault, Operations Director, was called and stopped by the home during the inspection. Team DD was told Freddie Tucker is the house manager.

Overview:

This report contains information gathered from touring the home, reviewing residents' records, observations made while at the home, interviews conducted with residents, and conversations with the staff and individuals living in the home.

Home Tour:

Team DD arrived after second shift began. The men had not returned from day activities but came in shortly after we arrived. There were steps leading to the front entrance door. There was not a handrail on the steps. The front door opened into a wide foyer that had hardwood floors.

- To the left was a formal dining area with hardwood floors. There was a formal dining room table nicely decorated with place settings, and a matching buffet console.
- To the left of the dining area was a small office for staff. The office had hardwood floors.
- The kitchen had linoleum floors with counters and cabinets along both sides of the kitchen. A stove and refrigerator were on the right side, with a sink and dishwasher on the left side. The refrigerator and the kitchen cabinets were well stocked. Mr. Barton was cooking the dinner meal, which was a chicken and rice casserole.
- To the left of the kitchen was a hall with a half bath and a mudroom with a washer and dryer. The cabinets in the mudroom were locked. At the end of the hall, a door opened

to the backyard. At the other end of the hall, a door opened to a double car garage.

- The Kitchen also had a dining area. It was spacious and had a large dining table and six chairs. The table was set with dishes, napkins, and placemats. There was a matching buffet in the kitchen dining area. There was a large bowl of fresh fruit on the buffet. The dining area was surrounded by large glass windows looking out to the backyard.
- Off of the kitchen/dining area was a step-down game room. There was a large television with gaming devices, a pool table, a computer with a desk & chair, and four barstools. The room was carpeted.
- There is a screened in back porch off of the kitchen and game room. There were five old-fashioned porch rockers on the porch. There were two ceiling fans on the porch. The porch overlooks the entire backyard, which is on a creek. There was a large grill in the backyard. The staff told Team DD that the other CTH homes come to Linsbury for gatherings and cookouts.
- The den was connected to the kitchen/dining area. The den had a blue print sofa, love seat, matching chair and huge ottoman. Built-in shelves were on one end of the den. A television was on the shelf. The den had wooden paneling and carpet.
- The hall had hardwood flooring. There were linen closets along the hall.
- There was a black and gray tiled bathroom off the hall to the left. The bathroom had a large counter with a sink, a toilet, a bathtub with shower, and a large linen closet.
- There were four bedrooms at the end of the hall, one person per room. Each person had purchased his own furniture, which consisted of a bed, chest of drawers, dresser, nightstand, television, and stereo system.
    - Bedroom #1 was in the front of the house, right side of the hall. There was a four poster bed with a queen size mattress.
    - Bedroom #2 was the second bedroom on the right of the hall. There was a large king size bed. The room was personalized with the individual's preference of college team memorabilia, and pictures.
    - Bedroom #3 was on the right as you turn left to an extended hall. The individual had personalized his room with a comfortable chair in which to sit and watch TV.

- Bedroom #4 was at the end of the extended hall. A huge walk-in closet was neatly arranged with everything in its place. The individual showed Team DD his extensive stereo system and a keyboard. He was proud to show off his queen size bed decorated with the Palmetto Tree theme. He had new carpet in his room and told Team DD that he keeps everything in its place. There were a lot of pictures of the individual and his family. From the bedroom was a door leading to the backyard. There was a small deck at the top of the stairs that led to the yard. The individual living in this room stated he does not use this door; he goes out the other way.
    - A full bath is adjacent to this bedroom. The bathroom has a tub with a shower, a cabinet holding a sink, a toilet and a linen closet. The bathroom was tiled.
- Another green tiled bathroom was located across from bedroom #3. The bathroom has a sink, a tub with shower and a toilet.

Infection Control, Sanitation and Healthy/Safety:

The home was well ventilated. The thermostat was set on 75°. The fire extinguisher was accessible and last inspected April 2010. The smoke detector was working. The first aid kit was organized. Staff stated they have a hard time keeping band aids because one individual always wants one if they are available. Emergency exit routes were posted. The home had a written evacuation plan, which was contingent upon decisions by administrators. All of the instructions referred to going to Newberry and places in that vicinity. Team DD discussed the plan with staff and noted the plan might need to be updated to include areas in the Columbia area. The home water temperature was within the normal range. Mr. Barton had received CPR & First Aid training on October 7, 2009, and June 16, 2009.

Medication Storage & Administration:

The medications were not reviewed due to DDSN's position that consent is required for P&A to review medical records.

Team Advocacy DD Inspection for May 19, 2010
Linsbury Circle CTH II, Columbia, SC

Residents' Records and Access to Healthcare:

Two individuals' records were reviewed and both residents were present and were interviewed. The individuals' medical records were not reviewed due to DDSN's position that consent is required for P&A to review medical records.

- Neither of the individuals' records had a health care power of attorney or other advance directive.
- Both individuals' records contained a current residential support plan and a Behavior Support Plan.
- Individual A had a 1600 calorie diet. Individual B had a regular diet.
- No incident reports were on file at the home; they are kept at the main office.
- Both individuals attend a workshop during the day.

During the interview, both individuals stated that the home transports them to local doctor appointments. When asked if they needed any medical appointments, Individual B stated he needed to go to the eye doctor to get new glasses, because he broke his other pair, and to the dentist. Team DD could not confirm the accuracy of this information since DDSN has blocked access to medical records. Neither stated they have any problem getting transportation to medical appointments. They "LOVE" their rooms and stated they can take a nap if they want to rest. Neither reported needing to stay home because they are sick. They both report they want to go to work so they can make money.

Note according to the records review:

- Individual B last had a vision exam on May 26, 2009, and a dental exam on January 21, 2010.

Residents' Clothing, Hygiene, Supplies, & Special Equipment:

Both of the individuals interviewed reported wearing glasses. Both individuals stated they change their linens once a week. Both individuals stated they take a bath every day and get fresh towels

when they bathe. Individual A stated the water gets cold every time he bathes. Individual B stated he has plenty of hot water.

Individual A reported he would like to have more shoes; Team DD counted 20 pairs of shoes in his closet. He also would like to have more coats; Team DD noted there were multiple coats in his closet. Individual B reported that he did not need any more clothes.

Team DD noted that all of the men in the home appeared to be well dressed, clean, and neat. Team DD noted in the records review of the sample individuals that both individuals shop at nicer department stores and wear name brand clothing. Receipts and price tags were secured in the notebook reviewed. Staff stated the men work and have money so that they can afford to shop where they choose.

Spending Allowances:

- Individual A reported he receives $150.00 per month spending money. He receives assistance with his money. He spends his money on CDs, CD player and shoes.

- Individual B reported he receives $30.00 per week spending money. He does not receive help handling this money.

Meal Observation:

Team DD did not observe snacks during the inspection. Team DD noted that some of the individuals were going to get snacks until they found out there was someone there that wanted to talk to them so they did not go get a snack. The snacks posted on the menu were a fresh fruit or choice from the snack list.

Menus represented a balanced diet with food from four food groups. There was a variety of meals listed on the menus. The posted dinner menu was chicken pot pie with black eyed peas, cantaloupe or other fresh fruit, tea and water. The dinner menu served was chicken and rice casserole with cheese, black eyed peas, peaches, milk, and water. The men set the dining table independently. Mr. Barton served the plates and each individual took his plate to the table. All the men waited until everyone was served and sitting at the table before they said the blessing. Mr. Barton fixed his plate and joined the men for dinner. Team DD noted the food smelled good and looked very appetizing. Second servings were allowed depending upon diet restrictions.

Both individuals interviewed stated they have a choice in the food they eat. Both stated they go with staff to the grocery stores and can choose foods they want. Both reported that they get plenty to eat and the foods are served at the right temperatures. If individuals don't like what is being served, they can ask for something different. Individual A stated he would like to have "tater pie" when asked if there is food you'd like to have that you are not having now.

Resident Interviews:

Team DD interviewed two individuals. Both individuals stated that they really like where they live. Both reported that staff "Jamillah, James, Freda, Rosa" are helpful, nice to them, "never yell", and treat them with respect. Both stated that nobody breaks the house rules but if they did, they would have to clean house. When asked if they wanted to move, the response from Individual B was "absolutely not." Neither individual reported wanting to live anywhere other than where they are. Both individuals like their rooms and Individual B stated his room was "beautiful."

Everyone in the home talked about their recent week-long cruise on the Carnival Cruise Ship to the Caribbean. The men stated they "didn't want to leave." Staff stated they take nice vacations every year, last year they went to Pigeon Forge, Tennessee, and two years ago, they went to Hawaii. The men in the home are excited about planning a trip this summer to Myrtle Beach, SC.

Both individuals interviewed stated they did not have enough paid work to do at the workshop. They both attend day work programs. Individual B stated that there isn't any work at Williams Street; they "just sit and talk." Individual A stated they "sit down and do nothing" at his day program. Both stated that they like going to the workshop.

Both individuals interviewed stated that they know their rights and feel safe. Neither reported ever being locked in a room or out of the home. Both individuals stated they are given choices. Individual A and B stated that they attend the church of their choice. Team DD noted that they attend different churches.

Team DD noted the interaction between the men living in the home and the staff was one of mutual respect. Team DD was impressed that the men living in the home do their housework with little guidance from staff. Each individual in the home keeps his own room, chooses

bedroom furniture and accessories he likes, purchases his own clothes, and takes nice vacations.

Team Advocacy DD Project Inspection for July 7, 2009
Martha Bauer CTH II, Due West, South Carolina

Facility Information

Martha Bauer CTH II is located at 14 Beulah/Mills Street, Due West, South Carolina in Abbeville County. The home is operated by the Burton Center. The home is licensed for 3 beds and at the time of Team DD's visit had a full house. The home was occupied by male residents. The home is a house in a neighborhood. Additionally, the home is next door to another CTH II, Gordon Street CTH II. Team DD members entered the home at 4:04 pm and exited the facility at 5:49 pm. The house manager, Annie Moss was not present during Team DD's inspection but was available via telephone. The exit interview was conducted with the one staff member who was present. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, medications, medication administration records (MARs), observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Moldy foods
- Posted diets
- Staff schedule
- Posted menu
- Resident Safety
- Resident reported needing a coat/jacket
- Resident reported needing medical examinations

Home Tour

When Team DD arrived, all of the residents were in their bedrooms watching television and/or resting. The residents had just returned from their workshop. The home appeared to be homelike. The front porch had a few rocking chairs and was neatly kept. The back porch had a picnic table, a few chairs, and a grill. The living room area had comfortable and attractive furniture as well as a television. Team DD noted that the home had two and a half bathrooms with one of them being an accessible bathroom with a large roll-in shower. The home was cheerfully decorated with appropriate seasonal decorations. The home had three bedrooms with one bed in each. The residents' bedrooms included furniture of their choice, stuffed animals, curios, and individualized bed spreads. The residents' bedrooms were tidy. The residents appeared to be able to access all areas of the home. The side entryway featured a ramp which was gradual and accessible. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The facility appeared to be clean and well-ventilated. The residence water temperature was noted to be within range when tested at 101.3°F. The home was free of obvious fire hazards. Team DD also noted that the fire extinguisher was accessible and was last inspected July 2009. Additionally, smoke detectors were noted in each of the three bedrooms; the smoke detectors had labels that indicated that the batteries were last changed 8/2007 and 9/2007. A complete first aid kit was located in the medication closet. Each of the three bedrooms was also equipped with an operable flashlight. The home was properly lighted. The residence was maintained at a comfortable temperature and was free of insect infestation. The staff had documentation of training in first aid and CPR which was noted to be current.

There were emergency exit routes posted on the walls. The home had a written evacuation plan which noted that residents would relocate to the local workshop in Ware Shoals in the event of an emergency evacuation. The residence had an adequate supply of food on hand.

The following exceptions were noted.

- In the refrigerator there was a package of squash with mold.
- Resident B's diet was not posted in the kitchen (Note: the resident was noted to have a "restricted" diet in his records). Team noted that both of the other residents' diets were posted in addition to a former resident's diet.
- The supply closet was unlocked during Team DD's visit. The supply closet stored a number of chemicals such as bleach, laundry detergent, and odor deodorizers.
- There were two rusty gardening tools propped up against the house on the back patio. Team DD noted that one of the gardening tools was broken.
- The linoleum flooring was torn between the kitchen and dining room.
- The staff's schedule was not posted. Team noted that the schedule for the CTH II next door was available.

Medication Storage & Administration

Medications were stored in locked tackle boxes in the closet in the hallway. The medication area was free of loose pills or spills. Neither of the residents whose records were reviewed was prescribed controlled medications. The medication administration record (MAR) was accurate and current.

Residents' Records and Access to Healthcare

Two resident records were reviewed and both residents who were present agreed to be interviewed. One resident in Team DD's sample appeared to understand the questions and responded verbally. One resident answered, "Yes" to most questions; the resident also communicated by nodding.

- Both resident records contained documentation of a physical examination within the past year.

- Both resident records contained documentation of other medical examinations. Resident A had three other medical examinations within the past year such as a podiatry examination, vision examination, and a dental examination. Resident B also had other medical examinations such as a dental examination, eye examination, podiatry examination, and an oncology appointment.

- Both of the resident records noted whether the residents had a health care power of attorney or other advance directive. Neither resident had any advance directives.

- Both of the resident records reviewed noted the resident had received a tuberculin skin test or chest x ray.

- Both of the residents' records reviewed contained current resident support plans.

- Neither of the residents' records reviewed contained a behavioral support plan. Both residents were noted to not need a behavioral support plan.

- Both residents' records noted the residents' diets. Resident A was noted to have a *regular* diet and Resident B was noted to have a "restricted" diet.

- Both of the resident records reviewed noted that there were incident reports filed over the past year. Resident A was noted to have three incidents within the past year and Resident B was noted to have four incidents within the past year.

- Both residents' records noted that the residents attended a workshop.

When interviewed, residents communicated that they are transported to local doctor appointments by the home. Resident B reported needing an eye, dental, and podiatry examination. One of the residents stated that they did not have any problems getting transportation to medical appointments; one resident did not answer this question.

Residents' Clothing, Hygiene Supplies, & Special Equipment

One of the two residents interviewed stated he liked his bedroom at the facility; one resident reported that they did not like his bedroom because "staff has to check on you." Both of the residents reported they were able to take a nap as they wish. One of the two residents reported being allowed to stay home from their workshop if they aren't feeling well. Neither of the residents had roommates. When asked how frequently their sheets were changed, one resident reported that he changes his sheets every three month; one resident did not answer this question. Team DD observed that the residents had clean bath and bed linens and that their bedrooms were clean and decorated with personal items.

When asked if they had enough clothing, both residents stated they did have enough clothing. When asked how frequently their clothes were washed, one resident stated his clothes

were washed "everyday"; one resident did not answer this question. The residents interviewed appeared to be wearing their own clothing and shoes which were well-fitted and free of holes, stains, or tears. Both of the residents interviewed appeared to have at least seven seasonal outfits of clothing appropriately stored in their dressers and closets.

Both residents interviewed appeared to be clean and neatly groomed with clean faces, hair, and clothes. When asked how often the residents took a shower or bath, one resident stated bathing "everyday"; the second resident nodded yes when asked if he bathed daily. One of the two residents stated there was enough hot water for them to shower comfortably; one resident stated that his shower was "sometimes cold." Both residents stated that they were able to get in and out of the shower at ease. One of the two residents reported they received a clean bath towel "everyday"; one resident did not answer this question. One of the two residents stated that they had enough toilet paper which was kept in the bathrooms; when Team DD asked this question, one resident showed Team DD members his bathroom. Team DD noted that extra toilet paper was stored in the accessible bathroom.

The following exceptions were noted.

- One of the residents reported not being allowed to stay home from his workshop if he wasn't feeling well.
- Resident B reported needing a new jacket/coat.

Spending allowances:

Both residents whose records were reviewed contained financial information. Both residents were noted to receive a weekly allowance. The staff stated that the residents' funds were stored at First Citizens Bank.

When interviewed, both of the residents communicated that they received a weekly allowance. One resident reported spending his money on "games" and one resident reported spending his money on "anything." When asked if they had anyone hold onto their money for them, one resident mentioned staff.

Meal Observation

Team DD observed the dinner meal. The menu was not posted. Staff provided Team DD members with the menu for the week of Team DD's visit. The menu noted that the meal was cucumber and lettuce salad and sugar free banana pudding. Team DD asked the staff what residents with diabetes had for dessert and the staff member mentioned sugar free items. The residents were served hamburger, Waldorf salad, ice cream, and iced tea. The meal served looked appetizing, smelled good, and was served at the appropriate temperature. Second helpings were not available in the kitchen. Appropriate condiments were available for the residents at the tables including salt. The residents were afforded enough time to safely eat. The dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents.

When interviewed, both of the residents reported having a choice as to what foods they are served. One of the two residents reported that staff members take food requests prior to going to the grocery store; one resident did not answer this question. One of the residents reported that the staff did not take them to the grocery store; one resident did not answer this question. Both

residents reported receiving enough food to eat. When asked if there were any foods their doctors told them they should avoid, one resident stated that they weren't supposed to have sweets. The resident reported that food substitutes are given to him such as sugar free ice cream. One of the two residents stated that their food was served at the right temperatures; one resident did not answer this question. When asked if there were any foods they would like to have that they currently aren't being served, one resident mentioned that they like "all foods."

The following exception was noted.

- The menu was not posted.

Resident Interviews

Team DD members interviewed two residents. Both residents interviewed stated they liked living at the facility. Both residents reported that the staff was nice to them and treated them with respect. Both residents reported feeling safe at the home. When asked if they knew their rights, one of the residents mentioned knowing his rights; one resident did not answer this question. When asked whom they spoke to if they had a problem, one resident mentioned the staff; the second resident did not answer this question. When asked what happened if they did not follow the facility's rules, one resident stated they would get written up; one resident did not answer this question. Both residents reported having chores at the home. When asked what they would change about the facility, one resident mentioned that he would live on his own. One of the two residents reported wanting to move. When asked if they wanted to move, one resident communicated "yes" to this answer.

The residents interviewed were asked about activities they did in and outside of the home. When asked if they worked, both residents reported working; one resident reported working at Fuji Cameras. One of the two residents reported getting paid for their work; one resident did not answer this question. Both residents reported they liked attending the workshop. When asked about activities the residents did in the community, both residents reported attending church, going shopping at stores such as Wal-Mart, and going out to eat at Ryan's. One resident reported going to the park. One of the two residents mentioned that they get to go to the places that they choose; one resident did not answer this question. One of the two residents reported going places with other people besides the other residents from the home; one resident did not answer this question. Both of the residents reported visiting their friends. One of the two residents reported going on vacation. One of the two residents reported that he spends the night out with family/friends; one resident did not answer this question. One of the two residents reported attending a self-advocacy group; one resident did not answer this question.

The residents were also asked about activities they did in the home. One resident reported watching television, playing BINGO, cards, and board games. The second resident reported watching television, listening to the radio, and playing games. When asked what activities they would like to do, one resident mentioned wanting to go on vacation to Disney World. One of the residents mentioned that they had family members and friends visit them at the home; the second resident stated they did not have any visitors. When asked where the telephone they used was located, one resident mentioned the telephone in the living room and one resident appeared to not know where the telephone was located. When asked if the home had any pets, one resident stated that they did not have any pets; one resident did not answer this question.

The following exception was noted.

- Both residents mentioned being locked out of the home or in certain rooms. One resident mentioned that they were "accidently" locked our but staff let him back in. The second resident was not able to communicate any examples.

Team Advocacy DD Project Inspection for June 15, 2009
Sam Smith CTH II, Sumter, South Carolina

Facility Information

Sam Smith CTH II is located at 1 Sam Smith Street, Sumter, South Carolina in Sumter County. The home is operated by the Sumter County DDSN Board. The home is licensed for 4 beds and at the time of Team DD's visit had a full house. The home was occupied by male residents. The home is a brick house in a neighborhood. Team DD members entered the home at 4:18 pm and exited the facility at 6:19 pm. The house manager, Sheila Bell was not present during Team DD's inspection. The exit interview was conducted with one of the two staff members. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, medications, medication administration records (MARs), observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Staffing
- Expired foods
- Maintenance
- Records
- Residents reported needing medical examinations
- Resident reported needing assistance
- Financial request
- Resident Rights
- Resident Safety/Abuse Allegation

Home Tour

When Team DD arrived, the residents had just returned from their workshop. As Team DD arrived, one resident was exiting the home's van while the other three residents were entering the home. The residents were served a snack which consisted of iced tea, cookies, and one resident was observed eating chips and a soda. The home appeared to be homelike. The inside of the home had attractive and comfortable furniture for the residents' use. The living room area had comfortable and attractive furniture and a television which one of the residents appeared to be enjoying. The home had wide hallways which were accessible. Team DD noted two bathrooms with one of them being an accessible bathroom with a large roll-in shower. The home was cheerfully decorated with appropriate seasonal decorations. The home had four bedrooms with one bed in each. The residents' bedrooms included double beds with furniture of their choice, stuffed animals, curios, individualized bed spreads, and one resident was noted to have a small fish aquarium. The residents' bedrooms were tidy. The home also had a screened porch with a table and chairs; one resident appeared to discard his/her cigarette butts in an

appropriate container. The residents appeared to be able to access all areas of the home. The entryways featured ramps which were gradual and accessible. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The facility appeared to be clean and well-ventilated. The residence water temperature was noted to be within range when tested at 115.7°F. The home was free of obvious fire hazards. Team DD also noted that the fire extinguisher was accessible and was last inspected 5/15/2009. Additionally, smoke detectors were noted in each of the four bedrooms. A complete first aid kit was located in the laundry room/office area. Each of the four rooms was also equipped with an operable flashlight. The home was properly lighted. The residence was maintained at a comfortable temperature and was free of insect infestation.

There were emergency exit routes posted on the walls. The home had a written evacuation plan which noted that residents would relocate to the local DDSN workshop, Sumter Work Enterprise in the event of an emergency evacuation. The residence had a substantial supply of food on hand.

The following exceptions were noted.

- There was no documentation in the home of staff training in first aid and CPR.
- In the refrigerator, there was a 16 ounce container of sour cream which had an expiration date of May 23, 2009. Additionally, there was a 32 ounce container of low fat plain yogurt with an expiration date of May 28, 2009.
- Bedroom # 1 closet door was detached from the closet frame and was propped up against the wall.
- Bedroom #3 had a lamp without a lampshade. Team DD noted that the lampshade's frame still remained on the lamp. Team DD noted that the frame was sharp and protruded out. Staff removed the lampshade's frame during Team DD's visit.
- A clothes iron was stored in the front hall closet.

Medication Storage & Administration

Medications were stored in a locked filing cabinet in the laundry room/office area. The medication area was free of loose pills or spills. Neither of the residents whose records were reviewed was prescribed controlled medications. The medication administration record (MAR) was accurate and current.

Residents' Records and Access to Healthcare

Two resident records were reviewed and both residents who were present agreed to be interviewed.

- Both resident records contained documentation of a physical examination within the past year.

- Both resident records contained documentation of other medical examinations. Resident A had three other medical examinations within the past year such as a podiatry examination, vision examination, and an OT visit. Resident B had several other medical examinations such as a podiatry examination, dental examination, vision examination, cardiology examination, and a hearing examination.

- Both of the resident records noted whether the residents had a health care power of attorney or other advance directive. Neither resident had any advance directives.

- One of the two resident records reviewed noted the resident had received a tuberculin skin test or chest x ray. Resident B's records did not contain documentation of a tuberculin test.

- Both of the residents' records reviewed contained current resident support plans.

- One of the two residents' records reviewed contained a behavioral support plan.

- Both residents' records noted the residents' diets. Resident A was noted to have a 1500 calorie diabetic diet, low fat diet, low sodium diet, and a low cholesterol diet. Resident B was noted to have an 1800 calorie diet, low cholesterol diet, and a low sodium diet.

- Neither of the resident records reviewed noted that there were any incident reports filed over the past year.

- Both residents' records noted that the residents attended a workshop.

When interviewed, residents stated they are transported to local doctor appointments by the home. Resident A reported needing an eye and dental examination and Resident B was reported needing a podiatry examination. Neither of the residents stated that they have any problems getting transportation to medical appointments.

Residents' Clothing, Hygiene Supplies, & Special Equipment

Both of the residents interviewed stated they like their bedroom at the facility; one resident reported liking his bedroom because of the "back porch" and one resident stated they liked their bedroom because it was "big" and could hold all of his stuff. Both of the residents reported they were able to take a nap as they wish. Both residents reported being allowed to stay home from their workshop if they aren't feeling well. Neither of the residents had roommates. When asked how frequently their sheets were changed, one resident stated his sheets were changed once a week and the second resident did not know how often his sheets were changed. Both residents reported that staff members changed their sheets for them. Team DD observed that the residents had clean bath and bed linens and that their bedrooms were clean and decorated with personal items.

When asked if they had enough clothing, both residents stated they did have enough clothing. When asked how frequently their clothes were washed, one resident stated his clothes were washed daily and one resident stated his clothes were washed three times a week. The residents interviewed appeared to be wearing their own clothing and shoes which were well-fitted and free of holes, stains,

or tears. Both of the residents interviewed appeared to have at least seven seasonal outfits of clothing appropriately stored in their dressers and closets.

Both residents interviewed appeared to be clean and neatly groomed with clean faces, hair, and clothes. When asked how often the residents took a shower or bath, one resident stated "every night and morning" and one resident stated that he tries to bathe twice a day. Team DD noted that a staff member was assisting residents with bathing during this visit. Both residents stated there was enough hot water for them to shower comfortably and that they were able to get in and out of the shower at ease. Residents reported they received a clean bath towel every time they bathed and that they had enough toilet paper which was kept in the bathrooms.

The following exception was noted.

- Resident A reported that "nobody" helps him with putting on his socks. The resident mentioned that he cannot put on his socks without assistance. The resident was without socks on during Team DD's visit.

Spending allowances:

Team DD noted that the staff reported that the residents' checkbooks were kept at the main office. Additionally, the staff reported that both residents received a weekly allowance. When interviewed, both of the residents stated they received a weekly allowance. The residents reported spending their money on snacks and one resident reported going to "Chuck E Cheese's" with their weekly allowance. When asked if they had anyone hold onto their money for them, neither of the residents mentioned anyone.

The following exception was noted.

- Resident B reported wanting a higher wage at the workshop. The resident also mentioned wanting more allowance.

Meal Observation

Team DD observed the dinner meal. The posted meal was beef vegetable stew, biscuit, pear salad, reduced fat milk or water. Team DD asked the staff what residents with diabetes had for dessert and the staff member mentioned fruit. The menu posted reflected a variety of foods. The residents were served beef stew, dinner rolls, white rice, pears and cottage cheese, tea or diet soda. Team DD noted that one resident was served two hotdog franks instead of beef stew as a choice. The meal served looked appetizing, smelled good, and was served at the appropriate temperature. Second helpings were not available in the kitchen. Appropriate condiments were not available for the residents at the tables. The residents were afforded enough time to safely eat. The dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents. Team DD did note that one resident prefers to stand at the counter to eat.

When interviewed, one of the two residents reported having a choice to what foods they are served. Both residents reported that staff members take food requests prior to going to the grocery store. Neither resident reported going to the grocery store with staff members. When asked if there were any foods their doctors told them they should avoid, one resident mentioned they were supposed to stay away from bacon; the resident reported that they received grits instead of bacon as their accommodation. Both residents stated that their food was served at the

right temperatures. When asked if their were any foods they would like to have that they currently aren't being served, one resident mentioned that they would like grits, and the second resident mentioned wanting colored butter beans, fried okra, and fried chicken.

The following exceptions were noted.

- One resident reported that he did not have a choice of foods he were served. The resident reported they "have to get what they fix."
- Neither of the residents reported receiving enough foods. One resident reported that they want more foods; this resident also reported that they did not eat the snack the day of Team DD's visit because they were served "cheap cookies." The resident reported wanting "better cookies." The second resident reported that they received enough food "some days yes, some days no." This resident mentioned that the days Barbara cooks they receive enough food.
- Neither of the residents reported being allowed second meal helpings. One resident reported that they were not allowed because they were on a "special diet." The second resident mentioned that the "they [staff] pour it [seconds] out."

Resident Interviews

Team DD members interviewed two residents. Both residents interviewed stated they liked living at the facility. When asked if the staff treated them with respect, one resident stated that "everybody" treated them with respect and one resident reported "some do." Both residents reported that staff was nice to them. When asked if they knew their rights, one resident said yes but could not give examples; the second resident stated yes and did give an example. Both residents reported that they felt safe at the facility. When asked whom they spoke to if they had a problem, one resident mentioned the house manager and a staff member at the workshop and the second resident mentioned a staff member at the workshop. When asked what happened if they did not follow the facility's rules, one resident stated the staff would call the police and one resident stated they would get written up. The residents interviewed stated they were never locked out of the home or in certain rooms. When asked what they would change about the facility one resident stated "nothing" and the other resident stated they would "change the flowers so they would bloom and not be green all year." One of the two residents reported wanting to move. One resident reported they would like to move to a SLP II if he could.

The residents interviewed were asked about activities they did in and outside of the home. When asked if they worked, both residents reported sorting clothes hangers at the workshop. Both residents reported getting paid for their work. Both residents reported they liked attending the workshop. When asked about activities the residents did in the community, one resident reported attending church; both residents reported going shopping at stores such as Wal-Mart, Belk, and J.C. Pennys; one resident reported going out to eat, the second resident mentioned they haven't gone out to eat since the last three to four months; and one resident mentioned going to parks. Both residents mentioned that they get to go to the places that they choose. One of the two residents reported going places with other people besides the other residents from the home. One of the residents reported visiting his friends; the other resident reported not having any friends. One of the residents reported going on vacation with family

members. One of the two residents reported that he spends the night with family for up to three nights. Neither resident reported attending a self-advocacy group.

The residents were also asked about activities they did in the home. One resident reported watching television, listening to the radio, and sitting on the back porch. The second resident reported watching television, working on crossword puzzles, reading books, and keeping his dresser drawers clean and neat. When asked what activities they would like to do, one resident mentioned watching television and listening to the radio and one resident mentioned wanting to play cards. One of the residents mentioned that they had family members visit them at the home; the second resident stated they did not have any visitors. When asked where the telephone they used was located, one resident mentioned that the home had three telephones, and the second resident mentioned using the phone in the living room or office. When asked if the home had any pets, one resident mentioned his three gold fish.

The following exception was noted.

- Resident B reported that "Kendall" (Staff member) "slapped" him on the head and "poked" his ribs. The resident stated that he reported this to his family. The resident reported that the family complained and told Kendall not to put his hands on the resident again. Team DD noted that a staff member named Kendall was at the facility the day of Team DD's visit (Note: a complaint was reported to SLED as well as the State Long Term Care Ombudsman.)

Team Advocacy DD Project Inspection for October 22, 2009
St. David CTH II, Charleston, South Carolina

Facility Information

St. David CTH II is located at 2004 St. David Lane, Charleston, South Carolina in Charleston County. The home is operated by CASLS Ltd. The home is licensed for 4 beds and at the time of Team DD's visit had a full house. The home was occupied by young adult female residents. The home is a brick house in a neighborhood. Team DD members entered the home at 2:48 pm and exited the facility at 4:33 pm. The house manager was not present during Team DD's inspection. The exit interview was conducted with one of the staff members and with Phil Blevins via telephone. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Room temperature
- Maintenance
- Housekeeping
- Resident Safety
- Fire hazards

Home Tour

When Team DD arrived, one of the residents was taking a nap in her bedroom. Three residents were at school; they all arrived home towards the end of Team DD's visit. The inside of the home had comfortable furniture for the residents' use. The living room area had older, but comfortable furniture and a television. The carpet throughout the facility appeared to have been carpeted with carpet remnants. Team DD noted two bathrooms in the home. The home was decorated with appropriate seasonal decorations. The home had four bedrooms with one bed in each room. The residents' bedrooms included furniture of their choice, stuffed animals, individualized bed spreads, and toys. Additionally, the bedrooms were cheerfully painted. The residents appeared to be able to access all areas of the home. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The residence water temperature was noted to be within range when tested at 114°F. Team DD also noted that the fire extinguisher was accessible and was last inspected September/2009. Smoke detectors were noted in each of the four bedrooms with a 2004 date. A complete first aid kit was located in the kitchen. An operable flashlight was available in the kitchen. The residence was free of insect infestation. The home had a written emergency plan which was stored at the main office; the emergency plan was faxed to P&A on 10/23/2009. The residence had an adequate supply of food on hand.

The following exceptions were noted:

- When Team arrived, the facility was warm. Team DD measured the air temperature between 80°F and 84°F throughout the home. The staff stated they could not adjust the temperature. Team DD noted that the heat was on. Team DD members turned the air conditioner on during the visit which was operable.

- Bedroom #1- there was dried vomit on the floor next to the resident's bed and on the resident's bed sheets. The staff appeared to be unaware that the resident had thrown up. The staff did not clean up the area during Team DD's visit.

- Team DD noted that the carpet throughout the facility was stained/dirty and buckling. Additionally, the linoleum flooring in the kitchen was torn.

- There was an older swing set in the backyard. The swing set appeared to be appropriate for small children and not the residents. Additionally, the seating on one of the swings was broken causing the plastic to be sharp.

- Bedroom #1- the dresser drawers had broken hardware. The window was unlocked. The window could not lock securely. Team DD noted that this window is located in front of the house.

- Bedroom # 2- one of the two closet doors was missing.

- Bedroom #4- The window blinds were too long for the window and causing the blinds to fall. The overhead light was without a cover/shield. The bathroom in this bedroom had a broken handrail attachment on the toilet; Team DD noted that the handrail attachment was sharp.

- The hallway overhead light was without a cover/shield.

- The outside light on the back porch was without a cover/shield.

- The hall bathroom- the bathroom drawers were not appropriately aligned. Team DD noted broken cabinet hardware in the drawers including sharp screws and a water pipe. The towel rack was not attached to the wall. The bathtub had rust spots and appeared to be dirty. The bathtub would not appropriately drain.

- Large floor tacks were on the floor in the living room area.

- The air vents in the facility were dirty/dusty.

- There was no liquid hand soap in the kitchen. Team DD observed the residents washing their hands with liquid dish soap.

Medication Storage & Administration

The medications were not reviewed due to DDSN's position that consent is required for P&A to review records.

The following exception was noted:

- Team DD noted that the medications were stored in a locked tackle box in the kitchen. The tackle box was stored in a cabinet; the cabinet door was missing.

Residents' Records and Access to Healthcare

Two resident records were reviewed. Neither of the residents were interviewed. The residents' healthcare records were not reviewed because of DDSN's position on allowing P&A to review records without consent. Team DD did review non-healthcare records.

- Both residents' records contained daily plans, support plans, monthly progress notes, annual assessments, and behavioral support plans.
- One of the two resident records noted whether the residents had a health care power of attorney or other advance directive.
- Neither of the residents' records noted the residents' diets.
- Neither of the resident records reviewed noted that there were any incident reports filed over the past year.
- Neither of the residents' records noted that the residents attended a workshop. Team DD noted that one of the residents attended middle school and one resident attended high school.

Spending allowances:

Team DD noted that the residents were both noted to receive a weekly allowance of $7.50.

Meal Observation

A meal was not observed. The staff was preparing the dinner meal as Team DD was departing the home. Team DD noted that the menu rotated monthly. The posted meal was baked chicken, salad, macaroni and cheese, sweet peas, and water. The menu posted reflected a variety of foods. The dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents.

Resident Interviews

Neither of the residents were able to be interviewed.

Team Advocacy DD Project Inspection for August 25, 2009
Turning Leaf CTH II, Columbia, South Carolina

Facility Information

Turning Leaf CTH II is located at 108 Turning Leaf Drive, Columbia, South Carolina in Richland County. The home is operated by Mentor. The home is licensed for 3 beds and at the time of Team DD's visit had five residents. The home was occupied by male residents. The home is a one and a half story home in a neighborhood. Team DD members entered the home at 3:41 pm and exited the facility at 5:59 pm. The house manager, Ditashia Brayboy was not present during Team DD's inspection but was available via telephone. The exit interview was conducted with one of the staff members. The DDSN license was posted and current.

Overview

As detailed below, this report contains information gathered from touring the Home, reviewing residents' records, medications, medication administration records (MARs), observations made while at the facility, and interviews conducted with residents. The report addresses concerns Team DD found relating to:

- Resident privacy
- Fire hazard
- Maintenance
- Sanitation
- Housekeeping
- Food storage
- Accessibility
- Resident hygiene
- Resident reported needing clothing
- Resident Safety

Home Tour

When Team DD arrived, three residents were in the living room watching television, one resident was watching television in his room, and one resident was outside in the back yard. The home appeared to be homelike. The inside of the home had comfortable furniture for the residents' use. The living room area had two comfortable looking couches, a television, and two air mattresses that were being used for beds. The home had three bedrooms. One of the three bedrooms was upstairs above the garage. Each of the bedrooms had one bed. The bedrooms were scarcely decorated with personal items. The residents' bedrooms were tidy. The home also had a back patio with a table and chairs. The entryways featured ramps which were gradual and accessible. The residence had an adequate number of staff to meet the needs of the residents.

Infection Control, Sanitation and Health/Safety

The facility appeared to be tidy. The residence water temperature was noted to be within range when tested at 101.8°F. The home was free of obvious fire hazards. Team DD also noted that the fire extinguisher was accessible and was last inspected 8/2009. A complete first aid kit was located in the office area. The facility was equipped with an operable flashlight. The residence was maintained at a comfortable temperature and was free of insect infestation.

There were emergency exit routes posted on the walls. The home had a written evacuation plan which noted that residents would relocate to a local shelter or to another CTH II in the event of an emergency evacuation.

The following exceptions were noted.

- The staff reported that one of Mentor's other homes, Kingston Ridge CTH II had a tree fall on the house Saturday evening. Therefore, two of the residents from Kingston Ridge CTH II evacuated to Turning Leaf CTH II. The two residents who were evacuated were sleeping on air mattresses on the floor in the living room. The mattresses were made with sleeping bags (Note: the House Manager stated that the two residents should return to Kingston Ridge CTH II by the week of August 31, 2009).

- One of the residents is required to use a wheelchair. The resident had two wheelchairs, one manual wheelchair and one motorized wheelchair. Both of the wheelchairs were stored in the office area because the resident requires assistance with transferring. When the resident needs something, he notifies the staff by yelling. The resident reports that he spends most of the day in his bed. Team DD noted a hole in the resident's wall. The resident reported that he once fell into the wall when trying to transfer independently (Note: Team DD did confirm this incident on an incident report dated 2/23/2009).

- The bathrooms were not accessible for the resident who requires a wheelchair. The resident's bedroom is located next to the bathroom. The resident's wheelchair cannot manipulate the corners of the two rooms at ease. Additionally, the bathtub/shower was not accessible. There was no shower curtain. The bathroom appeared to be small and difficult for the bathroom door to completely close when a wheelchair is in inside.

- The staff reported that the home's van was in the shop. It was unclear how long the van would be away from the home.

- Resident A appeared to have a black bruise under his right cheek. When asked about the bruise, the resident reported an incident that happened "a long time ago". (Note: Team DD spoke with the House Manager who stated that the resident falls often and doesn't report it to the staff. Team DD reviewed several incidents reports for this resident but none of the reports specifically mentioned the resident's bruised cheek).

- Resident B's bed had the manufacturer's plastic covering the bed. The resident mentioned that the plastic causes the bed to feel warm. Additionally, the resident had a lamp without a lampshade or light bulb on his side table.

- The carpet in the hallway near the bathroom was torn and coming up. Therefore, this is a trip hazard. The torn carpet also made it difficult for the resident and/or staff to manipulate the wheelchair.

- The hall bathroom was without paper towels for hand drying. The toilet seat was noted to be too small for the toilet. Team DD also noted dried feces on the toilet seat. Additionally, as noted above the bathtub/shower was without a shower curtain.

- The master bathroom was without toilet paper, liquid hand soap, and paper towels.

- In Resident B's bedroom, the overhead light was without a cover/shield. Therefore, the light bulbs were exposed. Team DD noted that under the bedroom window there was an area where the carpet appeared to have been burnt. Additionally, the resident had a table lamp that was placed on the floor; the lamp was without a lampshade.

- Team DD noted that the carpet throughout the facility was dirty/stained.

- The office overhead light cover/shield had a significant amount of dead bugs and dirt.

- The refrigerator had a package of celery dated 7/18/2009. Team DD noted that the celery was decomposing. The staff disposed of the celery during Team DD's visit.

Medication Storage & Administration

Medications were stored in a locked filing cabinet in the office area. The medication area was free of loose pills or spills. None of the residents whose records were reviewed was prescribed controlled medications. The medication administration record (MAR) was accurate and current.

Residents' Records and Access to Healthcare

Three resident records were reviewed and all three residents who were present agreed to be interviewed.

- Two of the three resident records contained documentation of a physical examination within the past year. Resident A was noted to have a physical examination appointment on 9/4/2009.

- All three of the resident records contained documentation of other medical examinations. Resident A had dental and podiatry examinations within the past year; Resident B had podiatry, dental, and vision examinations within the past year; and Resident C had dental, vision, podiatry examinations and lab work within the past year.

- None of the resident records noted whether the residents had a health care power of attorney or other advance directive.

- One of the three resident records reviewed noted the resident had received a tuberculin skin test or chest x ray. Resident C's record noted that the resident had a tuberculin skin test fourteen months prior to admission.

- All three of the residents' records reviewed contained current resident support plans.

- All three of the residents' records reviewed contained a behavioral support plan.

- All three residents' records noted the residents' diets. Resident A was noted to have a *regular* diet, Resident B was noted to have a low cholesterol diet, and Resident C was noted to have a low fat diet.

- All three of the resident records reviewed noted several incident reports filed over the past year.

- None of the three residents' records noted that the residents attended a workshop.

When interviewed, residents stated they are transported to local doctor appointments by the home. Resident A reported needing a vision and dental appointment. None of the residents stated that they have any problems getting transportation to medical appointments.

Residents' Clothing, Hygiene Supplies, & Special Equipment

Two residents mentioned that they like their bedroom and one resident stated that his bedroom was "alright". All three residents reported they were able to take a nap as they wish. None of the residents had roommates. When asked how frequently their sheets were changed, one resident stated his sheets were changed once a week, one resident stated that they sleep on the floor due to his choice, and one resident did not answer this question. Two residents reported that they changed their own sheets and one resident did not answer this question. Team DD observed that the residents had clean bath and bed linens. One of the three resident bedrooms was clean and decorated with personal items.

When asked if they had enough clothing, two of the three residents stated they did have enough clothing. When asked how frequently their clothes were washed, one resident stated his clothes were washed twice a week; the other two residents did not answer this question. Two of the three residents interviewed appeared to be wearing their own clothing and shoes which were well-fitted and free of holes, stains, or tears. One of the three residents interviewed appeared to have at least seven seasonal outfits of clothing appropriately stored in their dressers and closets; Team DD was unable to observe Resident A's clothing due to his closet being locked.

Two of the three residents interviewed appeared to be clean and neatly groomed with clean faces, hair, and clothes. When asked how often the residents took a shower or bath, all three residents reported bathing daily. All three residents stated there was enough hot water for them to shower comfortably. Two of the three residents stated they were able to get in and out of the shower at ease. All of the residents reported they received a clean bath towel when needed. The residents stated that extra toilet paper was not stored in the bathrooms.

The following exception was noted.

- Resident B's bedroom was noted to have a hole in his wall.
- Resident B reported needing pants. Additionally, Resident B appeared to not have at least seven seasonal outfits of clothing.
- Resident B appeared to have oily hair. Team DD observed that the resident did not have shampoo. The resident reported that he was unable to shower because there was no shower curtain. Additionally, the resident reported that he was unable to get in and out of the shower with ease. The resident reported needing assistance from the staff.
- Resident C was wearing jeans with holes.

Spending allowances:

Team DD reviewed a note that all of the residents received a monthly allowance of $30. When interviewed, all three of the residents stated they received an allowance. The residents reported spending their money on snacks, drinks, and cigarettes. When asked if they had anyone hold onto their money for them, none of the residents mentioned anyone.

Meal Observation

Team DD observed the dinner meal. The posted meal was beef stroganoff on noodles, tossed salad, low calorie dressing, reduced fat milk, water, or sugar free beverage. Team DD asked the staff what residents with diabetes had for dessert and the staff members stated that they did not have any residents who had diabetes living in the home. The menu posted reflected a variety of foods. The residents were served Hamburger Helper's beef stroganoff on noodles, salad with dressing, dinner roll. Team DD noted that drinks were served to residents five minutes after they began eating. The meal served looked appetizing, smelled good, and was served at the appropriate temperature. Second helpings were not available in the kitchen. Appropriate condiments were not available for the residents at the tables. The residents were afforded enough time to safely eat. The dining area was equipped with a sufficient number of tables and chairs to meet the needs of the residents.

When interviewed, none of the residents reported having a choice to what foods they are served. One of the three residents reported that staff members take food requests prior to going to the grocery store. One of the three residents reported going to the grocery store with staff members. When asked if there were any foods their doctors told them they should avoid, one resident stated that they were not supposed to eat cheese. The resident reported that the staff fixes them something without cheese. All three residents stated that their food was served at the right temperatures. When asked if there were any foods they would like to have that they currently aren't being served, two residents reported that they would like to have steak and one resident stated that they didn't have any money to purchase the foods that they would like.

Resident Interviews

Team DD members interviewed three residents. One resident interviewed stated they liked living at the facility, one resident stated that they liked living at the facility "alright", and one resident stated that they did not like living at the facility. When asked if the staff treated them with respect, one resident stated that the staff was nice to them and treated them with

respect. When asked if the residents knew their rights, all three residents stated that they did know their rights. Two of the residents reported that they felt safe at the facility. When asked whom they spoke to if they had a problem, two residents mentioned the house manager and God, and one resident stated that they don't talk to anyone. When asked what happened if they did not follow the facility's rules, one resident stated "you get kicked out", one resident stated "get written up or they take the T.V.", and the last resident stated they would "get written up or have something taken away." The residents interviewed stated they were never locked out of the home or in certain rooms. Two of the three residents reported that they have choices in what they do in the home. When asked what they would change about the facility, one resident stated he would like privacy, one resident stated they would go back to his previous residence, and one resident stated he would have a job. Two of the three residents reported wanting to move. One resident reported wanting to move to the "Whitten Center", one resident reported wanting to move on his own.

The residents interviewed were asked about activities they did in and outside of the home. When asked if they worked, none of the residents reported working. However, all three residents reported wanting to work. None of the residents reported attending a workshop or day program. When asked about activities the residents did in the community, one resident reported attending church, two residents reported going shopping at Wal-Mart, three residents reported going out to eat at fast food restaurants, all three residents reported going to parks, one resident reported going to the State Fair last year, and one resident reported going to the movies. None of the residents mentioned that they get to go to the places that they choose. Two of the three residents reported visiting his friends. None of the residents reported going on vacation. One of the three residents reported that he spends the night with family members occasionally. None of the residents reported attending a self-advocacy group.

The residents were also asked about activities they did in the home. All three residents reported watching television and listening to the radio; one of the three residents mentioned playing cards and BINGO. When asked what activities they would like to do, one resident reported that he used to enjoy cutting the grass at the Whitten Center and one resident mentioned that they enjoyed going bowling. Two of the three residents mentioned that they had family members visit them at the home; the third resident stated they did not have any visitors. When asked where the telephone they used was located, all three residents mentioned the telephone in the office. When asked if the home had any pets, none of the residents mentioned any but one resident mentioned wanting a pet.

The following exceptions were noted.

- One resident stated that the "some" of the staff treated them with respect. The resident stated that one staff member, Hannah was not nice.
- Another resident reported feeling unsafe because "some" of the staff were "nasty".

Team Advocacy DD Inspection for May 18, 2010
Wilson CTH I, Columbia, SC

Team Advocacy DD Project Report by ***Susan Perry; Inspection by Susan Perry, Phyllis Ross,*** *and Stacy Arnold*

Facility Information:

Wilson I CTH II is located at 9828 Wilson Boulevard, Columbia, SC in Richland County. Fairfield County Disabilities and Special Needs Board (DSN) operates the home. The home is licensed for four beds. On the day of inspection, all beds were occupied; three females and one male live in the home. The home is a Medically Fragile CTH II with 24/7 nursing staff. The home is a brick structure on a road between Columbia and Blythewood. Team DD entered the home at 4:20 p.m. and left the home at 7:30 p.m. Beverly Williams, Health Care Administrator, Deborah Fogelle, nurse, and Martha Hemphill, CTH II Counselor/Support Giver. were present during the inspection.

Overview:

This report contains information gathered from touring the home, reviewing residents' records, observations made while at the home, interviews conducted with residents, and conversations with staff and individuals living in the home. This report addresses concerns Team DD found relating to the following:

- Expired food
- Maintenance – grab bars, hole in the bathroom wall, furniture knobs, blinds

Home Tour:

Team DD arrived at the home with second shift on duty. Two individuals were in their bedrooms and two were in the living area watching television. The home appeared comfortable. The floors were tiled and carpeted. The entrance to the home had wide double front doors for easy accessibility. All areas of the home were accessible. The doors inside the home were wide. No ramps were necessary for access to the home.

- The greatroom had cloth furniture: sofa, loveseat, chairs, and a lift chair for one individual. There were tables and lamps. The room had attractive window treatments, an entertainment system with a television and stereo, plants,

flowers, pictures, and a mirror. There were French doors leading to the outside on one side of the room. Team DD agreed the great room was a room where people would feel comfortable.

- The dining area was open to the great room with a dining table and six chairs. A small desk for staff use was in one corner.
- The kitchen was tiled. There was plenty of countertop space and cabinets. A large refrigerator/freezer was in the kitchen.
- There was a small office on the other side of the kitchen-end of the home for staff's use.
- There were two and a half bathrooms. Bedroom #1 & #2 accessed the bathroom on the right side of the hall. Bedroom #3 & #4 accessed the bathroom on the left side of the hall. All bathrooms had paper towels in a wall dispenser.

    - The bathroom on the right side of the hall had a roll-in shower with different types of shower chairs and a lift. There was a sink in this bathroom, but no toilet. The wall across from the shower had a hole the size of the doorknob.

    - The bathroom on the left side of the hall was large. There was a six-inch step leading up to the bathtub with a showerhead. There was a toilet.

    - The grab bars around the toilet were loose. The half bath was located off the great room. There was a toilet and sink in that bathroom.

- Bedroom #1 was the first bedroom on the right side of the hall. The room had a single hospital bed in it with a dresser, chest of drawers, small game table, and a bookcase. The room was personalized with family pictures, a radio, television, and sports emblems on the walls, including baseball, football, and basketball. The only light available was an overhead light. The venetian blinds were missing sections and those sections were covered with paper. Team DD noted the room was clean and tidy.
- Bedroom #2 was the second bedroom on the right side of the hall. The room had a single hospital bed in it with a television, dresser and chest of drawers. There were personal

items in the room. The individual in this room did not get out of bed during our visit.

- Bedroom #3 was in the front of the home. The room had a single hospital bed in it with a television, dresser and chest of drawers. A special mattress on the bed automatically shifted positions for the individual. The individual did not get out of bed during our visit. There was a baby monitor in the room. The individual had internet because she was chatting with her friends on Facebook while she was in the bed. Team DD noted the room was clean.
- Bedroom #4 was in the front of the home next to the foyer. This room had a hospital bed, dresser and chest of drawers. There were knobs missing from some of the drawers on the furniture. A leather recliner was in the room. There were portraits of family members.
- There were two accordion door closets in the hall. One was a washer & dryer closet on the left side of the hall. Inside there were locked cabinets containing cleaning supplies. The closet on the opposite side of the hall contained the hot water heater and access to breaker box, etc.
- The backyard was large and unfenced. There was a concrete patio with a rocker, pots with flowers, exercise equipment, and a charcoal grill. There was a freestanding wooden porch swing and the grass was neatly cut.
- The front yard had a small porch with two wooden rockers.
- On the front side yard there was an older van that had boxes stored in it. There was no license plate on the van. Next door (at a sister CTH II unit), there was a small 6-passenger van and a larger 10-passenger van with a lift.

Infection Control, Sanitation and Health/Safety:

The home was well ventilated. The thermostat was set on 75°. Team DD noted the fire extinguishers were accessible and last inspected on May 1, 2010 & May 3, 2010. The home was equipped with four fire alarm pulls and an overhead water sprinkler system. The first aid kit was organized and complete. Team DD saw no sign of insect infestation. Emergency exit routes were posted in the hall. The home had a written evacuation plan, which was contingent upon availability of specific sites. All water temperature samples taken were within the acceptable range.

Team Advocacy DD Inspection for May 18, 2010
Wilson CTH I, Columbia, SC

The following exceptions were noted:

- The refrigerator contained several items that were expired, cheese, chicken salad, cake, bread, yogurt, milk, and butter. When Ms. Williams was made aware of the situation, she immediately threw the items away while Team DD was still at the home. The refrigerator, freezer, and cabinets were well stocked.

- There was a doorknob hole in the wall of the bathroom between bedrooms #1 & #2. Team DD made Ms. Williams aware of the hole. She went directly to fill out a maintenance request.

- The bathroom between bedrooms #3 & #4 had grab bars around the toilet that were loose. This was not pointed out to Ms. Williams at the time of the exit interview.

Medication Storage & Administration:

- The medications were not reviewed due to DDSN's position that consent is required for P&A to review medical records.

Resident's Records and Access to Healthcare:

Two individuals' records were reviewed and one resident present was interviewed. The second resident's interview was terminated because the resident's answers where incoherent. The individuals' medical records were not reviewed due to DDSN's position that consent is required for P&A to review medical records.

- Neither of the individuals' records had a health care power of attorney or advance directive.

- Both individuals' records contained a current residential support plan. Neither individual had a Behavioral Support Plan.

- Both individuals' records contained incident reports filed over the past year. Ms. Williams informed Team DD that critical incident reports, such as a trip to the hospital, are filed in their main office.

- Records indicate that one resident attends an adult day care center and the other stays in the home during the day.

During the interview, Individual A stated that the home transports them to and from local doctor appointments. Individual A stated a need to see a dentist and eye doctor. Since DDSN has blocked access to the medical records of residents, Team DD could not determine the date of or length of time since Individual A's last appointments with the dentist and eye doctor.

Residents' Clothing, Hygiene, Supplies, & Special Equipment:

Individual A currently has a single hospital bed and has a helmet that is worn at certain times. Individual A stated that the staff changes his sheets every weekend, he takes a bath every night, and he needs shampoo and tennis shoes. Individual A reports he has enough clothes. Team DD noted Individual A's room was neat, items were folded neatly in drawers and neatly hung in the closet. He was wearing clean clothes that fit appropriately without tears, holes, or stains.

Team DD observed Individual B had a single hospital bed, walker, and a recliner/lift chair in the great room. Individual B was neatly dressed and well groomed. There were a number of personal hygiene items in her room, including several different bottles and brands.

Spending Allowances:

Individual A reported that he receives $10 million every day. Staff reported to Team DD that Individual B keeps her weekly allowance. Both individuals have checking accounts. Team DD noted documentation from their files that both individuals receive $10.00 each week for spending money.

Meal Observation:

Team DD did not observe snacks offered during the inspection. Team DD did observe the dinner meal. Team DD did not find a posted dinner menu. Menus were in a binder and not day specific. The menus were titled "spring/summer." Two individuals (not in the sample) were served their dinner meal in their beds. They appeared not to need assistance with eating. The other two individuals ate at the dining table. They were served crackers, rice, warm vegetables

(carrots & potatoes), stewed beef, a fruit bowl of strawberries and peaches, and had iced tea to drink. Resident B had the same meal, although her records indicated she is on a 1300 calorie diet. One resident had granola and banana pieces in addition to what everyone else had to eat. Staff stated that the dietitian comes in every Friday to review menus. When questioned, Individual A stated he has a choice in the food he eats. He reported that he likes chicken nuggets, celery, and wings.

Resident Interviews:

Team DD interviewed one individual; the second individual was not able to answer questions and the interview was terminated. Individual A states that he "LOVES IT" when asked if he likes where he lives. He reported that staff are very nice, treat individuals with respect, and are very helpful. Individual A responded that he feels safe in the home and he can talk to staff if he has a problem.

Individual A was asked about activities that he likes outside of the home. He reported that he goes out to eat, goes to the park, and other places in the community. He reports having friends and his parents visit him. Records indicated that Individual A attends an adult day care center during the day.

On the day of inspection, Individual A was upset and stated, "they stole my cell phone." Team DD asked Ms. Williams about the incident. She reported that he has a cell phone that does not work and that it must have been misplaced. She told Individual A that she has one at home and will bring it tomorrow.

Team DD noted that in the records reviewed the documentation was meticulous. The inventory list for the individuals reviewed had actual tags, photo copies of wrappings, and cash register receipts secured in the folders.

D's Ex. #1.

SERVICE COORDINATION ANNUAL ASSESSMENT

A. IDENTIFYING INFORMATION

Name: _____ SS#: _____ DOB: _____

Service Coordinator (SC): _____

Service Coordination Provider: _____

Assessment Completion Date: _____ Next Plan Due Date: _____

B. SOURCES OF INFORMATION

1. People Providing Input:

_____

Name Relationship/Agency Date

_____

Name Relationship/Agency Date

_____

Name Relationship/Agency Date

2. Records/Reports Used:

_____

Title of Report Submitting Party/Agency/Provider Date of Report

_____

Title of Report Submitting Party/Agency/Provider Date of Report

_____

Title of Report Submitting Party/Agency/Provider Date of Report

C. HEALTH

1. Physical:

a. Person has a Primary Care Physician: ☐ Yes ☐ No
b. Person has regular physician visits: ☐ Yes ☐ No

2. Dental:

a. Person has a Dentist: ☐ Yes ☐ No
b. Person has regular dental visits: ☐ Yes ☐ No
c. Concerns with teeth/gums/mouth/chewing: ☐ Yes ☐ No

3. Vision:

a. Concerns with vision: ☐ Yes ☐ No (If no, go to question 4)

Has this person's vision been evaluated by an Optometrist/Ophthalmologist? ☐ Yes ☐ No
If yes, were recommendations/orders followed? ☐ Yes ☐ No

If person wears glasses, list as an assistive device in chart (at question 7).

4. Hearing:

a. Concerns with hearing: ☐ Yes ☐ No (If no, go to question 5)

Has this person's hearing been evaluated by an Audiologist? ☐ Yes ☐ No
If yes, were recommendations/orders followed? ☐ Yes ☐ No

If person wears hearing aids, list as an assistive device in chart (at question 7).

5. Specialty:

a. Are other specialists seen regularly?: ☐ Yes ☐ No

If yes, list areas of specialty: _____ _____

_____ _____

6. Diet/Weight:

a. Person has a diet prescribed or recommended by a professional (i.e., doctor, dietician):
☐ Yes ☐ No/Unknown
If yes, type: _____
If yes, is prescribed diet followed? ☐ Always ☐ Most Times ☐ Rarely/Never ☐ N/A

b. Weight Range:
☐ Under ideal weight range
☐ Within ideal weight range
☐ Over ideal weight range

7. Does this person have a/medical condition(s) for which an intervention (e.g., medication, supplies, equipment) are used prescribed? ☐ Yes ☐ No
If yes, list those currently prescribed/provided:

Condition	Medication/Intervention /Treatment/Supplies and Medical Equipment	Provider Type	Being taken /used/received As Prescribed? Yes or No	Current Funding Source	Is Medication/Intervention/ Treatment/Supplies and/or Medical Equipment effective in meeting the concern/condition for which it is given?
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No

8. Type of Disability: (Check all that apply)

☐ Intellectual Disability
☐ Related Disability (specify): _____
☐ Spinal Cord Injury (SCI) Level of SCI (specify): _____
☐ Traumatic Brain Injury
☐ Similar Disability (specify): _____
☐ Autism
☐ Pervasive Developmental Disorder
☐ Other (specify): _____

9. Tobacco usage: ☐ Yes ☐ No

10. Does the administration of this person's care, medications or medical treatments require specific training and/or the use of nursing judgement (injections, giving/withholding medications based on current condition wound care, equipment operation/cleaning, etc.)? ☐ Yes ☐ No

If yes, explain: _____

_____

11. Any concerns related to medical conditions, medications, treatments, devices, and/or supplies?
☐ Yes ☐ No If yes, list: _____

12. Receives/has received Genetic Services/Counseling: ☐ Yes ☐ No
If No, person is interested in receiving this: ☐ Yes ☐ No ☐ N/A

13. Is information needed about medical screenings or other health related guidelines: ☐ Yes ☐ No

Comments related to Health :

D. CURRENT RESOURCES

1. Current resources: (Please check all that apply):

☐ Earned Income ☐ SSDI ☐ SSI
☐ VA Pension ☐ Disability Insurance ☐ Worker's Compensation
☐ Food stamps ☐ Housing Supplement ☐ Child Support
☐ Trust/Settlement ☐ Health Insurance ☐ Alimony
☐ Medicaid ☐ Medicare: Part ☐ A; ☐ B; ☐ C; ☐ D
☐ Retirement/Pension ☐ PASS plan
☐ IRWE ☐ Life Insurance/Burial
☐ HCB Waiver (list which one): _____
☐ Family Support Funds ☐ Other: _____
☐ No resources

2. Do additional resources appear to be needed to meet basic needs such as sufficient food, adequate shelter, or life sustaining medications? ☐ Yes ☐ No

Comments related to Current Resources:

E. ACTIVITIES/SKILLS/ABILITIES

1. Daily Living	Degree/Level of Support/ Supervision/Assistance Needed to Complete				Expected or typical frequency of task/activity	Frequency Support is currently provided	Type of Support currently provided	Anticipated/expected ability of each supporter to Continue	Would Training/ Instruction/Intervention to increase skills be beneficial and desirable?
	None or equal to others of the same age- *if chosen, do not answer other parts of chart*	Prompts, reminders or supervision needed to complete or assure quality	Hands on, physical assistance needed with any portion of the task/activity	Completed by another	MD: Multiple times daily D: Daily MW: Multiple times weekly W: Weekly MM: Multiple times monthly M: Monthly O: Other frequency NE: not expected due to young age	1: Provided as needed 2: Provided some of the times needed, but not all 3: No support provided	N= Natural P= Paid X= None	1: Likely to continue without change 2: Change probable/likely within six months 3: Need for change evident/expressed or immediate (if more than one supporter, answer for each)	Yes or No
Prepare Meals									
Housekeeping									
Medical Care/ monitoring									
Shopping									
Personal Financial Business									
Phone use									

Comments regarding Daily Living activities/skills/abilities:

ROA_0276

2. Personal Care	Degree/Level of Supervision Needed to Complete				Expected or typical frequency of task/activity	Frequency Support is currently provided	Type of Support currently provided	Anticipated/expected ability of each supporter to Continue	Would Training/ Instruction/Intervention To increase skills be beneficial and desirable?
	None or equal to others of the same age - *if chosen, do not answer other parts of chart*	Prompts, reminders or limited supervis-ion needed to complete or assure quality	Hands on, physical assistance needed with any portion of the task/activity	Completed by another/ Constant Supervision	MD: Multiple times daily D: Daily W: Weekly O: Other frequency NE: not expected due to age	1: Provided as needed 2: Provided some of the times needed, but not all 3: No support provider	N: Natural P: Paid X: None	1: Likely to continue without change 2: Change probable/likely within six months 3: Need for change evident/expressed or immediate (if more than one supporter, answer for each)	Yes or No
Bathe/Shower									
Toilet or Incontinence care									
Dress/Groom									
Eating									
Take or apply Medicine(s)									
Transferring									
Supervise self (manages self, can be alone)									

Comments regarding Personal Care activities/skills/abilities:

ROA_0277

3. **Toilet Use (check all that apply):**

☐ Independent ☐ commode ☐ bedpan ☐ urinal
☐ catheter ☐ ostomy ☐ bowel program ☐ diapers
☐ underpads ☐ independent with catheter/bowel care
☐ requires assistance with catheter/bowel care
☐ Other: _____

4. **Mobility and Access**

a. Person can get to all areas of their home:

☐ Without assistance
☐ With aid or equipment
☐ Must have personal assistance
☐ Cannot get to some or needed portions of home

b. Person has access to their possession (i.e., can use cabinets, storage areas, faucets, door knobs/handles):

☐ Without assistance
☐ With aid or equipment: Choose mode of Locomotion
☐ Must have personal assistance
☐ Cannot get to some or needed portions of home

c. Method of Mobility: *check all that apply*

☐ Walks without aid or assistance (if checked, skip to letter e/question e)
☐ Walks with aid or assistance (Type of aid: ☐ Cane ☐ Crutch ☐ Walker ☐ Other
☐ Uses a wheelchair without aid or assistance (*i.e., propels self*)
Type of chair used: ☐ Manual ☐ Power
Wheelchair is primary mode of locomotion? ☐Yes ☐ No
☐ Uses wheelchair with aid or assistance, (*i.e., other person wheels*)

d. Does this person use an aid or equipment for mobility and access? ☐ Yes ☐ No
If yes, list Aids/Equipment Used for Mobility an Access:

Type of Aid/Equipment	Frequency Used	Condition of Aid/Equipment	Effectiveness of Aid/Equipment
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasionally ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need

e. Any injuries during the past year due to mobility issues (falls, equipment failure, etc.)?
☐ Yes ☐ No
If yes, describe each incident: _____

_____

f. Any mobility issues related to exit during fire/emergency (include issues related to emergency evacuation of home during disaster)? ☐ Yes ☐ No
If yes, describe: _____

_____

g. Would an evaluation of mobility or interventions to increase independence or slow down loss of mobility likely be beneficial and desirable? (e.g., physical therapy) ☐ Yes ☐ No

h. Is this person working with a professional to improve his/her mobility or to prevent regression?
☐ Yes ☐ No

Comments related to Mobility:

5. Fine Motor

a. Method used for performing fine motor tasks/grasping (holding utensils for dining, writing, tooth brushing, dressing, etc.): *check all that apply*

☐ Own hands without aid or assistance (If yes, skip to question c)
☐ Own hands with aid/equipment
☐ Performed by another

b. Does this person use aids/equipment to perform fine motor tasks? ☐ Yes ☐ No
If yes, list Aids/Equipment Used to perform fine motor tasks:

Type of Aid/Equipment Used	Frequency or Use	Condition of Aid/Equipment	Effectiveness of Aid/Equipment
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need

c. Any increased dependency noted in the past year with ability to perform fine motor tasks?
☐ Yes ☐ No
If yes, describe: _____

d. Might an evaluation of fine motor skills or interventions to increase independence or slow down the loss of fine motor ability be beneficial and desirable? (e.g. occupational therapy).
☐ Yes ☐ No

e. Is this person working with a professional to improve fine motor ability or to prevent loss of fine motor ability? ☐ Yes ☐ No

Comments related to Fine Motor:

6. Communication

a. **Communication is easily understood by:**

Primary/experienced caregivers? ☐ Yes ☐ No
Those with whom interactions occur regularly? ☐ Yes ☐ No
Others with whom he/she lives and/or works? ☐ Yes ☐ No
Strangers? ☐ Yes ☐ No

b. Does this person use devices/equipment to aid with communication? ☐ Yes ☐ No
If yes, list devices/equipment used for communication:

Type of Device/Equipment Used	Frequency or Use	Condition of Device/Equipment	Effectiveness of Device/Equipment
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ As ordered/needed ☐ Occasional ☐ Does not use	☐ Good ☐ Fair ☐ Poor	☐ Works ☐ Meets portion of need ☐ Does not meet the need

c. Primary methods/s of communication: (check all that apply)

☐ Verbal (with words)
☐ Oral (sounds but not discernable words)
☐ Physical responses/gestures (pointing, smiling, nodding; should also consider hitting, biting or other responses that would be considered "inappropriate or maladaptive")
☐ With equipment or device/s
☐ Other: _____

d. Were there significant changes noted in communication ability during the past year?
☐ Yes ☐ No
If yes, please explain changes: _____

e. If communication is not easily understood by all or if significant changes have occurred, would an evaluation or interventions to improve the likelihood of others understanding be beneficial and desirable (e.g., speech therapy)? ☐ Yes ☐ No ☐ N/A - is easily understood?

f. Is this person working with a professional to improve his/her communication ability?
☐ Yes ☐ No

Comments related to Communication:

7. Basic Transportation

a. Basic transportation (to/from work or school, to/from medical appointments, and to/from stores to obtain food and medicine) is available:

☐ At all times, as needed
☐ Sometimes
☐ Rarely or never

b. Does this person:

☐ Transport him\herself without assistance
☐ Make arrangements, but must be transported by another:
Explain: _____
☐ Rely on others

c. Has the most common vehicle used for transportation been adapted in order for this person to be transported? ☐ Yes ☐ No ☐ N/A
If yes, list adaptations:

Type of Adaptation	Condition/Quality of Equipment/Adaptation	Effectiveness of Equipment/Adaptation
	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need
	☐ Good ☐ Fair ☐ Poor	☐ Works well/meets need ☐ Meets portion of need ☐ Does not meet the need

d. Is there a need for an adapted vehicle? ☐ Yes ☐ No ☐ N/A
If yes, describe why adaptations are needed: _____

Comments related to Basic Transportation:

F. EMOTIONAL, MENTAL AND BEHAVIORAL HEALTH

1. Concerns with emotional/mental health: ☐ Yes ☐ No (If no, skip to next domain.)
If yes, please explain: _____

2 Behaviors that are concerning:

☐ Verbal aggression ☐ Physical aggression
☐ Sexual aggression ☐ Stealing
☐ Inappropriate sexual comments, gestures or touch ☐ Substance abuse
☐ Property destruction/damage ☐ Self-injury
☐ Pica ☐ Suicidal threats/attempts
☐ Withdrawn ☐ Wandering off/run-away
☐ Defiance ☐ Criminal/Illegal Activity (ies)
☐ Other: _____

Comments (include specifics regarding any criminal/illegal activity/ies):

3. Do concerns with emotional/mental health or behaviors affect the following areas:

Ability to function independently: ☐ Yes ☐ No
Ability to have positive relationships: ☐ Yes ☐ No
Ability to participate in desired activities: ☐ Yes ☐ No
Ability to attend school or be in a regular classroom: ☐ Yes ☐ No ☐ N/A
Ability to gain or maintain employment: ☐ Yes ☐ No ☐ N/A

4. Are services/supports being provided/prescribed to address emotional/mental health or behavior concerns? ☐ Yes ☐ No ☐ N/A
If yes, please list in the chart below:

Services/Supports	Provider type	Frequency	Funding Source	Is the service/support effective in addressing the concern for which it is provided?	Is the person/guardian satisfied with the service/support?
1.				☐ Yes ☐ No	☐ Yes ☐ No
2.				☐ Yes ☐ No	☐ Yes ☐ No
3.				☐ Yes ☐ No	☐ Yes ☐ No

Comments regarding Emotional, Mental, and Behavioral Health:

G. EDUCATIONAL OPPORTUNITIES

1. If not attending an educational program:

a. Person is interested in school or Adult Education Program: ☐ Yes ☐ No ☐ N/A
(If no, skip to next section.). If yes, explain why they are not attending: _____

_____

If yes, what are this person's educational interests: _____

_____

2. If attending an educational program:

a. Does the person attend: ☐ Public School ☐ College/University ☐ Technical College
☐ Trade/Vocational School ☐ Adult Education
☐ Other: _____

b. Are there any concerns related to the person's educational program? ☐ Yes ☐ No
If yes, please explain: _____

_____

Comments regarding Educational Opportunities :

H. VOCATIONAL

The person: ☐ works in a competitive job in the community ☐ works in a sheltered work setting
☐ works in an enclave or mobile work crew ☐ does not work (skip to question 2)
☐ is a child under working age? (If checked, go to section I.)

1. **If working** - Employer: _____

   a. Are there services/supports provided to enable the person to work? ☐ Yes ☐ No
   If yes, please list in the chart below:

Services/Supports	Provider Type	Frequency Service is Provided	Current Funding Source	Are services/supports being received effective in addressing the need?		Is the person satisfied with the services/supports?	
1.				☐ Yes	☐ No	☐ Yes	☐ No
2.				☐ Yes	☐ No	☐ Yes	☐ No
3.				☐ Yes	☐ No	☐ Yes	☐ No

   b. Concerns regarding employment or employment related services/supports: ☐ Yes ☐ No
   If yes, explain: _____

2. **If not working:**

   a. Has this person ever been previously employed? ☐ Yes ☐ No
   If yes, explain why he/she is no longer employed? _____
   _____

   b. In what kind(s) of work is this person most interested? (List interests): _____
   _____

   ☐ Does not want to work (skip to section I if the person does not want to work)

3. **Work Skills/Abilities:** (answer if working or if not working)

   a. Can the person:

Yes	No	
☐	☐	Follow/abide by general workplace rules
☐	☐	Engage in task until completed or acceptable stopping period
☐	☐	Work safely
☐	☐	Report to work on time as expected
☐	☐	Complete familiar or known tasks at an acceptable production speed or rate

   b. Person has pursued services through SC Vocational Rehabilitation: ☐ Yes ☐ No
   If yes, what was the outcome? Please explain: _____
   _____

   c. Does this person need 1:1 instruction and on the job training to learn job tasks? ☐ Yes ☐ No

   d. Does this person need assistance to solve work related problems and/or understand work related issues? ☐ Yes ☐ No

e. Does this person have a picture identification card? ☐ Yes ☐ No

f. Does this person have a Social Security card? ☐ Yes ☐ No

Comments regarding Vocational:

I. LIVING ENVIRONMENT

1. Independent Setting:

a. This Person lives in an independent setting: ☐ Yes ☐ No
If no, skip to "Supervised/Supported Setting" section.
If yes, specify type: ☐ Alone in own home/apartment ☐ With Spouse/Children
☐ With Roommate/Housemate ☐ With Parents/Family
If living with others, with whom does he/she live?(please list)

Relationship	Age	Is this person a:
		☐ Primary Caregiver ☐ Secondary Caregiver ☐ Does not provide care
		☐ Primary Caregiver ☐ Secondary Caregiver ☐ Does not provide care
		☐ Primary Caregiver ☐ Secondary Caregiver ☐ Does not provide care

b. Does this person seem to feel safe and be well in this setting? ☐ Yes ☐ No

c. Does this setting appear to have any obvious hazards that could jeopardize this person's health/safety? ☐ Yes ☐ No

d. Does this person appear to be satisfied with this setting? ☐ Yes ☐ No

e. Do others in the home appear to be satisfied/supportive of the living arrangements?
☐ Yes ☐ No ☐ N/A (Lives alone.)

f. Is there a plan for where this person will live if current living arrangements cannot continue?
☐ Yes ☐ No
If yes, explain: _____

g. Does the primary caregiver have the opportunity for rest/relief from care giving responsibilities?
☐ Yes ☐ No ☐ N/A (Care is not provided or is not desired)
If yes, does the amount of rest/relief appear to be enough? ☐ Yes ☐ No
Is the primary caregiver satisfied with the amount of rest/relief (respite)? ☐ Yes ☐ No

h. Is there a plan for how care will be provided if the primary caregiver is unexpectedly unable to provide care? ☐ Yes ☐ No ☐ N/A (care is not provided)
If yes, please explain: _____

i. Is there a plan for how supports/care will be provided when the primary caregiver can no longer provide care? ☐ Yes ☐ No ☐ N/A (no care provided)
If yes, explain: _____

j. Is there a plan for what to do in the event of specific types of emergencies/natural disasters that would require displacement from this home? ☐ Yes ☐ No
If yes, does the emergency/disaster plan seem sufficient to assure the person will likely be safe and well (as healthy as possible) while evacuated? ☐ Yes ☐ No

k. Does the person/family need more information on what to do in the event of specific types of emergencies/ natural disasters? ☐ Yes ☐ No

2. Does the person/family need information on emergency shelters and/or transportation options in the event of an emergency/natural disaster? ☐ Yes ☐ No

3. **Supervised/Supported Setting:**

a. This person lives in a supervised/supported setting: ☐ Yes ☐ No (If no, skip to next section.)
If yes, specify type: ☐ CTH-I ☐ CTH-II ☐ SLP-I ☐ SLP-II
☐ DSN operated CRCF ☐ Nursing Facility
☐ CRCF/ Private Boarding Home ☐ Assisted Living Facility
☐ Other: _____
Name of company/Residential Provider/Agency/Facility: _____

b. Is the supervision/support provided effective in addressing needs? ☐ Yes ☐ No

c. Does the person seem to be satisfied with the setting in which he/she lives? ☐ Yes ☐ No

d. Does this setting appear to have any obvious hazards that could jeopardize this person's health/safety? ☐ Yes ☐ No

e. Does the person seem safe in this setting? ☐ Yes ☐ No

f. Does the person seem to be satisfied with the company/agency providing the supervision/supports and the setting? ☐ Yes ☐ No

g. Is there a plan for how emergencies/natural disasters requiring evacuation will be handled? ☐ Yes ☐ No
If yes, does the emergency/natural disaster plan appear to be sufficient to assure that he/she will likely be safe and well? ☐ Yes ☐ No

h. Is this person aware of other options/settings that may be available to him/her? ☐ Yes ☐ No

i. Is this person aware of the other providers that are available? ☐ Yes ☐ No

Observations/Comments (re: Living Environment):

J. COMMUNITY CONNECTIONS

1 Is this person present in his/her community? ☐ Yes ☐ No
If yes, how often? ☐ Often/Always ☐ Sometimes ☐ Rarely

2. Does this person participate in his/her community? ☐ Yes ☐ No
If yes, how often? ☐ Often/Always ☐ Sometimes ☐ Rarely

3. Does this person fulfill any social roles in his/her community? ☐ Yes ☐ No
If yes, which roles?: _____

4. Does this person seem satisfied with his/her current connection to the community? ☐ Yes ☐ No

Comments regarding Community Connections:

K. NATURAL SUPPORT NETWORK:

1. Is this person in touch with family members? ☐ Yes ☐ No
If yes, what methods are used (check all that apply):
☐ visits/in person ☐ by phone ☐ through correspondence

2. Does this person appear to be satisfied with the amount of family contact? ☐ Yes ☐ No

3. Is this person in touch with friends (people who are not related and are not paid staff)? ☐ Yes ☐ No
If yes, what methods are used for contact (check all that apply):
☐ visits/in person ☐ by phone ☐ through correspondence

4. If living in a supervised/supported setting, does this person have someone who is not affiliated with the residential provider who visits him/her?

a) at his/her home? ☐ Yes ☐ No ☐ N/A
If yes, what is the visitor's relationship to this person?: _____

b) away from his/her home? ☐ Yes ☐ No ☐ N/A
If yes, what is the visitor's relationship to this person?: _____

5. Does this person appear to be satisfied with the amount of contact with friends? ☐ Yes ☐ No

6. Does this person have relationships that are comfortable, familiar, and/or dear to them? ☐ Yes ☐ No

Comments regarding Natural Support Network:

L. SELF-ADVOCACY AND RIGHTS:

1. Does this person express personal preferences and interests? (including preferences regarding recreational/leisure activities)? ☐ Yes ☐ No
If yes, list examples of his/her preferences in the "Comments" box at the end of this section.
If no, explain: _____

2. Does this person make choices? ☐ Yes ☐ No

3. Does this person demonstrate basic problem-solving skills? ☐ Yes ☐ No

4. Does this person "speak up" for him/herself when needed? ☐ Yes ☐ No

5. Does this person participate in a local self-advocacy group? ☐ Yes ☐ No
If no, would they like to? ☐ Yes ☐ No

6. Does this person know and understand his/her human rights? ☐ Yes ☐ No

7. Does this person know and understand his/her civil rights? ☐ Yes ☐ No

8. Does this person exercise his/her rights? ☐ Yes ☐ No

9. Person is registered to vote? ☐ Yes ☐ No
If no, person would like assistance to register to vote? ☐ Yes ☐ No

10. Does this person feel that he/she is treated fairly? ☐ Yes ☐ No
If no, explain: _____

11. Does this person's rights appear to be restricted? ☐ Yes ☐ No
If yes, has he/she been afforded due process? ☐ Yes ☐ No ☐ N/A

Comments regarding Self-Advocacy and Rights:

M. PERSONAL PRIORITIES:

1. Has this person chosen personal goals for his/her life? ☐ Yes ☐ No
If no, would he/she like assistance in doing so? ☐ Yes ☐ No
If yes and he/she wishes to share, what are his/her goals?: _____

2. Does this person express a need for assistance to achieve his/her personal goals? ☐ Yes ☐ No
If yes, please explain: _____

Comments regarding Personal Priorities:

Needs Identified

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why not:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why not:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why not:

Need:

Will this need be included in this year's Support Plan? ☐ Yes ☐ No

If No, please explain why not:

Support Plan

for

_____

(Full Name)

Social Security #: _____ Medicaid #: _____

Date of Birth: _____ Plan Date: _____

Service Coordinator's Signature: _____

A. Service Coordination

This person's Service Coordination status:

- ☐ Will continue as Level I
- ☐ Has changed from Level II to Level I
- ☐ Has changed from Optional to Level I

Level I Service Coordination is warranted for this person because they will likely need a combination of services which may include intake, needs assessment, plan development to identify and address needs, plan implementation to access services/supports to address needs, monitoring of services/supports for effectiveness and satisfaction, advocacy, consultation/collaboration, and crisis intervention.

Current circumstances indicate a need for increased monitoring: ☐ Y ☐ N

If yes, explain: _____

B. Compliance Officer Information

This agency must comply with Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975. This agency has designated the person noted below to coordinate the Agency's complaint process. If you feel you have been discriminated against, please contact this person at the number noted below.

_____ _____

Compliance Officer's Name Telephone Number

C. Emergency Planning

How, in the event of an unscheduled absence by the/a caregiver, will this person's needs be met so that his/her health, safety, and welfare will be assured?
How will emergency situations, such as natural disasters, be managed by or on behalf of this person?

D. Needs and Services/Interventions

This section must include the services / interventions that will be (or continue to be) authorized / implemented for this person in order to address the identified need/s. Do not include the need for Service Coordination Services.

____. What does this person need? Does this need relate to a personal goal expressed by this person? ☐ Yes ☐ No ☐ Unknown If known, explain how:
Service / Intervention to address the need:
Date Service / Intervention was included in this Plan: | Funding Source for the Service / Intervention:
Amount, Frequency and Duration of Service/Intervention:
Service/Intervention Provider Type:
Service Coordinator's Responsibilities related to Service/Intervention and Timeframes/ Expected Completion Dates:
Person/Legal Guardian's Responsibilities related to Service/Intervention and Timeframes/ Expected Completion Dates:
Need/Service/Intervention Change: *This Need:* ☐ *Has been met* ☐ *Has not been met* *This Service / Intervention is being:* ☐ *Revised - Explain the changes:* ☐ *Discontinued - If this Need has <u>not</u> been met, explain why the Service/Intervention is stopping:* *Changes Made by:* *Date*

E. Meeting Attendees

My signature indicates that I attended a meeting on _____ during which services and supports for _____ were discussed.

Signature	Relationship/Agency

* Page included only if meeting is held.

Dss #2

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information

1. The State of South Carolina requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
2. **Program Title:**
   Head and Spinal Cord Injury (HASCI) Waiver
3. **Waiver Number: SC.0284**
   Original Base Waiver Number: SC.0284.
4. **Amendment Number: SC.0284.R03.03**
5. **Proposed Effective Date:** (mm/dd/yy)
   Approved Effective Date: 04/01/11
   Approved Effective Date of Waiver being Amended: 07/01/08

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Character Count: out of 12000
The State of South Carolina is seeking to amend the Head and Spinal Cord Injury (HASCI) Waiver for the following purposes: (1.) Respite Care will only be offered on an hourly basis when provided in the home or another private residence. Non-institutional respite care on a daily basis is being eliminated with the amendment effective date;(2.) Appendix G has been updated to reflect current policies;(3.) Appendix J has been updated accordingly; The Quality Improvement Sections have been updated, as well as. any other sections of the document to more accurately describe performance measures, data sources, definitions, references, provider qualifications, remediation activities, MOA, service contract information, and policies currently used for the provision of this waiver. The State has modified references such as "South Carolina Department of Disabilities and Special Needs" or "the operating agency" to "DDSN".

3. Nature of the Amendment

1. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (check each that applies):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A – Waiver Administration and Operation	
Appendix B – Participant Access and Eligibility	
Appendix C – Participant Services	
Appendix D – Participant Centered Service Planning and Delivery	
Appendix E – Participant Direction of Services	
Appendix F – Participant Rights	
Appendix G – Participant Safeguards	
Appendix H	
Appendix I – Financial Accountability	
Appendix J – Cost-Neutrality Demonstration	

2. **Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):
Modify target group(s)
Modify Medicaid eligibility
Add/delete services
Revise service specifications
Revise provider qualifications
Increase/decrease number of participants
Revise cost neutrality demonstration
Add participant-direction of services
Other
Specify:
Character Count: out of 6000
Updated Quality Improvement sections used in the provision of this waiver.

Application for a 1915(c) Home and Community Based Services Waiver

1. Request Information (1 of 3)

1. The **State of South Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
2. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Head and Spinal Cord Injury (HASCI) Waiver
3. **Type of Request: amendment**
Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)
3 years 5 years

Original Base Waiver Number: SC.0284
Waiver Number: SC.0284.R03.03
Draft ID: SC.09.03.04
4. **Type of Waiver** (select only one):
Model Waiver Regular Waiver
5. **Proposed Effective Date of Waiver being Amended: 07/01/08**
Approved Effective Date of Waiver being Amended: 07/01/08

1. Request Information (2 of 3)

6. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):
Hospital
Select applicable level of care
Hospital as defined in 42 CFR §440.10
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
Character Count: out of 6000
Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160
not selected
Nursing Facility
Select applicable level of care
Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
Character Count: out of 6000
Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
not selected
Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:
Character Count: out of 6000

1. Request Information (3 of 3)

7. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:
Not applicable
Applicable
Check the applicable authority or authorities:
Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
Waiver(s) authorized under §1915(b) of the Act.
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
Character Count: out of 6000
Specify the §1915(b) authorities under which this program operates (check each that applies):
§1915(b)(1) (mandated enrollment to managed care)
§1915(b)(2) (central broker)
§1915(b)(3) (employ cost savings to furnish additional services)
§1915(b)(4) (selective contracting/limit number of providers)
A program operated under §1932(a) of the Act.
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
Character Count: out of 6000
A program authorized under §1915(i) of the Act.
A program authorized under §1915(j) of the Act.
A program authorized under §1115 of the Act.
Specify the program:
Character Count: out of 6000
Not applicable
not selected
8. **Dual Eligiblity for Medicaid and Medicare.**
Check if applicable:
This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives.

organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Character Count: out of 6000

South Carolina is seeking to renew the South Carolina Head and Spinal Cord Injury Waiver. This Waiver will serve persons with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to the aging. All persons must meet either the Nursing Facility level of care or the ICF-MR level of care criteria. Administrative authority for this Waiver is retained by the South Carolina Department of Health and Human Services (DHHS). The South Carolina Department of Disabilities and Special Needs (DDSN) perform Waiver operations under a memorandum of agreement and service contract with DHHS. DDSN has the operational responsibility for ensuring that participants are aware of their options under this Waiver. DDSN utilizes an organized health care delivery system that includes both county Disability and Special Need Boards and private providers as Waiver service providers. Services in this Waiver are provided at the local level mainly through a traditional service delivery system. This Waiver does have a participant-directed service that allows individuals or responsible party to direct their own attendant care services if they chose this option. The services offered in this Waiver are meant to prevent and/or delay institutionalization in a nursing home or ICF/MR. This Waiver reflects the State's commitment to offer viable community options to institutional placement.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

1. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

2. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

3. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

4. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

5. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

   Yes. This waiver provides participant direction opportunities. Appendix E is required.
   No. This waiver does not provide participant direction opportunities. Appendix E is not required.
   not selected

6. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

7. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

8. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

9. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

10. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

1. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to

provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

2. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:
   Not Applicable
   No
   Yes
   not selected
3. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

   No

   Yes

   If yes, specify the waiver of statewideness that is requested *(check each that applies)*:
   Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
   Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
   Character Count: out of 6000
   Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
   Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:
   Character Count: out of 6000

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

1. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

   1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

   2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

   3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

2. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

3. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

4. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

5. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

6. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

7. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

8. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

9. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

10. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

'onal Requirements

' be completed.

In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for ' employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan describes: (a) the waiver services that are furnished to the participant, their projected type of provider that furnishes each service and (b) the other services (regardless of funding source, services) and informal supports that complement waiver services in meeting the needs of the 'ce plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not vices furnished prior to the development of the service plan or for services that are not included in

'with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in- ; facility or ICF/MR.

'e with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except 'ite services in a facility approved by the State that is not a private residence or (b) 'l food that may be reasonably attributed to an unrelated caregiver who resides in the 's provided in **Appendix I**.

'limit or restrict participant access to waiver services except as provided in

E. **Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H.**

I. Public Input. Describe how the State secures public input into the development of the waiver:
Character Count: out of 6000
The intent for the quality amendments were presented at a public meeting for the CS waiver on July 8, 2010, and at the DHHS Medical Care Advisory Committee (MCAC) on August 17, 2010. DDSN presented the waiver amendments to their Commission at the August 12, 2010 meeting. In addition, DDSN held a special called meeting on September 2, 2010, to review the amendments. The amendments were approved as presented.

J. **Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

1. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: South Carolina

Zip:

Phone: Ext: TTY

Fax:

E-mail:

2. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:
Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: South Carolina

Zip:

Phone: Ext: TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver

services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **South Carolina**

Zip:

Phone:

Fax:

E-mail:

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Character Count: out of 12000

Incontinence Supply Transition Plan: Through the State's Invitation For Bid (IFB) process, SCDHHS will select the lowest responsible and responsive vendor to provide incontinence supplies for home and community-based waivers, including the HASCI waiver. Prior to the IFB, waiver participants could receive authorized incontinence products from durable medical equipment providers enrolled with SCDHHS. Mandated product consistencies were price and count per case. Quality varied between products and there were no requirements regarding provider shipping dates. The IFB seeks to implement standards of quality and service delivery, as well as achieve cost savings for the State. Within two (2) weeks of the bid award, the Contractor must send samples of each brand of incontinence product allowed under the HASCI waiver to Service Coordinators/Early Interventionists (SC/EI). SC/EI staff will use these samples to assist waiver participants in making informed choices about the product selection. Incontinence supplies will be available to waiver participants who have been assessed by SCDDSN to have this need and whose service plans reflect it. Within a month of the contract award, the Contractor shall begin accepting revised service authorizations and delivering incontinence products to waiver participants. Deliveries will be staggered over the second and third months of the contract. By the end of the third month the Contractor shall be delivering incontinence supplies to all authorized waiver participants. Deliveries of incontinence supplies will be made at least monthly, bi-monthly or at some other authorized frequency arrangement, but not more often than monthly. All products will be first quality and latex-free. Waiver participants must have a choice of at least three (3) different brands of each type of incontinence supply available in the waiver. If the waiver participant is not satisfied, a solution will be offered by the Contractor including, if needed, products not currently available under the contract.

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

1. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

not selected
Not applicable - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
Applicable - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Character Count: out of 24000
Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Character Count: out of 24000
Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Character Count: out of 24000
Other Type of Limit. The State employs another type of limit.
Describe the limit and furnish the information specified above.

Character Count: out of 24000
Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title: Support Plan

1. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
Registered nurse, licensed to practice in the State
Licensed practical or vocational nurse, acting within the scope of practice under State law
Licensed physician (M.D. or D.O)
Case Manager (qualifications specified in Appendix C-1/C-3)
Case Manager (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Character Count: out of 6000
Social Worker.
Specify qualifications:

Character Count: out of 6000
Other
Specify the individuals and their qualifications:

Character Count: out of 6000
Service Coordinator / Early Interventionists must hold at least a Bachelor's Degree in Social Work or a related field from an accredited college or university, or hold at least a Bachelor's degree in an unrelated field from an accredited college/university and have at least one year of experience working in case management and knowledge of disabilities.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

2. Service Plan Development Safeguards. *Select one:*
Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

Character Count: out of 6000
The state utilizes a standardized tool for assessing the needs of all waiver participants. Once needs are identified and prioritized, service coordinators explain the service options that are available to meet those needs. Participants are given the names of all available providers of needed services from which they may choose. Their choice is documented.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

3. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Character Count: out of 12000
During the planning process the participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The information obtained is used by the service coordinator in order to develop the Support Plan. The participant/legal guardian will receive a copy of the Support Plan upon completion. Copies will also be provided to other service providers of the participant's/legal guardian's choosing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

4. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Character Count: out of 24000
The Service Plan is developed by the service coordinator and is based on the comprehensive assessment of the waiver participant's strengths, needs, and personal priorities (goals) and preferences. The participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing may provide input. Service plans are developed prior to the delivery of a waiver-funded service and at least within 365 days of the previous service plan or more often as the participant's needs change. Participants are informed in writing at the time of enrollment of the names and definitions of waiver services that can be funded through the waiver when the need for the service has been identified by the service coordinator. Participation in the planning process by the participant, his/her guardian, knowledgeable professionals and others of the participant's choosing, helps to assure that the participant's personal priorities and preferences are recognized and addressed by the plan. The service coordinator must utilize information about the participant's strengths, priorities, and preferences to determine how prioritized needs will be addressed. The plan will include a statement of the participant's need, indication of whether or not the need relates to a personal goal, the specific service to meet the need, the amount, frequency, duration of the service, and the type of provider who will furnish the service. The plan will include the roles and responsibilities of the service coordinator and the participant and his/her guardian for each service included in the plan. The service coordinator will have primary responsibility for coordination of services but must rely on the participant/guardian to choose a service provider from among those available, and honor appointments scheduled with providers when needed for initial service implementation, and cooperate with coordination efforts. The degree of coordination may vary based on the needs of the participant and his/her support network and their preferences for self-coordination. On at least a quarterly basis, there will be a review of the entire plan to determine if updates are needed. On an annual basis, there will be a face-to-face contact with the participant/family during which the effectiveness, usefulness, and benefits of the plan will be discussed along with the participant's/family's satisfaction with the services/providers. Changes to the plan will be made as needed by the service coordinator when the results of monitoring or when information obtained from the participant, his/her guardian, and/or service providers indicates the need for a change to the plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

5. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Character Count: out of 12000
Waiver participants' needs, including potential risks associated with their situations, are assessed and considered during the annual planning process. The plan of service document includes a section for a description of a back-up plan to be implemented during an emergency/natural disaster and a description of how care will be provided in the unexpected absence of a caregiver/supporter. A standardized assessment tool is used for all waiver participants. This tool assesses the person's current situation, risks, and his/her personal preferences. Risks and preferences are considered as part of annual planning. The plan of service document includes sections that outline the responsibilities of the waiver

participant/representative and the responsibilities of the case manager. When back-up plans are needed, those details are included with responsibilities for all parties delineated.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

6. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

   Character Count: out of 6000
   Upon request or as service needs change, participants are given a list of providers of specified waiver services for which a change is requested or needed in order to select a provider. This list includes phone numbers. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

7. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

   Character Count: out of 6000
   The format and content of the questions for the service plan document, as well as the intended planning process must be reviewed and approved by DHHS prior to implementation. Participant plans are available upon request. A sample of participant plans are reviewed by DDSN and results shared with the service coordinator and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS in an annual report.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

8. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:
   Every three months or more frequently when necessary

   Every six months or more frequently when necessary

   Every twelve months or more frequently when necessary

   Other schedule

   Specify the other schedule:

   Character Count: out of 6000
   Updated at least annually (within every 365 days from the date of the previous Plan).
9. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a

minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies)*:

Medicaid agency
Operating agency
Case manager
Other
Specify:

Character Count: out of 4000
Service Coordinator/Early Interventionist (SC/EI)

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

1. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

   Character Count: out of 24000
   At a minimum, Service Coordinators will provide quarterly contact with the participant and/or family. On a quarterly basis, there will be a review of the Support Plan which includes the most recent contact with the participant/family.
2. Monitoring Safeguards. *Select one:*
   Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

   Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant

   The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

   Character Count: out of 24000
   DDSN policy dictates the minimum frequency with which monitoring must occur and the elements (service effectiveness/usefulness, service providers, frequency and duration, and participant/family satisfaction with services) that must be included. Monitoring is documented using a standardized format that includes the noted elements along with actions to be taken when concerns are noted. As appropriate, when concerns are noted, participants/families are given information about all service providers of needed services from which they may choose. Monitoring is reviewed by DDSN as part of its quality assurance/compliance process.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

1. **Methods for Discovery: Service Plan Assurance/Sub-assurances**
   1. Sub-Assurances:
      1. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

         Performance Measures

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND Protection and Advocacy for People with Disabilities, Inc., PLAINTIFF, vs. Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs, and The South Carolina Department of Disabilities and Special Needs and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Susan Lait, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, DEFENDANTS.	IN THE COURT OF COMMON PLEAS CIVIL ACTION NO.: 2010-CP-40-1095 MOTION FOR SUMMARY JUDGMENT

FILED
2011 JUL -8 PM 3:54
JEANETTE W. McBRIDE
C.C.P. & G.S.

COMES NOW Plaintiff South Carolina Protection & Advocacy for People with Disabilities, Inc., and moves, pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, for summary judgment in the above-captioned case, as there is no genuine issue as to any material fact and Plaintiff is entitled to a judgment as a matter of law for the reasons set forth in

Plaintiff's Memorandum In Support of Its Motion for Summary Judgment, filed with this motion and incorporated herein by reference. Plaintiff's motion is also supported by the Affidavit of Gloria M. Prevost and Plaintiff's First Set of Interrogatories and Requests for Production of Documents and Defendants' Responses to Plaintiff's First Interrogatories and Request for Production all filed with the Court along with this motion.

Dated this 8th day of July, 2011.

Respectfully submitted,

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

Anna Maria Darwin
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STATE OF SOUTH CAROLINA COUNTY OF RICHLAND Protection and Advocacy for People with Disabilities, Inc., PLAINTIFF, vs. Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs, and The South Carolina Department of Disabilities and Special Needs and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, DEFENDANTS.	)	IN THE COURT OF COMMON PLEAS Civil Action No: 10-CP-40-1095 PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

2011 JUL -8 PM 3:53
JEANETTE W. WALDE
C.C.P. & G.S.

COMES NOW Plaintiff Protection and Advocacy for People with Disabilities, Inc. (P&A), pursuant to Rule 56 of the South Carolina Rules of Civil Procedure, and files its Memorandum of Law in Support of its Motion for Summary Judgment as follows:

INTRODUCTION

The primary issue must be resolved by the Court at this hearing: whether P&A must obtain written consent from residents or their legal guardians before reviewing records containing medical information (plans of care) during Team Advocacy inspections authorized in the South Carolina Protection and Advocacy System for the Handicapped Act[1] (Enabling statute). See S.C. Code Ann. § 43-33-350(4) (Supp. 2010). Defendants concede that P&A has the authority to conduct inspections but object to P&A's attempts to review records during its inspections of Community Training Homes II (CTHs).[2] Defendants argue that, due to the federal Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191. 110 Stat. 1936 (1996) (codified as amended in scattered sections of Title 42 of the United States Code), P&A cannot see any record which contains health information without the consent of the individual residents or their legal guardians. Defendants admit that they then instructed CTH II operators not to allow P&A access to resident records without such consent.

P&A is entitled to summary judgment in its favor because: (1) no genuine issue of material fact exists concerning P&A's authority to conduct inspections without the written consent of residents or their legal guardians; (2) Team Advocacy inspections fall outside HIPAA's restrictions because they are required by the Enabling statute[3] and they are health

[1] Effective July 1, 1996, Plaintiff's board of directors changed its name to Protection and Advocacy for People with Disabilities, Inc. as authorized in Senate Bill 599. S. 599, Act No. 251, Sess. 111 (Eff. Apr. 1, 1996); S.C. Code Ann. §43-33-330 (Supp. 2010).

[2] Community Training Homes (CTHs) are small residential settings. Defendants offer two levels of CTHs. In the CTH I setting, caregivers are trained private citizens who provide care in their own homes. In the CTH II setting, caregivers are employees who provide care in homes owned or rented by a provider organization. P&A inspections efforts in this case concern the CTH II setting. See S.C. Dep't of Disabilities & Special Needs, Residential Habilitation Standards (February 2011), http://ddsn.sc.gov/about/directives-standards/Documents/currentstandards/ResHabStan2%2011rev.pdf

[3] 45 C.F.R. § 164.512(a) (1) (2010) (disclosure allowed where required by law and disclosure complies with and is limited to the relevant requirements of that law).

oversight activities[4]; and (3) Defendants are required by the Enabling statute to cooperate with P&A and by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), 42 U.S.C. § 15043(a) (3) (b) (2003), to provide information concerning the adequacy of health care for people with developmental disabilities who are on Medicaid waivers[5] to P&A.

I. FACTS

In a recent case, the United Stated Supreme Court recognized the unique role of protection and advocacy systems:

> The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), 114 Stat. 1677, 42 U. S. C.§15001 *et seq.*, offers States federal money to improve community services, such as medical care and job training, for individuals with developmental disabilities. See §§15023(a), 15024. As a condition of that funding, a State must establish a protection and advocacy (P&A) system "to protect and advocate the rights of individuals with developmental disabilities." §15043(a)(1). The P&A system receives separate federal funds, paid to it directly.§15042(a) and (b). A second federal law, the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act), 100 Stat. 478, 42 U. S. C. §10801 *et seq.*, increases that separate funding and extends the mission of P&A systems to include the mentally ill. §§10802(2), 10803, 10827. At present, every State accepts funds under these statutes.
>
> Under the DD and PAIMI Acts, a P&A system must have certain powers. The system "shall . . . have the authority to investigate incidents of abuse and neglect . . . if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred."§15043(a)(2)(B); §10805(a)(1)(A). Subject to certain statutory requirements, it must be given access to "all records" of individuals who may have been abused, see §15043(a)(2)(I)(iii)(II); §10805(a)(4)(B)(iii), as well as "other records that are relevant to conducting an investigation," §15043(a)(2)(J)(i). The Acts also require that a P&A system have authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of" its charges. §15043(a)(2)(A)(i);see §10805(a)(1)(B). And in addition to pressing its own rights, a P&A system may "pursue

[4] 45 C.F.R. § 164.512(d) (1) (2010) (disclosure allowed to health oversight agency for oversight activities authorized by law for appropriate oversight of entities subject to civil rights laws for which health information is necessary for determining compliance).

[5] "Waivers" are programs created under Medicaid to provide home and community-based services. 42 U.S.C. § 1396n(c). The part of the Medicaid statute authorizing waivers specifically calls the provision of home and community based services "medical assistance." 42 U.S.C. §1396n(c) (commonly referred to as §1915(c)) Medical assistance is defined in §1396d(a) and in §1396n(c), the waiver provision, of the Social Security Act as payment of part or all of the costs of home and community-based services: *Id.*

administrative, legal, and other remedies on behalf of" those it protects. §10805(a)(1)(C); see §15044(b).

> A participating State is free to appoint either a state agency or a private nonprofit entity as its P&A system. §15044(a); §10805(c)(1)(B).....Once a State designates an entity as its P&A system, it may not change its selection without "good cause."

Va. Office for Prot. & Advocacy v. Stewart, 131 S. Ct. 1632, 1635-36, 563 U.S. _____ (2011).

South Carolina law designates P&A as the protection and advocacy system for the State of South Carolina. S.C. Code Ann. § 43-33-310 *et seq*. The Enabling statute also authorizes P&A to perform Team Advocacy inspections in addition[6] to, and as part of, its other functions:

> **SECTION 43-33-350.** Powers and duties of System.
>
> The system has the following powers and duties:
>
> (4) It may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program. Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. The designee must meet criteria developed by the Joint Legislative Committee on Mental Health and Mental Retardation, after consultation with the system and the South Carolina Association of Residential Care Homes. The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Committee on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

S.C. Code Ann. § 43-33-350(4) (Supp. 2010).

Based upon this provision, P&A has been conducting Team Advocacy inspections of community residential care facilities (CRCFs) across the state since 1986 and, to date, has

[6] 45 C.F.R. § 1386.21(f) (2010) (Requirements and authority of the Protection and Advocacy System) "A Protection and Advocacy System may exercise its authority under State law where the authority exceeds the authority required by the Developmental Disabilities Assistance and Bill of Rights Act, as amended. However, State law must not diminish the required authority of the Protection and Advocacy System." Id.

conducted over 1000 inspections of CRCFs.[7] The Team Advocacy program has reviewed records containing medical information, such as Medication Administration Records (MARs), in the CRCF context for many years now, as part of its Team Advocacy program and its contract with the Department of Mental Health to inspect CRCFs. That review has been a keystone of the program: many residents of these homes have critical, daily medical needs for which review of medical information is as essential, and as much a part of their "living conditions," as an inspection of their home's sanitation or physical structure.

Over the years, Team Advocacy inspections of CRCFs have revealed life-threatening medication errors and lack of appropriate medical care. Team Advocacy inspection reports have provided information critical to maintaining resident health and safety. If serious concerns regarding health and safety are noted, P&A files a complaint with the Department of Health and Environmental Control (DHEC), the Long Term Care Ombudsman (Ombudsman), the appropriate Regional Ombudsman, the South Carolina Department of Health and Human Services (DHHS), Department of Mental Health (DMH) and any other appropriate state agencies, such as Defendants, within twenty-four hours after each inspection. Complaints are emailed directly to agency employees who have been designated to receive the complaints by each agency. Inspection reports are then submitted to DHEC, the Long-Term Care Ombudsman and Regional Ombudsman, DHHS, DMH, the Department of Labor, Licensing and Regulation (LLR), Defendants, the Attorney General's Office (AG), the Department of Social Services (DSS), and, if appropriate, Veterans Affairs.[8] (Prevost Aff.)

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[7] See P&A, No Place To Call Home: How South Carolina Has Failed Residents of Community Residential Care Facilities July 21, 2009, http://www.pandasc.org/crcfreport.pdf.

[8] Team Advocacy CRCF inspection reports also go to three other organizations which work with people with mental illness.

Beginning in 2009, P&A attempted to conduct Team Advocacy inspections of CTHs licensed by Defendants.[9] (See Pl.'s Compl.¶ 11; Defs.' Answer¶ 10.) CTHs are residences for individuals with developmental and related disabilities. Most are directly administered by local disabilities and special needs boards and certain private providers, in accordance with standards, that have not been promulgated as regulations, established by Defendants.[10] (See Pl.'s Compl.¶ 12; Defs.' Answer, ¶ 11.) Like CRCFs, CTHs provide food, housing and care, including arrangement of medical care and medication administration, to people who are unable to live independently. Unlike CRCFs, almost all residents of CTHs require an Intermediate Care Facility/Mental Retardation (ICF/MR) level of care. (See Defs.' Resp. to Pl.'s First Interrog. No. 8.) The ICF/MR level of care is a higher level of care than that required of residents of the CRCFs P&A has been inspecting under Team Advocacy. (See Prevost Aff..) The ICF/MR level of care is similar to that required for nursing home admission but it focuses on people with intellectual or related disabilities and the special care they may need. There are approximately two thousand five hundred (2500) residents of CTHs in South Carolina. These residents are scattered among seven hundred seventy-five (775) CTHs. (See Defs.' Resp. to Pl.'s First Interrog. No. 9.)

In 2009 P&A notified Defendants that it was beginning Team Advocacy inspections of CTHs. Defendants objected to P&A's attempts to review resident records containing health information during its Team Advocacy inspections arguing that, due to HIPAA, P&A could not review any record which contained health information without the prior written permission of the

[9] Defendants also provide residential services in regional centers (Midlands Center), intermediate care facilities for people with intellectual or related disabilities, and CRCFs.

[10] See also S.C. Dep't of Disabilities & Special Needs, Directive No. 104-01-DD, SCDDSN Certification & Licensure of Residential & Day Facilities (Oct. 1, 2009), http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/104-01-DD(Revised%20100109)%20with%20memo.pdf, included as Attachment A to the Complaint. (Attach. A)

individual residents. (See Attach. C to Pl.'s Comp.) Defendants then instructed its operators not to allow P&A access to resident records without such consent. At the Team Advocacy inspections P&A conducted after Defendants' instructions to its operators, the operators have followed Defendants' direction and refused to allow P&A permission to look at records which contain health information without obtaining consent from the residents or legal guardian. (See Pl.'s Complaint¶¶ 24, 25; Defs.' Answer¶ 19.)

By refusing to allow P&A to complete its inspections, Defendants have effectively prevented P&A from ensuring that people living in CTHs have adequate health care, that they are safe and that they have the same protection from abuse and neglect as those living in CRCFs.[11] P&A's inspections will fulfill one of the main purposes of the South Carolina legislation: the protection of some of the most vulnerable people in South Carolina.

II. LEGAL ARGUMENTS

Under South Carolina law, summary judgment is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law. Fleming v. Rose, 350 S.C. 488, 493, 567 S.E.2d 857, 860 (2002). The party seeking summary judgment has the initial responsibility of demonstrating the absence of a genuine issue of material fact. Baughman v. Am. Tel. and Tel. Co., 306 S.C. 101, 115, 410 S.E.2d 537, 545 (1991) (citing Celotex Corp. v. Catrett, 477 U.S. 317 (1986)).

> With respect to an issue upon which the nonmoving party bears the burden of proof, this initial responsibility "may be discharged by 'showing'- that is, pointing out to the [trial] court- that there is an absence of evidence to support the nonmoving party's case." Celotex, 477 U.S. at 325, 106 S. Ct. at 2554, 91 L.Ed.2d at 275. The moving party need

[11] This is especially problematic when added to the fact that Defendants have not promulgated regulations for CTHs. DHEC has promulgated regulations for CRCFs. 25A S.C. Ann. Regs 61-84 (Supp. 2010).

not "support its motion with affidavits or other similar materials *negating* the opponent's claim." *Id.* at 323, 106 S. Ct. at 2553, 91 L.Ed.2d at 274. (Emphasis in original)

Baughman, 306 S.C. at 115, 410 S.E.2d at 545. All reasonable inferences must be viewed in the light most favorable to the non-moving party when determining if any triable issues of fact exist. Fleming, 350 S.C. at 493-94, 567 S.E.2d at 860 (citing Summer v. Carpenter, 328 S.C. 36, 492 S.E.2d 55 (1997)).

"The determination of legislative intent is a matter of law." Jones v. State Farm Mut. Auto Ins. Co., 364 S.C. 222, 228, 612 S.E.2d 719, 722 (2005) (citing City of Myrtle Beach v. Juel P. Corp., 344 S.C. 43, 543 S.E.2d 538 (2001)); *see also* Hardee v. McDowell, 372 S.C. 413, 417, 642 S.E.2d 632, 634 (2007) (citing, Thompson v. Ford Motor Co., 200 S.C. 393, 21 S.E.2d 34 (1942) (noting that the interpretation of the meaning of a statutory term is not a finding of fact)); Johnson v. Pratt, 200 S.C. 315, 20 S.E.2d 865 (1942) (acknowledging that statutory construction is the province of the court).

A. SUMMARY JUDGMENT IS PROPER BECAUSE P&A HAS THE AUTHORITY TO CONDUCT TEAM ADVOCACY INSPECTIONS OF FACILITIES PROVIDING RESIDENCE FOR PEOPLE WITH DISABILITIES TO REVIEW LIVING CONDITIONS, INCLUDING PLANS OF CARE.

P&A is the designated protection and advocacy system for the state of South Carolina. S.C. Code Ann. § 43-33-310 (Supp. 2010). As the protection and advocacy system for South Carolina, P&A is authorized to conduct Team Advocacy inspections under S.C. Code Ann. § 43-33-350(4) (Supp. 2010). Team Advocacy inspections are "**unannounced visits to review the living conditions of a residential facility, including the plans of care** for individuals in a residential care facility and a community mental health center day program." Id. (emphasis added). Defendants admit that P&A attempted to conduct Team Advocacy inspections in CTHs,

but Defendants refused P&A access to records and plans of care without prior written consent from CTH residents or their legal guardians. By demanding that P&A obtain prior written consent before its review of records or plans of care, Defendants interfered with P&A's exercise of its authority and violated South Carolina law.

1. S.C. Code Ann. §43-33-350(4) clearly and unambiguously allows P&A to conduct Team Advocacy inspections without prior written consent of the residents or their legal guardians.

In determining the meaning of the Team Advocacy provision, the court should begin its analysis with an examination of the language of the statute to determine whether the provision at issue is clear on its face and harmonizes with the purposes of the entire statute or whether the provision is ambiguous. See Multi-Cinema, Ltd. v. S.C. Tax Comm'n, 292 S.C. 411, 414, 357 S.E.2d 6, 7 (1987). The court must first review the plain meaning of all of the words used in the statutes, not just selected terms. See Gilstrap v. S.C. Budget & Control Bd., 310 S.C. 210, 214, 423 S.E.2d 101, 103 (1992). When reviewing the plain and ordinary meaning of words used in a statute, "the terms must be construed in context and their meaning determined by looking at the other terms used in the statute." Id. at 214, 423 S.E.2d at 103. Furthermore, in ascertaining the plain meaning of words used in a statute, "a provision should be given a reasonable and practical construction consistent with the purpose and policy of the Act." Id.

"In construing statutory language, the statute must be read as a whole, and sections which are part of the same general statutory law must be construed together and each one given effect, if it can be done by any reasonable construction." Higgins v. State, 307 S.C. 446, 415 S.E.2d 799, 801 (1992); see also S.C. Coastal Council v. S.C. State Ethics Comm'n, 306 S.C. 41, 44, 410 S.E.2d 245, 247 (1991) (the court does not look merely to a particular clause, but instead

looks to the provision and its meaning in conjunction with the purpose of the whole statute, and in light of the object and policy of the law).

> The true guide to statutory construction is not the phraseology of an isolated section or provision, but the language of the statute as a whole considered in the light of its manifest purpose. In applying the rule of strict construction the courts may not give to particular words a significance clearly repugnant to the meaning of the statute as a whole, or destructive of its obvious intent. Every technical rule as to construction of a statute is subservient to and must yield to the expression of the will of the legislature, since all rules of statutory construction have for their sole object the discovery of the legislative intent and are valuable only insofar as in their application they aid the courts in their endeavor to ascertain that intent.

City of Columbia v. Niagara Fire Ins. Co., 249 S.C. 388, 391-92, 154 S.E.2d 674, 676 (1967).

The purpose of the South Carolina Protection and Advocacy System for the Handicapped Act (the Enabling statute) as stated by the legislature is:

> [T]o permanently establish as advocate under Section 113 of Public Law 94-103, as amended by 95-602, an eleemosynary corporation already formed under the corporate name, South Carolina Protection and Advocacy System for the Handicapped, Inc. It is the further purpose of this act to express the desire of the General Assembly that South Carolina Protection and Advocacy System for the Handicapped, Inc., exercise protection and advocacy functions not only for the developmentally disabled citizens of South Carolina but also for all other handicapped citizens of the State.

S.C. Code Ann. § 43-33-310 (Supp. 2010). To achieve this stated purpose, the Code requires that P&A protect and advocate for the rights of all people with disabilities by pursuing legal, administrative, and other appropriate remedies to insure the protection of the rights of these persons. S.C. Code Ann. § 43-33-350(1). The Code also authorizes P&A to investigate complaints by or on behalf of people with disabilities, § 43-33-350(2); to establish priorities for the delivery of its services, § 43-33-350(3); and to conduct team advocacy inspections of facilities providing residence to people with disabilities. § 43-33-350(4).

In § 43-33-350(4), the Team Advocacy provision, the Code requires that (1) the inspections be performed by P&A staff and trained volunteers; (2) the visits be unannounced; (3) the inspections be reviews of the living conditions of a residential facility, including plans of care of the residents; (4) the review of the plans of care be made by the team advocacy coordinator or that person's designee; and (5) P&A prepare and submit a report on the inspection to certain state entities. § 43-33-350(4). Thus, the Code creates the Team Advocacy inspection program and specifically spells out many aspects of that program, but does not require that residents of the facilities consent to either the inspection or a review of their records. Nor does § 43-33-350(4) even require that the residents receive notice of the inspections. In fact, the Team Advocacy provision specifically requires that the inspection visits be **unannounced**. To require that P&A obtain consent from residents and their legal guardians before its inspections would, in effect, re-write the statute and defeat the legislature's intent that the inspections be unannounced.

Defendants argue that their denial of access to P&A does not stop P&A from performing inspections. According to Defendants, P&A can either perform limited inspections or get consent from residents or their legal guardians. However, limited inspections defeat the purpose of the provision since care and treatment, including medication administration, of these vulnerable individuals is a very important part of the services provided in these facilities.

Consent of residents or their legal guardians is unnecessary under § 43-33-350(4), it would defeat the purpose of the provision requiring unannounced inspections, and would impose a limit on the access authority of P&A that the legislature did not intend. A clear reading of the statute shows P&A is supposed to be able to conduct these inspections regardless of the cooperation of the workers, the facilities or the residents. If P&A obtains consent, as suggested by Defendants, the statutory grant of authority is unnecessary. Under Defendants' interpretation,

if a resident or their legal guardian refused consent, P&A would be denied access to the records or plans of care of a CTH resident. This would effectively re-write the SCP&A statute by eliminating "including the plans of care" from it.

2. P&A ACCESS TO PLANS OF CARE IS ESSENTIAL TO RESIDENT SAFETY AND PROTECTION. DEFENDANTS' INTERPRETATION WOULD BE REPUGNANT TO THIS PURPOSE AND ADD IN A REQUIREMENT THE LEGISLATURE DID NOT INTEND.

Although Defendants concede that P&A can conduct Team Advocacy inspections, they dispute the meaning of the clause, "living conditions . . ., including the plans of care . . ." S.C. Code Ann. § 43-33-350(4). Defendants claim that this phrase does not refer to plans which include medical information. Defendants also argue that this authority encompasses only a particular, individual document, the "residential treatment/support plan," which contains no medical information. As noted above, the clear and unambiguous language of the Code requires that staff and trained volunteers conduct the inspections; that the visits be unannounced; that the inspections review the living conditions, including the plans of care for individuals living in the facility; that only the coordinator or her designee review the plans of care; and that P&A prepare and submit a report of the inspection to certain state entities, including DHEC. S.C. Code Ann. § 43-33-350(4). Defendants' interpretation is contrary to the plain meaning of the Code and particularly the term "plans of care "in § 43-33-350(4). This interpretation would also give to this term a significance which is clearly repugnant to the meaning of the statute as a whole and destroy the obvious intent of the statute.

a) The plain meaning of "living conditions, including . . ." includes medical care and treatment.

The term "living conditions" is not specifically defined in any controlling statutory law or regulations, either state or federal.[12] There is a similar lack of conclusive case law on the subject.

The court must first review the plain meaning of all of the words used in the statutes, not just selected terms. See Gilstrap v. S.C. Budget & Control Bd., 310 S.C. 210, 214, 423 S.E.2d 101, 103 (1992). When reviewing the plain and ordinary meaning of words used in a statute, "the terms must be construed in context and their meaning determined by looking at the other terms used in the statute." Id. at 214, 423 S.E.2d at 103. Furthermore, in ascertaining the plain meaning of words used in a statute, "a provision should be given a reasonable and practical construction consistent with the purpose and policy of the Act." Id.

Again, the purpose of the Enabling statute is to permanently establish P&A as advocate under the DD Act and to extend P&A's protection and advocacy functions so as to protect all other people with disabilities in the State. S.C. Code Ann. § 43-33-310. As the U.S. Supreme Court recognized in Va. Office for Prot. & Advocacy v. Stewart, 131 S. Ct. 1632, 563 U.S. _____ (2011), states receive federal money under the DD Act to "improve community services, such as medical care...for individuals with developmental disabilities." Va. Office for Prot. & Advocacy v. Stewart, 131 S. Ct. 1632,1636, 563 U.S._____, (citing 42 U.S.C.§§15023(a), 15024). In order to receive federal funds, South Carolina had to establish a protection and advocacy system "to protect and advocate the rights of individuals with developmental

[12] There are a small number of other uses of the phrase in S.C. Statutes, apart from the usage in P&A's Team Advocacy law, but none give a clear definition beyond the plain meaning of the term. See, e.g., S.C. Code Ann. § 13-1-350(4) (k) (S.C. Commerce Development Board should endeavor to secure for S.C. residents "an improvement in their living conditions and general welfare"); S.C. Code Ann. § 46-43-20 ("The duties and authority of the [Migrant Farm Workers] Commission shall be: . . [to examine labor programs] relating to living conditions; health, housing and sanitation. . .").

disabilities." 42 U.S.C. § 15043(a) (1). Both the DD Act and the South Carolina Code emphasize the need to protect as well as advocate. The Code also repeatedly refers to the "care" and "treatment" of people with disabilities. See S.C. Code Ann. § 43-33-340(2) (e) (1976) (developmental disability is a severe, chronic disability which reflects the person's need for combination and sequence of special, interdisciplinary or generic care and treatment which are lifelong or extended); § 43-33-340(3) (developmentally disabled person is a person who has a developmental disability and who receives or is entitled to receive treatment); § 43-33-340(5) (complaint is an allegation "to the effect that the developmentally disabled or handicapped person is being subjected to injury or deprivation with regard to his **health**, safety, welfare, rights or **level of care.**") (emphasis added); § 43-33-350(1) (P&A shall protect and advocate for rights of all people with disabilities by pursuing legal, administrative and other appropriate remedies to insure the protection); § 43-33-380 (system may make such disclosures as may be necessary to protect).

Looking at the plain meaning of all the words used, the context, and the comparison with other terms used in the statute, it is clear on its face that the legislature included medical care and treatment as living conditions of a person who needs lifelong or extended care. § 43-33-340(2) (e). Giving the Team Advocacy provision this reasonable and practical construction is consistent with the legislature's purposes of compliance with the DD Act and protection of people with disabilities and their health. Only this construction is consistent with achieving the purpose of the statutes.

Finally, Defendants' attempt to interpret "plans of care" to exclude documents with medical information is destructive of the Enabling statute's obvious intent. The Team Advocacy provision creates a program focused on protecting people with disabilities who require a high

level of care by requiring: unannounced visits; staff and trained volunteers; review of living conditions, including the plans of care; review of plans of care only by the coordinator of the program or her designee; and reports on the inspections to state entities, including DHEC.[13]

Defendants admitted in their response to Plaintiff's Interrogatory No. 8 that, "Almost every resident of a CTH meets the ICF/MR level of care...." (See Defs.' Resp. to Pl.'s First Interrog. No. 8.) ICF/MRs are highly regulated at both the state and federal level because of the multiple needs of their residents, many of whom could not communicate effectively if they were abused or neglected. CTH residents are very similar. In fact, Defendants note in one of their directives that,

> "In South Carolina, DDSN operated Home and Community-Based MR/RD Waiver programs, which allow services similar to those provided in an ICF/ID to be funded by Medicaid when provided outside of an ICF/ID. Therefore, DDSN Waivers allow ICF/ID residents to move from the ICF/ID to another setting (e.g., ... Community Training Home,...)....

S.C. Dep't of Disabilities & Special Needs, Directive No. 738-01-DD, Discharge Planning for Those Leaving ICFs/ID and Enrolling in a MR/RD DDSN Operated Home and Community-Based Waiver (with the exception of the PDD Waiver) (May 9, 2011), http://ddsn.sc.gov/about/directives-standards/Documents/currentdirectives/738-01-DD%20-%20Revised%20%28050911%29.pdf

Administration and monitoring of medication are necessary and critical parts of the daily life for most residents of CTHs, and, thus, just as much a part of their "living conditions" as their food or clothing. Defendants' "Residential Licensing Standards" for Community Training

[13] DHEC is the state agency charged with protecting public health as authorized under multiple state and federal laws. DHEC inspects and regulates care facilities and providers across the state. http://www.scdhec.gov/administration/aboutDHEC.htm

Homes[14] include, among other safety matters such as regular fire inspections and the presence of a first aid kit, that "medications must be safely and accurately given." S.C. Dep't for Disabilities & Special Needs, Residential Licensing Standards 7 (Revised Feb. 2011) (Standard 3.4), http://ddsn.sc.gov/about/directives-standards/Documents/currentstandards/Residential%20Licensing%20Standards%20(Revised%20050111).pdf. The fact that the single subcategory "Health Services" encompasses both medication administration and the provision of "a nourishing, well-balanced diet," speaks to the degree to which health care and medication are an integral part of residents' daily lives – on par with their food. Id. at 7, 8 (Standards 3.4, 3.5, 3.6).

b) "Including" indicates that the list is not exhaustive.

The word "including" and the clause following it were added to P&A's enabling legislation by S.C. Legis. Act 133 (1993), which stated that the amendment was "so as to provide for the review of plans of care for individuals. . ." S.701, Act No. 133, Sess. 110 (S.C. 1993). Despite the general rule of statutory construction that, "to express or include one thing implies the exclusion of another,"[15] and items not on a list are assumed excluded, the use of the word "including" typically inverts that assumption, and indicates that the following nouns are examples, not exclusive. See Black's Law Dictionary (8th ed. 2004):

[14] S.C. Dep't of Disabilities & Special Needs, Residential Licensing Standards (Revised Feb. 2011), http://ddsn.sc.gov/about/directives-standards/Documents/currentstandards/Residential%20Licensing%20Standards%20(Revised%20050111).pdf.

[15] Berkeley County Sch. Dist. v. S.C. Dep't of Revenue, 383 S.C. 334, 348, 679 S.E.2d 913, 920 (2009); see also Riverwoods, LLC v. County of Charleston, 349 S.C. 378, 384, 563 S.E.2d 651, 655 (2002) ("The enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded. Exceptions strengthen the force of the general law and enumeration weakens it as to things not expressed.") (quoting Norman J. Singer, *Sutherland Statutory Construction* § 47.23 at 227 (5th ed.1992)).

> [I]nclude, *vb.* To contain as a part of something. • The participle *including* typically indicates a partial list <the plaintiff asserted five tort claims, including slander and libel>. But some drafters use phrases such as *including without limitation* and *including but not limited to* — which mean the same thing.[16]

Therefore, the use of "including" implies that P&A's power to inspect "living conditions, including plans of care . . . ." should be construed broadly, particularly for records affecting safety. Given the purpose of the DD Act, the South Carolina Enabling statute, and the specialized setting and high level of care required by most of the residents, "living conditions" in a CTH setting necessarily include the quality of the ongoing medical care that the residents are receiving.

Whether construed as an expansion or clarification of P&A authority, the phrasing indicates a legislative desire to establish P&A's broad inspection authority over the "living conditions" of these residents, including their "plans of care."

c) Medical information may be included in "the plans of care."

i. "Plans of Care" in the Team Advocacy provision

There is no explicit definition of "plans of care" in the Team Advocacy provision or state enabling statue, again requiring a plain-language reading of the term. S.C. v. Sweat, 379 S.C. 367, 375, 665 S.E.2d 645, 649 (Ct. App. 2008). A plain-language construction would indicate the Team Advocacy inspector has access to all "plans," *plural*, that relate to "care," of whatever kind, for the stated residents. When this language was added to the Enabling statute in 1993, the legislature would have been aware of the DD Act and its purpose to "improve community

[16] *See also* In re Grewe, 4 F.3d 299, 305 n.5 (4th Cir. 1993) (citing "the general rule of statutory construction that the parenthetical beginning with "including" enlarges the scope [of the statute interpreted] rather than limits it."); Am. Sur. Co. of New York v. Marotta, 287 U.S. 513, 517 (1933) ("In definitive provisions of statutes and other writings, 'include' is frequently, if not generally, used as a word of extension or enlargement rather than as one of limitation or enumeration.").

services, such as medical care..." Va. Office for Prot. & Advocacy v. Stewart, 131 S. Ct. 1632, 1636 563 U.S. ____ ,(citing 42 U S C. §§ 15023(a), 15024). Both the DD Act and the Code emphasize the need to protect as well as advocate. The Code also repeatedly refers to the "care" and "treatment" of people with disabilities. See S.C. Code Ann. §§ 43-33-340(2) (3),43-33-340(3), 43-33-340(5), 43-33-350(1). The legislature was obviously referring to a general concept of plans of care in the Team Advocacy provision. Defendants should not be in the position of arbitrarily changing the scope of P&A's Enabling statute just by changing Defendants' own description or definition of plans of care.

Defendants argue that the phrase "plans of care" only means the residential/treatment plan which may be used in CTHs. Defendants' Responses to Plaintiff's First Set of Interrogatories No. 19. This argument, however, flies in the face of the plain meaning of the phrase and the law of statutory construction. The phrase itself indicates that there may be more than one plan P&A can review as part of its inspection and that the plans targeted for review concern "care" of the residents. Defendants admit in their Answer to Plaintiff's Complaint that "plans of various kind" are used for CTH residents but then argue that, for purposes of a Team Advocacy inspection, they are only required to disclose the residential plan to P&A. The residential plan proffered by Defendants does not contain information about the medical care given to residents. Again, this interpretation would limit P&A's review to one plan and to the one plan which does not contain information about the care provided to CTH residents. Such an interpretation is completely contrary to the language of the statute and would destroy the obvious intent of the legislature.

Finally, in their responses to Plaintiff's interrogatories, Defendants state that "Residential Habilitation standard (RH5.0) requires that each person receive continuous and coordinated

health care. People must be evaluated by a licensed physician, physician's assistant or nurse practitioner (and dentist) and the plan of care must be followed." (Defs.' Resp. to Interrog. No. 13.) This response shows that, in spite of their assertion that the phrase "plans of care" is a term of art which refers only to their residential/treatment plan, Defendants' use of the term plan of care and shows that its use is directly related to health care for residents.

State law contains several other references to "plans of care", all of which refer to a written plan that details whatever care, medical or otherwise, that a particular individual is receiving See S.C. Code Ann. § 44-81-40 (2002) (Bill of Rights of Residents of Long –Term Care Facilities) ; S.C. Code Ann. § 44-113-10; S.C. Code Ann. § 44-7-350 ; S.C. Code Ann. § 40-33-44 ; S.C. Code Ann. §43-35-10 (Supp. 2010) (Omnibus Adult Protection Act); S.C. Code Ann. § 44-36-290 (2010) (Childcare Facilities); S.C. Code Ann. § 63-13-80 (2010)(Childcare Facilities-Investigations and inspections) (2010) , §63-13-420(B) (Childcare Facilities-Licensure requirements) and §63-13-620(B) (Childcare Facilities—Statement of approval requirements); S.C. Code § 40-45-280(c) (2) (2011), (Physical Therapists); S.C. Code Ann. § 59-63-80 (Supp.2010) (Pupils Generally; health care plans for students) .

Similarly, several South Carolina agency regulations also refer to "plans of care" in varying contexts, generally following the plain meaning, and often including medical care as an aspect of the plan. See, e.g., 24A S.C. Code Ann. Regs. 61-13 (Supp. 2010) (DHEC Regulation 61-13 § E (3) A, Standards for Licensing Habilitation Centers For The Mentally Retarded or Persons With Related Conditions). This section deals with staffing requirements and refers to "the health aspects of the individual plans of care" (implying the "plans of care" could include medical information suitable for review by a nurse). See 25 S.C. Code Ann. Regs 61-78 (Supp. 2010) (DHEC Regulation 61-78, Standards for Licensing Hospices, §704 (plans of care to be

developed by the interdisciplinary team, approved by a physician and shall include the care, treatment and services relative to the needs of the patient...)); S.C. Code Ann. Regs 126-314 (Supp. 2010) (S.C. DHHS Regulation 126-314, Nursing Facility Services,(Medicaid nursing services to be provided according to a written plan of care supervised by a physician)).

ii. This Interpretation Is Also Supported by Other Relevant State Provisions.

One additional portion of the P&A Enabling statute gives interpretive guidance here. Significantly, the legislature put in place extensive safeguards on the Team Advocacy Inspector's review authority. Section 43-33-350 (4) states:

> Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care.... The system shall prepare a report based on the inspection which must be submitted to..., South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

S.C. Code Ann. § 43-33-350(4) (Supp. 2010). Additionally, the Enabling legislation also states, in section 43-33-380, that:

> The System shall not disclose the name or identity of any person, complainant, witness or subject of a complaint or any information or writing relating thereto unless the person or his parent or legal guardian authorizes in writing the release of such information but the System may make such disclosures as may be necessary to protect or advocate for the rights of the developmentally disabled or handicapped person concerned.

S.C. Code Ann. § 43-33-380 (Supp. 2010).

Both of these sections, taken together, constitute strong protections for residents' privacy rights. Only a specific Team Advocacy staff member or designee is authorized to review "plans of care," and inspection reports are sent to specific state agencies. Furthermore, P&A staff generally are bound from disclosing the name or identity of any person without specific authorization from that person, his parent, or his legal guardian.

Such strong protections indicate that the legislature intended P&A Team Advocacy inspectors to review sensitive and private information; otherwise, these protections would not be necessary. Cf. S. C. v. Sweat, 379 S.C. 367, 377, 665 S.E.2d 645, 651 (Ct.App. 2008) ("When interpreting a statute, courts must presume the legislature did not intend to do a futile act. . . . 'A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous . . . .' ") (quoting Matter of Decker, 322 S.C. 215, 219, 471 S.E.2d 462, 463 (1995)).

P&A's own interpretation of its enabling statutes should carry weight, even though it is not a state agency as is usually considered when courts defer to agency interpretations of statutes that they administer . See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837 (1984); S. C. v. Sweat, 379 S.C. at 374, 665 S.E.2d at 649 ("The construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons."). Since the State has delegated the administration and performance of protection and advocacy functions to P&A, P&A should be given Chevron deference when it interprets its own statute. The Team Advocacy program has reviewed records containing medical information, including MARs, in the CRCF context for many years now, as part of its Team Advocacy program. That review has been a keystone of the program: many residents of these homes have critical, daily medical needs for which review of medical information is as essential, and as much a part of their "living conditions," as an inspection of their home's sanitation or physical structure.

3. TEAM ADVOCACY INSPECTIONS FALL OUTSIDE HIPAA'S RESTRICTIONS BECAUSE THEY ARE REQUIRED BY LAW AND THEY ARE HEALTH OVERSIGHT ACTIVITIES.

a) "Required by Law"

Defendants argue that they cannot allow P&A access to residents' medical records without consent of the residents due to the medical privacy rights established under HIPAA. Supra. In most cases, HIPAA requires explicit, detailed authorization for the release of any medical records or information, and the requirements of HIPAA typically override state laws.[17] P&A activities, however, are protected by two HIPAA exemptions. The most significant exemption is in 45 C.F.R. § 164.512(a) (1), which states that,

> A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

45 C.F.R. § 164.512(a) (1) (2010).

The United States Department of Health and Human Service's own interpretation clearly states protected health information may be released to State Protection and Advocacy services when "required by law" according to this provision.

> Question:
>
> **May a covered entity disclose protected health information to a Protection and Advocacy system where the disclosure is required by law?**
>
> Answer:
>
> Yes. The Privacy Rule permits a covered entity to disclose protected health information (PHI) without the authorization of the individual to a state-designated Protection and Advocacy (P&A) system to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law. 45 CFR 164.512(a). . . . Thus, a covered entity may disclose PHI as required by the

[17] See 42 U.S.C. § 1320d-7(a) (1) ("shall supersede any contrary provision of State law").

> DD and PAIMI Acts to P&As requesting access to such records in carrying out their protection and advocacy functions under these Acts. **Similarly, covered entities may disclose PHI to P&As where another federal, state or other law mandates such disclosures, consistent with the requirements in such law.** Where disclosures are required by law, the Privacy Rule's minimum necessary standard does not apply, since the law requiring the disclosure will establish the limits on what should be disclosed. Moreover, with respect to required by law disclosures, a covered entity cannot use the Privacy Rule as a reason not to comply with its other legal obligations.

U.S. Dep't of Health & Human Servs., Aug. 8, 2008, http://www.hhs.gov/hipaafaq/permitted/require/909.html (last visited July 8, 2011) (emphasis added). The statement by the U.S. DHHS is an interpretation of its own regulations and is entitled to judicial deference. See Chevron, U.S.A., Inc. v. Natural Res's Def. Council, Inc., 467 U.S. 837 (1984).

At least one federal court has ruled that the "required by law" provision under 45 C.F.R. § 164.512 (a) (1) applies to P&A inspections authorized by state law. In Ohio Legal Rights Serv. v. Buckeye Ranch, Inc., 365 F. Supp. 2d 877, 888-89 (S.D.Ohio 2005), a state law provision granted the Ohio Legal Rights Service (OLRS) (the state designated Ohio protection and advocacy system) the right of "ready access" to "all records" relating to the following:

> [T]he commitment, care, treatment, and habilitation of all persons represented by the legal rights service, including those who may be represented pursuant to division (L) of this section, or persons detained, hospitalized, institutionalized, or receiving services under this chapter or Chapter 340., 5119., ...
>
> ....
>
> The Court finds that OLRS has a right under Ohio law to obtain access to the wrist records and the seclusion and restraint logs. Under § 5123.60(E)(1), OLRS's right of access includes access to all records maintained by a community residential facility relating to the care and treatment of persons receiving services under Chapter 5119 of the Ohio Revised Code.

Ohio Legal Rights Serv. v. Buckeye Ranch, Inc. at 888-89. The court held that because OLRS had a right of access to records under state law, that right fell within the 45 C.F.R. § 164.512(a)(1) "required by law" HIPAA exception, stating:

> Subparagraph (1) is an exception that stands on its own, allowing a covered entity to make a disclosure otherwise prohibited by HIPAA if that disclosure is required by another law. In disclosing the information, the covered entity must simply comply with the requirements of the other law-HIPAA imposes no further conditions.

Id. Other federal courts have made similar decisions. See also Prot. & Advocacy Sys., Inc. v. Freudenthal, 412 F.Supp.2d 1211, 1218 (D.Wyo. 2006) (Holding, in the context of the federal P&A acts, that "the HIPAA Privacy Rule does not bar the State Hospital and State Training School from disclosing 'protected health information' without the authorization of the individual to P & A if such disclosure is required by a P & A act, and that P & A complies with the requirements set forth in the act.").

The court in Ohio Legal Rights Serv. v. Buckeye Ranch explicated its reasoning by quoting extensively from the Comments in the Federal Register:

> A reading of the final commentary accompanying the HIPAA regulations confirms that the Court's interpretation is correct. The commentary notes that the phrase "required by law" "is intended to be read broadly to include the full array of binding legal authority, such as constitutions, statutes, rules, regulations .... [I]t encompasses federal, state or local actions with legally binding effect ...." 65 Fed.Reg. 82462, 82668. The commentary states that § 164.512(a) was generally meant not to interfere with, or add onto, the requirements of those other laws:
>
> > [W]e intend this provision to preserve access to information considered important enough by state or federal authorities to require its disclosure by law.... [S]uch required uses and disclosures arise in a myriad of other areas of law, ranging from topics addressing national security (uses and disclosures to obtain security clearances), to public health (reporting of communicable diseases), to law enforcement (disclosures of gun shot wounds). Required uses and disclosures also may address broad national concerns or particular regional or state concerns. It is not possible, or appropriate, for [Health and Human Services] to reassess the legitimacy of

> or the need for each of these mandates in each of their specialized contexts.

Ohio Legal Rights Serv. v. Buckeye Ranch, Inc. at 890 (quoting 65 Fed. Reg. 82462 (Dec. 28, 2000), 65 Fed. Reg. 82668 (Dec. 28, 2000).

As shown above, P&A is authorized by South Carolina law to conduct Team Advocacy inspections. S.C. Code Ann. § 43-33-350(4). Under § 43-33-350(4), it is clear that Team Advocacy inspections require review of records. Additionally, § 43-33-400 states, "All departments, officers, agencies and institutions of the State shall cooperate with the System in carrying out its duties." Since P&A has a right of access to resident records under state law, that right falls within the 45 C.F.R. § 164.512(a) (1) "required by law" exception. Defendants cannot use HIPAA as an excuse to refuse to allow P&A access to resident records during Team Advocacy inspections. "Moreover, with respect to required by law disclosures, a covered entity cannot use the Privacy Rule as a reason not to comply with its other legal obligations." See U.S. Dep't of Health & Human Servs., Aug. 8, 2005, http://www.hhs.gov/hipaafaq/permitted/require/909.html (last visited July 8, 2011).

b) **P&A conducts "Health Oversight Activities" and is therefore outside of HIPAA.**

Like Ohio Legal Rights Service, P&A also falls within the health oversight activities exception to HIPAA. Under this exception, covered entities may disclose protected health information to:

> A health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, **inspections**, licensure or disciplinary actions; civil , administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of :
>
> (i) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;
(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or
(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

45 C.F.R. § 164.512(d) (1) (2010) (emphasis added).

The court in Ohio Legal Rights Serv. v. Buckeye Ranch, Inc., found that the Ohio Legal Rights Service met the definition of a "health oversight agency" because it is a state agency which is authorized by federal and state law to enforce civil rights laws for which health information is relevant. 365 F. Supp. 2d 877, 891-92 (S.D. Ohio 2005). P&A is officially designated to perform all the same functions and to fill all of the same roles as the Ohio Legal Rights Service. The only remaining issue is whether P&A fits within the definition of "health oversight agency" since it is not a state agency.

A "health oversight agency" under HIPAA is defined as:

> [A]n agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or **a person or entity acting under a grant of authority from or contract with such public agency,** including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, **that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.**

45 C.F.R. §164.501 (2010) (emphasis added).

First, P&A is a health oversight agency because it is "a person or entity acting under a grant of **authority from** or contract with such public agency... Id. (emphasis added). As noted above, first the governor and then the legislature designated P&A to be the protection and

advocacy system for the state. S.C. Code Ann. § 43-33-310. This is a specific grant of authority from the State of South Carolina. P&A is also recognized as an "instrumentality" of the state in the South Carolina Tort Claims Act. S.C. Code Ann. § 15-78-20 *et seq.* (Supp. 2010). S.C. Code Ann. § 15-78-30 says:

> "State" means the State of South Carolina and any of its offices, agencies, authorities, departments, commissions, boards, divisions, **instrumentalities, including the South Carolina Protection and Advocacy System for the Handicapped, Inc.....**

S.C. Code §15-78-30(e) (Supp. 2010), *available at* http://www.scstatehouse.gov/code/t15c078.htm.

The United States Supreme Court has recognized the special nature, position and authority of protection and advocacy systems:

> The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), 114 Stat. 1677, 42 U. S. C.§15001 *et seq.*, offers States federal money to improve community services, such as medical care and job training, for individuals with developmental disabilities. See §§15023(a), 15024. As a condition of that funding, **a State must establish a protection and advocacy (P&A) system "to protect and advocate the rights of individuals with developmental disabilities." §15043(a)(1). The P&A system receives separate federal funds, paid to it directly.**§15042(a) and (b). **A second federal law, the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act), 100 Stat. 478, 42 U. S. C. §10801 *et seq.*, increases that separate funding and extends the mission of P&A systems to include the mentally ill.** §§10802(2), 10803, 10827. At present, every State accepts funds under these statutes.
>
> **Under the DD and PAIMI Acts, a P&A system must have certain powers.**

Va. Office for Prot. & Advocacy v. Stewart, 131 S. Ct. 1632, 1635-36, 563 U.S. _____ (2011) (emphasis added).

Second, P&A is "authorized by law....to enforce civil rights laws for which health information is relevant." 45 C.F.R. §164.501 (2010). Like Ohio Legal Rights Service, P&A is charged with protecting and advocating the rights of individuals with disabilities. See South Carolina Protection and Advocacy System for the Handicapped, S.C. Code Ann. § 43-33-310 *et seq.*; Developmental Disabilities Assistance and Bill of Rights Act of 2000, 114 Stat. 1677, 42 U.S.C.§ 15001 *et seq.*; Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 100 Stat. 478, 42 U.S.C. §§ 10801, 10802(2), 10803, 10827 (extending the mission of P&A systems to include individuals with mental illness); Protection & Advocacy for Individual Rights, 29 U.S.C. § 794e) (extending the mission of P&A systems to include people with disabilities who are not covered under PAIDD, PAIMI, or the Client Assistance Program (CAP)); and, Protection and Advocacy for Traumatic Brain Injury, 42 U.S.C. § 300d-53) (extending the mission of P&A systems to include people with traumatic brain injury). Under federal law, P&A has the authority to investigate complaints and incidents of abuse and neglect, to monitor facilities and to pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of persons with disabilities who are receiving care or treatment in South Carolina. South Carolina also gave P&A the authority conduct Team Advocacy inspections. S.C. Code Ann. § 43-33-350(4). Federal and state law both equip P&A with ability to gather health information relevant in determining if the civil rights of a person with a disability have been violated. In essence, P&A performs the oversight function of protecting people with disabilities in South Carolina.

Finally, P&A was engaged in a health oversight activity when it attempted to conduct Team Advocacy inspections in CTHs. Included among "health oversight activities" are "audits, civil, administrative, or criminal investigations, **inspections**,....necessary for appropriate

oversight of...entities subject to civil rights laws for which health information is necessary for determining compliance" 45 C.F.R. §164.512(d) (1) (2010) (emphasis added). P&A made its inspections in an effort to determine whether the civil rights of residents in CTHs had been violated.

Based upon the above, P&A Team Advocacy inspection activity falls within the "health oversight activities" exception to HIPAA.

B. SUMMARY JUDGMENT IS APPROPRIATE ON THE SECOND CAUSE OF ACTION BECAUSE DEFENDANTS ARE REQUIRED TO COOPERATE WITH P&A.

S.C. Code Ann. § 43-33-400 (Supp. 2010) states: "All departments, officers, agencies and institutions of the State shall cooperate with the System in carrying out its duties." As the protection and advocacy system for South Carolina, P&A is authorized to conduct Team Advocacy inspections under S.C. Code Ann. § 43-33-350(4). Team Advocacy inspections are **"unannounced visits to review the living conditions of a residential facility, including the plans of care** for individuals in a residential care facility and a community mental health center day program." Id.(emphasis added).

The evidence reveals that P&A attempted to conduct Team Advocacy inspections in CTHs, one of the powers or duties provided in § 43-33-350. Defendants, however, refused to cooperate with P&A by denying P&A access to records and plans of care during Team Advocacy inspections without prior written consent from CTH residents. When notified of Defendants' concerns, P&A attempted to persuade Defendants to cooperate and notified Defendants of its interpretation of the state law, its federal enabling statutes, and that the Team Advocacy inspections fell within exceptions to HIPAA. In spite of these efforts by P&A, Defendants continued to refuse to cooperate with P&A by allowing access to medical records and plans of

care. Defendants admitted they ordered the operators of CTHs to refuse to cooperate with P&A during its Team Advocacy inspections and that the operators also refused to cooperate with P&A.

By refusing P&A access to records and plans of care during its Team Advocacy inspections and ensuring that the CTH operators also refused P&A access to such records, Defendants interfered with P&A's exercise of its authority, refused to cooperate with P&A in its efforts to carry out its duties and violated South Carolina law.

Based on the foregoing, no genuine issue of material fact exists concerning whether Defendants refused to cooperate with P&A in its performance of its duties. Thus, summary judgment should be granted.

CONCLUSION

For the foregoing reasons, the Court should grant P&A's motion for summary judgment.

Respectfully submitted,

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

Anna Maria Darwin
545 N. Pleasantburg Drive, Suite 106
Greenville, South Carolina 29609
(864)235-0273

Jerrilea S. Davison
545 N. Pleasantburg Drive, Suite 106
Greenville, South Carolina 29609
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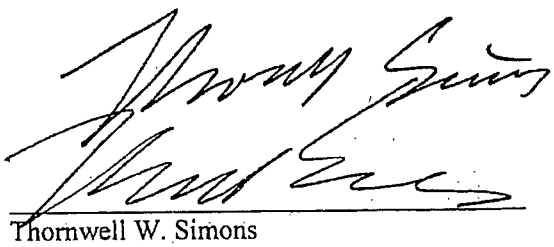

Thornwell W. Simons
3710 Landmark Drive, Suite 208
Columbia, South Carolina 29204
(803)782-0639

ATTORNEYS FOR PLAINTIFF

Columbia, South Carolina

July 8, 2011

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND Protection and Advocacy for People with Disabilities, Inc., PLAINTIFF, vs. Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs, and The South Carolina Department of Disabilities and Special Needs and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, DEFENDANTS.	IN THE COURT OF COMMON PLEAS Civil Action No: 2010-CP-400-1095

RICHLAND COUNTY FILED
2011 JUL -8 PM 3:54
JEANETTE W. WALDRIDGE C.C.P. & G.S.

AFFIDAVIT OF GLORIA M. PREVOST

PERSONALLY APPEARED before me the undersigned who, being duly sworn, deposes and states:

1. I am the Executive Director of Protection and Advocacy for People with Disabilities, Inc. (P&A). I have been executive director since 1997.

2. I have a Master's degree in Social Work from Tulane University. I am a Licensed Master Social Worker. My previous work experience includes both direct and administrative social work in public mental health facilities, including units for persons with dual diagnosis of developmental disabilities and mental

illness. I was director of a state human rights division within a state developmental disabilities and mental health department. In that position I routinely visited facilities and supervised the staff responsible for advocating for the rights of the residents.

3. P&A is a private, non-profit corporation. In 1977 the South Carolina General Assembly designated P&A as the entity to serve as the protection and advocacy system for the State of South Carolina; this designation was made so that the State could receive federal funds through the Rehabilitation Act of 1973. P&A receives federal funds through several different sources and also accepts private donations.

4. Although South Carolina Code §43-33-310 refers to "South Carolina Protection and Advocacy System for the Handicapped, Inc.," the Board of Directors changed the name of the entity to "Protection and Advocacy for People with Disabilities, Inc." pursuant to Senate Bill 599, signed by Governor David Beasley on April 1, 1996. (See Attachment A)

5. As Executive Director of P&A I have supervised the Team Advocacy program. I am familiar with P&A's attempts to review plans of care at Community Training Homes.

6. P&A has been conducting Team Advocacy inspections of community residential care facilities (CRCFs) across the state since 1986 and, to date, has conducted over 1000 inspections of CRCFs.[1] Over the years, Team Advocacy inspections of CRCFs have revealed life-threatening medication errors and Team Advocacy inspection reports have provided information critical to maintaining resident health and safety.

7. Within twenty-four hours after each inspection, P&A files a complaint with the Department of Health and Environmental Control (DHEC), the Long Term Care Ombudsman (Ombudsman), the appropriate Regional Ombudsman; the South Carolina Department of Health and Human Services (DHHS), Department of Mental Health (DMH), and any other appropriate state agencies, including Defendants, if serious concerns regarding health and safety are noted. Complaints are emailed directly to agency employees who have been designated by each agency. Inspection reports are then submitted to DHEC; the Ombudsman and Regional Ombudsman; DHHS; DMH; the Department of Labor, Licensing and Regulation (LLR); Defendants; the Attorney General's Office (AG); the Department of Social Services (DSS); and, if appropriate, Veterans Affairs.[2]

8. During such Team Advocacy inspections, P&A has reviewed resident records, including records containing information about health care and treatment. To my knowledge, apart from this litigation, no agency, entity or person has refused P&A access to resident records, including those containing health information

[1] See No Place To Call Home: How South Carolina Has Failed Residents of Community Residential Care Facilities, issued by P&A July 21, 2009; http://www.pandasc.org/crcfreport.pdf.

[2] Team Advocacy CRCF inspection reports also go to three other organizations which work with people with mental illness.

except Bellwood Manor. Bellwood Manor, a CRCF, refused to allow P&A to conduct Team Advocacy inspections. DHEC subsequently fined Bellwood Manor for violation S.C. Code §44-7-320(A)(1)(e); the decision and fine were upheld by the Administrative Law Court.[3] Since 1994 P&A has contracted with the South Carolina Department of Mental Health (DMH) to conduct Team Advocacy inspections of some CRCFs. These inspections include a review of resident plans, including medication administration. DMH recognizes that proper administration of medication is an essential component of residence at a CRCF.

9. P&A notified Defendants that it was beginning Team Advocacy inspections of CTHs via letters dated November 30, 2007 and June 11, 2009. (Attachment B).

10. Beginning in 2009, P&A attempted to conduct Team Advocacy inspections of community training homes (CTHs) licensed by Defendants. CTHs are residences for individuals with intellectual and related disabilities[4]. CTHs are directly administered by local Disabilities and Special Needs Boards and certain private providers, in accordance with standards established by Defendants. Like CRCFs, CTHs provide food, housing and care, including arrangement of medical care and oversight of medication administration, to people who are unable to live independently.

11. CTHs house and serve some of the most vulnerable people in the state. Many people in CTHs meet the level of care required to be placed in an intermediate care facility (ICF/MR) for people with mental retardation or related disabilities.

12. The ICF/MR level of care is a very restrictive, high level of care. People who meet this level of care need significant assistance in many of the activities of daily living such as toileting, bathing, ambulating, feeding themselves, medication management, and assistance with taking their medications. One of the initial eligibility requirements for the Mental Retardation/Related Disabilities Medicaid Waiver in South Carolina is that an individual meet the ICF/MR level of care.

13. By email from DDSN General Counsel Tana Vanderbilt to P&A Attorney Anna Maria Darwin, Defendants objected to P&A's attempts to review of records during its Team Advocacy inspections, arguing that, "due to laws protecting health information of all Americans, i.e., Protected Health Information (PHI) and Health Insurance Portability and Accountability Act (HIPAA), P&A must get a signed HIPAA authorization from all CTH II residents . . .". (Attachment C).

---

[3] *See* SC DHEC vs. Bellwood Manor, Inc., S.C. Administrative Law Division, Docket No. 09-ALJ-07-0551-CC, 2010 WL 6782577

[4] Intellectual disabilities were previously referred to as "Mental Retardation" in the state code. However, On June 7, 2011, Governor Nikki Haley signed S.C. Bill S. 687 The act will remove the terms "mental retardation" and "mentally retarded" from state law, and requires state agencies, boards, committees, and the Code Commissioner to substitute the term "intellectual disability" for "mental retardation" and "person with intellectual disability" for "mentally retarded". Current Act 47 http://www.scstatehouse.gov/php/web_bh10.php

14. P&A informed Defendants that we disagreed with their interpretation of the South Carolina Code and that our Team Advocacy inspections fell within at least one exception to the Health Insurance Portability and Accountability Act (HIPAA).

15. Defendants then informed P&A, via letters dated August 12 and August 31, 2009, that they disagreed with P&A as to P&A's access to medical records as part of a Team Advocacy inspection, and that their position was that "the regulations of the Health Insurance Portability and Accountability Act (HIPAA)" required P&A to obtain the prior written permission of the individual residents or their legal guardian in order to review any document which contained protected health information. Defendant also informed P&A via the August 31 letter that Defendant had instructed its operators not to allow P&A access to resident records without such consent,(Attachment D)

16. At the Team Advocacy inspections P&A conducted after Defendants' instructions to its operators, the operators followed Defendants' order and refused to allow P&A permission to look at records without obtaining consent from the residents.

17. After Defendants refused to cooperate with P&A and after Defendants' operators also refused to cooperate, P&A filed this case.

18. Based on my experience with our Team Advocacy program and with other facilities and community programs in which I have worked, review of the medical components of a plan of care is essential to determine whether individuals are safe. Our report, referenced above, identified numerous deficiencies in medical care that put individuals at risk of harm or actually caused them harm. It is not realistic to attempt to separate medical issues from questions of nutrition or exercise; for example, review of the plan of care for someone with diabetes would indicate both whether the person received a special diet and appropriate medication.

19. P&A is mandated to protect and advocate for people with disabilities. Defendants' actions are impeding our ability to fulfill this mandate.

Further affiant sayeth not.

So sayeth Affiant this the 8th day of July, 2011.

Gloria M. Prevost

Sworn to and subscribed before me
this 8th day of July, 2011.

NOTARY PUBLIC, State of South Carolina

My commission expires: Oct 15, 2018

Attachment A

SCP&A

SOUTH CAROLINA PROTECTION & ADVOCACY
SYSTEM FOR THE HANDICAPPED, Inc.

RESOLUTION

Be it resolved by the Board of Directors of the South Carolina Protection and Advocacy System for the Handicapped, Inc. that, as authorized by Senate Bill 599 signed on April 1, 1996, by Governor David M. Beasley, the name of the corporation is changed to Protection and Advocacy for People with Disabilities, Inc. effective July 1, 1996.

This 11th day of May, 1996.

Secretary, Board of Directors
Billy R. East

CENTRAL OFFICE
[illegible]

REGION I
[illegible]

REGION II
[illegible]

REGION III
520 W. PALMETTO STREET
FLORENCE, SC 29501
(803) 662-0352
1-800-868-0252
serving the Pee Dee
(Voice and TDD)
FAX 662-0760

REGION IV
1 OLASHEE RIVER ROAD
CHARLESTON, SC 29407
(803) 763-8571
1-800-743-2351
serving the Low Country
(Voice and TDD)
FAX 571-0480

STATE OF SOUTH CAROLINA
SECRETARY OF STATE
JIM MILES
NONPROFIT CORPORATION
ARTICLES OF AMENDMENT

Jim Miles
SECRETARY OF STATE
FILED
MAY 24 1996
AM PM
7 8 9 10 11 12 1 2 3 4 5 6

Pursuant to the provisions of § 33-31-1005 of the 1976 South Carolina Code, as amended, the applicant delivers to the Secretary of State these articles of amendment.

1. The name of the nonprofit corporation is South Carolina Protection and Advocacy System for the Handicapped, Inc., (SCP&A) is renamed: Protection and Advocacy for People with Disabilities, Inc. (P&A)

2. Specify (a) the text of every amendment adopted, and (b) list when each amendment was adopted:
See attached document - adopted May 11, 1996

3. [x] By checking this paragraph #3 the applicant represents that (a) approval of the amendment by the members was not required, and (b) that the amendment was approved by a sufficient vote of the board or directors or the incorporators. (Do not check this paragraph #3 if member vote was required or if the required vote of directors or incorporators was not obtained.)

4. If the approval of the members was required to adopt the amendment(s), provide the following information:

   (a) Designation (Classes of Membership)

   (b) Number of memberships outstanding

   (c) Number of votes entitled to be cast by each class entitled to vote separately on the amendment:

   (d) Number of votes of each class indisputably voting on the amendment:

   (e) Complete one of the following as appropriate:
   (i) Total number of votes cast for and against the amendment by each class entitled to vote separately:
   (ii) Total number of undisputed votes cast for the amendment by each class which was sufficient for approval for that class:

5. [ ] By checking this paragraph #5 the applicant represents that approval of the amendment by some person or persons other than the members, the board, or the incorporators is required pursuant to Section 33-31-1030 of the 1976 South Carolina Code, as amended, and that the approval was obtained. (Do not mark paragraph #5 if either of these statements is not true.)

CERTIFIED TO BE A TRUE AND CORRECT COPY
AS TAKEN FROM AND COMPARED WITH THE
ORIGINAL ON FILE IN THIS OFFICE

JUN 2 7 2006

96-012699BC

SECRETARY OF STATE OF SOUTH CAROLINA

6. If the amendment provides for an exchange, reclassification, or cancellation of memberships, provisions for implementing the amendment must be set forth here if provisions are not contained in the amendment itself: _____

7. [ ] If this corporation is converting from either a public benefit or religious corporation into a mutual benefit corporation, mark this paragraph #7 which certifies that a notice, including a copy of the proposed amendment, was delivered to the South Carolina Attorney General at least twenty days before the consummation of the amendment.

Date: July 5, 1996

By: _____
(Signature of Officer)

Billy R. East, Secretary
(Type or Print Name & Office)

FILING INSTRUCTIONS

1. Two copies of this form the original and either a duplicate original or a conformed copy, must be filed.

2. If space in this form is insufficient, please attach additional sheets containing a reference to the appropriate paragraph in this form, or prepare this using a computer disk which will allow for expansion of space on the form.

3. This form must be accompanied by the filing fee of $10.00 payable to the Secretary of State.

Form Approved by South Carolina
Secretary of State Jim Miles
June, 1994

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection & Advocacy System for South Carolina

Attachment B

November 30, 2007

Stanley J. Butkus, Ph.D.
Director
South Carolina Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240

Dear Dr. Butkus:

Protection and Advocacy for People with Disabilities, Inc., (P&A) is expanding its successful Team Advocacy Program to include inspections of housing in the community for people with intellectual disabilities.

Since 1990 Team Advocacy has been inspecting Community Residential Care Facilities (CRCFs) to determine whether individuals who reside in those settings receive the services they need, including medical care, transportation, employment opportunities, and recreation. Team Advocacy staff and volunteers work closely with the Department of Mental Health, the Department of Health and Environmental Control, and the Long Term Care Ombudsman in the Lieutenant Governor's Office on Aging.

Team Advocacy is established by South Carolina law, S.C. Code § 43-33-350(4), which provides:

> (4) It [P&A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program.... The system shall prepare a report based on the inspection which must be submitted to the...South Carolina Department of Health and Environmental Control, and State Department of Mental Health (material omitted).

Federal regulations implementing the Developmental Disabilities Assistance and Bill of Rights Act also authorize P&A access to residents for monitoring individual rights and safety, 45 C.F.R. §§ 1386.22(g) and (h)

CENTRAL OFFICE
SUITE 208
3710 LANDMARK DRIVE
COLUMBIA, SC 29204
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(Voice and TTY)
FAX (803) 790-1946

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SUITE 106
545 N. Pleasantburg Drive
GREENVILLE, SC 29607
(864) 235-0273
1-800-758-5212
(Voice and TTY)
FAX (864) 233-7962

INFORMATION AND REFERRAL
Toll Free:
1-866-275-7273
(Voice)
or
1-866-232-4525
(TTY)
Email:
info@protectionandadvocacy-sc.org

PEE DEE OFFICE
2137 B HOFFMEYER ROAD
FLORENCE, SC 29501
(843) 662-0752
1-800-868-0752
(Voice and TTY)
FAX (843) 662-0786

LOW COUNTRY OFFICE
1569 SAM RITTENBERG BLVD
CHARLESTON, SC 29407
(843) 763-9571
1-800-743-2553
(Voice and TTY)
FAX (843) 571-0880

Under this expansion of our Team Advocacy program, staff and volunteers will make unannounced visits to community-based residential facilities. P&A anticipates that the first visits will be to Community Training Homes. As you may know, we have asked Ms. Vanderbilt for a list of community facilities operated by or under the authority of DDSN but she has, to date, refused to provide this information to us. As the protection and advocacy system for South Carolina we are entitled to this information. We have informed Ms. Vanderbilt that, if necessary, we will take appropriate action to uphold our position as the P&A. Additionally, P&A intends to fulfill its statutorily-mandated role of inspecting and monitoring facilities serving individuals with disabilities.

During their visits the Team will review records and speak with staff and residents. As with CRCFs, Team Advocacy will provide a report and an opportunity to respond to each facility. The reports will also be submitted to DDSN, the Ombudsman, local DSN boards, other facility operators as applicable and, as required by statute, DMH and DHEC.

Since its inception Team Advocacy has worked to improve the quality of life for South Carolinians with disabilities. We are looking forward to increasing the number of South Carolinians benefiting from this important program. We request that you advise local boards and other contractors of the expansion of our Team Advocacy activity.

Please contact me at 803 217-6713 or prevost@protectionandadvocacy-sc.org if you have any questions about Team Advocacy.

Very truly yours,

Gloria M. Prevost

Gloria M. Prevost
Executive Director

Cc: J. David Almeida
Anna Maria Darwin, Esq.
SC DDSN Commissioners

Since its inception Team Advocacy has worked to improve the quality of life for South Carolinians with disabilities. We are looking forward to increasing the number of South Carolinians benefiting from this important program. We request that you advise local boards and other contractors of the expansion of our Team Advocacy activity.

Please contact me at 803 217-6713 or prevost@protectionandadvocacy-sc.org if you have any questions about Team Advocacy.

Very truly yours,

Gloria M. Prevost
Executive Director

Cc: Anna Maria Darwin, Esq
SC DDSN Commissioners

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection & Advocacy System for South Carolina

June 11, 2009

Eugene A. Laurent, Ph.D.
Interim State Director
South Carolina Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, South Carolina 29240

Dear Dr. Laurent:

Sometime ago, Protection and Advocacy for People with Disabilities, Inc., (P&A) informed DDSN that P&A would be expanding its successful Team Advocacy Program to include inspections of housing in the community for people with intellectual (and related) disabilities.

Under this expansion of our Team Advocacy program, staff and volunteers will make unannounced visits to community-based residential facilities. The first visits will be to Community Training Homes (CTH II). We are now ready to begin inspections under this program. These initial inspections will be made using only P&A staff members. Eventually, we will recruit, train and utilize volunteers to assist in these inspections.

During their visits the Team will review records and speak with staff and residents. As with Community Residential Care Facilities (CRCFs), Team Advocacy will provide a report and an opportunity to respond to each facility. The reports will also be submitted to DDSN, the Ombudsman, local DSN boards, other facility operators as applicable and, as required by statute, DMH and DHEC. Enclosed for your information are copies of the tools which we plan to use during these inspections.

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FAX (843) 571-0880

Anna Maria

The agency has received inquiries about the Team Advocacy project and this is the information that we will be sharing with them and I would like your input if there is anything else you would like to include.

Re: P & A Team Advocacy Project

The S.C. Code Ann §43-33-350(4) refers to Team Advocacy inspections as unannounced visits to review the living conditions and reviewing plans of care. DDSN's position on the plan of care is that is refers only to the residential treatment/support plan. No other records, including the medication administration record, treatment notes, logs, and the like may be reviewed. Further the law stipulates that only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of the plans of care. You may assume that P & A will adhere to this requirement upon entering the home.

Second, due to laws protecting health information of all Americans, i.e., Protected Health Information (PHI) and Health Insurance Portability and Accountability Act (HIPAA), P & A must get a signed HIPAA authorization from all CTH II residents, their legal guardian, or parent if a minor, when reviewing the plans of care (i.e., residential treatment/support plan). A sample HIPAA authorization is attached. Note that it only covers what the state and federal codes allow P & A to review. If a resident et al. does not sign a written release, then P & A cannot review his/her residential treatment/support plan.

Third; the Federal Law under which Protection and Advocacy Programs are established permits such programs to investigate alleged abuse when there is reason to believe that abuse has occurred or when there is a complaint concerning a specific facility. So unless they announce either of the two situations upon arrival at a CTH II home, they are limited to inspections to "review the living conditions" of a CTH II home and the residential treatmentsupport plan.

SC Code §43-33-350(4) does not require the facility to produce a plan of correction.

Attachment D

P & ...region 1

Eugene A. Laurent, Ph.D.
State Director
Robert W. Barfield
Deputy State Director
Administration
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department OF Disabilities AND Special Needs

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PO Box 4706, Columbia, South Carolina 29240
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Toll Free: 888/DSN-INFO
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W. Robert Harrell
Chairman
John C. Vaughn, D.D.
Vice Chairman
Otis D. Speight, MD, MBA, CPE
Secretary
Edythe C. Dove
John Powell
Kelly Hanson Floyd

August 12, 2009

Ms. Anna Maria Darwin, Esq.
Protection and Advocacy, Inc.
545 N. Pleasantburg Drive, Suite 106
Greenville, SC 29607

RE: Team Advocacy

Dear Anna Marie:

Thank you for your response to our proposed notice dated July 24, 2009. DDSN supports P&A's efforts to review living conditions and give DDSN feedback.

It is the opinion of DDSN that inspection of living conditions is similar to a home study to assess the physical surroundings. The Agency disagrees that would involve the review of medical records. S.C. Code §43-33-350(4) is specific as to plans of care and not an example of what is to be reviewed. The Agency understands that P&A has been doing similar inspections in CRCF's; however, there is no oversight body for these residences.

DDSN has a federally certified quality assessment organization that reviews plans of care and does direct observation of the Agency's contract providers of CTH IIs. DHEC, which as of August 2, 2009, will be doing the licensing inspections of the CTH IIs as well.

The DD Act that you cite and the website state that medical records can be provided to P&A under certain circumstances. 42USCA1504.3 (9)(2) I & J refer to access to records when the person with a disability is a client of the system or when P&A is conducting an investigation based on a report of abuse. There is no provision for access to medical records for the Team Advocacy inspections. If access to the medical records is to be granted, a release must be given by the person whose records are to be reviewed.

The goal of DDSN is to protect the rights of persons with disabilities. Therefore, when applicable, plans of correction may be done if the Team Advocacy inspections raise concerns not already identified by one of the other systems of quality monitoring.

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

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

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

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

If you have any questions, please feel free to contact me at 898-9683 or by email at tvanderbilt@ddsn.sc.gov.

Sincerely,

Tana Vanderbilt

Tana Vanderbilt
General Counsel

TV/cch

Attachment D

Eugene A. Laurent, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department OF Disabilities AND Special Needs

COMMISSION
Kelly Hanson Floyd
Chairman
Richard C. Huntress
Vice Chairman
Otis D. Speight, MD, MBA, CPE
Secretary
W. Robert Harrell
Nancy L. Banov
Susan K. Lait
Deborah C. McPherson

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

August 31, 2009

Ms. Gloria Prevost
Executive Director
Protection & Advocacy for People with Disabilities
3710 Landmark Drive, Suite 208
Columbia, SC 29204

RE: P&A Team Advocacy DD Project

Dear Ms. Prevost:

The Agency's attorney, Ms. Tana Vanderbilt and your attorney, Ms. Anna Marie Darwin, have been in discussions since July 1, 2009, regarding the law pertaining to team advocacy inspections.

S.C. Code Ann. §43-33-350(4) gives P&A the provision to make unannounced visits to review the living conditions of residential facilities, and specifically states "including plans of care for individuals in a residential care facility." The disagreement between our attorneys is over the interpretation of "plans of care." While we appreciate P&A's efforts to conduct inspections in community training homes, our obligation is to ensure that the rights of our consumers are protected.

Due to the regulations of the Health Insurance Portability and Accountability Act (HIPAA), P&A must get a signed HIPAA authorization from all CTH II residents, their legal guardian or parent if a minor, before reviewing any Protected Health Information (PHI), including the medical records, the medication administration record or any other record protected under HIPAA except for the residential treatment/support plan as required by state law.

We have informed our contracted providers of our position for CTH II staff to release only the residential treatment/support plan, which we consider the same as the plan of care, to the P&A team advocacy coordinator. If the coordinator obtains a signed HIPAA authorization to disclose health information from the consumer, his/her legal guardian, or parent if a minor, then the P&A advocacy coordinator can review medical documents specifically listed on the authorization.

Thank you again for your efforts in inspecting the living conditions of CTH IIs. We pledge our cooperation with P&A in carrying out these inspections.

Sincerely,

Eugene A. Laurent, Ph.D.
State Director
EAL/cch

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

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

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

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

Eugene A. Laurent, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department OF Disabilities AND Special Needs

COMMISSION
Kelly Hanson Floyd
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Website: www.ddsn.sc.gov

September 28, 2009

Ms. Anna Maria Darwin, Esq.
Protection and Advocacy, Inc.
545 N. Pleasantburg Drive, Suite 106
Greenville, SC 29607

RE: Team Advocacy

Dear Anna Maria:

On behalf of Dr. Laurent and the Agency, I want to assure you that the South Carolina Department of Disabilities and Special Needs (SCDDSN) is cooperating fully with Protection and Advocacy (P&A) and allowing the Team Advocacy Inspections to go forward in the CTH II homes. I do want to point out that SCDDSN does not supervise the daily operations of the CTHs, except in those few situations where SCDDSN directly operates the CTHs.

Dr. Laurent finds it strange that the Agency is having to protect the privacy rights of our consumers, when that job should be one that P&A performs. The Agency, as previously stated, understands that if P&A were conducting an investigation based upon a report of abuse or neglect, the federal statute allows P&A access to protected health information.

As has been suggested by a member of the SCDDSN Commission, signing the release provided to you by email on July 1, 2009, would be the best way to settle this issue. SCDDSN will facilitate in anyway necessary having the releases executed.

If P&A is still unwilling to have the releases signed, the Agency is going to seek an opinion from the Office of the Attorney General as to the release of the protected healthcare information during the Team Advocacy Inspections.

If you have any further questions, please feel free to contact me at (803) 898-9683 or by email at tvanderbilt@ddsn.sc.gov.

Sincerely,

Tana Vanderbilt
General Counsel
TV/cch
cc: Dr. Eugene A. Laurent, State Director-SCDDSN
Ms. Gloria Prevost, Director-S.C. Protection and Advocacy

RECEIVED
SEP 29 2009
P & A Region 1

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DISTRICT II
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STATE OF SOUTH CAROLINA **COUNTY OF RICHLAND**	**IN THE COURT OF COMMON PLEAS** Civil Action Number: 10-CP-40-1095
Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	**DEFENDANTS' REPONSES TO PLAINTIFF'S FIRST REQUESTS FOR PRODUCTION OF DOCUMENTS**

Defendants respond to Plaintiff's First Requests for Production as follows:

GENERAL OBJECTION

Defendants object to the production of any information referenced in these requests that is subject to the attorney-client privilege or the attorney work product privilege.

1) Copies of any and all documents identified in response to Plaintiff's First Set of Interrogatories to Defendants.

Response: Defendants object to this Request on the ground that with the exception of Attachment A to those Interrogatories, the referenced documents are available online, and therefore equally available to Plaintiff.

2) Copies of any and all statements given by any named Defendant, representative of a named Defendant, a member of Defendant's employees, representative of Defendants, or any witness, whether written or recorded, which relate to the matters complained of in the Complaint.

Response: None, unless some of the attachments to the Complaint could be deemed as falling within this category.

3) Copies of any and all photographs and/or other visual aids which relate to the claims or defenses in this case in possession of Defendants or Defendants' counsel.

Response: None.

4) Copies of any and all reports, opinions, correspondence, memoranda, or other documentation provided to Defendants or Defendants' counsel from any expert consulted by or retained by Defendants in this litigation.

Response: None.

5) Copies of any and all reports, opinions, correspondence, memoranda, or other documentation provided by Defendants or Defendants' counsel to any expert consulted by or retained by Defendants in this litigation.

Response: None.

6) Copies of current curricula vitae for Defendants' experts.

Response: None.

7) Copies of any and all documents relied upon by Defendants or counsel in responding to Plaintiff s First Set of Interrogatories to Defendants.

Response: See Response to Request 1.

8) Copies of any and all documents, directives, manuals, standards, policies or regulations or portions of internal manuals that define, establish or control the structure, formatting or content of any resident plan for care of the residents of CTHs, from 1993 to the present, including but not limited to medication, nutrition, recreation, socialization, life skills training, training to perform the activities of daily living, with the exception of CTH residents' individual records.

Response: Defendants object to this Request on the ground that it is overly broad in terms of date, and therefore is burdensome and not reasonably calculated to lead to the discovery of admissible evidence. However, see Response to Request 1 and Documents 8338-A-001 through 8338-A-056, served herewith.

9) Copies of any and all documents which relate to the claims or defenses in this case.

Response: Defendants object to this Request on the ground that it is overly broad, and therefore is burdensome and not reasonably calculated to lead to the discovery of admissible evidence. See, however, Responses to Requests 1 and 8. See also, attachments to the Complaint..

STATE OF SOUTH CAROLINA	)	**IN THE COURT OF COMMON PLEAS**
	)	
COUNTY OF RICHLAND	)	Civil Action Number: 10-CP-40-1095
	)	
	)	
Protection and Advocacy for People with Disabilities, Inc.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission,	)	**DEFENDANTS' REPONSES TO PLAINTIFF'S FIRST INTERROGATORIES**
	)	
Defendants.	)	
	)	

The Defendants Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, that is, all Defendants, respond to Plaintiff's First Interrogatories as follows:

GENERAL OBJECTION

Defendants object to the production of any information referenced in these interrogatories that is subject to the attorney-client privilege or the attorney work product privilege.

1) Give the names and addresses of persons known to Defendants or Defendants' counsel to be witnesses concerning the facts of the case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

Response: Dr. Kathi Lacy, whose address is DDSN, Columbia. No written or recorded statements.

2) Set forth a list of photographs, plats, sketches, or other prepared documents in possession of Defendants that relate to the claims or defenses in this case.

Response: None at present, but see responses to Requests for Production.

3) For each person known to Defendants or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the other parties of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

Response: Dr. Lacy is generally familiar with the matters addressed in Defendants' discovery responses and with the subject matter of this case.

4) List the types of plans that a CTH resident may currently have along with its purpose; a description of the contents of each and any corresponding directive, standard, regulation or portion of an internal manual which deals with that plan.

Response: See Attachment 1 hereto.

5) List all possible types of plans that a CTH resident may have had between 1993 and the present time, along with the purpose of each, a description of its contents and any corresponding directive, manual, standard or regulation or portion of an internal manual which dealt with that plan.

Response: Defendants object to this Interrogatory on the ground that it is overly broad in terms of date, and therefore is burdensome and not reasonably calculated to lead to the discovery of admissible evidence. See, however, the response to Interrogatory 4 for information related to current conditions.

6) List and describe any and all documents which may present an "up-to-date, comprehensive plan for or record of the daily administration of each individual's medications" for residents of CTHs in South Carolina.

Response: See DDSN Residential Licensing Standard 3.5, online at http://ddsn.sc.gov/about/directives-standards/Documents/currentstandards/ResLic%20Stand8.10rev.pdf ; DDSN Directive 100-29-DD, Med Error/Event Reporting.

In addition, through its contract with DHEC, DDSN licensing standards require a review of 3 months' worth of medication administration records (MARs) to assess correct medication administration and reporting of any errors. If DHEC licensing staff find patterns of medication errors on the MARs, they will go beyond the three months' timeframe. Also, through its contract with Delmarva, Inc., a CMS-designated Quality Improvement Organization, DDSN requires residential providers to track and trend medication administration errors, and requires corrective action on both systemic and person levels.

7) What level of care is required for a person to be appropriate for placement in a CTH? Describe or define the level of care required to be eligible for placement in a CTH in South Carolina.

Response: Defendants object to producing this information, on the ground that it is equally available to Plaintiff through examining DDSN's Medicaid Waiver documents, as well as DDSN's Directives and Standards, all of which are online.

8) How many residents of CTHs in South Carolina require an ICF/MR or nursing home level of care?

Response: Almost every resident of a CTH meets the ICF/MR level of care, subject to requirements about the least restrictive setting. Few would meet the nursing home level of care, although DDSN does not assess for people in CTHs. The fact that such persons are in CTHs versus ICFs/MR indicates that all are receiving services in the least restrictive environment.

9) How many residents are in CTHs operated or licensed to operate by or under the authority of DDSN? How many CTHs are there in South Carolina? Are there any CTHs which are not operated under the authority or approval of DDSN?

Response: There are approximately 2500 residents in 775 CTHs in South Carolina. Six of these are operated by the Autism Division of DDSN. With respect to all other CTHs, which are not operated by DDSN, Defendants would request clarification about the term "operated under the authority or approval of DDSN."

10) How many residents of CTHs require prescription medication on a daily basis? How many require more than one prescribed medication on a daily basis?

Response: This information is not available to the Defendants. It may be known by local DSN authorities.

11) How many residents of CTHs require assistance or supervision in taking their medication?

Response: This information is not available to the Defendants. It may be known by local DSN authorities.

12) Describe how assistance or supervision in taking medication is provided to residents of CTHs who require it and identify who is responsible for this assistance.

Response: Residential Habilitation standards (RH 4.4) require that a person be assessed regarding their ability to self-medicate. If assistance or supervision is required, this is provided by trained staff. The majority of CTHs have a Certified Medication Technician. Those who do not, use staff that are trained on assisting with medication in pre-service training, with refresher training required annually. See also, DDSN Directives (online) 603-13-DD, 603-11-DD, and 100-26-DD.

13) How does DDSN ensure that residents of CTHs receive appropriate care and medical treatment? Please describe the process and who is responsible for its successful completion in detail.

Response: Among other things, residents of CTHs are required by the residential standards to have a functional assessment (RH 4.3 & 4.4) to determine their need for supervision, skills training, and care. A plan must be developed (RH 4.7) to meet those needs.

In addition, residents have a service coordinator who completes a global assessment of their needs. All residents choose a personal physician. If they require assistance with this, their Service Coordinator helps.

Residential Habilitation standard (RH 5.0) requires that each person receive continuous and coordinated health care. People must be evaluated by a licensed physician, physician's assistant or nurse practitioner (and dentist) and the plan of care must be followed. The standards also outline what must occur to ensure proper treatment when acute care is needed (RH 5.1-5.3).

DDSN contracts with a private entity (Delmarva) who completes a periodic review to determine how well a Provider is meeting required standards/policy. As a part of this review, direct observations are made in a sample of CTHs.

Each home is licensed by DHEC and inspected periodically to ensure it meets required policy.

Annual contracts require that upper level management of Providers periodically visit all homes on all three shifts.

All Providers must have a risk management policy per 100-26-00 Risk Management Program.

All Providers must report risk data such as injuries, abuse. DDSN tracks and trends this data and requests additional follow up and/or provides technical assistance as needed. Periodic reports are sent to Providers.

14) How does a local provider in a CTH document care and treatment provided to its residents?

Response: Homes are licensed by DHEC via a contract with DDSN. One third of CTHs are inspected annually. All homes where children (17 or below in CTH I, and 20 or below in CTH II) reside are inspected annually.

Delmarva reviews each provider every 12 months (or 18 months if the Provider did well on previous reviews) to determine how well they are meeting required policy/standards. As a part of this review, direct observations are done in a sample of CTH homes.

15) Identify any other entities which review the provision of medical care and treatment, including administration of medication, of residents of CTHs or which are responsible for the appropriate care and treatment of those residents. Describe the relationship of these entities and Defendants.

Response: See Response to Interrogatory 13.

16) How often does an employee of DDSN visit a CTH and how many inspections or reviews of a CTH are made? Describe what is reviewed or inspected.

Response: See Response to Interrogatory 14.

17) State and explain the basis for Defendants' assertions that S.C. Code §43-33- 350(4) (Supp. 2009) alone does not give P&A the authority to review the records of CTH residents which contain health information as part of its team advocacy inspections.

Response: That section mentions only "plans of care" (twice), which as referenced below is a term of art, and not a reference to all records generally.

18) State the basis for your denial of the second and third sentences of paragraph 26 of Plaintiff s Complaint.

Response: Those sentences were denied because they merely express Plaintiff's opinions about the issues discussed therein, and Defendants do not agree with those opinions.

19) State and explain the basis for your claim that the term "plans of care" in S.C. Code Ann. §43-33-350(4) (Supp. 2009) refers only to the residential treatment/support plan.

Response: The term "plan of care" is a term of art that in practice refers only to the residential/treatment plan, also known as the "Single Plan."

20) State and explain the basis for your denials of Paragraphs 43, 45-46, 50-55, and the second sentence of Paragraph 44 of the Complaint.

Response: The basis for those denials is the Defendants' belief that the statutes cited in the Complaint do not grant the powers claimed by Plaintiffs in this case.

21) State the basis for the Second, Third and Fourth defenses asserted in Defendants' Answer to the Complaint.

Response: The Second Defense in effect expresses the view of counsel for Defendants that this action is without legal merit. See response to Interrogatory 20. The Third Defense is based on counsel's opinion that if relief is granted to Plaintiffs, the agency would comply with such an

order, without the need for individuals to be named as parties. The Fourth Defense is based on counsel's opinion that this issue is one for which the Plaintiff is not a party who would have standing to raise.

22) Please identify in complete detail each person whom Defendants expect to call as an expert witness at the trial of the case.

Response: None known at present.

23) Please set forth each and every opinion to which Defendants' experts are expected to testify. In so doing, identify:

a. which expert holds the opinion;

b. the substance of the opinion;

c. the fact(s) upon which the opinion is based; and

d. a list of all books, treatises, chapters, articles, journals, cases or other publications upon which the expert relies as authoritative in making such opinion.

Response: Not applicable at present.

DAVIDSON & LINDEMANN, P.A.

By: /s/

WILLIAM H. DAVIDSON, II
KENNETH P. WOODINGTON
1611 Devonshire Drive, Second Floor
Post Office Box 8568
Columbia, South Carolina 29202
T: (803) 806-8222
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ATTORNEYS FOR DEFENDANTS

Columbia, South Carolina

October 8, 2010

STATE OF SOUTH CAROLINA	**IN THE COURT OF COMMON PLEAS**
COUNTY OF RICHLAND	Civil Action Number: 10-CP-40-1095
Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	**MOTION FOR SUMMARY JUDGMENT (All Defendants)**

2011 APR -8 AM 11:58
JEAN H. TOAL
CLERK OF COURT
S.C.

TO: ANNA MARIA DARWIN, ESQUIRE, ATTORNEY FOR PLAINTIFFS

YOU WILL PLEASE TAKE NOTICE that the undersigned attorneys for the Defendants will move at such time at such time and place as may be set by the Court, for an Order granting summary judgment on the ground that there is no genuine issue as to any material fact, and Defendants are entitled to judgment as a matter of law. The specific grounds for this motion are that here is no provision of statute or law that requires or even permits the disclosure to Plaintiff, in the course of a team advocacy inspection, of medical records of residents of certain facilities that are the subject of this action.

This motion is based upon the pleadings filed in this case; and on such other matters on file in this case or as may be presented to the Court at or before the time of the hearing. In addition, this motion is based on the attached Affidavit of Kathi Lacy, with exhibits attached.

Respectfully submitted,

DAVIDSON & LINDEMANN, P.A.

BY: /s/

WILLIAM H. DAVIDSON, II
KENNETH P. WOODINGTON
1611 Devonshire Drive
Post Office Box 8568
Columbia, SC 29202
(803) 806-8222

ATTORNEYS FOR DEFENDANTS

Columbia, South Carolina

July 8, 2011

STATE OF SOUTH CAROLINA	**IN THE COURT OF COMMON PLEAS**
COUNTY OF RICHLAND	Civil Action Number: 10-CP-40-1095
Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	**MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT (All Defendants)**

JEANNETTE W. GRAM
CLERK OF COURT
RICHLAND COUNTY, S.C.
2011 JUL -8 AM 11:58

STATEMENT AND SUMMARY

Plaintiff in this action claims a right to review certain medical records of individuals during the course of statutorily-authorized inspections by plaintiff of living conditions in facilities that house developmentally disabled persons. Defendants have denied that there is any statutory authority for plaintiff to review individual medical records in the absence of individualized complaints. Instead, the statute that authorizes plaintiff to investigate living conditions limits the kind of records available for inspection to "plans of care." *S.C. Code Ann.* § 43-33-350(4), That term refers to a very specific document that sets forth the services that will be provided to an individual. See generally the attached Affidavit of Kathi Lacy. Plans of care

are different from the medical and drug administration records to which plaintiff seeks access, and are beyond the scope of an examination of "living conditions," As will be shown from a review of the pertinent statutes, the General Assembly determined that when living conditions were being inspected, the only record that needed to be disclosed was the plan of care for each resident, i.e., the document that showed generally what kinds of services the residents were supposed to be receiving. Presumably, the plans of care would provide sufficient information for an inspector to determine whether the living conditions were in accord with the stated needs of the clients, as set forth in their plans of care.

In contrast, where the medical records and medication administration records of individuals were involved, the General Assembly provided for substantially more restricted access, limiting such access to instances where an individual or guardian has filed a specific complaint. § 43-33-370(2). Even then, only the records of the one individual are subject to inspection. Contrary to plaintiff's assertions, there is simply no provision for an inspection of all records of residents of the subject facilities. Nor is there any need for such access, since plaintiff's inspection authority is limited to an inspection of living conditions, and does not extended to an open-ended, unlimited power to examine the facilities and the treatment offered to persons. The General Assembly, consistent with medical privacy principles in general, has clearly declined to provide plaintiff with the kind of access to records that it now seeks.

FACTS

A. Background.

The plaintiff, Protection and Advocacy for People with Disabilities, Inc. ("P & A"), is a corporation which has been given certain powers and duties under state law. *S.C. Code Ann.*,

§§43-33-310, et seq. The existence of such an entity is a prerequisite to the State receiving certain federal funding. *See* 42 U.S.C. § 15043.

As detailed in the Complaint, the basic facts of this case are that Plaintiff sought to conduct "team advocacy inspections" of living conditions in facilities in which developmentally disabled or handicapped persons reside. This is a power conferred on the Plaintiff by *S.C. Code Ann.* § 43-33-350(4), which will be discussed below in detail.

In the course of seeking to inspect living conditions, Plaintiff sought generally to review the medical records of the residents of the institutions, regardless of whether they were clients of Plaintiff, and regardless of whether specific complaints had been made by them or persons acting on their behalf. In particular, P & A has sought to review MARs (Medication Administration Records,, or drug charts). Complaint, Par. 26.

DDSN declined to permit the examination of any records other than "plans of care," the only kind of record mentioned in the statute. Specifically, § 43-33-350(4) provides that in the course of a team advocacy inspection of living conditions, Plaintiff may review "the plans of care for individuals in a residential care facility and a community mental health center day program." (Emphasis added.) No other types of records are mentioned in that section. This term, "plan of care," has a very specific meaning in the context of service delivery to DDSN clients. It is a document that is mandated by Medicaid law, which uses that precise term, as discussed below. It is prepared by the person's Service Coordinator. Lacy Affidavit, Par. 3. As set forth in Par. 4 of the Lacy Affidavit, the Service Coordinator "conducts a formal, standardized assessment of the person's needs by gathering information from the person, family members, friends, service providers and medical care providers. The Service Coordinator then works with the person and the family to determine what services would best address the identified needs."

The plan "typically includes the medical and other services to be provided, their frequency, and the type of provider to furnish them." *Id.* The document that performs this function has had different working names from time to time, but those names have always referred to the plan of care. Lacy Affidavit, Par. 5. The document in which the recommendations are made is a form, Lacy Affidavit, Exhibit 1, and is the document generally referred to as the "plan of care." This meaning of the term is one that has had long usage. *Id.*, Par. 6.

As already indicated, the statute permits only "plans of care" to be reviewed by P & A in the course of a team advocacy inspection into "living conditions." DDSN so advised Plaintiff in 2009. After several rounds of correspondence on the issue, which are attached to the Complaint, the parties' respective positions did not change. As a result, Plaintiff filed the present action.

B. Statutory provisions pertaining to P & A.

The powers and duties of the plaintiff organization are set forth in § 43-33-350. The specific power involved in the present case is the power to "conduct team advocacy inspections. . . to review living conditions" in facilities that provide residences to developmentally disabled persons. To put this specific grant in context, a review of the general powers and duties of P & A, set forth in § 43-33-350, is appropriate. There are four powers in all. Only one, the one set forth in § 43-33-350(4), is involved in this action.

The first power is found in § 43-33-350(1). It provides that P & A "shall protect and advocate for the rights of all developmentally disabled persons . . . and for the rights of other handicapped persons by pursuing legal, administrative, and other appropriate remedies to insure the protection of the rights of these persons." This general grant of power does not specifically address the issues in the present claim.

The second power is found in § 43-33-350(2). It provides that P & A "may investigate complaints by or on behalf of any developmentally disabled or handicapped person." This power is related to specific complaints, and is not the same as the power involved here, which is the power to conduct general random inspections of facilities in the absence of such specific complaints.

The third power is found in § 43-33-350(3). It provides for the prioritization of the services that P & A provides to its clients. Specifically, it provides that P & A "may establish a priority for the delivery of protection and advocacy services according to the type, severity, and number of handicapping conditions of the person making a complaint or on whose behalf a complaint has been made." Obviously, this provision for internal prioritization by P& A itself is not related to the issues in this case.

The fourth and final power conferred by state law is found in § 43-33-350(4). That subsection provides for the team inspections of facilities. Those inspections are the subject matter of this case. The subsection provides in its entirety as follows:

> [P & A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program. Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. The designee must meet criteria developed by the Joint Legislative Committee on Mental Health and Mental Retardation, after consultation with the system and the South Carolina Association of Residential Care Homes. The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Committee on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

(Emphases added.) As can be seen, the "team advocacy inspections" of "living conditions" contemplated by this subsection are general in nature, and not the result of particular complaints by or behalf of any particular person.

Plaintiff may argue that federal law, specifically, parts of 42 USC §15043, authorizes record reviews of the kind sought here. While DDSN will address this issue more fully after reviewing Plaintiff's contentions, DDSN submits that that statute, like *S.C. Code Ann.* § 43-33-370(2), pertains to investigations into complaints relating only to specific individuals. This section, unlike South Carolina law, contains no mention of any authority to perform team advocacy inspections into living conditions.

ARGUMENT

In the course of its team advocacy inspections into living conditions, P & A is entitled to review only "plans of care," and that term does not include the medical records of individuals.

There are a number of reasons why P & A's efforts to review medical records, other than "plans of care," of all residents of facilities should be denied. The term "plan of care," as used in the statute, is a term with a specific and well-understood meaning in this context. Indeed, the General Assembly, far from extending this power to P & A, has determined that access by P & A to medical records should be limited to individualized situations. Clearly, the General Assembly was concerned with protecting the privacy of residents of the facilities. Each of the reasons for denying P & A's claims will be discussed separately below.

1. The common meaning of the term "plans of care" does not extend to the kinds of medical records sought by P & A.

Even before taking a detailed look at the governing statutes, it is clear from the plain meaning of the term that a "plan of care" is something different from a medical record, and specifically from a medication administration record, or MAR. A plan of care is a guidance

document that sets forth what will be provided to the person. MARs, in particular, are not "plans," but rather are documentations of the administration of medications. A plan of care is comparable to a baseball starting lineup card, while a MAR is comparable to a box score. The first sets forth what is planned to occur, and the second documents what actually did occur. Presumably, by limiting the records reviewable by P & A in the course of a review of "living conditions," § 43-33-350(4), the General Assembly intended that P & A would be able to review plans of care in order to see what kinds of services the facilities were to be providing, but, since such inspections pertain only to living conditions, and not to each individual's specific situation, the line was drawn at plans of care.

2. As a matter of law and administrative practice, the term "plan of care," in the context of Medicaid Waiver clients, refers to a specific document which sets forth the services to be provided to the client.

As set forth above and in the Lacy Affidavit, the term "plan of care" is used in the Medicaid waiver services context to refer to the specific document that contains the service plan for the individual. In addition to the factual information set forth in that affidavit, these specific documents are also specifically mentioned in the parts of the U.S. Code and Code of Federal Regulations that pertain to Medicaid waiver services. (It is undisputed that the Medicaid waiver program provides the funding for the vast majority of people who live in the facilities that P & A seeks to inspect. Complaint, Par. 49.) Specifically, 42 U.S.C. § 1395n(c)(1) provides:

> (1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally

> retarded the cost of which could be reimbursed under the State plan.

(Emphasis added). To the same effect is 42 C.F.R. § 441.301(b)(1)(i), which provides as follows:

> (b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—
>
> (1) Provide that the services are furnished—
>
> (i) Under a written plan of care subject to approval by the Medicaid agency;

(Emphasis added.) Another regulation, 42 C.F.R. § 441.351(f), while addressed only to waiver programs covering persons aged 65 and over, illustrates the kinds of information that are to be found in plans of care:

> **(f) Plan of care.** The request must provide that the home and community-based services described in § 440.181 of this subchapter, are furnished under a written plan of care based on an assessment of the individual's health and welfare needs and developed by qualified individuals for each recipient under the waiver. The qualifications of the individual or individuals who will be responsible for developing the individual plan of care must be described. Each plan of care must contain, at a minimum, the medical and other services to be provided, their frequency, and the type of provider to furnish them. Plans of care must be subject to the approval of the Medicaid agency.

The term is also used in South Carolina's Medicaid Waiver document, excerpt of which are attached as Exhibit 2 to the Lacy Affidavit. In that document, the plan of care is described in the same manner as in the Lacy Affidavit.

A typical illustration of the use of the term in South Carolina to mean this document is found the recent unreported case, *Doe v. Kidd,* 2011 WL 1058542 (4th Cir. 2011). There the Fourth Circuit described a plan of care as follows:

> DDSN approved a "plan of care" that was developed for Doe pursuant to 42 C.F.R. § 441.301(b) (hereinafter the "2003 plan"). J.A. 616–44. The 2003 plan included a regime of personal care, psychological evaluations, and other services to be provided in-

> home at the residence of Doe's mother. It also recommended that Doe "receive residential habilitation from a DDSN approved provider" within three months at a "setting located within the Columbia area to be chosen by her family."

2011 WL 1058542 at 2. *See also, e.g., McCrann v. Department of Health and Human Services,* 704 S.E.2d 899, 901 (N.C. App. 2011)(plan of care in the Medicaid wavier program is "a schedule of services to be provided to the program participant"); *Boatman v. Murphy*, 2010 WL 2178821, 1 (S.D.Ind. 2010)(case manager assesses the Medicaid waiver applicant's specific needs and creates a plan of care and cost comparison budget, which are submitted to the Division of Aging for review). These cases, the statutes and regulations, as well as longstanding administrative practice and the plain meaning of the term, make it clear that the reference to "plans of care" in § 43-33-350(4) is a reference to a term which has a very specific meaning in this context. It does not include MARs and other individual medical records that serve functions other than those served by plans of care.

3. The statute creating P & A makes it clear that P & A can review individual medical records only in limited instances, which do not include team advocacy inspections.

A review of the entire state statutory scheme creating P & A makes it clear that the General Assembly actually intended that P & A would not be permitted to review individual medical records in the course of facilities inspections relating only to living conditions. Section 43-33-370(2) states that, upon receipt of a complaint pertaining to the treatment of a particular individual, P & A may "inspect and copy any documents . . . which bear upon the subject matter of the individual complaint, except for the individual medical, treatment or other personal records of other persons in the program or facility." In other words, it is clear that P & A can only view medical records of a specific individual in response to a specific complaint by or on

behalf of that individual. This section leaves no doubt that the General Assembly was aware of the need for privacy as to medical records on the part of disabled individuals.

Also, Section 43-33-400, discussed below, provides that in the context of agency cooperation with P & A, the agencies "shall permit [P & A] to inspect and copy any record or documents provided for in 43-33-370(2)." (Emphasis added). As shown above, those records are reviewable only in cases involving individual complaints, and only the records of the specific individual are permitted to be copied.

4. Plaintiff's claims based on vague language in statutes pertaining to cooperation, and on allegations of "equity," are insufficient to overcome the specific limitations on the kinds of documents that can be disclosed to Plaintiff.

Plaintiff's Second Cause of Action alleges that certain other language in state and federal statutes is a source for the authority it claims. First, Plaintiff cites § 43-33-400. That section, however, only provides as follows:

> All departments, officers, agencies and institutions of the State shall cooperate with the System in carrying out its duties. . . . Notwithstanding any other provision of law, any program or facility shall permit the System to inspect and copy any record or documents provided for in 43-33-370(2).

(Emphases added.) The first emphasized part of the statute, and the one on which Plaintiff relies, simply provides for cooperation with Plaintiff in its carrying out of the duties it already has. This provision is not the source of any duty not previously mentioned in the statute. In addition, the sole reference to making records available is a reference back to § 43-33-370(2), which as seen above, provides only for disclosure in situations where individualized complaints are made.

In addition, Plaintiff cites 42 U.S.C. § 15043(a)(3)(b), which states that the State should provide to P&A, "to the extent that information is available, . . . "information about the adequacy of health care and other services . . . that individuals with developmental disabilities who are

served through home and community based waivers (under Medicaid) receive..." This section does not suggest that the State is required to provide P&A with confidential medical information of DDSN clients. That information is authorized to be released only in the individualized circumstances set forth earlier in the statute, specifically in 42 U.S.C. § 15043(a)(2)(F) and –(J), both of which provide for the release of the records of individuals only when complaints are made relating to specific individuals. It is unreasonable to think that Congress would have provided elaborate limitations of the disclosure of such information in those two specific sections, only to then authorize virtually unlimited access in a later section that deals only with general reviews of adequacy of health care and other services.

Finally, in an unnumbered third cause of action entitled "Equity," Plaintiff adds no new substantive claim, but simply argues that injunctive relief should issue in its favor. However, this claim is without merit, because the underlying substantive claims are without merit.

5. Plaintiff's citations to other uses of the term "plan of care" are inapposite.

In the Complaint, Plaintiff cites numerous other provisions of state and federal law as supposedly containing definitions of the term "plan of care," or similar terms, that support Plaintiff's position in this case. DDSN will respond in its response brief to any specific claims of this kind that P & A chooses to brief in its opening brief. However, it is already apparent that no use of even the identical term in some other context can overcome the very specific nature of the documents referred to in this particular context.[1]

[1] While the initial correspondence between the parties contained some discussion of the Health Insurance Portability and Accountability Act (HIPAA). Pub. L. No. 104-191, 110 Stat. 1936 (1996), that section does not govern the outcome of this case. As Plaintiff notes, Complaint, Par. 40, 45 C.F.R. § 164.512(a)(1) provides that "a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." (Emphasis

CONCLUSION

For the foregoing reasons, Defendants respectfully submit that their motion for summary judgment should be granted, Plaintiff's motion for summary judgment should be denied, and this case dismissed.

Respectfully submitted,

DAVIDSON & LINDEMANN, P.A.

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July 8, 2011

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added). Here, however, it is DDSN's position that disclosure of medical records is neither required by law, nor even permitted by law. As a result, HIPAA simply has no application.

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND	IN THE COURT OF COMMON PLEAS Civil Action Number: 10-CP-40-1095
Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	RECEIVED JUL 12 2011 P & A Region 1 **AFFIDAVIT OF KATHI LACY**

PERSONALLY APPEARED BEFORE ME, KATHI K. LACY, Ph.D., who first being duly sworn deposes and states as follows:

1. I am employed as the Associate State Director, Policy at the South Carolina Department of Disabilities and Special Needs ("DDSN"), and have held that position since May 2002. Prior to that, I had been the Director of the Mental Retardation Division at DDSN since September 1997.

2. I am personally familiar with the matters set forth herein.

3. For as long as I have been employed by DDSN, the term "plans of care," has had a very specific meaning in the context of service delivery to DDSN clients. Such plans, which are required by federal and state Medicaid law for the provision of Targeted Case Management services and as the vehicle to provide supports to people in home and community based waivers, are prepared by the person's Service Coordinator.

4. The Service Coordinator conducts a formal, standardized assessment of the person's needs by gathering information from the person, family members, friends,

service providers and medical care providers. The Service Coordinator then works with the person and the family to determine what services would best address the identified needs. Those determinations are subject to review by the Medicaid agency, which in South Carolina is DHHS. The plan typically includes the medical and other services to be provided, their frequency, and the type of provider to furnish them.

5. While the document in which the needs are listed and the recommendations are made has been known at times by different names, such as "Single Plan," "service plan," or "support plan," those designations are simply different terms for the federally-required "plan of care."

6. Plans of care have never been regarded by DDSN as including the kinds of records that would be found in a physician's files for an individual, such as diagnostic and treatment notes. Nor have plans of care even been regarded as including medical records, such as medication administration records, that are maintained by the facilities in which DDSN clients reside.

7. A sample form for a plan of care is attached hereto as Exhibit 1.

8. Attached hereto as Exhibit 2 are several pages from the current South Carolina Medicaid Waiver document that has been approved by CMS, the federal Medicaid agency. Those pages describe the plan of care, with reference in particular to 42 C.F.R. § 441.301(b)(1)(i), which refers to the plan of care. Those pages have been essentially the same for a number of years.

FURTHER AFFIANT SAYETH NOT.

KATHI K. LACY, Ph.D

SWORN TO BEFORE ME THIS 7TH

DAY OF JULY, 2011.

NOTARY PUBLIC FOR SOUTH CAROLINA (SEAL)

COLLEEN HONEY NOTARY PUBLIC SOUTH CAROLINA

MY COMMISSION EXPIRES:

9-25-17

EXHIBIT 1

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

SINGLE PLAN

Mental Retardation and Related Disabilities
Head and Spinal Cord Injury and Similar Disabilities
Autism

Including Those Persons in
HCB Waivers and ICF/MR's

July 2001 Version

DLSCN 08/27/10

8338-A-000025

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I. OVERVIEW

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GENERAL INSTRUCTIONS

Effective September 1, 1998, the Single Plan format will be used for all people receiving services through SCDDSN except for those receiving Early Intervention (EI). **For DDSN children receiving Early Intervention** (ages birth to six), the facilitator and the early interventionist will work together to complete the IFSP. The plan format can be expanded at the discretion of the plan developer, but cannot be reduced nor can sections be deleted. A facilitator cannot be required by the Board to use an expanded version of the *Life Plan Worksheet* or *Plan of Supports*.

The formulation and completion (Note: formulation and completion does not mean attendance at the meeting) of the Single Plan are the responsibilities of the consumer, all who are invited by the consumer to participate as members of the circle of support, the Plan Manager, a facilitator, unless specifically refused; and other professionals who provide services/supports to the consumer. The Plan Manager and facilitator are charged with the greatest degree of responsibility when formulating and completing the Plan. The Plan Manager will have the primary responsibility for monitoring the implementation of the Plan (see "Plan Monitoring" section) and assuring its accuracy at all times. The Plan Manager may be the service coordinator, QMRP, or program coordinator (i.e. day program or steps coordinator if on optional status).

By June 30, 2001 consumers of DDSN services will have the opportunity to choose annually who will lead their planning meeting. The planning meeting may be led by: 1) the service coordinator, early interventionist, QMRP, or program coordinator (if on optional status); 2) an approved independent facilitator; or 3) an approved agency-based facilitator. The consumer or family may lead their own planning meeting with the involvement of an independent facilitator or their service coordinator. The consumer's decision regarding who leads their planning meeting must be documented in the file.

There are many approaches to achieving a self-determined or self-directed plan (also known as a person centered plan - PCP). Regardless of the process used and the activities that support that process, the desired result is a final plan that focuses on the consumer's desires and goals as well as his/her needs. Necessary information should be included in the sections of the Plan as needed without regard to space provided.

The Single Plan is comprised of three parts, the Background Document, the Life Plan Worksheet and the Plan of Supports. All three parts are required for a complete Single Plan.

The *Background Document* supplies basic identifying information about a consumer. This information is needed before the planning process begins. It includes information about the progress made during the previous year, assessment results from professionals/paraprofessionals and their recommendations for the coming year.

The gathering and compiling of information on the *Background Document* is the responsibility of the assigned Plan Manager with input from all relevant professionals, staff, family, etc. A copy must be made available to the facilitator, if one is being used, at least 7 working days prior to the planning meeting.

The *Life Plan Worksheet*, to be completed by a facilitator or Plan Manager when a facilitator is not involved, is intended to record information that is made available through an activity or series of activities involving persons selected by the consumer because of the meaningful role they play in his/her life. Additionally, it is used to record decisions reached during the planning process.

The *Plan of Supports*, requires the notation of each prioritized need, want or desire, an action plan for addressing each need, want or desire, who is responsible, when it will be put in place, the funding required and the date these activities are expected to be completed during the coming year. The *Plan of Supports* is to be completed by a facilitator, or Plan Manager when a facilitator is not involved. Some portions of the *Plan of Supports*, such as dates or provider names, that are not available at the time of planning will be completed by the Plan Manager as the information becomes available.

Amending the Plan

As routine changes occur, the Plan Manager must update the *Background Document*, *Life Plan Worksheet* or *Plan of Supports* to reflect the consumer's current situation. Changes that necessitate modifications to the existing program or service provision must be approved, at a minimum, by the consumer and/or guardian , the Plan Manager, and the professional/paraprofessional affected by the change. The approval must be documented in the consumer's file.

Documentation of Plan changes may be made in service notes or on a separate page (see Amendment to the Single Plan). Either way, the original Single Plan should note the change.

Any changes or updates to the Plan must be made so as not to compromise or lose the original wording of the Plan. The reader should be able to determine the consumer's situation at all points in time throughout the life of the Plan.

Formulating the Plan

At a minimum, the Single Plan must be reformulated every year. This reformulation must occur within 365 days of the Plan date, which is the date the Plan is accepted by the Plan Manager ("Signature/Date" of assigned Plan Manager on *Plan of Supports*). This reformulation will include updating the *Background Document* (update must include notation of "date completed" and signature of Plan Manager) and updating and rewriting the *Life Plan Worksheet* and the *Plan of Supports*.

In the rare situation that it is not possible to reformulate the Plan by the 365th day, the consumer's current plan should be reviewed by the Plan Manager and the consumer with input from others, updated as needed and a statement made that the plan is current and valid. This statement, the Plan Manager's signature and date should appear below the signature which originally accepted the Plan. **The Plan must remain current and valid at all times. (Note: the IFSP must be completed by the 365th day and cannot be extended.)** The Plan Manager should document this in service notes or on a separate form that documents the amending of the Plan. The Single Plan should reference the note or amendment form and contain the signature and date of the Plan Manager.

Once completed, a copy of the Single Plan must be given to the consumer and/or guardian. Copies should also be made available to those responsible for implementation of a portion of the Plan and those who participated in planning.

Monitoring Plan Implementation

Once the Plan has been formulated, it must be implemented. The Plan Manager is responsible for assuring that all actions on the *Plan of Supports* are being implemented. At a minimum, it must be completed as needed, but at least quarterly. The **Quarterly Single Plan Review** form must be used to complete the monitoring.

The quarterly reviews must be completed every three months and must be completed by the last day of the third month. One annual Plan and three quarterly reviews will be conducted annually.

Annual Plan	Quarterly Review	Quarterly Review	Quarterly Review
January	April 30	July 31	October 31
February	May 31	August 31	November 30
March	June 30	September 30	December 31
April	July 31	October 31	January 31
May	August 31	November 30	February 28
June	September 30	December 31	March 31

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July	October 31	January 31	April 30
August	November 31	February28	May 31
September	December 31	March 31	June 30
October	January 31	April 30	July 31
November	February 28	May 31	August 31
December	March 31	June 30	September 30

All of the needs/actions listed on the *Plan of Supports* must be reviewed. Additionally, as needs/actions change throughout the year, the Quarterly Single Plan Review must be updated to reflect the changes.

For each need/action, all four (4) questions on the Quarterly Single Plan Review form must be answered.

"Actions Taken/Implemented?": Answer yes or no. If the required actions have been taken, only a "yes" is required. However, if the required actions have not been taken and "no" is entered, a comment must be written to explain the reason the actions were not taken. Additionally, the corrective actions, if warranted, to assure future implementation must be noted.

"Progress Made?": Answer yes or no to indicate if progress toward the desired goal has been made. In some cases, during the quarter, there may be some months during which measurable progress was made and other months during which measurable regression may have occurred. In these situations, determine if progress was made from the previous quarter.

"Need Met?": Indicate if the actions were successful in addressing the need, want, desire.

"Continue as Written?": Determine if the actions outlined should continue to be implemented as written. If there has been no progress or the need has not been met, a written comment must be included to explain continued implementation as written or recommend changes.

As stated, Quarterly Single Plan Reviews must be completed every three months. Annually, one Plan will be completed with three subsequent reviews. A choice of review forms is offered. One form allows for the entire year's monitoring to be completed on one form. With this form, required comments must be made in service notes/contact notes which identify the entry as monitoring and is dated the same date as the date on the review form.

The other option allows one quarter's monitoring on one form. Space is available for the required comments.

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II. INSTRUCTIONS

INSTRUCTIONS FOR THE COMPLETION OF THE BACKGROUND DOCUMENT

It is the Plan Manager's responsibility to compile the information to be included in the *Background Document*. This information may be included from previously completed reports that are available in the consumer's file or it may be solicited input from professionals, paraprofessionals or agencies currently providing services/supports. However compiled, the Plan Manager must assure the information used is current and accurate.

All sections of the *Background Document* must be completed and forwarded to the person responsible for facilitating the person centered planning activities at least 7 working days prior to the scheduled meeting date.

I. **Identifying Information** - All information in this section is required, if available. The consumer may not have a Medicare number and the primary contact may not have phone numbers. Enter the basic information requested. Be sure to include the name of any company providing insurance coverage and the type of insurance provided. For example, HealthSource - health insurance; Mutual of Omaha - life insurance.

Include any "Critical Information". This is any information that is important or necessary to know when working with or interacting with this consumer. This may include allergies, strong preferences, illegal or inappropriate behaviors and DO NOT RESUSCITATE orders.

"Emergency/Disaster Plan": Include information about this consumer's plan in the event of an emergency or natural disaster. Consider whether State Plan Medicaid transportation services would be required if the situation mandated evacuation. For those served in SCDDSN sponsored residential facilities, an emergency plan has already been developed; therefore, a statement indicating such is all that is required.

For those who live with family members who will accept the responsibility for emergency planning, notation of such is required. For example, "John lives with his parents who will make all needed arrangements in case of an emergency or disaster."

For those who live alone, assistance should be provided as needed to develop a specific plan for dealing with emergencies or natural disasters. Once developed, the emergency plan should either be included in the Single Plan or the Single Plan should reference the location of the specific emergency plan.

Enter the date this consumer most recently met level of care. ***For waiver recipients***, this is the date the consumer was determined to meet ICF/MR or nursing facility Level of Care. If determined to meet ICF/MR Level of Care, this date should be the same as the "effective date" on the Certification Letter. For consumers not enrolled in a waiver, this item will not be completed.

II. **Current Life Situation** - Include a full description of those aspects of the consumer's living arrangement that are relevant to the development of a plan of supports. Be sure to include pertinent information such as whether or not he/she has mental retardation, a related disability, a head injury, spinal cord injury or similar disability. If the consumer needs supervision, provide information about why the supervision is needed and who provides (i.e., family, facility, etc.). Include information about whether he/she needs services to acquire skills or prevent regression.

Include information about the consumer's current activities such as: employment, educational activities, retirement, transitional situations, significant familial status, (past and current) etc. To the extent necessary, input from professionals, paraprofessionals or agencies providing services must be included. These professionals, etc., should include a description of the activities/services currently provided, results of assessments conducted, as well as any recommendations regarding those activities/services to be implemented in the coming year.

For waiver recipients, include any waiver funded service received, the frequency with which it is provided, and the type of provider. Services such as habilitation (residential, day and prevocational), supported employment, respite, homemaker, companion, personal assistance (attendant care), adult day health, and environmental modifications should be included. It is important that the specific interventions/training provided as a part of habilitation, supported employment and companion be included. Any recommendations to be addressed in the coming year should also be included. For MR/RD waiver recipients, the "Waiver Service Information" page may be used to communicate this information.

III. Physical Health - Note that this section is to include: 1) medical conditions; 2) behavioral/emotional conditions; 3) dental conditions; 4) reproductive health issues; 5) any allergy conditions and the 6) treatments and/or 7) medications related to any of these. Although not required items, this is the section where medical/psychiatric diagnoses, IQ/adaptive level and related information and any conditions such as HIV, hepatitis, etc. should also be noted. Space has not been dedicated for genetic information but should be included, when appropriate, including the need for evaluation and/or any follow up. Other agencies involved in addressing the health needs of the consumer should also be noted. The comment section allows for further information that may be important.

For waiver recipients, this section should include any of the following waiver services that are currently received: nursing, psychological, vision, audiological, pharmacy, speech/language pathology, occupational therapy, physical therapy and communication services. Personal care aide services, assistive technology, personal assistance, personal emergency response system and specialized supplies and adaptations are waiver services that may be included in this section or in another if more appropriate. The service name, and frequency must be noted. Any recommendations for the coming year should be included in this section. The "Waiver Services Information" page may be used to record this information for MR/RD Waiver recipients.

For waiver recipients, the Plan must include all services regardless of the funding source. This includes Medicaid State Plan services for which no prior authorization is needed. For example, the Plan must reflect physician visits, hospitalizations, emergency room visits, non-routine or short term medications, emergency dental care, durable medical equipment, Home Health Services, etc. At the time of annual planning, consideration as to which services will likely be received during the coming year should be given. For those services likely to be received, statements such as those noted below must be added to the Plan. If it is discovered during monitoring that a State Plan service has been received but is not on the Plan, the Plan must be updated to include the services. For example, the *Background Document* may read: "John may receive physician visits, hospitalizations and emergency services as needed or recommended by his physician. Additionally, he may receive prescribed drugs as ordered by this physician." Please remember, prescribed drugs may be funded by the State Plan or by the Waiver.

For waiver recipients, enter the requested information along with the any medical condition(s) including any medical or emotional/behavioral conditions, treatments, equipment, the medication

or intervention and frequency, the prescriber or provider, and the service name and funding source.

For Example:

Condition	Medication/Intervention & Frequency/Schedule for Use	Physician/Prescriber/ Provider	Service Name & Funding Source or Person Responsible
Seizure Disorder	Phenobarbitol - Daily	Dr. Joe Payne Riley's Pharmacy	Prescribed Drugs; M'caid State Plan
	Dilantin - Daily	Dr. Joe Payne Riley' Pharmacy	Prescribed Drugs; M'caid State Plan
Diabetes	Insulin - Daily	Dr. Jim Sugarbaker Riley's Pharmacy	Prescribed Drugs; M'caid State Plan
	Syringes - Daily	Dr. Jim Sugarbaker Riley's Pharmacy	Prescribed Drugs - M'caid State Plan
	ADA Diet - Daily	Dr. Jim Sugarbaker CTHII Staff	Residential Hab. - MR/RD Waiver
Acid Reflux	Prilosec - Daily	Dr. Bill Throat Riley's Pharmacy	Prescribed Drugs - MR/RD Waiver
Underweight	Ensure/Daily/1 case per mo.	Dr. Bill Throat Riley's Pharmacy	Asst. Tech. MR/RD Waiver
Nearsightedness	Eyeglasses/ PRN	Dr. Bob Pupil Lens Crafters	Vision Services MR/RD Waiver
Depression	Prozac - Daily	Dr. Bowman Riley's Pharmacy	Prescribed Drugs - MR/RD Waiver
	Behavior Support Plan - Daily	Dr. Blue CTH II Staff	Behavior Support Svs & Res. Hab MR/RD Waiver

Include any comments needed to fully explain the information presented in this section along with any recommendations for the coming year if not previously noted. List any therapies, assistive technology or supplies received or needed on a regular basis. Include the frequency with which the supplies are received and the schedule for use. Include the provider and/or prescriber and the name of the service and the funding source. For example:

Therapy/Assistive Technology/Equipment and Supplies	Schedule for Use/ Frequency	Provider/ Prescriber	Name of Service/Funding Source or Person Responsible
Speech Therapy	Twice weekly	Speech and Hearing Center	Speech/Language Path. - MR/RD Waiver
Alpha Talker	Daily/PRN	Prentke Romich	Assistive Tech. MR/RD Waiver
Diapers	Daily/2 cases per month	Riley's Pharmacy	Assistive Tech. - MR/RD Waiver
Wipes	Daily/2 cases per month	Riley's Pharmacy	Assistive Tech. - MR/RD Waiver

Provide any other medical or health related comments that will be helpful. Information such as diseases or history of behaviors that may cause the consumer to have a higher risk of certain diseases or significant family history of diseases may be included. Note any recommendations for the coming year not previously noted.

IV. **Rights Issues** - When applicable, include information regarding any termination of rights and/or declaration of incompetency, date of such, name and address of court, court appointed guardian/custodian and contact information. Other relevant information may include the consumer's possible need for assistance in understanding or exercising his/her rights when not adjudicated incompetent, per Adult Health Care Consent Act (SCDDSN Policy 535-07-PD).

For Waiver recipients, list any issues regarding rights that are applicable to this consumer. This may include adjudication or restrictions not related to age. Include any recommendations for the coming year. Additionally, this section can be used to remind consumers of their right to appeal.

V. **Financial Resources** - Check all that apply. In the comment section note when there is an SSI/SSA payee and the name. If it is relevant to have information regarding the consumer's assets (including checking and savings accounts, other holdings/property) and designated co-signers, include that information here also. In some circumstances, burial plans may be appropriate.

For those who reside in a SCDDSN sponsored residential option (SLP, CTH, CRCF) a financial plan as required by "Management of Funds for Individuals Participating in Community Residential Programs" (200-12-DD) must be included. This information should be provided by residential staff.

For waiver recipients, indicate any financial resources the consumer is receiving. Indicate the ICAP level that has been determined for this consumer by the SCDDSN Regional Office. Include any comments needed to explain the information presented or make recommendations for pursuit of resources.

The *Background Document* is intended to provide basic information that is essential for all consumers. Other information should be added selectively so that all important information is included. Consumers should never be subjected to questioning that is embarrassing or inappropriately invasive or intrusive.

Instructions for Completion of the Background Document for Recipients of an ICF/MR

For ICF/MR residents, the *Background Document* is completed by the interdisciplinary team lead by the QMRP. The total plan must be completed within 30 days of admission and annually thereafter. Therefore, the *Background Document* must be completed by the team and delivered to the facilitator in sufficient time to allow for the completion of the remaining portions of the plan (i.e., *Life Plan Worksheet, Plan of Supports*).

The *Background Document*, **for ICF/MR residents**, will be composed by the QMRP or designee and will be based on written reports submitted by interdisciplinary team members. Each team member will prepare a report describing the progress made on interventions/supports that have been provided, the results of assessments (strengths, needs, preferences, need for services), and recommendations for interventions/supports to be provided in the coming year. The written reports from interdisciplinary team members will be maintained in the consumer's file and must be signed.

Once all needed reports are gathered, the QMRP or designee should use these reports to compose the *Background Document*. Information from the detailed reports may be summarized to formulate the document or, if appropriate, reports may be included verbatim . Attaching team members' reports to the basic information is not sufficient.

Once drafted (before forwarding to the facilitator), the *Background Document*, must be shared with all team members for comment. This may be done by meeting. If so, minutes of the meeting should be taken along with a dated signature sheet of attendees. The minutes and signature sheet should be maintained in the consumer's file. If a meeting is not held, the QMRP must assure and document that each team member agrees that the information included in the Background Document is an accurate representation of the information submitted in the detailed report. If reports are included as written by the professional/paraprofessional, agreement is assumed.

These guidelines should be used when completing the *Background Document* for **ICF/MR residents:**

I. ***Identifying Information***

Enter the basic information requested. Be sure to include the name of any company providing insurance coverage and the type of insurance provided. For example, HealthSource - health insurance; Mutual of Omaha - life insurance.

Include any "Critical Information". This is any information that is important or necessary to know when working with or interacting with this consumer. This may include allergies, strong preferences, illegal or inappropriate behaviors, DO NOT RESUSCITATE orders, etc.

Enter the date this consumer met level of care. This is the date this consumer was determined by the Utilization Review team to meet ICF/MR Level of Care.

II. ***Current Life Situation***

For ICF/MR residents, include information about the progress made on residential and day interventions or training objectives that have been or are being implemented, the results of assessments completed, and recommendations for the coming year. Include any pertinent social and recreational information including progress on interventions or training objectives that have been or are being implemented, results of assessments, and recommendations for the coming year. The results of the following assessments should be reported in this section: cognitive development (W222), social development (W223), adaptive behaviors or independent living skills necessary for the consumer to function in the community (W224), and vocational skills as applicable (W225). Information about training to be provided in personal skills essential for privacy and independence should also be included in this section (W242).

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The results of assessments in the following areas may be reported in this section **for ICF/MR residents** or in *Section III, Physical Health* whichever is deemed most appropriate: sensorimotor development (W218), affective development (W219) and speech and language development (W 220).

Also, **for ICF/MR residents,** opportunities for choice and self management (W247), information about the consumer's ability to manage his/her own money (W126) and any systematic interventions used to manage inappropriate behavior (W289) may be included in this section or in *Section IV, Rights.*

III. ***Physical Health***

For ICF/MR residents, this section should include information about assessment results and progress made on current training objectives or interventions in the following areas: physical health and development (W216), nutritional status (W217), auditory functioning (W221), and need for mechanical supports and schedule for use.

Information about the results of assessment performed in the areas of sensorimotor (W218), affective development (W219); speech/language development, and the use of systematic intervention to manage inappropriate behaviors may be included in this section if not included in *Section I: Current Life Situation.*

Indicate the consumer's medical condition(s) including any emotional/behavioral conditions; the treatments, equipment, medication or intervention provided and frequency or schedule for use; the prescriber or provider; and for people in the ICF/MR, the person responsible for assuring that the intervention is provided. For example:

Condition	Medication/Intervention & Frequency/Schedule	Physician/Prescriber/Provider	Service Name and Funding Source or Person Responsible
Seizure Disorder	Phenobarbitol – 5 p.m.	Dr. Joe Payne Riley's Pharmacy	Nursing staff
	Dilantin – 5 p.m.	Dr. Joe Payne Riley' Pharmacy	Nursing Staff
Diabetes	Insulin – 12 p.m.	Dr. Jim Sugarbaker Riley's Pharmacy	Nursing staff
	ADA Diet – each meal	Dr. Jim Sugarbaker S. Brown, RD	All involved
Acid Reflux	Prilosec – 8 a.m.	Dr. Bill Throat Riley's Pharmacy	Nursing staff
Underweight	8 oz. Ensure/each meal/ 1 case per mo.	Dr. Bill Throat S. Brown, RD	Nursing staff
Nearsighted	Eyeglasses/ PRN	Dr. Bob Pupil Lens Crafters	All involved

~~Add any comments that are needed to fully explain the information presented in this section.~~

List any therapies, assistive technology, equipment or supplies the consumer has received or is receiving on a regular basis. Include the frequency with which the equipment/supplies are received and the schedule for use. Include the provider's name and for people in an ICF/MR, the persons responsible for implementation.

For example:

Therapy/Assistive Technology Equipment/Supplies	Schedule for Use/Frequency	Provider/Prescriber	Name of Service/Funding Source or Person Responsible
Speech Therapy	Twice weekly	Speech and Hearing Center	Speech Therapist
Alpha Talker	Daily/PRN	Prentke Romich	Speech Therapist and All staff
Diapers	Daily/2 cases per month	Riley's Pharmacy	All staff
Wipes	Daily/2 cases per month	Riley's Pharmacy	All staff

Provide any other medical or health related comments that will be helpful. Information such as significant family history of diseases or history of behaviors that may cause the consumer to have a higher risk of certain diseases may be included.

IV. ***Rights Issues***

List any issues regarding rights that are applicable. This may include adjudication or restrictions not related to age. If not covered in *Section I Current Life Situation*, include assessment results and training on money management.

V. ***Individual Financial Plan***

Include the financial plan as required by "Management of Funds for Individuals Participating in Community Programs" (200-12-DD). Indicate the funding level that has been approved for this consumer by the SCDDSN Regional Office. Include any comments needed to explain the information presented or make recommendations for pursuit of resources.

Instructions for Completion of the Life Plan Worksheet

The *Life Plan Worksheet* is to be completed by a facilitator, or by the Plan Manager if a facilitator is not involved. It is used to record information obtained during the planning process from the consumer and those who play an important or meaningful role in his/her life and to record pertinent discussion that occurs during the meeting. Throughout the *Life Plan Worksheet* examples, cues and things to consider are presented in the shaded area at the left margin. These are included only as prompts and are not nesessarily intended to be answered or commented on in the planning document.

In the section noted "Group Members Involved," the names of the people who participated in the planning process should be listed and their relationship to the consumer. Participation in the planning process may be by a means other than physical presence at the meeting. Participation may occur through written report, telephone conversation, etc. If you choose to list all who participate regardless of the means by which they do so, you must also note the means by which they participate for example, "John Jones, Workshop Supervisor (through written report)". **For those receiving Rehabilitation Supports,** the Lead Clinical Staff (LCS) must participate along with the consumer and/or his/her advocate. These names must be listed in this section.

Through the planning process, the consumer's dreams, goals and/or ambitions for the future may be determined. These should be entered in the corresponding section of the *Life Plan Worksheet.*

The characteristics and values of the consumer should be discovered or identified through the planning process and those should be entered into the corresponding sections on the *Life Plan Worksheet.*

Section 4 of the *Worksheet* should outline the recommendations made by the professionals or paraprofessionals which are recorded in the *Background Document.* Each recommendation should be discussed and a decision regarding its priority recorded. Each of the wants, needs, and desires expressed by the consumer and recorded in earlier sections of the *Worksheet* should be discussed and its priority recorded. By priority it is meant that the meeting participants determine if the recommendation, need, want or desire will be addressed or if it will be deferred until those considered more urgent or important are addressed.

Instructions for Completion of the Plan of Supports

The *Plan of Supports* will initially be completed by a facilitator, or by the Plan Manager if a facilitator is not involved. It will include the prioritized needs, wants or desires and any supports, services, actions or interventions to be provided to meet the prioritized needs, wants or desires. These should include supports that are currently provided and should continue, as well as those that need to be implemented. These supports, services, actions or interventions should address needs, wants or desires from all areas of the consumer's life (i.e., physical and mental health, behavioral/emotional, living arrangements, living skills, employment/education, financial, transportation, leisure/interests, adaptive/assistive equipment).

The prioritized needs, wants and desires will be identified in the "Needs/Actions" section of the *Plan of Supports* and should be followed by the specific support, service, action or intervention to be provided. The date the "Needs/Actions" are accepted as part of the *Plan* should be noted along with the initials of the person making the entry.

The "Timeframe/Projected Completion" date must be included. This is the date by which it is believed the specific action will be completed. This date should be used to evaluate progress toward completing the action and must be updated if the time lapses and the action has not been completed. Remember, updates or changes to the Plan must be completed with the approval of the recipient, his/her legal guardian (if applicable), the person responsible for the actions and the Plan Manager.

If not selected by the consumer or if unknown at the time of the planning, the "Provider Name", "Service Name" and "Funding Source" may be added by the Plan Manager at a later date.

Some examples of how the needs, wants or desires may be listed in the Needs/Actions section are:

- John has difficulty grasping small objects which impedes his ability to work productively. An Occupational Therapy Evaluation will be conducted to determine if specific exercises could help improve John's ability to grasp.

- John wishes to learn to appropriately manage his own behavior without hitting others, throwing objects or being verbally aggressive towards others.
  - ⇒ He will receive training to manage his behaviors thus reducing the incidents of these behaviors.
  - ⇒ The behavior analyst will monitor John's progress monthly, making recommendations for revisions as needed.

- John wishes to manage his own money.
  - ⇒ He will receive training in managing his checking account.

- John wishes to maintain his health.
  - ⇒ He will continue to take Pravochol to help reduce his cholesterol.
  - ⇒ He will eat a specially prescribed low cholestrol diet.
  - ⇒ He will have his cholestrol checked in June.

- In an effort to improve his health, John's doctor has recommended that he stop smoking. John does not want to refrain from smoking. To assure that he is aware of the health risks related to his decision to continue to smoke, the risks and the consequences of cigarette smoking will be reviewed with John.

- John wants a new pair of athletic shoes.
  - ⇒ He will be taken shopping by May 1.

The initials of persons making entries onto the plan must be identified. This is done by initialing and printing the name that corresponds to the initials.

Once the facilitated Plan is completed and has been approved by regional office, the Plan Manager must sign and date the *Plan of Supports*. This signature signifies the Plan Manager's acceptance of the plan. It is at this point that the plan is considered "formulated" and from this date that the 365 days will be counted. A copy of the completed Plan must be sent to the consumer and/or his/her legal guardian.

Any needs, wants or desires included in the *Plan* should be supported by information in the *Background Document, Life Plan Worksheet*, or plan amendment.

For HCB Waiver recipients, the *Plan of Supports* must include the services to be provided, their frequency and the type of provider in addition to those items requested by the form. Also, the *Plan* must include the following:

- the care, skills training, and supervision to be provided if Residential Habilitation is provided,
- the assistance to be provided with the acquisition, retention, or improvement of self-help, socialization or adaptive skills if Day Habilitation is provided,
- the services aimed at preparing the consumer for work if Prevocational is provided,
- the services provided to obtain and sustain employment if Supported Employment is provided,
- the therapeutic goal to be addressed if Companion is provided,
- the care provided by the PCA and/or attendant,
- the prescribed drugs provided by Medicaid State Plan and MR/RD or HASCI Waiver
- a statement about the State Plan services the consumer may receive. For example, "John needs appropriate medical care. Hospitalizations, physician visits, emergency room visits will be available as needed. To maintain good health, prescribed drugs will be provided as needed".

NOTE: For **HASCI Waiver recipients**, the HASCI Waiver services page (HASCI Form 17) must be included as an attachment to the *Plan of Supports*.

For ICF/MR residents, in addition to the information requested by the form, the *Plan* must include the following:

- training for those who lack personal skills essential for privacy and independence unless the consumer is deemed developmentally incapable of acquiring them,
- description of the relevant interventions to support the consumer toward independence,
- the identification of the mechanical supports to achieve proper body position, balance, or alignment,
- any systematic interventions used to manage the client's behavior.

If it is determined, upon review of the plan, that information required **for waiver and ICF/MR recipients** is not included and those omissions have not been identified prior to regional approval, the Plan Manager must add the required information/intervention. This should be done with the approval of the consumer and other appropriate circle/team members.

III FORMS

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Background Document

I. Identifying Information

Name _____

Address _____

_____

Phone # _____

Date of Birth _____ Social Security # _____

Medicaid # _____ Medicare # _____

Other Insurance _____

Primary Contact _____

Address _____

_____

Phone # _____

Primary Emergency Contacts

Name _____ Phone _____ _____

Name _____ Phone _____ _____

Critical Information _____

_____

Emergency/Disaster Plan _____

_____

Signature of Plan Manager and Date _____

Level of Care Date _____

Division: Autism ☐ HASCI/SD ☐ MR/RD ☐ At Risk ☐

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Name: _____
Date: _____

II. Current Life Situation

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Name: _____

Date: _____

III. Physical Health

Primary Physician _____

Address _____

_____

Phone _____

Date of Last Physical Exam _____

Date of Last PPD, if applicable _____

Date of Last OB/GYN, if applicable _____

Date of Last Dental Exam _____

Describe current medical and emotional/behavioral conditions, treatments, medications, to include dosage (include dental, vision, allergies and reproductive health).

Condition	Medication/Intervention & Frequency/Schedule for Use	Physician / Prescriber / Provider	Service Name & Funding Source or Person Responsible

Comments _____

_____

_____

_____

_____

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Name: _____

Date: _____

List any therapies or assistive technology received, frequency and provider.

Therapy/Assistive Technology Equipment/Supplies	Schedule for Use/Frequency	Provider/Prescriber	Name of Service/Funding Source or Person Responsible

Type of Diet Required: _____

Medication Administered by Whom: _____

Medical/Health Related Comments _____

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Name: _____

Date: _____

IV. Rights Issues

List any rights issues that apply: _____

_____

_____

_____

V. Financial Resources

Resources	Receiving
None	☐
Medicaid	☐
Medicaid Waiver	☐
Medicare	☐
Private Insurance	☐
SSI	☐
SSA	☐
SSDI	☐
Food Stamps	☐
Housing Subsidy	☐
Earned Income (employment)	☐
DSN Family Support	☐
ABC Voucher	☐
Workers Compensation	☐
Vocational Rehab.	☐
Home Health	☐
Veteran's Affairs	☐
Other	☐

ICAP Level as Determined by Regional Office _____

Comments _____

_____

_____

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Life Plan Worksheet

Name_____ Date(s) of Plan Meetings_____ Facilitator/SC_____

1. Group Members Involved (Add another page if needed)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What does the consumer want? What are the most important things to him or her? What does s/he want to work toward or accomplish?

2. Dreams, goals, ambitions

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Characteristics and Values

a. Who is important to the consumer (include caregivers, family, friends and significant others; addresses, phone numbers, relationship and other relevant information)

Does the consumer have friends? Intimate relationships? Is s/he connected to family or other natural support networks? Is there anyone else in the consumer's life other than paid staff? Are these people participating in planning? Are relationships important to the consumer? The group may need to explore with the consumer ways to support him/her in reconnecting with family or significant others or ways to facilitate his or her developing and maintaining new relationships.

_____

_____

_____

_____

_____

_____

_____

_____

_____

b. preferences/likes/dislikes/needs/wants/desires

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What are the things that s/he must have (non-negotiable) or are highly desired? (Ex. Live near family, live alone, work outdoors, work at night, keep in contact with sister, etc.) These are what the consumer must have, not necessarily what others perceive as preferences, likes, etc. Also consider what things are important to keep consumer safe and healthy even though s/he does not see them as important or needed.

c. current or desired routines

How does the consumer spend his/her day? What routines are important to the consumer? (Ex. Sleeping through 2 snooze alarms, grabbing a power nap right after work; bowling with the church league every week; monthly lunch with old friend...) Consider the degree of control the consumer has with current or desired routines.

d. abilities/talents relevant to the achievement of desires or plan for future

What strengths does s/he possess that can be used or capitalized on to support the consumer in achievement of her/his personal goals? What supports are already in place that could be utilized to assist the consumer in achieving his/her goals? (Ex. Supportive family or coworkers, great transportation system; wide and varied circle of support...)

e. financial status

Does the consumer have enough money to achieve personal goals? Does the consumer want/need more money? How much control does the consumer currently have over finances? How much does s/he want?

4. Identification of supports to achieve and maintain:

a. personal goals (ex., dreams, ambitions, major life decisions)

What goals did the consumer establish? A better job? More control over his/her money? A vacation? A new TV? Going fishing? What is needed to support the consumer in achieving or beginning to achieve his/her goals? A job coach? Retraining for a marketable skill? More connections with the neighborhood or community?

b. mental and physical health/wellness/prevention (nutrition, exercise, stress management, hygiene, medication management)

What actions/supports are needed for the consumer to experience the best possible health? How much control does the consumer have or exercise over his/her own health? What is needed for the consumer to exercise more autonomy in maintaining his/her health? Consider any health issue listed in 3b. What supports are needed to help the consumer accept the importance of the health concern or the measures needed to maintain good health?

c. safety (environmental, community, injury, prevention)

What actions/supports are needed for the

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consumer to be safe at home, at work, within the neighborhood? More locks? A better neighborhood? Wrist guards? Sun screen? Enhanced safety equipment? How much control does the consumer have or exercise over his own safety? What is needed for him/her to exercise more control over personal safety? Knowledge? First aid class? Programmable phone? Consider any safety-related issue listed in 3b. What supports are needed to help the consumer accept the importance of the safety concern or measures needed to maintain safety?

d. financial security

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Name: _____

Date: _____

Plan of Supports

Date Added	*	Needs/Actions	** Provider Name and Person Responsible for Coordinating	** Service Name and Funding Source	Timeframe/ Projected Completion Date	** Date Met

* Initials of Persons Making Additions (Please identify initials below.)

_____ _____

_____ _____

_____ _____

_____ _____

Signature/Date of Assigned Service Coordinator/QMRP

_____

** These items may be finalized/completed by the service coordinator/QMRP following Regional Office approval as information is available. Other items to be revised by the service coordinator/QMRP as indicated.

ROA_0414

Amendment to the Single Plan

Name: _____

Date: _____

Current Situation: _____

Recommendations/Discussion: _____

Decision: _____

Signatures:

_____ _____

_____ _____

_____ _____

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QUARTERLY SINGLE PLAN REVIEW

Name: _____ Plan Date: _____

Needs/Actions	Actions Taken Implemented?	Progress Made?	Need Met?	Continue as Written	Comments

Signature of Person Completing Review: _____

Date: _____

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QUARTERLY SINGLE PLAN REVIEW

Name: _____ Plan Date: _____

Needs/Actions	Actions Taken Implemented?	Progress Made?	Need Met?	Continue as Written?	Actions Taken Implemented?	Progress Made?	Need Met?	Continue as Written?	Actions Taken Implemented?	Progress Made?	Need Met?	Continue as Written?
Signature and Date of Review												

Y=Yes
N=No

8338-A-000055

ROA_0417

MR/RD Waiver Services Information

Need: _____

Service (exact waiver service name): _____

Frequency of Service: _____

Number of Units (____ units per _____): _____

Need: _____

Service (exact waiver service name): _____

Frequency of Service: _____

Number of Units (____ units per _____): _____

Need: _____

Service (exact waiver service name): _____

Frequency of Service: _____

Number of Units (____ units per _____): _____

Need: _____

Service (exact waiver service name): _____

Frequency of Service: _____

Number of Units (____ units per _____): _____

Need: _____

Service (exact waiver service name): _____

Frequency of Service: _____

Number of Units (____ units per _____): _____

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EXHIBIT 2

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **South Carolina** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Mental Retardation and Related Disabilities Waiver

C. **Waiver Number: SC.0237**
Original Base Waiver Number: SC.0237.

D. **Amendment Number: SC.0237.R04.02**

E. **Proposed Effective Date:** *(mm/dd/yy)*
03/01/11
Approved Effective Date: 03/01/11
Approved Effective Date of Waiver being Amended: 01/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The State is taking this amendment opportunity to update the Quality Improvement sections, and other sections of the document, to more accurately reflect and describe performance measures, data sources, definitions, provider qualifications, remediation activities, MOA, service contract information, and policies currently used in the provision of this waiver. Many references to the "South Carolina Department of Disabilities and Special Needs" or "the operating agency" have been changed to "DDSN". Clerical errors/oversights have been corrected. In some sections text has been streamlined to enhance clarity.

The requested effective date is March 1, 2011.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the

development of the service plan or for services that are not included in the service plan.

B. **Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. **Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I.**

D. **Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C.**

E. **Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H.**

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The intent for these quality amendments was presented at a public meeting for the CS waiver on July 8, 2010, and at the DHHS Medical Care Advisory Committee on August 17, 2010. DDSN presented the waiver amendments to their Commission at the August 12, 2010 meeting. In addition, DDSN held a special called meeting on September 2, 2010, to review the amendments. The amendments were approved as presented.

J. **Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Support Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- **Registered nurse, licensed to practice in the State**
- **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- **Licensed physician (M.D. or D.O)**
- **Case Manager** (qualifications specified in Appendix C-1/C-3)
- **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- **Social Worker.**
  Specify qualifications:
- **Other**
  Specify the individuals and their qualifications:

  Service Coordinators/Early Interventionists must hold at least a Bachelor's degree in Social Work or a related field from an accredited college or university, or hold at least a Bachelor's degree in an unrelated field from an accredited college/university and have at least one year of experience working with individuals with intellectual disabilities or in a case management program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

DDSN's "Procedures for Qualified Provider Implementation" require that participants must be offered a choice of SC/EI providers initially and annually thereafter. The offering of choice must be documented and adherence to policy is monitored through the DDSN QIO review process. Another available option, in addition to the local SCs/EIs, is a Life Planner. On an annual basis DDSN offers the opportunity for a Life Planner to assist the participant in identifying personal goals, and the paths necessary to reach those goals. Life Planners have been certified by the University of South Carolina, Centers for Disability Resources.

Once a SC/EI provider is chosen, he/she is required to utilize standardized tools to assess needs. These tools must be supported by current professional reports. Once needs are identified, SCs/EIs explain the service options available to meet the assessed need. When a service option is chosen, the participant/guardian is provided a listing of all service providers for the needed service from which they must select a provider. (A complete list of Qualified Providers and services is available on the SCDDSN website: www.state.sc.us/ddsn). Waiver policy requires the offering of choice among all qualified providers of each needed service. This offering of choice must be documented. Adherence to policy regarding the offering of choice and the appropriate completion of the assessment are monitored through the DDSN QIO review process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

During the planning process input from the participant, his/her legal guardian, caregivers, professional service providers and others of the participant's choosing is sought. The information obtained is used by the Service Coordinator/Early Interventionist in order to develop the service plan. The participant/legal guardian will receive a copy of the plan upon completion.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Service Plan process begins with an assessment. The State utilizes standardized tools which specifically assesses participants' health care status. Needs identified by the assessment are then added to the plan and services/interventions are included to address the assessed needs.

The service plan is developed by the Service Coordinator or Early Interventionist (SC/EI) and is based on a comprehensive

review of the waiver participant's needs, strengths, and personal preferences through use of an annual formal assessment. Input from the participant, his/her legal guardian, caregivers, professional service providers and others of the participant's choosing is sought. The information obtained is used by the SC/EI to assess the person's strengths, personal priorities and preferences, and needs in order to develop the service plan. Plans are developed prior to the delivery of a waiver funded service and annually thereafter. Plans are updated as participant needs for waiver services change.

When the need for the waiver has been established by the SC/EI, participants/legal guardians are informed at the time of enrollment of the names and definitions of waiver services that can be funded through the waiver if the need for the service/services is appropriately assessed by the SC/EI. Participants/legal guardians are also instructed that waiver services are meant to supplement supports already available in the home/community and will not be a source of 24 hour care. The only exception to this is the Residential Habilitation service.

Participation in the planning process by the participant, his/her guardian, knowledgeable professionals and others of the participant's choosing, helps to assure that all of the participant's needs are recognized and addressed by the service plan. The participant's strengths and preferences will be identified on the service plan in order to define how needs will be addressed.

The service plan will include a statement of the participant's need, and will identify specific service(s) to meet the need, along with the service amount, frequency, duration of the service, and the type of provider who will furnish the service.

The SC/EI will be primarily responsible for coordinating services but must rely on the participant /guardian to choose a service provider from among those available, make him/herself available for appointments with providers, including those needed for initial service implementation, and cooperate with service coordination efforts. The degree of intervention by the SC/EI may vary based on the needs of the participant and his/her support network and their preferences for self-coordination.

On at least a quarterly basis there will be a review of the entire plan to determine if updates are needed. On an annual basis, there will be face to face contact with the participant/family during which the effectiveness, usefulness, and benefits of the plan will be discussed along with the participants/family's satisfaction with the services/providers.

Amendments to the plan will be made as needed by the SC/EI based on the results of monitoring or when information obtained from the participant, his/her legal guardian, and/or service providers indicates the need for a change to the plan.

SC/EI will provide the participant/ legal guardian with information about providers for needed services as often as needed or requested by the participant/ legal guardian, or as indicated through monitoring.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The State utilizes standardized tools which globally assess the person's current situation including the anticipated and expected ability of caregivers to continue to provide care, the condition of equipment, and safety concerns. Identified needs are addressed in the service plan which also includes a section dedicated to emergency planning.

~~Participants' needs, including potential risks associated with their situations, are assessed during the planning process and~~ considered during plan development. The service plan includes a section for a description of the plan to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver. The SC/EI provider agency also conducts training with staff annually to review proper reporting procedures for abuse or neglect.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from

among qualified providers of the waiver services in the service plan.

SC/EI's share information about available providers of needed services to help participants make an informed choice. Annually, upon request, and as needs change, information regarding available providers of needed services is again shared. Information includes phone numbers. Participants are encouraged to call providers with questions to include if providers are accepting referrals. Participants are also encouraged to ask friends about their experiences with providers and utilize other information sources in order to select a provider. Participants can contact their SC/EI with questions about available providers and/or check DDSN's website for the most current listing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Service Plan documents and the description of the planning process are approved by DHHS prior to implementation and whenever any changes are made to the planning document/process. Waiver service plans are maintained either electronically in accordance with DDSN policy or by the SC/EI in the participant's record but are available to DHHS for review at any time. At their discretion, the DHHS Division of Medicaid Program Integrity makes scheduled and unannounced visits to review waiver records based on referrals from DHHS Waiver Staff, advocates, families, internal claims reports, etc. These record reviews compare the participant's service plan, SC/EI narrative notes, waiver service authorizations, and MMIS claims history to detect or identify any anomalies, ensure appropriateness of services authorized and verify documentation of services billed to DHHS. Recoupment of Federal Financial Participation (FFP) may occur as needed. Additionally, DHHS Waiver Staff also review waiver service plans during quality assurance reviews. These reviews focus on the appropriateness of participant service plans as well as timeliness standards, documentation to support Medicaid claims and provider qualifications.

Annually, throughout the year, 5% of waiver participants' plans are reviewed by DDSN using a standardized review instrument. The results of the review are provided to the staff of the service coordination provider so that corrections can be made. An annual report is created and shared with DHHS that outlines areas of concerns noted through the reviews.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ◉ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

Within 365 days of the previous plan.

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

Service Coordinator/Early Interventionist (SC/EI)

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

SCs/EIs are required to monitor the service plan at least quarterly. This monitoring is completed for the entire service plan including all waiver and non-waiver services or interventions included in the service plan. The form used for monitoring specifically requires the SC/EI to indicate if the service/intervention was furnished, if the service was effective, and if the participant was satisfied with the service and/or provider. The form also requires the SC/EI to document the actions taken to follow-up and remediate identified problems. SCs/EIs routinely monitor the participants' emergency plan and health/welfare status. This monitoring is documented in the SC/EI service notes in the participant's waiver record.

SC/EI monitors the service plan on a quarterly basis or more frequently as needed. This is performed by phone calls, review of progress reports and records and/or discussions with the participant/legal guardian or service providers. This monitoring also includes obtaining information about the participant's health, safety and welfare as well as information about service delivery/utilization and appropriateness of interventions.

b. **Monitoring Safeguards.** *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

DDSN policy dictates the minimum frequency with which monitoring must occur and the elements (service effectiveness/usefulness, service providers, service delivery and participant/family satisfaction with services) that must be included. Annually or more often as concerns are noted, information about available providers of needed services including Service Coordination/Early Intervention, is shared with participants/families. Waiver service monitoring is reviewed by DHHS as part of its quality assurance/compliance process.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

i. **Sub-Assurances:**

a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

STATE OF SOUTH CAROLINA	**IN THE COURT OF COMMON PLEAS**
COUNTY OF RICHLAND	
Protection and Advocacy for People with Disabilities, Inc.,	**Civil Action No: 10-CP-40-1095**
PLAINTIFF,	
vs.	
Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs,	
and	
The South Carolina Department of Disabilities and Special Needs	
and	
Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission,	
DEFENDANTS.	

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PLAINTIFF'S RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

COMES NOW Plaintiff Protection and Advocacy for People With Disabilities, Inc. (P&A) and responds to Defendants' Motion for Summary Judgment as follows:

FACTS

As the protection and advocacy system for South Carolina, P&A[1] is authorized in the South Carolina Protection and Advocacy System for the Handicapped Act (Enabling Statute) to conduct Team Advocacy inspections. See S.C. Code Ann. § 43-33-350(4) (Supp. 2010). "Team advocacy inspections are **unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals** in a residential care facility and a community mental health center day program." S.C. Code Ann. § 43-33-350(4) (Supp. 2010) (emphasis added). Based upon this provision, P&A has been conducting Team Advocacy inspections of community residential care facilities (CRCFs) across the state since 1986 and, to date, has conducted over 1000 inspections of CRCFs.[2] The Team Advocacy program has reviewed records containing medical information, such as Medication Administration Records (MARs), in the CRCF context for many years now, as part of its Team Advocacy program. That review has been a keystone of the program: many residents of these homes have critical, daily medical needs for which review of medical information is as essential, and as much a part of their "living conditions," as an inspection of their home's sanitation or physical structure. Over the years, Team Advocacy inspections of CRCFs have revealed life-threatening medication errors and lack of appropriate medical care. Team Advocacy inspection reports have provided information critical to maintaining resident health and safety.

Beginning in 2009, P&A attempted to conduct Team Advocacy inspections of Community Training Homes (CTHs) licensed by Defendants. (See Pl.'s Compl. ¶ 11; Defs.'

[1] Effective July 1, 1996, Plaintiff's board of directors changed its name to Protection and Advocacy for People with Disabilities, Inc. as authorized in Senate Bill 599. S. 599, Act No. 251, Sess. 111 (Eff. Apr. 1, 1996); S.C. Code Ann. §43-33-330 (Supp. 2010).

[2] See P&A, No Place To Call Home: How South Carolina Has Failed Residents of Community Residential Care Facilities July 21, 2009, http://www.pandasc.org/crcfreport.pdf.

Answer ¶ 10) CTHs are residences for individuals with developmental and related disabilities. Like CRCFs, CTHs provide food, housing and care, including arrangement of medical care and medication administration, to people who are unable to live independently. Unlike CRCFs, almost all residents of CTHs require an Intermediate Care Facility/Intellectual Disability (ICF/ID) level of care. (See Defs.' Resp. to Pl.'s First Interrog. No. 8) The ICF/ID level of care is a higher level of care than that required of residents of the CRCFs P&A has been inspecting under the Team Advocacy provision. (See Prevost Affid.)

When P&A notified Defendants that it was extending its Team Advocacy program to CTHs, Defendants objected to P&A's review of records during Team Advocacy inspections. After attempting unsuccessfully to resolve this matter, P&A filed this case. Both parties filed motions for summary judgment on July 8, 2011.filed

LEGAL ARGUMENTS

In their motion for summary judgment, Defendants argue that P&A is not entitled to review medical records during its Team Advocacy inspections because the term "plans of care" does not include medical records. Additionally, Defendants argue that rather than extending P&A's authority when it revised the Enabling Statute in 1993, the legislature limited P&A's ability to review medical records to individualized situations, where P&A has consent. Defendants argue that: 1) the common meaning of "plans of care" does not extend to medical records; 2) as a matter of law and administrative practice, the term "plan of care" in the Medicaid waiver context refers to one specific document which does not include medical information; and 3) the enabling laws limit P&A's review of records to times when the protection and advocacy

system has consent from the individuals involved. Defendants have misread both the State Enabling Statute and Federal law.

I. "LIVING CONDITIONS, INCLUDING THE PLANS OF CARE FOR INDIVIDUALS..." IS AN EXPANSIVE PHRASE PROVIDING AN EXAMPLE OF RECORDS P&A CAN REVIEW DURING INSPECTIONS.

Defendants' first argument is that by adding the phrase "including the plans of care" to the statute, the legislature somehow limited P&A's review to only one item, the plan of care. Defendants define[3] that term for purposes of this case as a document which excludes medical information or records.[4] This construction of **P&A's Enabling Statute** goes against the rules of statutory construction and common usage. The provision under review actually states "Team advocacy inspections are unannounced visits to review living conditions, **including the plans of care for individuals**...." S.C. Code Ann. §43-33-350(4) (Supp. 2010) (emphasis added). The word "including" and its offset comma, clearly indicates that the phrase "plans of care" is an **example** of what P&A can review as part of its Team Advocacy inspections.[5] As mentioned in P&A's Memorandum in Support of Its Motion for Summary Judgment, the legislature inserted "including the plans of care" into §43-33-350(4) in 1993. S.701, Act No. 133, Sess. 110 (S.C. 1993). The use of the word "including" typically indicates that the following nouns are

[3] Interpretations of legislation made by those lacking statutory authority to do so are given less weight than interpretations made by those who do have the requisite statutory authority. 2B Sutherland Statutory Construction § 49:6 (7th ed.); see also Social Sec. Bd. v. Nierotko, 327 U.S. 358 (1946); Jewell Ridge Coal Corp. v. Local No. 6167, United Mine Workers of America, 325 U.S. 161 (1945); U.S. v. Stewart, 311 U.S. 60 (1940) ("An officer or agency of the United States to whom no administrative authority has been delegated cannot estop the United States even by an affirmative undertaking to waive or surrender a public right"); Helvering v. Wilshire Oil Co., 308 U.S. 90 (1939); Biddle v. Commissioner of Internal Revenue, 302 U.S. 573 (1938); Helvering v. New York Trust Co., 292 U.S. 455 (1934); Texas & P. Ry. Co. v. U.S., 289 U.S. 627 (1933); Lynch v. Tilden Produce Co, 265 U.S. 315 (1924); Mission Critical Solutions v. U.S., 91 Fed. Cl. 386 (2010).

[4] In contrast to their current argument, Defendants admitted in their Answer to Plaintiff's Complaint that "plans of various kind" are used for CTH residents. (See Defs.' Answer ¶ 17)

[5] The regulations implementing the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of Title 42 of the United States Code), recognize inspections as health oversight activities which are "necessary for appropriate oversight of...entities subject to civil rights laws **for which health information is necessary for determining compliance.**" 45 C.F.R. §164.512(d) (1) (2010) (emphasis added).

examples, not exclusive. See Black's Law Dictionary (8th ed. 2004); *See also* In re Grewe, 4 F.3d 299, 305 n.5 (4th Cir. 1993) (citing the "general rule of statutory construction that the parenthetical beginning with "including" enlarges the scope [of the statute interpreted] rather than limits it."); Am. Sur. Co. of N.Y. v. Marotta, 287 U.S. 513, 517 (1933) ("In definitive provisions of statutes and other writings, 'include' is frequently, if not generally, used as a word of extension or enlargement rather than as one of limitation or enumeration.").[6]

P&A has been conducting Team Advocacy inspections of CRCFs across the state since 1986. The Team Advocacy program has reviewed records containing medical information during inspections, including MARs, in the CRCF context for many years now. Numerous agencies, including Defendants, have known that P&A was reviewing medical records as part of Team Advocacy inspections. None of these agencies has complained about P&A's review of these records or opposed it until now. The review of records containing health information has been a keystone of the program: many residents of these homes have critical, daily medical needs for which review of medical information is as essential, and as much a part of their "living conditions," as an inspection of their home's sanitation or physical structure. Established usage in regard to the meaning and effect of a statute is a relevant and persuasive guide to its authoritative interpretation. 2B Sutherland Statutory Construction § 49:6 (7th ed.); citing McKeen v. Delancy's Lessee, 9 U.S. 22 (1809); Basey v. Gallagher, 87 U.S. 670 (1874); Swift & Courtney & Beecher Co. v. U.S., 105 U.S. 691 (1881).

[6] A plain-language construction of "plans of care" shows that the term is plural and is directed at the care, of whatever kind, of residents.

II. THE COMMON MEANING OF "PLANS OF CARE" INCLUDES MEDICAL RECORDS.

Defendants argue next that the common meaning of "plans of care" does not extend to medical records. Defendants' arguments do not take into account the context of the phrase in question or the Team Advocacy provision itself. The rules of statutory construction require a review of the **entire statute and its purpose.** S.C. Coastal Council v. S.C. State Ethics Comm'n, 306 S.C. 41, 44, 410 S.E.2d 245, 247 (1991) (the court does not look merely to a particular clause, but instead looks to the provision and its meaning in conjunction with the purpose of the whole statute, and in light of the object and policy of the law). The purpose of the Enabling Statute is to designate P&A, under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), 42 U.S.C. §15001 *et seq.*, as the State's protection and advocacy system for people with disabilities.[7] S.C. Code Ann. §43-33-310 (Supp. 2010). The United States Supreme Court has recognized that states receive federal money under the DD Act to "improve community services, such as medical care....for individuals with developmental disabilities." Va. Office for Prot. & Advocacy v. Stewart, 131 S. Ct. 1632, 1636, 563 U.S. ___, (2011) (citing 42 U.S.C.§§15023(a), 15024). Failure to provide adequate health care is included in the definition of neglect in the federal regulations under the DD Act. 45 C.F.R. §1386.19 (2011). Likewise, the Enabling Statute clearly indicates that one of the main purposes of having a protection and advocacy system is to ensure that people with disabilities are not "subjected to

[7] The Enabling Statute also repeatedly refers to the "care" and "treatment" of people with disabilities. See S.C. Code Ann. § 43-33-340(2)(e) (1976) (developmental disability is a severe, chronic disability which reflects the person's need for combination and sequence of special, interdisciplinary or generic care and treatment which are lifelong or extended); § 43-33-340(3) (developmentally disabled person is a person who has a developmental disability and who receives or is entitled to receive treatment); § 43-33-340(5) (complaint is an allegation "to the effect that the developmentally disabled or handicapped person is being subjected to injury or deprivation with regard to his health, safety, welfare, rights or level of care."); §43-33-350(1) (P&A shall protect and advocate for rights of all people with disabilities by pursuing legal, administrative and other appropriate remedies to insure protection); § 43-33-380 (system may make such disclosures as may be necessary to protect...). Clearly, the legislature was aware of the importance of medical care and treatment to people with disabilities and intended to ensure that P&A could monitor that care and treatment for people in facilities by conducting Team Advocacy inspections.

injury or deprivation with regard to his **health**, safety, welfare, rights or **level of care**." §43-33-340(5) (emphasis added). As the entity authorized by law to serve and protect the health, welfare and rights of people with disabilities in South Carolina, P&A's authority to conduct Team Advocacy inspections should be liberally construed. Cf. City of Columbia v. Bd. of Health & Envtl. Control, 292 S.C. 199, 202, 355 S.E.2d 536, 538 (1987) ("The delegation of authority to an administrative agency is construed liberally when the agency is concerned with the protection of the health and welfare of the public.").

Additionally, in Ohio Legal Rights Serv. v. Buckeye Ranch, Inc., 365 F. Supp. 2d 877, 888-89 (S.D.Ohio 2005), the court found that the Ohio Legal Rights Service, the state designated Ohio protection and advocacy system, is authorized by federal and state law to enforce civil rights laws **for which health information is relevant**. P&A is officially designated by South Carolina to perform all the same functions and to fill all of the same roles as the Ohio Legal Rights Service. Like Ohio Legal Rights Service, P&A is charged with protecting and advocating the rights of individuals with disabilities.[8] Under federal and state law, P&A has the authority to investigate complaints and incidents of abuse and neglect, to monitor facilities and to pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of persons with disabilities who are receiving care or treatment in South Carolina. South Carolina also gave P&A additional authority to conduct Team Advocacy inspections. S.C. Code Ann. §

[8] See South Carolina Protection and Advocacy System for the Handicapped, S.C. Code Ann. § 43-33-310 *et seq.*; Developmental Disabilities Assistance and Bill of Rights Act of 2000, 114 Stat. 1677, 42 U.S.C.§ 15001 *et seq.*; Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 100 Stat. 478, 42 U.S.C. §§ 10801, 10802(2), 10803, 10827 (extending the mission of P&A systems to include individuals with mental illness); Protection & Advocacy for Individual Rights, 29 U.S.C. § 794e (extending the mission of P&A systems to include people with disabilities who are not covered under PAIDD, PAIMI, or the Client Assistance Program (CAP)); and, Protection and Advocacy for Traumatic Brain Injury, 42 U.S.C. § 300d-53) (extending the mission of P&A systems to include people with traumatic brain injury).

43-33-350(4).[9] Federal and state law both equip P&A with the ability to gather health information relevant in determining if the civil rights of a person with a disability have been violated. In essence, P&A performs the oversight function of protecting people with disabilities in South Carolina.[10] Under Defendants' interpretation of the Enabling Statute, P&A would not be able to fulfill this function. "In applying the rule of strict construction the courts may not give to particular words a significance clearly repugnant to the meaning of the statute as a whole, or destructive of its obvious intent." City of Columbia v. Niagara Fire Ins. Co., 249 S.C. 388, 391-92, 154 S.E.2d 674, 676 (1967).

Defendants admit that most of the residents of CTHs require an Intermediate Care Facility/Intellectual Disability (ICF/ID) level of care. (See Defs.' Resp. to Pl.'s First Interrog. No. 8) ICF/IDs are highly regulated at both the state and federal level because of the multiple needs of their residents, many of whom could not communicate effectively if they were abused or neglected. See 42 C.F.R. §440.150 (2011) (Intermediate care facility services); 42 C.F.R. §483.136 (2011) (Evaluating whether an individual with mental retardation requires specialized services). Administration and monitoring of medication are necessary and critical parts of the daily life for most residents of CTHs, and, thus, just as much a part of their "living conditions" as their food or clothing.[11] Under Defendants' interpretation, when conducting Team Advocacy

[9] 45 C.F.R. §1386.21(f) (2010) (Requirements and authority of the Protection and Advocacy System) "A Protection and Advocacy System may exercise its authority under State law where the authority exceeds the authority required by the Developmental Disabilities Assistance and Bill of Rights Act, as amended. However, State law must not diminish the required authority of the Protection and Advocacy System." Id.

[10] Under S.C. Code Ann. §44-26-130(B) (3), Rights of Mental Retardation Clients, for purposes of disclosure of the identity of clients or of confidential information concerning clients, P&A is on par with the Governor's Ombudsman. This supports P&A's claim that it must be allowed access to resident records, including those containing health information, when conducting Team Advocacy inspections.

[11] Defendants' "Residential Licensing Standards" for Community Training Homes include, among other safety matters such as regular fire inspections and the presence of a first aid kit, that "medications must be safely and accurately given." S.C. Dep't for Disabilities & Special Needs, Residential Licensing Standards 7 (Revised Feb. 2011) (Standard 3.4), http://ddsn.sc.gov/about/directives-standards/Documents/currentstandards/Residential%20Licensing%20Standards%20(Revised%20050111).pdf. The

inspections of CTHs, P&A would be allowed to review only one document, a mere list of services. P&A would then be prevented from comparing that document to any other documentation in order to evaluate the adequacy of the care and services being provided by the facility. Likewise, without the ability to review anything other than the one document listing the services to be provided, P&A would be unable to determine if residents were provided with medical appointments and treatment as needed or if medications were safely and accurately given. P&A would have no way to determine if the CTH was in compliance with the "plan" for that individual or the law.

Defendants' attempt to interpret "plans of care" to exclude documents with medical information is destructive of the legislature's obvious intent. The Team Advocacy provision creates a program focused on protecting people with disabilities who require a high level of care by requiring: unannounced visits; staff and trained volunteers to perform reviews; review of living conditions, including the plans of care; review of plans of care only by the coordinator of the program or her designee; and reports on the inspections to state entities, including DHEC- the state agency charged with protecting public health as authorized under multiple state and federal laws. http://www.scdhec.gov/administration/aboutDHEC.htm.

Considering the plain meaning of all the words used, the context, and the comparison with other terms used in both statutes, it is both clear on the face of the statute- as well as consistent with common usage- that medical care and treatment are part of the living conditions of a person who needs lifelong or extended care. Only giving the Team Advocacy provision this

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fact that the single subcategory "Health Services" encompasses a wide range of safeguards, including medication administration and the requirement of the provision of "a nourishing, well-balanced diet," shows that Defendants regard health care and medication as an integral part of residents' daily lives. Id. at 7, 8 (Standards 3.4, 3.5, 3.6).

reasonable and practical construction is consistent with the legislature's purposes of compliance with the DD Act and protection of people with disabilities and their health.

III. THE TERM "PLANS OF CARE" DOES NOT REFER TO ONE SPECIFIC DOCUMENT WHICH EXCLUDES MEDICAL INFORMATION.

Defendants also argue that the term "plans of care" in the Team Advocacy provision refers to only one document used in the Medicaid waiver context. Defendants argue that the Medicaid waiver document contains the service plan for individuals on the waiver but that it does not include medical information or MARs. Defendants then assert that P&A's Enabling Statute should be construed using this limited application of the plan of care for the Team Advocacy provision. In support of this assertion, Defendants cite to parts of the Medicaid statute that mention a plan of care but do not define it.[12]

The Team Advocacy provision does not limit P&A to a review of a single document. In fact, as argued above, the structure of the provision indicates that "plans of care" is only an example of records subject to inspection. Likewise, Medicaid's requirement that a state have a plan of care if it is going to provide waiver services is a minimum requirement. Medicaid does not prohibit states from having additional plans for waiver recipients. Defendants admitted in their Answer that "Since 1991, DDSN has always required a residential plan for those people receiving residential services as approved by the federal and state Medicaid programs. Each service has always required its own service plan. Plans of various kinds are required for residents of CTHs as appropriate and as required...." (See Defs.' Answer ¶ 17)

[12] Similarly, the cases Defendants cite in support of this narrow definition also do not actually **define** plans of care since the definition is not central to the cases. McCrann v. Dept. of Health and human Services, 704 S.E.2d 899, 901 (N.C. App. 2011), comes the closest in its bare statement that the individualized plan is a schedule of services to be provided to the person.

In another attempt to support their narrowly defined version of "plans of care," Defendants cite to one Medicaid regulation, 42 C.F.R. §441.351(f) (2011), dealing with waiver programs for people aged sixty-five and over. However, this regulation does not define "plans of care" as narrowly as Defendants claim. 42 C.F.R. §441.351 actually states that services are provided under a "written plan of care based on an assessment of the individual's **health** and welfare needs...Each plan of care must contain **at a minimum, the medical and other services to be provided,...**" Id. (emphasis added) Additionally, another Medicaid regulation not cited by Defendants, 42 C.F.R. §484.18, dealing with home health services, states that "The plan of care developed in consultation with the agency staff covers all pertinent **diagnoses**, including mental status, types of services and equipment required, frequency of visits, **prognosis**, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, **medications and treatments**, any safety measures to protect against injury, instructions for timely **discharge or referral, and any other appropriate items**" Id. (emphasis added)

South Carolina law is the most important source here since the primary issue in this case is an interpretation of a State statute. The South Carolina Code contains many references to "plans of care," all of which refer to a written plan that details whatever care, medical or otherwise, that a particular individual is receiving. See S.C. Code Ann. §44-81-40 (2002) (Bill of Rights of Residents of Long–Term Care Facilities); S.C. Code Ann. §44-113-20(12) (2010) (Provider Self-Referral Act); S.C. Code Ann. §44-7-350 (2002) (Creation and Monitoring of Plan of Care; responsibility of agency placing individual in community care facility); S.C. Code Ann. §40-33-44 (2011) (Exceptions to supervision requirements for licensed practical nurses); S.C. Code Ann. §43-35-10 (Supp. 2010) (Omnibus Adult Protection Act); S.C. Code Ann. §40-36-290 (2010) (Childcare Facilities); S.C. Code Ann. §63-13-80 (2010) (Childcare Facilities-

Investigations and inspections), §63-13-420(B) (Childcare Facilities-Licensure requirements) and §63-13-620(B) (Childcare Facilities—Statement of approval requirements); S.C. Code §40-45-280(c)(2) (2011), (Physical Therapists); S.C. Code Ann. §59-63-80 (Supp. 2010) (Pupils Generally; health care plans for students).

Similarly, several South Carolina agency regulations also refer to "plans of care" in varying contexts, generally following the plain meaning of the term, and often including medical care as an aspect of the plan. See, e.g., 24A S.C. Code Ann. Regs. 61-13 (Supp. 2010) (DHEC Regulation 61-13 § E (3) A, Standards for Licensing Habilitation Centers For The Mentally Retarded or Persons With Related Conditions). This section deals with staffing requirements and refers to "the health aspects of the individual plans of care" (implying the "plans of care" could include medical information suitable for review by a nurse). See 25 S.C. Code Ann. Regs 61-78 (Supp. 2010) (DHEC Regulation 61-78, Standards for Licensing Hospices, §704 (plans of care to be developed by the interdisciplinary team, approved by a physician and shall include the care, treatment and services relative to the needs of the patient...)); S.C. Code Ann. Regs 126-314 (Supp. 2010) (S.C. DHHS Regulation 126-314, Nursing Facility Services (Medicaid nursing services to be provided according to a written plan of care supervised by a physician)).

Just as it does elsewhere in state law, the phrase "plans of care" in the Team Advocacy provision of §43-33-350 follows the plain meaning – "plans," plural, that relate to medical "care." The medical records at issue here, such as the MARs, both set forth the daily plan for the residents' medication administration and record compliance with that plan. As such, they fall within the ambit of allowed inspection under §43-33-350(4).

IV. THE LEGISLATURE INTENDED THAT P&A HAVE THE AUTHORITY TO REVIEW INDIVIDUAL MEDICAL RECORDS AS PART OF TEAM ADVOCACY INSPECTIONS.

"In construing statutory language, the statute must be read as a whole, and sections which are part of the same general statutory law must be construed together and each one given effect, if it can be done by any reasonable construction." Higgins v. State, 307 S.C. 446, 449, 415 S.E.2d 799, 801 (1992); see also S.C. Coastal Council v. S.C. State Ethics Comm'n, 306 S.C. 41, 44, 410 S.E.2d 245, 247 (1991) (the court does not look merely to a particular clause, but instead looks to the provision and its meaning in conjunction with the purpose of the whole statute, and in light of the object and policy of the law). As established above and in Plaintiff's Memorandum in Support of Its Motion for Summary Judgment, when read as a whole, the Enabling Statute clearly sets forth P&A's authority to review individual medical records during Team Advocacy inspections.

Defendants argue, however, that P&A can only review medical records of specific individuals in response to a specific complaint by or on behalf of that individual. This is a misinterpretation of the Enabling statute. The provision which Defendants rely upon for this argument, S.C. Code Ann. §43-33-370 (Supp. 2010), applies **only** when P&A has received a "written request to investigate a complaint...or upon...the receipt of a complaint of abuse or threatened abuse...." Id. When it has received a complaint, P&A can review any documents, records or files maintained in the regular course of business and which bear upon the subject matter of the individual complaint, except for the individual medical records of other people in the facility. Id. §43-33-370 does not contain any language which extends this limitation to the Team Advocacy provision. The authority to investigate complaints is contained in the second paragraph of §43-33-350, completely separate from the provision giving P&A authority to

conduct Team Advocacy inspections, which is in the last paragraph of §43-33-350. The Team Advocacy provision does not condition performance of inspections on complaints. Its purpose is in addition to P&A's mandatory state and federal responsibilities: to provide ongoing oversight of an especially vulnerable group of individuals without the need for specific complaint. To limit P&A's review of medical records to when it has received a complaint would give effect to §43-33-370 but then eliminate the effect of the Team Advocacy provision. Again, this would defeat the legislature's intention in creating the Team Advocacy program.

One additional portion of the P&A Enabling Statute should be noted. Significantly, the legislature put in place extensive safeguards on the Team Advocacy Inspector's review authority. Section 43-33-350 (4) states:

> Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. . . . The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Commission on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

S.C. Code Ann. § 43-33-350(4) (Supp. 2010). This section recognizes the importance of residents' privacy rights and makes it clear that confidentiality is protected. Volunteers review the condition of the facility, the activities or programs, meals and other aspects of the facility. **Only a specific Team Advocacy staff member or designee is authorized to review "plans of care." Inspection reports are sent to specific state entities.** Such specific reference to plans of care indicates that the legislature intended P&A Team Advocacy inspectors to review sensitive and private information; otherwise, these protections would not be necessary. Cf. S.C. v. Sweat, 379 S.C. 367, 377, 665 S.E.2d 645, 651 (Ct.App. 2008) ("When interpreting a statute, courts must presume the legislature did not intend to do a futile act. . . . 'A statute should be so

construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous . . . .' ") (quoting Matter of Decker, 322 S.C. 215, 219, 471 S.E.2d 462, 463 (1995)).

V. PLAINTIFF IS ENTITLED TO SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION BECAUSE THE EVIDENCE CLEARLY SHOWS DEFENDANTS VIOLATED THE LAW BY REFUSING TO COOPERATE WITH P&A.

S.C. Code Ann. §43-33-400 (1976) states: "**All departments**, officers, agencies and institutions of the State **shall cooperate with the System** in carrying out its duties." As the protection and advocacy system for South Carolina, P&A is authorized to conduct Team Advocacy inspections under S.C. Code Ann. §43-33-350(4). The evidence reveals that P&A attempted to conduct Team Advocacy inspections, one of the powers or duties provided in §43-33-350, in CTHs. Defendants, however, refused to cooperate with P&A by denying P&A access to records and plans of care during Team Advocacy inspections claiming that P&A must have prior written consent from CTH residents. When notified of Defendants' concerns, P&A attempted to persuade Defendants to cooperate, referring Defendants to its Enabling Statute, its federal enabling statutes, and the United States Department of Health and Human Services' interpretation of HIPAA. In spite of these efforts by P&A, Defendants continued to refuse to cooperate with P&A by allowing access to medical records and plans of care. The evidence also reveals that Defendants then ordered the operators of CTHs to refuse to cooperate with P&A during its Team Advocacy inspections and that the operators also refused to cooperate with P&A.

By refusing P&A access to records and plans of care during its Team Advocacy inspections and ensuring that the CTH operators also refused P&A access to such records, Defendants

interfered with P&A's exercise of its authority, refused to cooperate with P&A in its efforts to ensure the health and safety of CTH residents, and violated South Carolina law.

CONCLUSION

For the foregoing reasons, Plaintiff respectfully submits that Defendants' motion for summary judgment should be denied and Plaintiff's motion for summary judgment should be granted.

Respectfully submitted,

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

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ATTORNEYS FOR PLAINTIFF

Columbia, South Carolina
July 22, 2011

STATE OF SOUTH CAROLINA	)	**IN THE COURT OF COMMON PLEAS**
	)	
COUNTY OF RICHLAND	)	Civil Action Number: 10-CP-40-1095
	)	
Protection and Advocacy for People with Disabilities, Inc.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission,	)	**MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT (All Defendants)**
	)	
Defendants.	)	

The following is submitted in opposition to Plaintiff's Motion for Summary Judgment and in response to Plaintiff's legal arguments advanced in support of that motion. Defendants respectfully submit that virtually all of the points to be made by Defendants were made in their original brief, and that the points made by Plaintiff are either irrelevant or lack in merit.

First and foremost, Plaintiff's arguments fail to satisfy the most basic definition of what a "plan of care" might be. A "plan" is a document providing for guidance in the future. As typically defined in dictionaries, a "plan" is "a scheme or method of acting, doing, proceeding,

making, etc., developed in advance."[1] (Emphasis added.) Most medical records, and especially the medication administration records Plaintiff seeks, are not advance planning documents, but rather are documentation of something that occurred in the past. There are a number of other reasons why Plaintiff's arguments lack merit, but this is probably the simplest and clearest.

ARGUMENT

1. The reference in § 43-33-350(4) to the unannounced nature of team advocacy inspections does not affect the definition of the term "plans of care."

Plaintiff's first argument concerns DDSN's suggestion, made prior to this litigation, that P & A could obtain medical records with the consent of residents or their guardians. P & A claims that this would conflict with the unannounced nature of the inspections. This is not necessarily true, but in any event, has nothing to do with the definition of the term "plans of care" found in § 43-33-350(4).

In correspondence that took place prior to the filing of this action, DDSN had suggested that P & A could review the residents' medical records, in addition to their plans of care, if consent from the residents or their guardians could be obtained. P & A now argues that to do so would make P & A's intent to conduct inspections known to the facilities. This claim does not follow logically. P & A could simply appear at a facility, show the proof of the consent, and review the records, while leaving the inspection of living conditions at the facility for another day. Merely to do this would not necessarily have the effect of "tipping off" the facility that an inspection of living conditions might be in the works.

In any event, this argument is merely addressed to an alternative approach that had been suggested by DDSN. Even if this approach were to have the effect of advising the facility in advance that an inspection of living conditions might be forthcoming, that effect still cannot

[1] http://dictionary.reference.com/browse/plan

expand the meaning of the term "plans of care" beyond the clear meaning that the term has in this context, as DDSN has already argued. This entire argument is therefore simply beside the point.

2. Plaintiff's arguments concerning the meaning of the term "plans of care" find no support in the statute and its context.

Plaintiff argues at pp. 13-21 of its opening brief that for various reasons, the term "plans of care," as used in § 43-33-350(4), should be read to include medical records of residents. None of these arguments has any basis in the statute itself, and none can overcome the clear meaning that the term "plan of care" has in this context.

a. The term "living conditions."

Plaintiff claims that the provision of health and medication services is part of what is meant by "the living conditions of a residential facility." § 43-33-350(4). This is a broader definition of the term "living conditions" than the context indicates. In addition, even if Plaintiff's broad definition of "living conditions" were to be accepted, it still would not change the reference in the statute to the "plan of care," which is a very specific document in this context.

First of all, in common parlance, the term "living conditions" tends to refer to the physical surroundings in which a person lives, such as the sanitation of the residence and whether it is adequately heated and cooled. *See, e.g., South Carolina Dept. of Social Services v. Sims*, 359 S.C. 601, 604, 598 S.E.2d 303, 305 (Ct. App. 2004), where the term was used to describe the physical aspects of a home; *Benjamin v. Housing Authority of Darlington County*, 198 S.C. 79, 15 S.E.2d 737, 739 (1941)(rural housing act would "provide sanitary homes and living conditions for farm families of low income"). Additionally, this connotation of physical surroundings is clearly the meaning intended in other similar provisions of the Code. These

include, for instance, § 31-13-180, which deals with moderate to low income housing, and provides that "a serious shortage of sanitary and safe residential housing . . . will contribute to the creation and persistence of substandard living conditions."

There is at least one definition in a state statute in this precise context that appears to be directed at the same kinds of things envisioned by § 43-33-350(4). In 34-B *Maine Revised Statutes Annotated* § 1431(1)(a), which pertains to facilities comparable to residential facilities providing services to DDSN clients, the following definition of "living conditions" is set forth:

> A. "Living conditions" includes, but is not limited to, the physical conditions of a residential facility, the individual treatment plan provided for each outpatient client and the programs for treatment available to and appropriate for each outpatient client.

(Emphases added.) In other words, and as the Defendants have previously argued, the General Assembly, like the Maine legislature, determined that when living conditions were being inspected, the only record that needed to be disclosed was the plan of care for each resident, i.e., the document that showed generally what kinds of services the residents were supposed to be receiving. Presumably, the plans of care would provide sufficient information for an inspector to determine whether the living conditions were in accord with the stated needs of the clients, as set forth in their plans of care.

Finally, even if the term "living conditions" extended as far as Plaintiff claims, which is surely not the case, this still would not change the very specific and limited meaning that the term "plans of care" carries in this context, as discussed in Defendants' opening brief. As a result, any argument of Plaintiff based on the use of the term "living conditions" in the statute is unavailing.

b. Plaintiff's claim based on the word "including" is without merit.

Plaintiff next claims that when the statute provided for P & A to make "unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility," the term "including" suggests that other records might be reviewed as well. Pl. opening br. at 16-17.

The first problem with this argument, is that it contradicts the well-settled rule that that "to express or include one thing implies the exclusion of another," also known as "inclusio unius est exclusio alterius." *Nelson v. Ozmint*, 390 S.C. 432, 436-437, 702 S.E.2d 369, 371 (2010).[2] The fact that plans of care are referenced, but no other types of records, is a compelling indication that the General Assembly intended for only those records to be inspected. Secondly, and as Plaintiff itself points out, this language was inserted specially by Act No. 133 of 1993. Prior to that act, the statute provided for team advocacy inspections of living conditions, but did not reference plans of care. Act No. 133 added the language about plans of care. The title of the 1993 Act was

> AN ACT TO AMEND SECTION 43-33-350, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO THE POWERS AND DUTIES OF THE PROTECTION AND ADVOCACY SYSTEM FOR THE HANDICAPPED, INC., SO AS TO PROVIDE FOR THE REVIEW OF THE PLANS OF CARE FOR INDIVIDUALS IN A RESIDENTIAL CARE FACILITY AND A COMMUNITY MENTAL HEALTH CENTER DAY PROGRAM BY THE TEAM ADVOCACY PROJECT'S COORDINATOR OR HIS DESIGNEE AND REQUIRE THE DESIGNEE TO MEET CERTAIN CRITERIA.

(Emphasis added.) The language added is shown below with underlining:

[2] Plaintiff references cases in which the presumption is reversed, but those involve situations where the word "including" modifies the term to be defined. In order for that rule to apply in the present case, the statute would have to say "records, including plans of care," but it does not say that. Instead, it says "living conditions . . . , including plans of care. . . ."

> [P & A] may conduct team advocacy inspections of a facility providing residence to a developmentally disabled or handicapped person. Inspections must be completed by the system's staff and trained volunteers. Team advocacy inspections are unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility and a community mental health center day program. Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. The designee must meet criteria developed by the Joint Legislative Committee on Mental Health and Mental Retardation, after consultation with the system and the South Carolina Association of Residential Care Homes. The system shall prepare a report based on the inspection which must be submitted to the Joint Legislative Committee on Mental Health and Mental Retardation, South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

In other words, the only additional information made reviewable by the 1993 amendment was the information in plans of care. To argue otherwise, as Plaintiff tries to do, is to argue exactly the opposite of what the General Assembly intended with this limited addition to the statute.

c. Other arguments based on the language of the statute in issue or unrelated statutes provide no support for Plaintiff's contentions.

Plaintiff makes several other arguments, most of which are based on unrelated provisions of the Code. The one remaining contention that is based on § 43-33-350(4) itself is the claim that the General Assembly must have intended more than one kind of document, because it used the plural term "plans of care." The short answer to this is that each facility has more than one resident, each of whom will have a plan of care, so it is completely appropriate to refer to those specific plans, one per resident, in the plural. This reference is clearly insufficient to overcome the specificity of the reference in other contexts, as discussed in the Defendants' opening brief.[3]

[3] Plaintiff argues that it has inspected another kind of facility, Community Residential Care Facilities (CRCF's) and has not been prevented from reviewing medical records in that context. However, those facilities are mostly small, private, and probably unaware of which records they should produce and should not produce. In addition, their residents may have other documents that are properly embraced by the term "plan of care" in that different context. But that context,

Plaintiff also makes passing reference to the use of the term "plans of care" elsewhere in the Code, but suggests no reason why those references should overcome the specificity of the reference in § 43-33-350(4). Moreover, and as pointed out previously, a "plan" is a document providing for guidance in the future, while a medication administration record is a documentation of something that occurred in the past. In other words, the medication administration records are simply not the kinds of records that would be included in the most fundamental definition of a "plan."[4] As the term "plan of care" is used in the references cited by Plaintiff, it is clear that it normally has this connotation of a document that contains plans for the future, not documentation of past events.[5]

Defendants would reiterate another point previously made, and that is that Section 43-33-400, not § 43-33-350(4) is the only part of the P & A legislation that refers to inspection by P & A of medical records of individuals. It refers to § 43-33-370(2), which provides that, upon receipt of a complaint pertaining to the treatment of a particular individual, P & A may "inspect and copy any documents . . . which bear upon the subject matter of the individual complaint, except for the individual medical, treatment or other personal records of other persons in the program or facility." Clearly, by limiting the review of the medical records of individuals to

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which does not involve DDSN, is not before the Court, and should not govern the present situation, where the term has a specific meaning and where the matter is being contested.

[4] Plaintiff points to an Interrogatory Answer by Defendants to the effect that Residential Habilitation standard RH 5.0 requires that medical and dental evaluations must occur and the plan of care must be followed. However, the language of the standard itself is that there must be "documentation that the physician's [or dentist's] recommendations are being followed" (emphasis added). The term "plan of care" is not actually used in that standard.

[5] The statutes and regulations cited by Plaintiff are all more or less the same as § 44-7-350 (DHEC licensure of Nursing Homes: an "agency placing a client in a community residential care facility shall develop an individual plan of care in cooperation with the provider") While the context is different from that in this case, the concept of an advance plan is the same.

single individuals whose cases are under investigation, the General Assembly has chosen to afford great privacy to residents' medical records. The overall statutory scheme therefore provides full support for limiting the term "plans of care" to its normal usage as referring to one specific document.

Finally, Defendants submit that Plaintiff's argument based on giving deference to agency construction of a statute fails for several reasons. First, Plaintiff is not really a state agency. Secondly, its interpretation is entirely self-serving, rather than, for example, one that simply involves an issue of policy. Most importantly, though, Plaintiff's interpretation is simply not in accord with the language of the statute. *See, e.g., Brown v. Bi-Lo, Inc.*, 354 S.C. 436, 440, 581 S.E.2d 836, 838 (2003)("where, as here, the plain language of the statute is contrary to the agency's interpretation, the Court will reject the agency's interpretation). Again, though, Plaintiff is not entitled to be regarded as an "agency" for this purpose.

3. Plaintiff's arguments based on HIPAA are irrelevant, because that statute does not expand the types of records which Plaintiff can review.

Plaintiff argues that HIPAA does not preclude review of medical records as long as the records are "required by law" to be disclosed. P & A brief, pp. 21-25. As indicated in n. 1, pp. 11-12, of DDSN's prior brief, DDSN recognizes that HIPAA and/or the pertinent regulations so provide. However, HIPAA does not address itself to which records are required by law to be produced and which ones are not. Since, as argued in DDSN's opening brief, there is nothing in state or federal law that requires or even permits disclosure to P & A of these residents' medical records, the "required by law" concept under HIPAA simply has no application.

By way of further background, it should be noted that the purpose of HIPAA was generally to make private certain medical records that previously might have been disclosable to third parties. As a result, the regulations cited by Plaintiff are in the nature of exceptions to a

general rule of nondisclosure. The function of the HIPAA regulations cited by Plaintiff is therefore not to be a source of authority that authorizes disclosure of otherwise-private documents. Instead, those regulations were intended to provide that HIPAA would not prohibit disclosures required by other provisions of law.

Thus, for example, the HHS regulation containing the "required by law" language, 45 C.F.R. § 164.512(a), was said by the federal HHS agency to be "necessary to harmonize the rule with existing state and federal laws mandating uses and disclosures of protected health information." 65 FR 82462, 82666 (2000). The same agency also stated that "we intend this provision to preserve access to information considered important enough by state or federal authorities to require its disclosure by law." *Id.* at 82667. Finally, and fatally to Plaintiff's argument, the agency noted that the HIPAA regulation, 45 C.F.R. § 164.512, did

> not create any new duty or obligation to disclose protected health information. Rather, it permits covered entities to use or disclose protected health information when they are required by law to do so.

Id. at 82666 (emphases added.).

The other part of the same HIPAA regulation that Plaintiff cites is 45 C.F.R. § 164.512(d). That subsection provides that protected health information may be disclosed "to a health oversight agency for oversight activities authorized by law, including . . . inspections." (Emphasis added.) Again, however, the purpose of this and other parts of the regulation is not to create "any new duty or obligation," but rather is to make sure that HIPAA would not prohibit a disclosure that some other provision of law requires. There is no such provision of state or federal law in this instance. Plaintiffs cite only general provisions establishing that they might constitute a "health oversight agency," but other than their claim based on § 43-33-350 (4), they cite no specific authorization for the kind of record review they seek. Simply put, the HIPAA

regulations were clearly not intended not create a duty to disclose where one did not exist before. As a result, since Plaintiff can show nothing in its state or federal enabling legislation that requires the disclosures it seeks, it simply has no authorization to inspect the medical records it seeks.[6]

4. Plaintiff's claim based on the "cooperation" language of § 43-33-400 has previously been addressed.

Plaintiff's fourth and last point is based on § 43-33-400, which provides that agencies should "shall cooperate with the System in carrying out its duties." (Emphasis added.) This point was addressed in the Defendants' opening brief. The quoted section is simply an exhortation to be cooperative where a duty is conferred by statute on P & A. It does not purport to set forth any additional powers or duties in and of itself. As a result, it provides no support for Plaintiff's claims.

CONCLUSION

For the foregoing reasons, Defendants respectfully submit that their motion for summary judgment should be granted, Plaintiff's motion for summary judgment should be denied, and this case dismissed.

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[6] Plaintiff places some reliance on *Ohio Legal Rights Service v. Buckeye Ranch*, 365 F.Supp.2d 877(S.D. Ohio 2005). However, in that case, the court held that the plaintiff "has a right under Ohio law" to obtain access to the records sought. 365 F.Supp.2d at 888 (emphasis added). The court then went on to find that the HIPAA regulations did not prohibit the release of the records. There was no suggestion that the regulations themselves authorized the release of the records.

Respectfully submitted,

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By: /s/

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ATTORNEYS FOR DEFENDANTS

Columbia, South Carolina

July 22, 2011

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND Protection and Advocacy for People with Disabilities, Inc., PLAINTIFF, vs. Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs, and The South Carolina Department of Disabilities and Special Needs and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, DEFENDANTS.	)	IN THE COURT OF COMMON PLEAS Civil Action No: 10-CP-40-1095

PRE-TRIAL BRIEF

Plaintiff Protection and Advocacy for People with Disabilities, Inc. (P&A) seeks declarative and injunctive relief permitting it to review records containing health information at

certain facilities operated by or contracted for operation by Defendant South Carolina Department of Disabilities and Special Needs (DDSN) during Team Advocacy inspections.

INTRODUCTION

The primary issue that must be resolved by the Court at this hearing is whether or not S.C. Code Ann. § 43-33-350(4) (Supp. 2010), the South Carolina Protection and Advocacy System for the Handicapped Act[1], which authorizes Plaintiff to conduct Team Advocacy inspections of Community Training Homes (CTHs),[2] authorizes Plaintiff to inspect residents' medical records as part of said Team Advocacy inspections. Defendants concede that P&A has the authority to conduct inspections but object to P&A's attempts to review medical records. Plaintiff conversely contends that the review of medical records is both authorized by statute and a necessary and integral part of the inspection program.

I. Facts of the Case.

P&A is a South Carolina nonprofit corporation designated as the protection and advocacy system for the State in S.C. Code Ann. §§ 43-33-310 et seq. (Supp. 2011) and Section 113 of Public Law 94-103, the Developmental Disabilities Act. Defendant DDSN is established by S.C. Code Ann. § 44-20-240. DDSN provides services to individuals with intellectual and developmental disabilities, including autism, and head and spinal cord injuries. DDSN licenses

[1] Effective July 1, 1996, Plaintiff's board of directors changed its name to Protection and Advocacy for People with Disabilities, Inc. as authorized in Senate Bill 599. S. 599, Act No. 251, Sess. 111 (Eff. Apr. 1, 1996); S.C. Code Ann. §43-33-330 (Supp. 2010).

[2] Community Training Homes (CTHs) are small residential settings. Defendants offer two levels of CTHs. In the CTH I setting, caregivers are trained private citizens who provide care in their own homes. In the CTH II setting, caregivers are employees who provide care in homes owned or rented by a provider organization. P&A inspections efforts in this case concern the CTH II setting. See S.C. Dep't of Disabilities & Special Needs, Residential Habilitation Standards (February 2011), http://ddsn.sc.gov/about/directives-standards/Documents/currentstandards/ResHabStan2%2011rev.pdf

and uses a range of housing types for its clients, from large institutions to foster homes, both directly and through local Disability and Special Needs Boards (DSN Boards) and private providers.

As part of its role to protect the right of South Carolinians with disabilities to be safe from abuse and neglect, P&A conducts Team Advocacy inspections pursuant to S.C. Code Ann. § 43-33-350(4) (Supp. 2010). P&A has been conducting such inspections in community residential care facilities (CRCFs) across the state since 1986 and, to date, has conducted over 1000 inspections of CRCFs.[3] (See Prevost Affid.) The Team Advocacy program has reviewed records containing medical information, such as Medication Administration Records (MARs), in CRCFs since its inception.

Beginning in 2009, P&A attempted to conduct Team Advocacy inspections of CTHs licensed by Defendants. (See Pl.'s Compl. ¶ 11; Defs.' Answer ¶ 10) CTHs are residences for individuals with developmental and related disabilities. Like CRCFs, CTHs provide food, housing and care, including arrangement of medical care and medication administration, to people who are unable to live independently. Unlike CRCFs, almost all residents of CTHs require an Intermediate Care Facility/Intellectual Disability (ICF/ID) level of care: that is, they need an institutional level of care or its equivalent in supportive services in the community. (See Defs.' Resp. to Pl.'s First Interrog. No. 8.) The ICF/ID level of care is a higher level of care than that of residents of the CRCFs P&A has been inspecting through the Team Advocacy provision. (See Prevost Affid.)

When P&A notified Defendants that it was extending its Team Advocacy program to CTHs, Defendants objected to P&A's review of records during Team Advocacy inspections,

[3] See P&A, No Place To Call Home: How South Carolina Has Failed Residents of Community Residential Care Facilities July 21, 2009, http://www.pandasc.org/crcfreport.pdf.

particularly to Plaintiff's review of the on-site "Medication Administration Records" (MARs). The MARs are documents for each resident that list the medications (and dosage) prescribed, the schedule for their administration, and staff compliance with the dosage and schedule. After attempting unsuccessfully to resolve this matter, P&A filed this case. Both parties filed motions for summary judgment on July 8, 2011, and responses to the motions on July 22, 2011. A hearing on the respective motions was held on August 2, 2011. On October 1, 2012, Judge Manning denied both motions, and this matter proceeded to trial.

II. Objective Statement of the Facts in Controversy

Plaintiff does not believe that there are any relevant facts in controversy.

III. Legal Issues Involved

A. State Enabling Statute

P&A is the designated protection and advocacy system for the state of South Carolina. S.C. Code Ann. § 43-33-310 (1976). P&A is authorized to conduct Team Advocacy inspections under S.C. Code Ann. § 43-33-350(4) (Supp. 2010). Team Advocacy inspections are, "unannounced visits to review the living conditions of a residential facility, including the plans of care for individuals in a residential care facility...." Id. When P&A attempted to conduct Team Advocacy inspections in CTHs, Defendants refused P&A access to records and plans of care without prior written consent from CTH residents or their legal guardians, and also ordered the operators of CTHs to refuse such access.

South Carolina law, specifically S.C. Code §43-33-350, grants P&A four separate powers and duties: (1) to "protect and advocate for the rights of all developmentally disabled persons . . . and for the rights of other handicapped persons by pursuing legal, administrative, and other

appropriate remedies"; (2) to "investigate complaints by or on behalf of people with disabilities"; (3) to "establish priorities for the delivery of its services, S.C. Code Ann. §43-33-350(3) (Supp. 2011); and (4) at issue here, to "conduct team advocacy inspections of facilities providing residence to people with disabilities." S.C. Code Ann. § 43-33-350(4). The first three of these listed duties are required in order for the state to obtain federal funding under the Developmental Disabilities Act, 42 U.S.C. § 15043(a)(1). The fourth is a separate duty established by the General Assembly. Team Advocacy requires that (1) the inspections be performed by P&A staff and trained volunteers; (2) the visits be unannounced; (3) the inspections be reviews of the living conditions of a residential facility, including plans of care of the residents; (4) the review of the plans of care be made by the team advocacy coordinator or that person's designee; and (5) P&A prepare and submit a report on the inspection to certain state entities. § 43-33-350(4).

Defendants admit that P&A is allowed to inspect their facilities under § 43-33-350(4), but maintain that "plans of care" do not include records containing medical information such as the MARS.

1. Plans of care are necessarily comprehensive.

Because the statute does not contain a definition of "plans of care," a plain-language reading of the term is appropriate. S.C. v. Sweat, 379 S.C. 367, 375, 665 S.E.2d 645, 649 (Ct. App. 2008). A plain-language construction would indicate the Team Advocacy inspector has access to all "plans" that relate to "care," of whatever kind, for the facility residents. The most logical interpretation is that the purpose of the inspection is to evaluate whether residents are receiving care in accordance with their defined needs, including necessary medication and therapies.

Essentially, Plaintiff contends that the clause allowing review of "living conditions, including plans of care" in its enabling statute encompasses review of MARs and other on-site medical documents, and that this review is so integral to the provision of services to individuals with significant disabilities that without it the Team Advocacy program cannot conduct a meaningful review of a facility. Defendants contend that they have the right to determine the contents of the "plan of care" referred to in P&A's enabling statute, and that medication records are not included. Both Plaintiff and Defendants have submitted numerous records and policies showing that over the years Defendants have used different terminologies for documents stating how services, including medical care, will be delivered to recipients of DDSN services. Defendants' interpretation would defeat the protective purpose of the Team Advocacy provision by allowing them to choose the documents that Team Advocacy would review. The Team Advocacy provision is part of the state enabling law of P&A, not DDSN. Therefore, as is required by rules of statutory construction, the Team Advocacy provision should be read with the rest of the P&A state law and with the purpose of the law in mind. "In construing statutory language, the statute must be read as a whole, and sections which are part of the same general statutory law must be construed together and each one given effect, if it can be done by any reasonable construction." Higgins v. State, 307 S.C. 446, 449, 415 S.E.2d 799, 801 (1992); see also Jackson v. Charleston Cty. Sch. Dist., 316 S.C. 177, 181, 447 S.E.2d 859, 861 (1994) ("The true guide to statutory construction is not the phraseology of an isolated section or provision, but the language of the statute as a whole considered in the light of its manifest purpose."). ""Courts will reject statutory interpretations that lead to results so plainly absurd they could not have been intended by the legislature or that defeat the plain legislative intention." Peake v. South Carolina Dept. of Motor Vehicles, 375 S.C. 589, 654 S.E.2d 284 (Ct. App. 2007).

While P&A is not a state agency, it has been delegated authority for Team Advocacy by the General Assembly and is thus entitled to deference in interpretation of the statutes it is charged with administering. See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837 (1984); S. C. v. Sweat, 379 S.C. at 374, 665 S.E.2d at 649 ("The construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons.") Since the State has delegated the administration and performance of protection and advocacy functions to P&A, P&A's interpretation of its statute should be given Chevron deference. This is especially true where, as here, the organization has followed the same practice for many years, with the knowledge of other state agencies (including Defendants) none of whom have objected until now. Rather, the South Carolina Department of Health and Environmental Control has successfully *enforced* P&A's right to inspect a CRCF, including specifically P&A's attempt to review medical records. See SC DHEC vs. Bellwood Manor, Inc., S.C. Administrative Law Division, Docket No. 09-ALJ-07-0551-CC, 2010 WL 6782577. ("As an organization authorized by statute to serve and protect the health, welfare, and rights of developmentally disabled and handicapped persons in South Carolina, P&A's authority to conduct Team Advocacy inspections should be liberally construed.")Established usage in regard to the meaning and effect of a statute is a relevant and persuasive guide to its authoritative interpretation. 2B Sutherland Statutory Construction § 49:6 (7th ed.); citing McKeen v. Delancy's Lessee, 9 U.S. 22 (1809); Basey v. Gallagher, 87 U.S. 670 (1874); Swift & Courtney & Beecher Co. v. U.S., 105 U.S. 691 (1881).

South Carolina law is an important source here since the primary issue in this case is an interpretation of a state statute. The South Carolina Code contains many references to "plans of care," all of which refer to a written "plan" that details whatever "care", medical or otherwise, that a particular individual is receiving. See e.g., S.C. Code Ann. § 44-81-40 (2002) (Bill of Rights of Residents of Long–Term Care Facilities); S.C. Code Ann. § 44-7-350 (2002) (Creation and Monitoring of Plan of Care; responsibility of agency placing individual in community care facility); S.C. Code Ann. § 43-35-10 (Supp. 2010) (Omnibus Adult Protection Act).

Similarly, several South Carolina agencies' regulations also refer to "plans of care" in varying contexts, generally following the plain meaning of the term, and often including medical care as an aspect of the plan. See, e.g., 24A S.C. Code Ann. Regs. 61-13 (Supp. 2010) (DHEC Regulation 61-13 § E (3) A, Standards for Licensing Habilitation Centers For The Mentally Retarded or Persons With Related Conditions); 27 S.C. Code Ann. Regs 126-314 (1976)) (DHHS Regulation 126-314, Nursing Facility Services (Medicaid nursing services to be provided according to a written plan of care supervised by a physician)).

The medical records at issue here, such as the MARs, both set forth the daily plan for the residents' medication administration and record compliance with that plan. As such, they constitute a "plan of care" within the meaning of § 43-33-350(4).

Defendants have also maintained that Plaintiffs should simply obtain the consent of residents or their legal guardians before inspecting medical records. Such would not only defeat the provision requiring unannounced inspections, it would also impose a limit on the access authority of P&A that the legislature did not intend. A clear reading of the statute shows P&A is supposed to be able to conduct these inspections regardless of the cooperation of the workers, the facilities or the residents; nowhere in § 43-33-350(4) is there any indication that P&A must

obtain any form of consent in advance of its inspections. Rather, if P&A were to obtain consent, as suggested by Defendants, the statutory grant of authority would be unnecessary; indeed, such consent could be obtained regardless of the statutory provision. Under Defendants' interpretation, if a resident or their legal guardian refused consent, P&A would be denied access to the records or plans of care of a CTH resident. This would effectively re-write the SCP&A statute by rendering the "including the plans of care" clause a nullity.

2. "Living conditions, including. . ."

Plans of care are one aspect of living conditions. P&A's inspections include review of physical conditions such as cleanliness; food choice and compliance with dietary requirements; recreational activities; and adequacy of the medical care and treatment of residents. The word "including" and the clause following it were added to P&A's enabling legislation by S.C. Legis. Act 133 (1993), which stated that the amendment was "to provide for the review of plans of care for individuals. . ." S.701, Act No. 133, Sess. 110 (S.C. 1993). Despite the general rule of statutory construction that "to express or include one thing implies the exclusion of another," and items not on a list are assumed excluded, the use of the word "including" typically reverses that assumption, and indicates that the following nouns are *examples*, not exclusive. See Black's Law Dictionary (8th ed. 2004):

> [I]nclude, *vb.* To contain as a part of something. • The participle *including* typically indicates a partial list <the plaintiff asserted five tort claims, including slander and libel>. But some drafters use phrases such as *including without limitation* and *including but not limited to* — which mean the same thing.

Defendants' concerns about confidentiality are adequately addressed by the statute's limits on who can review of plans of care. Section 43-33-350 (4) states:

> Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care....
>
> S.C. Code Ann. § 43-33-350(4) (Supp. 2010).

Volunteers can review living conditions but not the plan of care. Additionally, § 43-33-380 states that:

> The System [P&A] shall not disclose the name or identity of any person, complainant, witness or subject of a complaint or any information or writing relating thereto unless the person or his parent or legal guardian authorizes in writing the release of such information but the System may make such disclosures as may be necessary to protect or advocate for the rights of the developmentally disabled or handicapped person concerned.

S.C. Code Ann. § 43-33-380 (1976). See Higgins v. State, 307 S.C. 446, 415 S.E.2d 799, 801 (1992) ("In construing statutory language, the statute must be read as a whole, and sections which are part of the same general statutory law must be construed together and each one given effect, if it can be done by any reasonable construction.")

Based on the plain language of the statute, the privacy protections in P&A's enabling legislation, and in deference to P&A's long-standing interpretation of the legislation, P&A's authority to inspect "living conditions, including the plans of care" in §43-33-350(4) necessarily includes the power to inspect resident's on-site medical records.

3. The Team Advocacy Statute Does Not Require that P&A Receive a Specific Complaint

Defendants contend that P&A can review medical records of specific individuals only in response to a specific complaint by or on behalf of that individual, relying on S.C. Code Ann. §43-33-370 (1976). That section, "Authority of System upon receipt of written request to investigate complaint[,]" applies **only** when P&A has received a "written request to investigate a complaint...or upon...the receipt of a complaint of abuse or threatened abuse...." Id. P&A has

separate functions: its federally designated role in investigation of abuse and neglect, and as an advocate and a monitor, 42 U.S.C. § 15043(a)(1), and its State-created role to conduct Team Advocacy inspections. P&A does not dispute that there are some conditions which P&A must meet to review records when not conducting Team Advocacy inspections. P&A's authority under the Team Advocacy provision is different and Team Advocacy's function is different: to ensure ongoing, independent oversight of the care given to an especially vulnerable group of individuals without the need for specific complaint.

B. Medicaid

Defendants have argued that the term "plans of care" in the Team Advocacy provision refers to only one document used in the Medicaid waiver context. Defendants argue that the Medicaid waiver document contains the service plan for individuals on the waiver but that it does not include medical information or MARs. Defendants then assert that P&A's Enabling Statute should be construed using this limited application of the plan of care for the Team Advocacy provision. In support of this assertion, Defendants cite to parts of the Medicaid statute that mention a plan of care but do not define it.[4]

Defendant's argument here fails because this case is about the interpretation of a state statute, not federal Medicaid provisions. The Team Advocacy provision does not limit P&A to a review of a single document, no more than Team Advocacy inspections are limited to only facilities governed by DDSN's Medicaid Waiver agreement. P&A's statutory authorization is simply broader than that. As argued above, the structure of the provision indicates that "plans of care" is

[4] Similarly, the cases Defendants cite in support of this narrow definition also do not actually **define** plans of care since the definition is not central to the cases. McCrann v. Dept. of Health and Human Services, 704 S.E.2d 899, 901 (N.C. App. 2011), comes the closest in its bare statement that the individualized plan is a schedule of services to be provided to the person.

only an example of records subject to inspection, and DDSN CTH's are only one type of facility subject to P&A inspection.

It should also be understood that Medicaid's requirement that a state have a plan of care if it is going to provide waiver services is a *minimum* requirement; it does not limit residents to only a single, narrowly defined "plan of care," but simply states that they must have at least one such plan. Medicaid does not prohibit states from having additional plans for waiver recipients, and in fact many DDSN service recipients have multiple plans. Defendants admitted in their Answer that "Since 1991, DDSN has always required a residential plan for those people receiving residential services as approved by the federal and state Medicaid programs. Each service has always required its own service plan. Plans of various kinds are required for residents of CTHs as appropriate and as required...." (See Defs.' Answer ¶ 17).

In an attempt to support their narrowly defined version of "plans of care," Defendants cite to one Medicaid regulation, 42 C.F.R. §441.351(f) (2011), dealing with waiver programs for people aged sixty-five and over. However, even this regulation does not define "plans of care" as narrowly as Defendants claim. 42 C.F.R. §441.351 actually states that services are provided under a "written plan of care based on an assessment of the individual's **health** and welfare needs...Each plan of care must contain **at a minimum, the medical and other services to be provided,...**" Id. (emphasis added) Additionally, another Medicaid regulation not cited by Defendants, 42 C.F.R. §484.18, dealing with home health services, states that "[t]he plan of care developed in consultation with the agency staff covers all pertinent **diagnoses**, including mental status, types of services and equipment required, frequency of visits, **prognosis**, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, **medications and**

treatments, any safety measures to protect against injury, instructions for timely **discharge or referral, and any other appropriate items**" Id. (emphasis added)

C. Violation of the Duty to Cooperate

S.C. Code Ann. §43-33-400 (1976) states: "**All departments**, officers, agencies and institutions of the State **shall cooperate with the System** in carrying out its duties." As the protection and advocacy system for South Carolina, P&A is authorized to conduct Team Advocacy inspections under S.C. Code Ann. §43-33-350(4). The evidence reveals that P&A attempted to conduct Team Advocacy inspections, one of the powers or duties provided in §43-33-350, in CTHs. Defendants, however, refused to cooperate with P&A by denying P&A access to records and plans of care during Team Advocacy inspections claiming that P&A must have prior written consent from CTH residents. When notified of Defendants' concerns, P&A attempted to persuade Defendants to cooperate, referring Defendants to its Enabling Statute and other authorities and reminding DDSN of P&A's CRCF inspections. In spite of these efforts by P&A, Defendants continued to refuse to cooperate with P&A by allowing access to medical records and plans of care. The evidence also reveals that Defendants then ordered the operators of CTHs to refuse to cooperate with P&A during its Team Advocacy inspections and that the operators also refused to cooperate with P&A.

By refusing P&A access to records and plans of care during its Team Advocacy inspections and ensuring that the CTH operators also refused P&A access to such records, Defendants interfered with P&A's exercise of its authority, refused to cooperate with P&A in its efforts to ensure the health and safety of CTH residents, and violated South Carolina law.

IV. Listing of Exhibits and Witnesses

Plaintiff plans to call the following individuals as witnesses:

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E-Mail Perry@pandasc.org

Kathi Lacy, Ph.D.
Associate State Director for South Carolina Department of Disabilities and Special Needs
803-898-9686

Plaintiff plans to produce the following exhibits:

Affidavit of Gloria Prevost dated 8 July 2011, filed with the court July 8, 2011

Resolution of Board of Directors changing organizational name to from "Protection and Advocacy System for the Handicapped, Inc." to "Protection and Advocacy for People with Disabilities, Inc.", dated May 11, 1996.

November 30, 2007 letter from Gloria Prevost to Stan Butkus.

June 11, 2009 letter from P&A to Eugene Laurent.

August 12, 2009 letter from Tana Vanderbilt to Anna Maria Darwin.

August 31, 2009 letter from Eugene Laurent to Gloria Prevost.

September 28, 2009 letter from Tana Vanderbilt to Anna Maria Darwin.

Defendant's Responses to Plaintiff's First Interrogatories, dated October 8, 2010

Defendant's Responses to Plaintiff's First Requests for Production, dated October 8, 2010

Affidavit of Kathy Lacy dated July 7, 2011, with attachments.

South Carolina Department of Disabilities and Special Needs "Single Plan" Manual, July 2001 version.

South Carolina Department of Disabilities and Special Needs, "Residential Habilitation Standards," current and prior July 2009 version.

South Carolina Department of Disabilities and Special Needs, "Residential Licensing Standards," current and prior July 2009 version.

Team Advocacy CTH Inspection Reports for the following dates: June 15, 2009; June 24, 2009; July 7, 2009; July 29, 2009; August 11, 2009; August 28, 2009; September 16, 2009; September 17, 2009; October 29, 2009; April 19, 2010; May 10, 2010; May 18, 2010; May 19, 2010.

V. Unusual Problems Relating to Evidence

Plaintiff expects no unusual problems relating to evidence at this time.

VI. Unusual Matters

Plaintiff is unaware of any unusual matters at this time.

VII. Settlement Statement

Settlement between the parties has been attempted and has failed.

Respectfully submitted,

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

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ATTORNEYS FOR PLAINTIFF

Columbia, South Carolina
October 2nd, 2012

STATE OF SOUTH CAROLINA **COUNTY OF RICHLAND** **Protection and Advocacy for People with Disabilities, Inc.,** **Plaintiff,** **vs.** **Beverly A. H. Buscemi, Ph.D., In her official capacity as State Director, South Carolina Department of Disabilities and Special Needs,** **and** **The South Carolina Department of Disabilities and Special Needs** **and** **Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson, and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission,** **Defendants.**	**IN THE COURT OF COMMON PLEAS** **FIFTH JUDICIAL CIRCUIT** **Civil Action No: 10-CP-40-1095** **PLAINTIFF'S MOTION TO ALTER, AMEND, AND/OR RECONSIDER**

YOU WILL PLEASE TAKE NOTICE Plaintiff Protection and Advocacy for People with Disabilities, Inc. ("P&A"), through undersigned counsel, will move before the Honorable Edgar W. Dickson ten days hereafter, or as soon as the matter may be heard, pursuant to Rules 52 and 59, SCRCP, and other applicable law, for an Order (1) granting a new trial; and/or (2) taking additional testimony; and/or (3) altering or amending the findings of fact and conclusions of law; and/or (4) making new findings and conclusions; and/or (5) for the entry of a new judgment.

This motion relates to the Order filed November 29, 2012 and received by P&A's counsel on December 5, 2012, which dismissed Plaintiff's Complaint after the trial held October 3, 2012 (the "November 29, 2012 Order").

In support of this motion, P&A states as follows:

GENERAL RELIEF

Plaintiff generally moves for an order granting the relief sought at the trial of this action, for the reasons set forth and argued at trial and otherwise supported by the evidence. In this motion Plaintiff does not raise or re-assert every position or argument made at the trial because Plaintiff does not believe doing so is required in post-trial motions such as this motion. In maintaining this position Plaintiff does not abandon and specifically preserves any issue or argument presented at the trial.

SPECIFIC ERROR

I. The November 29, 2012 Order Did Not Give Effect To The Language Of The P&A Enabling Statue.

A. It unjustifiably set aside the plain meaning of the text of S.C. Code § 43-33-350.

Much of this case concerns the interpretation of the phrase "plans of care" within the context of S.C. Code 43-33-350(4). Rather than addressing the many other uses of this term in South Carolina law and regulation, the Court framed its analysis around a specific and narrow usage of that phrase in federal law, specifically its usage within 42 U.S.C § 1395n(c)(1), 42 C.F.R. § 441.301(b)(1)(i), and 42 C.F.R. § 441.351(f), the federal Medicaid regulations governing the Medicaid Waiver program of Defendant Department of Disabilities and Special Needs (DDSN). The Court erred for several reasons, as detailed below.

The Court's specialized, narrow reading impermissibly ignored the plain meaning of the statute's text. The clearest and simplest reading of the phrase "plans of care" in the context of S.C. Code § 43-33-350(4) is the phrase means precisely what it says: the Team Advocacy inspector has access to all "plans," *plural*, that relate to "care," of whatever kind, for the stated residents, not that it refers to the phrase as used in a specific federal context. This plain meaning should control and be given deference over more technical readings. The Court must first review the plain meaning of all of the words used in the statute, not just selected terms. See Gilstrap v. S.C. Budget & Control Bd., 310 S.C. 210, 214, 423 S.E.2d 101, 103 (1992). When reviewing the plain and ordinary meaning of words used in a statute, "the terms must be construed in context and their meaning determined by looking at the other terms used in the statute." Id. at 214, 423 S.E.2d at 103. Furthermore, in ascertaining the plain meaning of words used in a statute, "a provision should be given a reasonable and practical construction consistent with the purpose and policy of the Act." Id. The Court, therefore, erred by ignoring the plain language of § 43-33-350.

1. **There was no comparison to similar uses of the same language in state law and regulation.**

The Court set aside the plain meaning of § 43-33-350 in favor of a specific and technical usage based upon a narrow federal provision, and in doing so made an unjustifiable leap. S.C. Code § 43-33-350(4) is a state statute that was passed by the South Carolina General Assembly. The appropriate guide to its interpretation, therefore, is comparable uses in South Carolina state law and regulation, not federal, because state law provides the most direct guide to the intent of the state legislature. The South Carolina Code contains many references to "plans of care," all of which refer generally to a written "plan" that details whatever "care", medical or otherwise, that a particular individual is receiving. See e.g., S.C. Code Ann. § 44-81-40 (2002) (Bill of Rights

of Residents of Long–Term Care Facilities); S.C. Code Ann. § 44-7-350 (2002) (Creation and Monitoring of Plan of Care; responsibility of agency placing individual in community care facility); S.C. Code Ann. § 43-35-10 (Supp. 2010) (Omnibus Adult Protection Act). Similarly, several South Carolina agencies' regulations also refer to "plans of care" in varying contexts, generally following the plain meaning of the term, and often including medical care as an aspect of the plan. See, e.g., 24A S.C. Code Ann. Regs. 61-13 (Supp. 2010) (DHEC Regulation 61-13 § E (3) A, Standards for Licensing Habilitation Centers For The Mentally Retarded or Persons With Related Conditions); 27 S.C. Code Ann. Regs 126-314 (1976)) (DHHS Regulation 126-314, Nursing Facility Services (Medicaid nursing services to be provided according to a written plan of care supervised by a physician)). When the "plan of care" language was added to P&A's enabling statute in 1993, the state legislature would have been aware of the Developmental Disabilities Act (the "DD Act") and its purpose to "improve community services, such as medical care." Va. Office for Prot. & Advocacy v. Stewart, 131 S. Ct. 1632 (2011) (citing 42 U S C. §§ 15023(a), 15024). Both the DD Act and the S.C. Code emphasize the need to protect as well as advocate. The S.C. Code also repeatedly refers to the "care" and "treatment" of people with disabilities. See S.C. Code Ann. §§ 43-33-340(2) (3),43-33-340(3), 43-33-340(5), and 43-33-350(1). These references collectively indicate that the legislature was referring to a general concept of plans of care in the Team Advocacy provision. Thus, the Court erred by failing to consider and give proper weight to comparable state law and regulations when interpreting the language of § 43-33-350.

2. The Court improper relied on federal law.

The court's opinion relies on the usage of the phrase "plan of care" within 42 U.S.C § 1395n(c)(1), 42 C.F.R. § 441.301(b)(1)(i), and 42 C.F.R. § 441.351(f), the federal Medicaid

regulations governing the Medicaid Waiver program of the Department of Disabilities and Special Needs ("DDSN"). These provisions, however, operate within a much narrower context than P&A's general Team Advocacy inspection power. While it is true, and uncontested, that these statutes govern the Medicaid Waiver that provides funding for most residents of the facilities that P&A seeks to inspect in this case, that is only a fraction of the facilities that P&A inspects under its Team Advocacy program. As trial testimony showed, and as was undisputed by Defendants, Plaintiff's Team Advocacy program inspects other facilities as well (including private facilities and facilities run by the Department of Mental Health), and there is no evidence that residents of those facilities are being cared for under DDSN's Medicaid Waiver regulations. Indeed, many of the facilities inspected by the Team Advocacy program are Community Residential Care Facilities ("CRCFs"), which are not directly governed by any federal regulation at all, but only by state level regulatory requirements. *See* SCDHEC Reg. 61-84. Therefore, the Court erred by relying on federal law to limit the meaning of "plans of care" in a state law.

3. Even the federal regulations upon which the Court relies are not, in practice, as limited in meaning as the Court has held.

Even within the federal regulations to which the Court's opinion refers, there is no specific definition of "plan of care," nor do those regulations limit said plan to a specific document; rather, they simply state that services must be provided according to "a written plan of care." 42 USC § 1395n(c)(1), 42 C.F.R. § 441.301(b)(1)(i). Similarly, 42 C.F.R. § 441.351(f) (2011), which deals only with waiver programs for people aged sixty-five and over, does not define "plans of care" as narrowly as the Court's opinion relies upon it to do. 42 C.F.R. § 441.351 actually states that services are provided under a "written plan of care based on an assessment of the individual's **health** and welfare needs. . . . **Each** plan of care must contain **at a minimum, the medical and other services to be provided, ...**" Id. (emphasis added). The federal

regulations merely set a minimum; they do not fully define everything that must be included in a plan of care, and they do not limit individuals to only a single defined plan of care.

The Court relied on several cases interpreting DDSN's federal waiver document and on testimony from Kathy Lacy as to the history of DDSN's waiver policies. Those cases and that testimony is inapposite, because the relevant question is not the meaning of the language within DDSN's federal waiver, but the meaning of P&A's enabling statute under state law. To the extent that it is relevant, however, Defendants admit in their Answer to Plaintiff's Complaint, admitted into evidence at trial along with all other prior filings, that "plans of various kind" are used for residents of Community Treatment Homes ("CTH") but then argue that, for purposes of a Team Advocacy inspection, they are only required to disclose the residential plan to P&A. The residential plan proffered by Defendants does not contain information about the medical care given to residents. Again, this interpretation would limit P&A's review to one plan and to the one plan which does not contain information about the care provided to CTH residents. Such an interpretation is contrary to the language of the statute and would destroy the obvious intent of the legislature. In their responses to Plaintiff's interrogatories, also admitted by reference at trial, Defendants state the "Residential Habilitation standard (RH5.0) requires that each person receive continuous and coordinated health care. People must be evaluated by a licensed physician, physician's assistant or nurse practitioner (and dentist) and the plan of care must be followed." (Defs.' Resp. to Interrog. No. 13.) This response shows that, in spite of their assertion that the phrase "plans of care" is a term of art which refers only to their residential/treatment plan, Defendants' actual use of the term is to refer to any "plan" which relates to general "care" -- "the plan of care" under 42 USC § 1395n(c)(1), 42 C.F.R. §441.301(b)(1)(i), and 42 C.F.R. § 441.351(f) (2011) is simply a reference to any physician's "plan" for an individual's "care,"

again following the plain meaning. The fact that DDSN has chosen to designate a particular document as *the* "plan of care" for Medicaid Waiver participants is purely a choice on their part, not a matter of binding law or regulation. The Court, therefore, erred in its interpretation of and reliance on federal regulations.

4. The meaning of the phrase "living conditions" was misapprehended.

Section 43-33-350(4) does not simply state that P&A may inspect "plans of care"; it states that P&A may conduct inspections of "living conditions, including plans of care." The Court misinterpreted the meaning of "including" in this context. Despite the general rule of statutory construction that, "to express or include one thing implies the exclusion of another,"[1] and items not on a list are assumed excluded, the use of the word "including" typically inverts that assumption, and indicates that the following nouns are *examples*, not exclusive. See Black's Law Dictionary (8th ed. 2004):

> [I]nclude, *vb.* To contain as a part of something. • The participle *including* typically indicates a partial list <the plaintiff asserted five tort claims, including slander and libel>. But some drafters use phrases such as *including without limitation* and *including but not limited to* — which mean the same thing.[2]

The use of "including" in the statute here implies that P&A's power to inspect "living conditions, including plans of care " should be construed broadly, recognizing that inspecting medical records, including but not limited to "plans of care," is the only practical way to properly

[1] Berkeley County Sch. Dist. v. S.C. Dep't of Revenue, 383 S.C. 334, 348, 679 S.E.2d 913, 920 (2009); see also Riverwoods, LLC v. County of Charleston, 349 S.C. 378, 384, 563 S.E.2d 651, 655 (2002) ("The enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded. Exceptions strengthen the force of the general law and enumeration weakens it as to things not expressed.") (quoting Norman J. Singer, *Sutherland Statutory Construction* § 47.23 at 227 (5th ed.1992)).

[2] See also In re Grewe, 4 F.3d 299, 305 n.5 (4th Cir. 1993) (citing "the general rule of statutory construction that the parenthetical beginning with "including" enlarges the scope [of the statute interpreted] rather than limits it."); Am. Sur. Co. of New York v. Marotta, 287 U.S. 513, 517 (1933) ("In definitive provisions of statutes and other writings, 'include' is frequently, if not generally, used as a word of extension or enlargement rather than as one of limitation or enumeration.").

ascertain the resident's "living conditions[,]" especially in cases where the residents cannot speak for themselves. As P&A inspectors know due to their long experience, the inspection of records, including medical records, at facilities providing long term medical care, is the only practical way to inspect those areas of the facility "living conditions" most critical to resident safety. The legislature recognized this need, and specifically *included* resident care plans as a non-exclusive example of the records that Team Advocacy inspectors are authorized to review as part of their inspection of "living conditions." If the legislature had intended to limit P&A Team Advocacy inspectors to only review DDSN Medicaid Waiver "plans of care" under 42 U.S.C § 1395n(c)(1) and 42 C.F.R. § 441.301(b)(1)(i), it would have done so; it did not, instead using general language to give a non-exclusive example of one type of record of resident "living conditions" to which P&A had been granted access. The Court, therefore, erred in its interpretation of the term "living conditions" within the enabling statute.

5. An inspection of "living conditions" necessarily includes an inspection of the records that document those conditions.

An alternate example of the unintended consequences that will result from the Court's order arises from its failure to properly appreciate the extent to which medical care constitutes a necessary part of residents' "living conditions" within inspected facilities. The P&A enabling statute repeatedly refers to the "care" and "treatment" of people with disabilities. See S.C. Code § 43-33-340(2)(e) (developmental disability is a severe, chronic disability which reflects the person's need for combination and sequence of special, interdisciplinary or generic care and treatment which are lifelong or extended); § 43-33-340(3) (developmentally disabled person is a person who has a developmental disability and who receives or is entitled to receive treatment); § 43-33-340(5) (complaint is an allegation "to the effect that the developmentally disabled or handicapped person is being subjected to injury or deprivation with regard to his **health**, safety,

welfare, rights or **level of care.**") (emphasis added); § 43-33-350(1) (P&A shall protect and advocate for rights of all people with disabilities by pursuing legal, administrative and other appropriate remedies to insure the protection); and § 43-33-380 (system may make such disclosures as may be necessary to protect).

Looking at the plain meaning of all the words used, the context, and the comparison with other terms used in the statute, the legislature plainly included medical care and treatment as "living conditions" of a person who needs lifelong or extended care. S.C. Code § 43-33-340(2)(e). The "plans of care" mentioned in the statute are mentioned because those plans are the template, and often also the record, of the care actually provided to residents, the best guide to their "living conditions."

Many residents of these homes have critical, daily medical needs for which review of medical information is as essential, and as much a part of their "living conditions," as an inspection of their home's sanitation or physical structure. The on-site facility records are the most practical and direct, indeed the only, way to review those necessary parts of residents' living conditions. Without access to inspect those records, P&A will be unable to perform adequate inspections to protect resident safety in inspected facilities. Again, this is an issue that P&A inspectors appreciate due to their long direct experience of inspecting facilities – experience that, again, the Court should be reluctant to set aside absent "compelling" evidence, as per Chevron, infra. The Court set aside this reading, however, in favor of a speculative presumption as to what "living conditions" might have entailed in the minds of the legislature. (Pg. 11 of Order). Such presumption is unnecessary. The Court erred by failing to defer to the plain language of the statute, comparable state law, P&A's own interpretation of the statutes it is charged with administering, and long-standing practice.

II. The November 29, 2012 Order erred by adopting a narrow interpretation of S.C. Code § 43-33-350 because the Privacy Protections within P&A's enabling statute indicate that P&A's access to records should be construed broadly.

Other sections of P&A's enabling statute also indicate that the Team Advocacy Program's authority to review resident records should be construed broadly. The legislature put in place extensive safeguards on the Team Advocacy Inspector's review authority. S.C. Code § 43-33-350(4) states:

> Only the coordinator of the team advocacy project or the coordinator's designee is authorized to perform reviews of plans of care. . . . The system shall prepare a report based on the inspection which must be submitted to . . ., South Carolina Department of Health and Environmental Control, and State Department of Mental Health.

S.C. Code § 43-33-350(4). Additionally, the enabling legislation also states, in § 43-33-380:

> The System shall not disclose the name or identity of any person, complainant, witness or subject of a complaint or any information or writing relating thereto unless the person or his parent or legal guardian authorizes in writing the release of such information but the System may make such disclosures as may be necessary to protect or advocate for the rights of the developmentally disabled or handicapped person concerned.

S.C. Code Ann. § 43-33-380 (Supp. 2010).

Both of these sections, taken together, constitute strong protections for residents' privacy rights. Only a specific Team Advocacy staff member or designee is authorized to review "plans of care," and inspection reports are sent to specific state agencies. Furthermore, P&A staff generally are bound from disclosing the name or identity of any person without specific authorization from that person, his parent, or his legal guardian.

Such strong protections indicate that the legislature intended P&A Team Advocacy inspectors to review sensitive and private information; otherwise, these protections would not be necessary. Cf. State v. Sweat, 379 S.C. 367, 377, 665 S.E.2d 645, 651 (Ct. App. 2008) ("When interpreting a statute, courts must presume the legislature did not intend to do a futile act. . . . 'A

statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous . . . .'") (quoting Matter of Decker, 322 S.C. 215, 219, 471 S.E.2d 462, 463 (1995)).

III. The November 29, 2012 Order failed to recognize MARs are both a medical record and also a "plan" of "care" within the meaning of S.C. Code § 43-33-350.

The Court's overly narrow reading is a substantive issue because it led the Court into factual and legal error. The records most at issue here, the daily Medication Administration Records ("MARs"), both set forth the only comprehensive written plan for the administration of residents' medications and also record compliance with that plan. As such, whether or not they are a "plan of care" under U.S.C. § 1395n(c)(1) or 42 C.F.R. § 441.301(b)(1)(i), they constitute a "plan of care" within the meaning of S.C. Code § 43-33-350(4): they are "plans" that relate to medical "care." The Court repeatedly stated these are "records," and therefore not "plans," while failing to appreciate that those two categories are not mutually exclusive; the MARs are *both* plans for medication administration *and* the record of compliance with that plan. The MARs set forth the medications each resident is to receive, the planned dosage and the time it is to be given, then it tracks staff's actual administration of the medication.

IV. The November 29, 2012 Order failed to consider or apply appropriate Chevron deference to P&A's own interpretation of its enabling statutes.

While P&A is not a state agency, P&A has been delegated authority by the state legislature and is charged with administering its own statutes. The Governor of the State of South Carolina makes appointments to the P&A Board of Directors, and P&A is specifically defined as part of the "State" within the meaning of the South Carolina Tort Claims Act. S.C. Code § 43-33-330; S.C. Code § 15-78-30(e) ("State" means the State of South Carolina and any of its offices, agencies, authorities, departments, commissions, boards, divisions, instrumentalities, including

the South Carolina Protection and Advocacy System for the Handicapped, Inc., and institutions, including state-supported governmental health care facilities, schools, colleges, universities, and technical colleges"). P&A is therefore is entitled to deference in its interpretation of its own enabling legislation. See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837 (1984); Sweat, 379 S.C. at 374, 665 S.E.2d at 649 ("The construction of a statute by the agency charged with its administration will be accorded the *most respectful consideration* and *will not* be overruled absent *compelling* reasons.")(emphasis added); see also City of Columbia v. Board of Health and Environmental Control, 292 S.C. 199, 202, 355 S.E.2d 536, 538 (1987) ("The delegation of authority to an administrative agency is construed liberally when the agency is concerned with the protection of the health and welfare of the public.") Although this issue was raised to the Court, not only is there no evidence in the Court's opinion that the requisite "compelling" reasons were found, there is no evidence that any consideration at all was given to the appropriate deference due P&A's own interpretation of its statute under *Chevron.*

V. The November 29, 2012 Order erred in evaluating S.C. Code § 43-33-350 without reference to long-standing practice and interpretation.

Deference is especially due where, as here, the organization has followed the same practice for multiple decades, with the knowledge of state agencies, including Defendants, none of whom have objected until now. In fact, the South Carolina Department of Health and Environmental Control successfully *enforced* P&A's right to review records, including MARs, as part of its Team Advocacy inspection program. See SC DHEC vs. Bellwood Manor, Inc., S.C. Administrative Law Division, Docket No. 09-ALJ-07-0551-CC, 2010 WL 6782577 at *8 (Nov. 22, 2010). ("As an organization authorized by statute to serve and protect the health, welfare, and rights of developmentally disabled and handicapped persons in South Carolina, P&A's authority to conduct Team Advocacy inspections should be liberally construed.") The administrative law

judge there further recognized, as a finding of fact:

> Team Advocacy members perform a physical inspection of the facility and its records and interview residents, in order to ensure that the residence is properly maintained and staffed, supplied with sufficient food, medication is properly handled and administered, and **that residents have access to their** finances and **medications**, and are free to come and go as they wish.

Id. at *2 (emphases added).

P&A's long-standing practice has included, in the past, the allowed inspection of MARs at private CRCFs and at facilities controlled and operated by several separate state agencies, including the Department of Mental Health and **even facilities operated by Defendants**. Established usage in regard to the meaning and effect of a statute is a relevant and persuasive guide to its authoritative interpretation. 2B Sutherland Statutory Construction § 49:6 (7th ed.); citing McKeen v. Delancy's Lessee, 9 U.S. 22 (1809); Basey v. Gallagher, 87 U.S. 670 (1874); Swift & Courtney & Beecher Co. v. U.S., 105 U.S. 691 (1881).

Instead of deferring to P&A's own interpretation of its statute, or deferring to over twenty years of established practice, the Court adopted a novel interpretation over standard practice. The Court relied on DDSN's interpretation of a narrow provision of the federal regulations that govern DDSN's Medicaid Waiver program rather than P&A's own long-established and previously noncontroversial interpretation of its own statute. P&A has followed this interpretation when inspecting over a thousand facilities operated by numerous different providers for over 20 years, including but by no means limited to Defendants. As such, its interpretation of the Team Advocacy provision should be given more weight than that of Defendants. Defendants should further be prevented, by estoppels or otherwise, from maintaining a position contrary to what they have maintained in the past and which has been specifically rejected by a separate State agency.

VI. The November 29, 2012 Order risks setting precedent that could force P&A inspectors to apply the language of DDSN's Medicaid Waiver to contexts where it makes no sense to do so.

DDSN is only one organization out of several, both public and private, which maintain facilities P&A inspects. The Court's opinion risks forcing future Team Advocate inspectors to apply the court's construction of the phrase "plan of care" within 42 U.S.C § 1395n(c)(1) and 42 C.F.R. § 441.301(b)(1)(i) onto contexts in which such practice would make no sense, such as private CRCFs housing no Medicaid Waiver residents. This is partly why the P&A enabling statute refers to "plans of care" rather than the singular "plan of care." The Team Advocacy provision does not limit P&A to a review of a single DDSN document, no more than Team Advocacy inspections are limited to only facilities governed by DDSN's Medicaid Waiver agreement. P&A's statutory authorization is simply broader than that.

This failure to give appropriate deference to a long-standing interpretation and pattern of practice is not a purely technical failing; it led the Court to seriously misunderstand the difficulties and dangers which its ruling will create if allowed to stand, and risks forcing P&A inspectors to apply the terms of 42 USC §1395n(c)(1), 42 C.F.R. §441.301(b)(1)(i), and 42 C.F.R. §441.351(f) to situations and facilities in which it makes no logical sense to do so.

VII. The November 29, 2012 Order significantly undercuts P&A's ability to conduct effective "unannounced" inspections as required by the enabling statute and defeats the purpose of the statute, rendering the statutory requirement of unannounced inspections a nullity.

As an example of the difficulties and dangers that the Court's opinion creates, despite clear testimony otherwise, the Court's opinion asserts that requiring advance releases from all facility residents could be easily accomplished and would not seriously limit P&A's ability to conduct the "unannounced" inspections that S.C. Code § 43-33-350 requires. This misses one of the main arguments by P&A. The Team Advocacy provision authorizes inspections without **any**

requirement for permission from facilities or the residents of those facilities. If the statute intended to authorize access to records only on a grant of permission, the clause authorizing access to records would not need to exist at all. The interpretation accepted by the Court, however, renders the clause in question a nullity; another violation of the rules of statutory construction. **Under the Court's interpretation, if a resident or his guardian refused permission, P&A could not review records concerning that resident during its Team Advocacy inspection. Team Advocacy inspections would, therefore, be authorized by S.C. Code § 43-33-350 but P&A would be effectively blocked from performing those inspections in any instance where an individual or his legal guardian refused permission.** The failure to appreciate the damage that requiring advance releases would do to P&A's inspection program is *also* a legal error in that it fails to give effect to every part of the statute; if P&A inspectors are to be required to obtain advance consent, then there would be no need for the statute to authorize their inspections at all, or more specifically, no need to authorize access to inspect "living conditions, including plans of care[.]"

Despite clear testimony from P&A inspectors as to the harm such a requirement would do to the inspection program, the Court ignored that testimony, without any indication that proper *Chevron* deference was weighed and considered. P&A's interpretation of its own enabling statute is entitled to deference in part *because* P&A inspectors, who have long experience conducting inspections under S.C. Code § 43-33-350(4), understand how and why a requirement to obtain advance consent would render it impossible to perform "unannounced" inspections as the statute requires.

VIII. The November 29, 2012 Order erroneously conflated separate provisions of the P&A enabling statute.

The Court erroneously conflated P&A's power to inspect records as part of its Team Advocacy inspection program, under S.C. Code § 43-33-350(4), with its separate and distinct power to access resident records upon receipt of a complaint under § 43-33-370(2). S.C. Code § 43-33-370, "Authority of System upon receipt of written request to investigate complaint[,]" applies only when P&A has received a "written request to investigate a complaint . . .or upon . . .the receipt of a complaint of abuse or threatened abuse. . . ." Id.

Just like many other bodies delegated powers by the legislature, P&A has multiple separate functions: its federally designated role in investigation of abuse and neglect and as an advocate and a monitor under 42 U.S.C. § 15043(a)(1), and its separate, state-created role to conduct Team Advocacy inspections. P&A does not dispute that there are some conditions which P&A must meet to review records when *not* conducting Team Advocacy inspections. P&A's authority under the Team Advocacy provision, however, is distinct, and Team Advocacy's function is distinct, administered by separate personnel, and triggered in separate contexts. Limitations on P&A's authority to inspect records in one context do not apply in other legally distinct contexts; P&A Team Advocacy inspections are legally distinct from P&A investigations of abuse and neglect. Thus, the Court erred by conflating these separate provisions in the enabling statute.

IX. The November 29, 2012 Order does not accurately reflect the record at trial.

The November 29, 2012 Order contains several errors which are not supported by the record at trial. On page nine of the Court's order, the Court refers to the Plaintiff as seeking "any and all of the CTH patient's medical records"; this is not accurate, as Plaintiff has only ever sought access to on-site records at inspected facilities. Similarly, in a footnote on page nine, the Court stated that CRCFs, including those which P&A inspects under contract with the Department of Mental Health, are "mostly small, private, and probably unaware of which records they should

produce and should not produce." Not only is this an inaccurate statement not supported by any evidence at trial, it is in fact contradicted by including trial testimony which indicated some of those very CRCFs are maintained and operated by DDSN, not to mention the case of SC DHEC vs. Bellwood Manor, Inc., supra, which was raised and submitted at trial and in which DHEC successfully litigated against a CRCF operator to enforce P&A's authority to inspect and review records, including MARs.

X. The November 29, 2012 Order is contrary to South Carolina public policy, general principles of equity, and the needs of South Carolina citizens.

As the Court recognized, P&A "shall protect and advocate for the rights of all developmentally disabled persons . . ." (Order p. 4, citing enabling statute). The authorization of Team Advocacy inspections in the enabling statute is designed to allow P&A to review the living conditions, including records and plans of care, of individuals with disabilities who live in facilities such as CTHs. S.C. Code § 43-33-350(4). Such inspections are an essential part of South Carolina's legislative plan to protect individuals with disabilities. By providing independent, third-party oversight of the facilities that serve and house these citizens, Team Advocacy inspections help ensure that South Carolina residents with disabilities are receiving appropriate care and living in safe environments. This demonstrates our state's policy to ensure that people with disabilities are protected and that they have an advocate in P&A. For these reasons, P&A's power to conduct inspections should be liberally construed. By removing this power from P&A's inspectors, the Court's opinion endangers the safety and quality of life of South Carolina's most vulnerable residents.

CONCLUSION

For the foregoing reasons, the Court should grant P&A's motion.

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December _____, 2012

Columbia, South Carolina

STATE OF SOUTH CAROLINA	**IN THE COURT OF COMMON PLEAS**
COUNTY OF RICHLAND	Civil Action Number: 10-CP-40-1095
Protection and Advocacy for People with Disabilities, Inc., Plaintiff, v. Beverly A. H. Buscemi, Ph.D., in her official capacity as State Director, South Carolina Department of Disabilities and Special Needs and The South Carolina Department of Disabilities and Special Needs, and Kelly Hanson Floyd, Nancy Banov, W. Robert Harrell, Rick Huntress, Deborah McPherson and Dr. Otis Speight in their Official Capacities as Members of the Department of Disabilities and Special Needs Commission, Defendants.	**DEFENDANTS' RESPONSE TO PLAINTIFF'S MOTION FOR RECONSIDERATION**

FILED
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JEANETTE W. WALDRON
C.C.P. & G.S.

By Order filed December 4, 2012, the Court dismissed this action. On December 17, 2012, Plaintiff served a Motion for Reconsideration. Defendants submit that the motion should be denied for the reasons set forth below.

I. Plaintiff's claims concerning the language of the statute (Heading I of Plaintiff's motion).

Plaintiff initially contends that the Order ignores the plain meaning of the term "plans of care" as used in S.C. Code Ann. § 43-33-350(4). Defendants would first show that the Order did not rely solely on the use of the term "plan of care" in federal law, as Plaintiff seems to suggest (Motion at 2-3). The Court looked to federal law as an illustration of the use of a well-defined meaning of the term "plan of care" in a very similar, and often identical, context. Order 5-9. In

addition, the Court addressed the plain meaning of the term "plan" at pp. 10-11 of the Order. Specifically, the Court noted that the term "plan" plainly connotes the idea of guidance for the future. The medication administration records (MARs) sought by Plaintiff in this case, as their descriptive title would suggest, are records that serve to document past occurrences, i.e., the administration of medications, and therefore fall outside the normal definition of what is meant by a "plan."

Plaintiff also argues that the Order did not make adequate reference to other state statutes and regulations. Motion at 3-4. In that part of the motion, Plaintiff reiterates its reference in prior filings to various state law provisions that mention the term "plan of care" in some fashion. The Order, however, noted (p. 16, n. 6) that those state law references were generally similar to § 43-33-350(4) in referencing an advance plan. In addition, Plaintiff does not cite to any particular definition of the term in any of those references that would support its arguments in this case.

Plaintiff notes (Motion at 4-5) that the Court's reference in the Order to Medicaid usages and authorities would not strictly apply to those situations in which team inspections would be conducted in facilities whose clients are not Medicaid Waiver clients. Again, however, Plaintiff misperceives the nature of the Court's reliance on Medicaid authorities, as already mentioned above. The Medicaid authorities simply provide a detailed illustration of the meaning of the term in contexts that are the same as that in the present case, regardless of whether or not a particular individual is a Medicaid Waiver client. It should also be noted that in its Complaint, Plaintiff asserted its belief that with respect to the types of residences whose inspection is sought in this action, "the great majority of people with developmental disabilities in CTHs are recipients of Medicaid services under the Medicaid Mental Retardation/Related Disabilities Waiver." Complaint, Par. 49.

Plaintiff makes several other arguments (Motion at 5-7) regarding the interpretation of the statute. Most of these deal with the specific terms of the federal authorities referenced in the Order, and have already been discussed in the Order at pp. 5-9. Plaintiff also refers (Motion at 6) to an interrogatory response by Defendants, but as Defendants have previously pointed out, Defendants' Memorandum in Response to Plaintiffs' Motion for Summary Judgment at p. 7, n. 4, the language of the DDSN standard itself (as opposed to the interrogatory response) is that there must be "documentation that the physician's [or dentist's] recommendations are being followed" (emphasis added). The term "plan of care" is not actually used in that standard.

On pp. 7-8 of its motion, Plaintiff reasserts certain contentions about the use of the phrase "living conditions, including plans of care" in § 43-33-350(4). These contentions were considered and addressed at pp. 13-15 of the Order.

Finally, with respect to interpretation of the statute, Plaintiff puts forth its own unsupported allegation that medical care and treatment are so much a part of the "living conditions" of the residents of the facilities that a review of the residents' medical records must necessarily be a part of an inspection of their living conditions. The short answer to this is found at pp. 9-10 of the Order, in which the Court referenced the language of § 43-33-370(2). In that subsection, the General Assembly referenced "the individual medical, treatment or other personal records" of residents of inspected facilities, but only in order to exempt such records from review by P&A except where an individual complaint has occurred. In other words, the General Assembly was well aware of how to describe the kinds of records sought by Plaintiff in this case, but simply chose not to make such records available to Plaintiff in the course of conducting team inspections of living conditions at residential facilities.

II. Plaintiff's claims concerning broad construction of the statute (Heading II of Plaintiff's motion).

Plaintiff next contends that its position on the definition of the term "plans of care" is supported by the presence of limitations on who can see team inspection reports. Motion at 10-11. However, the definition of the term "plans of care" is not, as a matter of simple logic, determined by who can view the defined documents. Moreover, "plans of care," as that term is used by DDSN, are sufficiently private documents in themselves to warrant the limitations on who may see them. This claim is accordingly not relevant to the issue before the Court.

III. Plaintiff's claims concerning the nature of medication administration records as constituting "plans of care." (Heading III of Plaintiff's motion).

In this section of its motion (Motion at 11), Plaintiff contends that a medication administration record is a "plan of care" in and of itself. Plaintiff claims that such records "set forth the medications each resident is to receive, the planned dosage and the time it is to be given, then it tracks staff's actual administration of the medication." *Id.*

A significant problem with this argument is that (as far as Defendants' counsel can recall), Plaintiff did not introduce any medication administration records into evidence. As a result, there is nothing in the record that would permit the Court to review the merits of this contention. Even if one or more MARs had been placed in evidence by Plaintiff, however, the contents of those documents would still not necessarily contain everything that Plaintiff claims such documents contain. Moreover, such documents would at most normally only provide evidence of compliance with certain doctors' orders. Neither the physicians' orders themselves nor the records showing the extent of compliance with the orders can fairly be said to meet the definition of a "plan of care" in this context, for the reasons already set forth in the Order.

IV. Deference to P&A's construction of its enabling statute (Headings IV and V of Plaintiff's motion).

Plaintiff next argues that its own interpretation of the subsection in issue is entitled to deference as a construction by the agency charged with its administration. Plaintiff initially relies on *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). That reliance is misplaced, however, because *Chevron*-style deference is accorded only to regulations or other formally-adopted agency actions. *See, e.g., Christensen v. Harris County*, 529 U.S. 576, 587 (2000). Any agency action short of the described degree of formality does not receive such a high level of deference. *Id.* (no *Chevron* deference given to "interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law").

Plaintiff also claims that its interpretation of the statute is entitled to deference under the principle that such deference is given to construction of a statute by the agency charged with its administration, at least as long as the agency's construction is not contrary to the clear language of the statute. *See, e.g., State v. Sweat*, 379 S.C. 367, 374, 665 S.E.2d 645, 649 (Ct. App. 2008). However, as will be shown, that rule does not apply to an agency such as P&A, which is not charged with the administration of the statute in the sense used by courts in applying this rule of construction.

The rule of construction cited by Plaintiff is founded on the idea that the applicable legislative body (Congress or a state legislature) has delegated to the agency, either explicitly or implicitly, the authority to make policy. *See, e.g., Linemaster Switch Corp. v. U.S. E.P.A.*, 938 F.2d 1299, 1303 (D.C. Cir. 1991)("[b]efore we may defer to an agency's construction of a statute, we must find either explicit or implicit evidence of congressional intent to delegate interpretive authority"). This includes the filling in of gaps in the enabling legislation.

There is no indication in P&A's enabling legislation, S.C. Code Ann. §§ 43-33-310, et seq., that the General Assembly intended to delegate such authority to P&A. Instead of serving as a policymaking or regulatory agency, P&A was created to serve investigative and advocacy functions to the extent authorized by statute. Those functions actually exclude the role of serving as a policymaker, because neither an investigator nor an advocate is empowered to legislate the proper subjects of their own activities. In an analogous context, it has been held, for example, that a "civil prosecutor typically lacks authority to issue substantive regulations to interpret a statute establishing liability." *Kelley v. E.P.A.*, 15 F.3d 1100, 1106 (D.C. Cir. 1994). Here, P&A, as an investigator, lacks authority to decide what the General Assembly intended for it to be able to investigate. That decision is one for the courts, and specifically, for the Court in the present case.

It is regularly held that no deference should be given to the views of agencies to which policymaking authority has not been delegated. *See also, e.g., Pittston Stevedoring Corp. v. Dellaventura,* 544 F.2d 35, 49 (2d Cir. 1976)(no deference to an adjudicatory agency that was "not a policy making but entirely an umpiring agency"); *State of Fla., Dept. of Ins. v. National Amusement Purchasing Group, Inc.*, 905 F.2d 361, 366 (5th Cir. 1990)(no deference where agency was "not charged with administering the Act, but merely has responsibility under the Act to report on its implementation"); *Air North America v. Department of Transp.*, 937 F.2d 1427 (9th Cir. 1991)(deference to agency's construction of the Administration Procedure Act inappropriate as Congress did not direct the Department to implement the Act). [1] The duties

[1] While no South Carolina case has been located which has had the need to address the issue for some kind of legislative delegation of authority to interpret, state courts have reached the same conclusion as the federal cases cited above. *See, e.g., Committee of Consumer Services v. Public Service Com'n of Utah,* 75 P.3d 481, 484 (Utah 2003)(no deference to agency construction "[u]nless the legislature has granted discretion to an agency to interpret statutory language").

conferred on P&A simply are not the kinds of duties that carry with them the authority to make policy regarding the proper construction of P&A's enabling legislation.

In Heading V, Plaintiff argues that DDSN had knowledge of Plaintiff's investigatory practices and should be "prevented, by estoppels or otherwise," from objecting to Plaintiff's efforts to review personal medical records. Motion at 13. This contention is not supported by the record. Plaintiff may have introduced evidence that it managed to inspect those records at a few facilities that serve DDSN clients, but there is nothing in the record (to counsel's recollection) to indicate that the DDSN Director or anyone with statewide authority at the agency was aware of such inspections. Indeed, the attachments to the Affidavit of Gloria Prevost indicate that DDSN's supervisory officials objected to P&A's plan to inspect individual medical records as part of team advocacy inspections as soon as those officials were made aware of P&A's plans. In fact, it was those objections by DDSN's highest-ranking officials that led to the filing of this lawsuit.

Plaintiff also argue that other agencies, such as the Department of Mental Health and perhaps DHEC, have permitted P&A to review the kinds of records sought to be reviewed in the present case. Motion at 12-13. However, Ms. Prevost testified that P&A was acting pursuant to contract with DMH, which means in effect that P&A was an agent of DMH. *See* Order at 9, n.2. As for DHEC, the evidence of what DHEC would permit to be inspected was limited, at best.[2] Plaintiff has certainly made no showing of the precise nature of the other agencies' interpretations, or that DDSN actually knew of these interpretations, even assuming that such interpretations would apply in the present context. Plaintiff likewise has not cited any legal authority to show why DDSN should be bound by a interpretation given a statute by other

[2] Plaintiff cites *DHEC vs. Bellwood Manor, Inc.*, 2010 WL 6782577 (S.C. Administrative Law Court 2010), but the issue of which records could be reviewed was not the subject of that case.

agencies, probably in other contexts, and of which DDSN has not been shown to have been aware of. As a result, any claim based on alleged interpretations by other agencies is unmeritorious, both because of inadequate proof of the nature of the interpretations and DDSN's knowledge thereof, and also because no authority has been cited to support this claim as a matter of law.

V. Application of the Order to non-Medicaid settings (Heading VI of Plaintiff's motion).

Under Heading VI of its motion, Plaintiff asserts that some of the facilities that it inspects do not house persons who are Medicaid clients. Motion at 14. As noted above, however, the Order referred to Medicaid law and practice primarily for purposes of illustrating the meaning given to the term "plan of care." The Order did not hold that the Medicaid authorities were literally controlling, but only that given the clear meaning of the term in the Medicaid context, that same meaning should also apply in the present state law context as well. The Order additionally was based on the plain meaning of the term (Order at 10-11) and on other parts of the P&A statute itself (Order at 9-10). As a result, any concern that the Order might improperly extend Medicaid concepts to other contexts is misplaced.

VI. Effect of the Order on unannounced inspections (Heading VII of Plaintiff's motion).

In this part of its motion (pp. 14015), Plaintiff addresses the Order's discussion of a suggestion by DDSN that one way for P&A to review medical records would be to obtain prior consent from the residents or their representatives. As the Order points out, however,

> [T]his argument [by Plaintiff] is merely addressed to an alternative approach that had been suggested by DDSN. Even if this approach were to have the effect of advising the facility in advance that an inspection of living conditions might be forthcoming, that result still cannot expand the meaning of the term "plans of care" beyond the clear meaning that the term has in this context, as DDSN has

already argued. This entire argument is therefore simply beside the point.

Order at 12-13. In other words, if the statute did not grant to P&A the right to review medical records, as opposed to plans of care, then team advocacy inspections of medical records would be blocked, not because of the refusal of consent, but because the statute did not permit such records to be reviewed in the course of an inspection, as the Order has held. There was no suggestion in the Order that the review by P&A of plans of care, as defined in the Order, could be blocked by the nonconsent of the client or the client's representatives.

VII. Alleged conflation of different parts of the P&A statute (Heading VIII of Plaintiff's motion).

In Plaintiff's Issue VIII, it is contended that the Order was in error by holding, according to Plaintiff, that "[l]imitations on P&A's authority to inspect records in one context do not apply in other legally distinct contexts; . . ." Motion at 16. As with several other arguments made by Plaintiff, this misperceives the nature of what was held in the Order. The Order held that § 43-33-370(2) placed substantial limitations on the ability of P&A to review individual medical records, permitting such review only in response to a specific complaint by or on behalf of an individual, and even then, P&A's document review was not to include "the individual medical, treatment or other personal records of other persons in the program or facility." §43-33-370(2)(emphasis added). In other words, given the clearly-expressed desire of the General Assembly to protect individual medical records of facility residents even in situations where complaints have been made, it is not reasonable to think that the General Assembly would have intended to permit unrestricted access by P&A to those same protected records in the course of an inspection that was not necessarily even made in response to a complaint.

This holding by the Court was an application of the very familiar principle that "In ascertaining the intent of the legislature, a court should not focus on any single section or

provision but should consider the language of the statute as a whole." *Mid-State Auto Auction of Lexington, Inc. v. Altman*, 324 S.C. 65, 69, 476 S.E.2d 690, 692 (1996). Taking the statute as a whole, there can be no question that the General Assembly intended to make individual medical records available to P&A only in very limited circumstances, and not in the wholesale fashion for which P&A presently contends.

VIIII. Arguments pertaining to the trial record (Heading IX of Plaintiff's motion).

In this heading of its motion, Plaintiff cites two instances in which it contends that the Order went beyond the trial record. The first of the two is the following provision of the Order:

> The Court therefore finds that, although the term was not defined in the statute by the Legislature, it nonetheless was meant to have a specific meaning and not an expansive, all-inclusive definition that would include any and all of the CTH patients' medical records.

Order at 9. Plaintiff asserts that this holding constitutes a statement that Plaintiff was seeking "any and all of the CTH patients' medical records." Motion at 16. Actually, it does not constitute a statement about what Plaintiff was seeking at all. In the context of this case, this statement clearly meant that Plaintiff should not have access to any and all CTH patients' medical records at the facility.

Plaintiff's second and other argument about matters in the record is directed toward footnote 2 on p. 9 of the Order. That footnote provides as follows:

> Plaintiff argues that it has inspected another kind of facility, Community Residential Care Facilities (CRCF's) and has not been prevented by another agency, the Department of Mental Health, from reviewing medical records in that context. However, those facilities are mostly small, private, and probably unaware of which records they should produce and should not produce. In addition, as Ms. Prevost testified, Plaintiff was conducting those inspections as a contractor with the Department of Mental Health. In any event, that other context, which does not involve DDSN, is not before the Court, and cannot govern the present situation, where the matter is being contested.

Defendants would submit that the language to which Plaintiff objects is not necessarily material, but in any event, Defendants would suggest that the footnote might be amended slightly to resolve this issue raised by Plaintiff. As amended, the footnote might read as follows:

> Plaintiff argues that it has inspected another kind of facility, Community Residential Care Facilities (CRCF's) and has not been prevented by another agency, the Department of Mental Health, from reviewing medical records in that context. However, ~~those facilities are mostly small, private, and probably unaware of which records they should produce and should not produce. In addition,~~ as Ms. Prevost testified, Plaintiff was conducting those inspections as a contractor with the Department of Mental Health. In any event, that other context, which does not involve DDSN, is not before the Court, and cannot govern the present situation, where the matter is being contested.

IX. Public policy arguments (Heading X of Plaintiff's motion).

Finally, Plaintiff argues that the result reached in the Order is "contrary to South Carolina public policy, general principles of equity, and the needs of South Carolina citizens." Motion at 17. Plaintiff here asserts that having medical records subject to review is something that "helps ensure that South Carolina residents with disabilities are receiving appropriate care and living in safe environments." While no one would disagree with the worthiness of the goal quoted immediately above, Plaintiff does not recognize that those residents, like all other residents of the state, are entitled to have their medical records remain private, absent a clear expression of intent to the contrary by the General Assembly. That clear expression of intent is lacking in this case; indeed, the statute's plain meaning makes it very clear that the only records to be made available during team advocacy inspections would be plans of care, as that term is defined in the Order. Plaintiff's policy arguments are properly addressed to the General Assembly, which defines policy in this area, rather than to the courts, whose role is to effectuate the expressed intent of the legislature.

For the foregoing reasons, Defendants respectfully submit that Plaintiff's Motion for Reconsideration should be denied, with such additions or changes to the original Order as the Court deems appropriate.

Respectfully submitted,

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Edgar W. Dickson, Presiding Judge

Case No. 2010-CP-40-1095
Appellate Case No. 2015-000109

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CERTIFICATE OF COUNSEL

The undersigned certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

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