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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE COURT OF COMMON PLEAS
Honorable G. Thomas Cooper, Jr.
Circuit Court Case No.: 2007-CP-40-03365

Appellant Case No. 2014-001373

Estate of Edward James Mims,
Laura M. Cole, Personal Representative.....Appellant,

v.

The South Carolina Department of Disabilities
and Special Needs, Kathi Lacy and Stan Butkus, ...Respondents.

Volume VI

RECORD ON APPEAL

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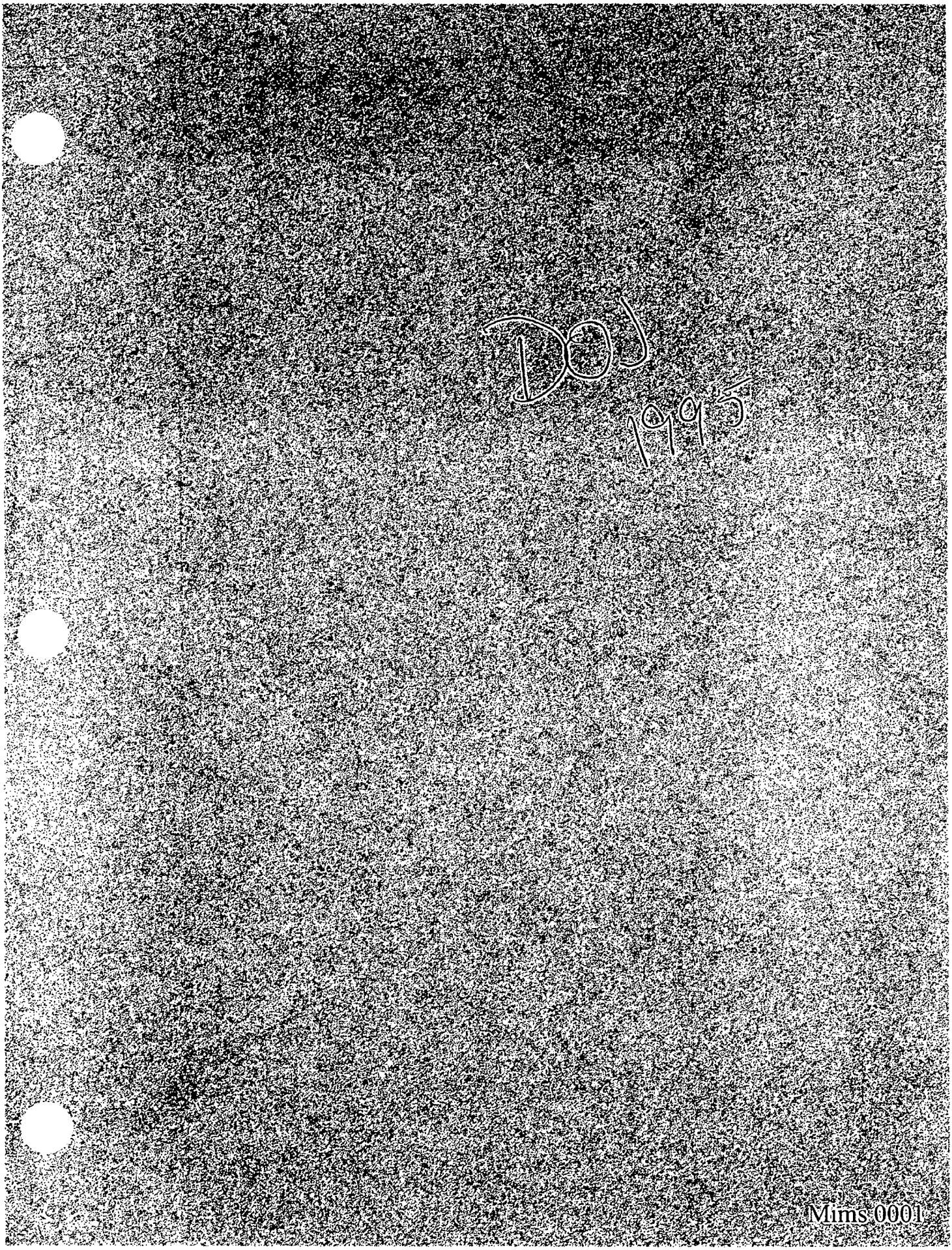
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DJ 168-67-86



Recommendation to Investigate
Whitten Center
Clinton, South Carolina

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

Arthur E. Peabody, Jr.
Chief
Special Litigation Section

INTRODUCTION

We recommend that the Department initiate an investigation into the conditions of confinement at the Whitten Center ("Whitten") in Clinton, South Carolina, pursuant to its authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. Whitten is a state-operated institution housing approximately 800 developmentally disabled children and adults.

Residents of state-operated facilities for the developmentally disabled and mentally retarded have a fundamental Fourteenth Amendment due process right to reasonable safety, adequate medical care and training. Youngberg v. Romeo, 457 U.S. 307 (1982). Such training must be sufficient to protect each resident's liberty interests and permit each resident an opportunity to function as independently as their individual handicapping conditions permit. See, e.g., Halderman v. Pennhurst State School & Hosp., 154 F.R.D. 594 (E.D. Pa. 1994); United States v. Tennessee, No. 92-2062, slip op. at 12 (W.D. Tenn. Feb. 17, 1994); Thomas S. by Brooks v. Flaherty, 699 F. Supp. 1178 (W.D.N.C. 1988). See also 42 C.F.R. § 483.440.

Information we have obtained indicates that residents of Whitten are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and statutory rights. Alleged unconstitutional conditions include abuse and neglect of residents, inadequate medical and psychiatric care, and failure to provide residents with adequate training. Such deficiencies subject residents at Whitten to unreasonable risks to their personal safety and violate their constitutional rights. In addition, Whitten is a large and isolated institution which unduly segregates its residents from the rest of society solely on the basis of their disabilities. As a result, the facility is failing to provide services to its residents in the least separate, most integrated setting as required by the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq.,

cc: Records Chrono Peabody Frohboese Farano Wilkinson Hold

and Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794 et seq.

POSSIBLE VIOLATIONS

A. The State Fails to Ensure that Whitten Residents are Free from Abuse and Neglect.

Abuse

Abuse against clients is far more prevalent at Whitten than at any other similar state-run facility in South Carolina.[1]/ A recent state-generated compilation of total abuse incidents at all the South Carolina institutional facilities reveals that in fiscal year 1992-93, Whitten had forty-four separate allegations of abuse.[2]/

Another local advocate indicated that there is "plenty" of staff abuse at Whitten.[3]/ She indicated that the Whitten staff regularly "whup their young'ins" at home, so it's natural that they would carry the same attitudes with them to work.[4]/ Naturally, this can lead to abuse of the residents. This account is corroborated by a Whitten parent who indicated that the staff at the facility can be "violent."[5]/ Last Fall, she noticed that one resident had a clearly marked shoe print on his buttock area revealing that he had been kicked.[6]/

State surveyors, who annually enforce the Health Care Financing Administration's ("HCFA") Title XIX regulations, have noted that Whitten staff are abusive in that they verbally insult residents. For example, for one resident with a urostomy bag, a staff member commented, "She can't come over here smelling like

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[1]/ Telephone Interview with Kimberly McAllister, South Carolina Protection & Advocacy System for the Handicapped, Inc., May 10, 1994.

[2]/ Id.

[3]/ Telephone Interview with Sharon Bellwood, Regional Coordinator, South Carolina Protection & Advocacy System for the Handicapped, Inc., May 10, 1994.

[4]/ Id.

[5]/ Telephone Interview with Jean Shirley, parent of a Whitten resident, September 14, 1994.

[6]/ Id.

this ... The smell burns my eyes."[7]/ The surveyor noted that the client was aware of the comment.[8]/ Staff also refer to adult clients inappropriately as "baby," "good little girl," "sweetie" or good boy."[9]/ Moreover, contrary to state law, the facility is failing to report the results of all abuse and/or neglect investigations to the administrator or other officials in a timely fashion.[10]/

The local Protection and Advocacy ("P&A") group expressed concerns about the compromised impartiality of the Whitten abuse and neglect investigator, stating "[w]e have some questions about the investigator being a paid department employee."[11]/ A parent of a client at the facility indicated that "there IS abuse" occurring at Whitten and that it occurs everyday.[12]/ She indicated that many of the incidents are not uncovered because the Whitten internal investigator is not to be trusted. In fact, she indicated that she trusts the Whitten abuse investigator "as far as she can throw him."[13]/ The parent implied that the Whitten facility director, Judy Johnson, may aid in covering up the truth. The parent said that the director "talks out of both sides of her mouth" and that she "tells parents what they want to hear regardless of the truth."[14]/

Neglect

It is clear that the staff at Whitten subject the residents to neglect. For example, on a recent site visit by Title XIX surveyors, they found that for over an hour, no staff intervened to assist one Whitten client who had urinated in her pants.[15]/

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[7]/ State Title XIX survey conducted for the Health Care Financing Administration ("HCFA Survey"), March 19, 1993, at 31.

[8]/ Id.

[9]/ Id.; HCFA Survey, June 16, 1993, at 17.

[10]/ HCFA Surveys, August 26, 1993, at 6, March 17, 1994, at 1.

[11]/ Letter from the South Carolina Protection & Advocacy System for the Handicapped, Inc. ("P&A Letter"), Sharon Bellwood, Regional Coordinator, Genia Batson, Institutional Advocate, Mary Barr Behlke, PAIMI Advocate, June 7, 1994 at 2.

[12]/ Telephone interview with Jean Shirley, September 14, 1994.

[13]/ Id.

[14]/ Id.

[15]/ HCFA Survey, June 16, 1993, at 7.

Staff also neglected to intervene to stop one female resident who had been repeatedly hitting her head on her knee.[16]/ Similarly, staff failed to intervene to assist a blind client who was sitting on a couch hollering and hitting himself for ten minutes.[17]/ The surveyors found that the staff allowed many residents to leave the dining area with food on their mouths and faces.[18]/ The staff also subject the Whitten residents to neglect by leaving them to sit for prolonged periods of time unengaged in any purposeful activity. On one of their recent visits, the surveyors observed the following during the day: clients not actively engaged in specified activities, clients sleeping in wheelchairs or in regular chairs, and clients sitting or laying by themselves.[19]/ One staff member was smoking outside leaving the residents unengaged.[20]/

The facility neglects to provide a sanitary environment for its residents. For example, on a recent visit, surveyors noted full urinals, commodes with unflushed feces, and dirty clothes with bad odors.[21]/ Staff made no effort to clean or disinfect a chair where one client had been sitting with urine soaked pants.[22]/ On a more recent visit, surveyors noted one client sitting in urine which had seeped down her legs and saturated her socks.[23]/ A staff member discarded the socks in the hamper, but then dispensed evening snacks without washing her hands.[24]/

B. The State Fails to Provide Whitten Residents with Adequate Medical Care.

The P&A group expressed great concern about the large number of recent deaths at the facility. The group indicated that "[d]uring the past month or so there have been approximately ten

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[16]/ Id.

[17]/ Id.

[18]/ Id.

[19]/ HCFA Survey, March 19, 1993, at 24.

[20]/ Id.

[21]/ Id. at 32.

[22]/ Id.

[23]/ HCFA Survey, September 24, 1993, at 15.

[24]/ Id.

deaths at Whitten."[25]/ They added "some of these deaths were totally unexpected."[26]/ One parent characterized some of the deaths as "out of the blue."[27]/ These comments are troubling and imply deficient medical care. This parent believed that more Whitten residents have died in the first six months of 1994 than the total number who died in all of 1993.[28]/

This parent indicated that the physician to client ratio is poor at Whitten. She believed there were only four doctors on staff to care for about 800 residents -- about a 1:200 ratio.[29]/ This ratio is well outside any acceptable limits. She also believes that Whitten does not provide the many epileptic individuals with the services of a consult neurologist.[30]/ She said that her son is epileptic, and yet, she is forced to transport him to a neurologist off-site.[31]/

Surveyors enforcing the Title XIX regulations have repeatedly cited Whitten for its failure to provide adequate preventive and general medical care for its residents. For example, the facility program team did not address the diagnosis of degenerative arthritis for one resident for either prevention or general care.[32]/ In another instance, a resident who was initially described as being hearing impaired and is listed as being deaf, has not had an audiological test in five years.[33]/ Two residents without a plan for alternate positioning have experienced skin breakdown from their inability to adjust their bodies independently.[34]/

Many of the cited medical deficiencies center on feeding or on the provision of meals and mealtime services to the residents. For example, during the swallowing assessment of one Whitten

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[25]/ P&A Letter, June 7, 1994, at 2.

[26]/ Id.

[27]/ Telephone Interview with Jean Shirley, September 14, 1994.

[28]/ Id.

[29]/ Id.

[30]/ Id.

[31]/ Id.

[32]/ HCFA Survey, September 17, 1992, at 14.

[33]/ Id.

[34]/ Id.

resident, an outside consultant recommended that the resident be provided with oral motor exercises to decrease his tongue thrust. The consultant recommended that the exercises be performed by a competent therapist with a goal to enable the client to swallow small bites of food. However, Whitten completely failed to follow up on the recommendation.[35]/

Facility staff present at mealtimes provide little prompting to self-feeders.[36]/ For example, the surveyors observed that clients stuff large amounts of food in their mouths at one time.[37]/ This is potentially dangerous. Clients who had been assessed as being independent in dining skills, were allowed to use their spoons inappropriately.[38]/ The surveyors also noticed that some clients were allowed to eat with their fingers and to eat off the tables and off their bibs.[39]/

The facility staff does not always observe strict dietary orders for certain residents. For example, staff have fed diabetic individuals foods that do not comport with their dietary orders.[40]/ In addition, staff fed a resident on a low salt, 1800-calorie diet a full bag of potato chips.[41]/ The facility also fails to coordinate weight reduction diets with plans for exercise. Some clients who are on weight reduction plans have actually gained weight. For example, one client, whose ideal body weight is 95-115 lbs., currently weighs 220.50 lbs.[42]/

Surveyors found that some clients never leave their wheelchairs despite a physical therapy recommendation to the contrary. For example, the facility ignored a physical therapist's recommendation that one client be taken out of his wheelchair regularly. As a result, this client's legs have turned blue and cold to the touch.[43]/ Another client was to be out of his wheelchair every third hour, yet, the staff indicated

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[35]/ HCFA Survey, March 17, 1994, at 8.

[36]/ Id.

[37]/ HCFA Survey, June 16, 1993, at 7.

[38]/ HCFA Survey, March 19, 1993, at 25.

[39]/ HCFA Survey, June 16, 1993, at 7.

[40]/ HCFA Survey, June 30, 1993, at 13.

[41]/ Id.

[42]/ Id.

[43]/ HCFA Survey, September 24, 1993, at 7.

that they were unaware of this order.[44]/ In fact, the surveyor observed that the client never left his wheelchair.[45]/

C. The State Fails to Ensure Appropriate Use of Psychotropic Medication at Whitten.

Chemical restraints are unduly utilized at Whitten Center.[46]/ The facility fails to ensure that prior to the use of more intrusive techniques that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.[47]/ For example, the facility increased one client's medications without attempting other less restrictive interventions to control his behavior.[48]/

In March 1993, the Title XIX surveyors noted that the facility had attempted no reduction of the behavior modifying medication for one resident since February of 1990 -- over three consecutive years.[49]/ The unsuccessful reduction in 1990 was attempted with no other accompanying revisions to the client's program plan.[50]/ The surveyors discovered that for another client, the facility provided no indication of systematic programmatic intervention between the discontinuation of Lithium and the implementation of Tegretol to assure success of the attempted medication change.[51]/ One resident with extreme attention getting behavior was seen by the hospital staff on three different occasions, approximately two weeks apart, for emergency suturing from self-inflicted wounds for more than fifty-five sutures.[52]/ The resident's dosage of Mellaril had been increased three times in four months but the incidents had increased in severity with no programming intervention.[53]/

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[44]/ Id. at 5.

[45]/ Id.

[46]/ HCFA Survey, September 24, 1993, at 11.

[47]/ HCFA Survey, June 30, 1993, at 11.

[48]/ Id.

[49]/ HCFA Survey, March 31, 1993, at 2.

[50]/ Id. at 3.

[51]/ HCFA Survey, September 24, 1993, at 4.

[52]/ HCFA Survey, August 10, 1992, at 6.

[53]/ Id.

Moreover, after one resident had been chemically restrained, the facility failed to convene the IDT within one working day, pursuant to facility policy.[54]/ Furthermore, the facility psychologist was only vaguely aware of the incident leading up to the restraint.[55]/

D. The State Fails to Provide Adequate Programming to Whitten Residents.

Restraint

Mechanical and physical restraint use appears to be common at Whitten.[56]/ Whitten staff frequently use various forms of restraint as a convenience instead of as a means of aiding the resident.[57]/ Whitten currently employs the papoose chair and other forms of restraint including masks, a full-bed, four-point restraint and a bed-net restraint.[58]/ Surveyors found that staff used restraint as a substitute for active treatment programs.[59]/ For example, one client's behavior support plan indicates that if staff suspect that the client is about to bite someone, he is to be placed in "full face mask and helmet."[60]/ When the face mask was used after a biting incident, the facility psychologist did not even attend the meeting that discussed the procedure.[61]/ Surveyors found that another resident had been placed in a papoose chair six times since his admission only a

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[54]/ HCFA Survey, September 24, 1993, at 11.

[55]/ Id.

[56]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[57]/ Id.

[58]/ Id.

[59]/ HCFA Survey, August 26, 1993, at 23. Staff behavior also exacerbates problematic situations. For example, the surveyors noticed that one client had been hollering and yelling for over an hour. In attempting to redirect the individual, the staff told her that if she did not stop, she would be restrained. However, the behavior program only directed staff to speak to her in a calm, low voice. HCFA Survey, June 16, 1993, at 13.

[60]/ HCFA Survey, August 26, 1993, at 24.

[61]/ Id.

few months earlier.[62]/ However, his behavior management program did not address the use of the chair, and after each use of the chair, his program was not revised.[63]/ Surveyors noted that because another client's verbal aggression and self-abuse increased, the staff felt compelled to restrain the resident.[64]/ A local advocate observed that Whitten employs the papoose chair inappropriately to teach.[65]/ Surveyors observed staff put one client in the papoose chair even though they never contacted the client's physician to get approval for the restraint.[66]/

Behavior Programs

Whitten fails to provide the professional program services and needed interventions necessary to implement successfully the active treatment programs defined on each resident's individual program plan.[67]/ Whitten's failure to adequately provide program services and needed interventions has been documented in eleven separate surveys from 1992 to the present.[68]/

This is having a very real and negative effect on the Whitten residents. For example, Title XIX surveyors recently found residents with PICA behavior outside picking up debris and putting it in their mouths.[69]/ They also observed another client sit unengaged for thirty minutes during which time she bit

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[62]/ Id. at 11. A papoose chair restraint involves placing a large strap over the chest and across the legs of a seated individual. Sometimes this restrictive procedure can be used for as long as an hour and a half. Telephone Interview with Jean Shirley, September 14, 1994.

[63]/ HCFA Survey, August 26, 1993, at 1.

[64]/ Id.

[65]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[66]/ HCFA Survey, June 16, 1993, at 19.

[67]/ HCFA Surveys, March 19, 1993, at 23, May 14, 1992, at 5-7, September 24, 1993, at 8.

[68]/ HCFA Surveys, January 31, 1992, May 14, 1992, May 22, 1992, August 10, 1992, September 17, 1992, March 19, 1993, June 16, 1993, July 29, 1993, August 26, 1993, September 24, 1993, and March 17, 1994.

[69]/ HCFA Survey, September 24, 1993, at 8-9.

her hand three times and twirled her head thirteen times.[70]/ On another visit, the surveyors observed one client biting her hand, but noticed that the staff did not redirect her into an activity nor hand her an object to manipulate as stated in her behavior program.[71]/ They observed that staff did not verbally correct or redirect another resident's repeated hand mouthing behavior even though this was specified in the client's behavior program.[72]/ Staff did not redirect another client who was constantly tugging and pulling at a surveyor's tie.[73]/ The surveyors found that in one year, another resident had engaged in 27 different episodes of physical aggression towards staff or other clients, and yet, the staff never intervened.[74]/

As a result, the Whitten residents are subjected to injuries from their own behaviors or from the behaviors of others. One local advocate reported that in her visits to Whitten, she routinely notices scratches, bruises and occasionally bite marks on the residents.[75]/ She also indicated that injuries from falls are quite common.[76]/

The attitude of the staff towards programming is troubling. For example, a staffer commented in front of a client, "He's not on a program for PICA. He's too low level for a program."[77]/ There is no one who is too "low level" for a program. Anyone can benefit from programming. This comment, therefore, was not only inconsiderate, it was also grossly inaccurate.

The P&A group indicated that Whitten males with "sexual acting out problems" are provided "no counseling ... in order to help with their needs."[78]/ The facility fails to provide individuals with deviant sexual behaviors with adequate

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[70]/ Id.

[71]/ HCFA Survey, March 19, 1993, at 23.

[72]/ HCFA Survey, June 16, 1993, at 13.

[73]/ Id.

[74]/ Id. at 8.

[75]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[76]/ Id.

[77]/ HCFA Survey, March 19, 1993, at 31.

[78]/ P&A Letter, June 7, 1994, at 2.

programming, qualified psychology staff or proper implementation of whatever programs are in place.[79]/

Training Programs

The facility is failing to promote the growth, development, and independence of the clients.[80]/ The facility is failing to ensure that individual program plans include opportunities for client choice and self-management.[81]/ For example, the facility has chosen to keep certain verbal residents in diapers. This impedes their growth and independence.[82]/ The facility has denied communication devices to other residents who could achieve greater independence and self-management with such devices.[83]/ Staff fail to reinforce sign language training with the Whitten clients.[84]/ Surveyors observed one client, who was on an objective to change into fresh clothing on a daily basis, wearing the same clothes throughout the survey.[85]/ Staff also open containers and other sealed items for clients instead of allowing them to do it.[86]/ Staff pour drinks for the clients and they fail to encourage or assist them to pour their own drinks.[87]/ The surveyors also noted that the facility staff missed many opportunities to reinforce independence already gained and reinforce on-going training as identified in the individual program plan.[88]/

The facility fails to ensure that written training programs are actually implemented. For example, Title XIX surveyors found that one client performed the same task repetitively for over an

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[79]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[80]/ HCFA Surveys, June 16, 1993, at 17, June 30, 1993, at 1, July 29, 1993, at 3, September 24, 1993, at 3, 12.

[81]/ HCFA Survey, March 17, 1994, at 5-6.

[82]/ Id. at 6.

[83]/ Id.

[84]/ HCFA Survey, September 24, 1993, at 9.

[85]/ Id.

[86]/ HCFA Surveys, March 19, 1993, at 31, June 16, 1993, at 17, September 24, 1993, at 12.

[87]/ HCFA Surveys, June 16, 1993, at 17, Sept. 24, 1993, at 12.

[88]/ HCFA Surveys, March 19, 1993, at 25, August 25, 1993, at 16.

hour despite having performed it correctly the first time.[89]/ Later, he sat doing nothing for thirty minutes instead of completing tasks as provided in his program. Apparently, the client had been working with the same program for the past five years with little progress.[90]/ Staff revealed that they were unaware of his and other clients' residential training objectives and behavior management program targeted behaviors and interventions.[91]/

The facility is failing to adequately review and revise individual program plans where the resident is failing to progress towards identified objectives after reasonable efforts have been made.[92]/ Some individuals have been kept on programs for months with no progress and no revision by the facility.[93]/ Surveyors found clients who had made no progress for five to six months on their residential training objectives, and yet, staff did not make any revisions to the clients' programs.[94]/ After no progress is made, staff often discontinue the objective entirely instead of revising it to achieve success.[95]/

In addition, the facility is failing to revise individual program plans as necessary when an individual has successfully completed an objective identified in the individual program plan.[96]/ For example, the surveyors noted that one client who had succeeded in independently washing his face was placed on another program to wash his face.[97]/ Other clients met program objectives to brush their teeth, drink from a cup, and take a bath, and yet, no revisions were made in their programs.[98]/

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[89]/ HCFA Survey, March 19, 1993, at 4.

[90]/ HCFA Survey, March 19, 1993, at 4.

[91]/ Id.; Surveyors found that staff were repeatedly not aware of the details of important client programs. HCFA Survey, August 26, 1993, at 3-4, 9-12.

[92]/ HCFA Survey, March 17, 1994, at 11-2, 29.

[93]/ Id. at 12.

[94]/ HCFA Survey, June 16, 1993, at 16.

[95]/ HCFA Survey, March 19, 1993, at 30.

[96]/ Id. at 28-29.

[97]/ Id.

[98]/ Id.

independence.[100]/ Often, staff feed the residents themselves instead of implementing their program by providing hand over hand assistance.[101]/ Surveyors noticed staff failing to provide training during the course of all meals observed.[102]/

Even for residents provided with training programs, the facility often fails to provide the direct care staff with the necessary methodology to actually implement the programs.[103]/ This has adversely affected individual residents' speech, ambulation, washing, brushing and dressing objectives.[104]/ The facility does not ensure that the staff are provided with current copies of the clients' training programs.[105]/

E. The State Fails to Provide Adequate Staff to Meet the Needs of the Whitten Residents.

The local advocacy group in South Carolina characterized Whitten as a "large facility, located in a rural area, with a limited draw for staff."[106]/ The P&A stated that some of the problems at Whitten are directly caused by "not enough direct care staff."[107]/ The P&A stressed that the "quality" of the staff was problematic in that "[m]ost have very limited 'people' skills, even after their required on job training."[108]/ A Whitten parent also expressed concerns about inadequate numbers and quality of staff at the facility.[109]/ She indicated that staff often do not show up for work, causing other staff to be "pulled" from other units to meet staffing ratios. She indicated

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[100]/ Id.

[101]/ Id. at 23-4.

[102]/ HCFA Survey, September 24, 1993, at 8.

[103]/ HCFA Surveys, March 19, 1993, at 3, June 30, 1993, at 7.

[104]/ HCFA Survey, March 19, 1993, at 3.

[105]/ HCFA Survey, June 16, 1993, at 12.

[106]/ P&A Letter, June 7, 1994, at 1.

[107]/ Id.

[108]/ Id.

[109]/ Telephone Interview with Jean Shirley, September 14, 1994.

staff often do not show up for work, causing other staff to be "pulled" from other units to meet staffing ratios. She indicated that this is a problem because the pulled staff are often unfamiliar with the residents they are to care for.[110]/

The surveyors noted that the facility is failing to provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. As a result, clients are left unattended while staff assisted wheelchair clients in bathing and toileting.[111]/ Staff are forced to hold, chase, and corral clients with challenging behaviors.[112]/ The surveyors noted that staff were so busy "catching and corralling" clients that behavioral data was not recorded. The psychologist responded that there was "nothing" he could do.[113]/ Staff were unable to engage clients in meaningful activities or to document the behaviors that were occurring because of the severity and frequency of interfering behaviors.[114]/

F. The State of South Carolina Fails to Provide Whitten Residents with Services in the Least Separate, Most Integrated Setting.

An isolated, self-contained, institutional environment which separates residents from the rest of society on the basis of their disabilities, necessarily subjects these individuals to conditions which are violative of the ADA and Section 504. Whitten is the largest such institution in the state, currently housing approximately 800 individuals with developmental disabilities. One local advocate indicated that most of these individuals should be placed in the community.[115]/

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[110]/ Id. This is exactly what the surveyors have found on their visits. Staff are pulled from other units and are forced to care for unfamiliar residents simply because of staff shortages. As a result, the pulled staff are totally unaware of the clients' individual programs or needs. HCFA Survey, March 19, 1993, at 24.

[111]/ HCFA Survey, March 19, 1993, at 12.

[112]/ Id. at 12.

[113]/ Id. at 11, 26.

[114]/ Id. at 13.

[115]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

CONCLUSION

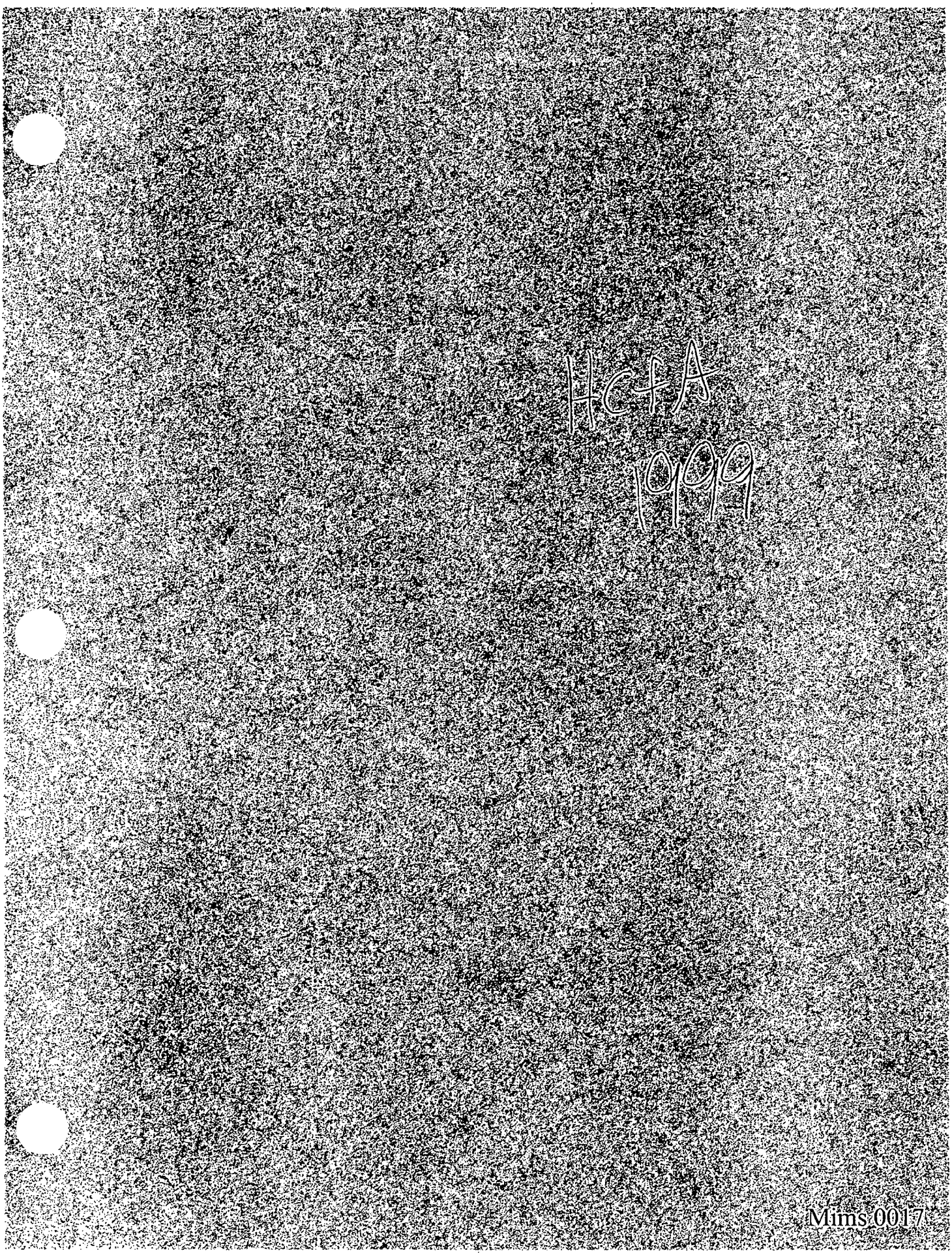
The information gathered thus far indicates that the inadequate conditions at Whitten deprive residents of their constitutional and statutory rights. We therefore recommend that an investigation of Whitten be instituted under our CRIPA authority. Funds are available to conduct this investigation.

Approved: _____

Disapproved: _____

Comments:

Mims 0016


HCFA
1999
Mims 0017

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Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration – Region IV

Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

November 30, 1999



J. Samuel Griswold, Ph.D.
Director
Department of Health and Human Services
State of South Carolina
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: George Maky

Dear Dr. Griswold:

Enclosed is the final compliance report for South Carolina's Home and Community Based Waiver for Individuals with Mental Retardation and Related Disabilities (#0237.90). The Department of Health and Human Services comments dated June 30, 1999, and the Department of Disabilities and Special Needs comments dated July 26, 1999, have been incorporated into the report.

We agree the corrective actions taken in response to our findings, revised to include our final responses will address the cited concerns and improve the waiver program. Please include an update on the progress of corrective action and results of monitoring with the renewal package for the waiver.

Please express our appreciation to your staff for the assistance provided during our review. We wish you continued success with your waiver program. If there are any questions, please contact Terrie Morris at (404) 562-7414.

Sincerely,

Eugene A. Grasser,
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosure

cc: Mary Jean Duckett / CO

FILE: FL / HCBW #0237.90 / compliance review

Mims 0018

SOUTH CAROLINA HOME AND COMMUNITY BASED WAIVER FOR INDIVIDUALS WITH MENTAL RETARDATION AND RELATED DISABILITIES

COMPLIANCE REVIEW

Conducted by:

Terrie Morris and Roberta Kelley
Medicaid Operations Branch

Mims 0019

INTRODUCTION

South Carolina was granted a waiver of Section 1902(a)(10)(B), "amount, duration, and scope requirements," of the Social Security Act in order to provide home and community based services to individuals who would otherwise require institutionalization in an intermediate care facility for the mentally retarded. The current effective period of this waiver is October 1, 1994 through September 30, 1999.

The mandatory compliance review is the principal mechanism for monitoring the home and community based program. The compliance review consists of the following elements:

Element A - Eligibility and Post-Eligibility Treatment of Income and Resources
Element B - Plans of Care and Provider Qualifications
Element C - Evaluation of Need Processes
Element D - Beneficiary Due Process, Informing and Freedom of Choice Protections
Element E - Administration and Management

The scope of our review included:

(1) Desk review of the approved waiver.

(2) Interviews with State staff (Department of Health and Human Services and Department of Disabilities and Special Needs).

(3) Interviews with waiver clients and day habilitation staff.

(4) Review of 20 individual case records, plans of care, level of care evaluations, documentation of recipients informing, eligibility files and recipient payment history files.

(5) Review of waiver provider agreements and subcontracts.

(6) Review of client / provider complaint files.

Mims 0020

SOUTH CAROLINA HOME AND COMMUNITY BASED WAIVER
FOR INDIVIDUALS WITH MENTAL RETARDATION AND RELATED DISABILITIES

ELEMENT A — TARGETING, ELIGIBILITY AND POST-ELIGIBILITY TREATMENT OF INCOME

Eligibility

Assure that the State properly offers waiver services to one or more of the categorically, optional categorically (these are individuals who the State, at their option, determines eligible for services; e.g., special income) and the medically needy (42 CFR 435 and 441.301(b)(3)). For an eligibility group to be included under the waiver, it must be included under the State plan.

Factor A1: Do the individuals who are receiving home and community based services fall into one of the eligibility groups or target groups specified in the State's approved waiver (42 CFR 441.301(b)(3))?

Finding: The approved waiver stipulates that in order to receive waiver services, individuals must be eligible under a categorically needy or optional categorically needy group or the HCBW group under 42 CFR 435.217. Each case reviewed contained documentation that the client was eligible under one of the categories specified in the approved waiver.

Factor A2: If applicable, determine if the State is properly applying the spousal impoverishment eligibility rules.

Finding: This factor is not applicable.

Post Eligibility Treatment of Income and Resources

All home and community based waiver beneficiaries found eligible under section 42 CFR 435.217 are subject to the post-eligibility calculations. Assure that the State follows the procedures in 42 CFR 435.726, 435.735 and section 1924 of the Act, as applicable, in applying the post-eligibility calculations for individuals found eligible under the special home and community based waiver eligibility group specified at 42 CFR 435.217.

The post-eligibility rules at 42 CFR 435.726 apply to SSI States and the post-eligibility rules at 42 CFR 435.735 apply to 209(b) States.

For individuals with a community spouse, if the State elects to use the spousal impoverishment eligibility rules, the State may also elect to use the spousal impoverishment post-eligibility rules specified at 1924 of the Social Security Act. If a State chooses not to use the spousal impoverishment post-eligibility rules, it must use the post eligibility rules specified at 42 CFR 435.726 or 42 CFR 435.735.

Finding:

The State has procedures in place to calculate post eligibility for individuals eligible under the special income and HCBW groups. However, the maintenance needs allowance approved for this waiver is an amount equal to the maximum amount allowed by Federal law to be retained by a community spouse of an institutionalized individual, not to exceed the income eligibility limit. Since this amount is equal to or greater than the income allowed for an individual to become eligible under 42 CFR 435.217, there are no circumstances under which an individual receiving services under this waiver would have a recurring income subject to the requirements of 42 CFR 435.726. Therefore, Factors related to post eligibility are deemed met.

ELEMENT B PLANS OF CARE AND PROVIDER QUALIFICATIONS

Factor B1:

Assure that the State has in place a formal system to monitor quality of care and access to care by which it assures the health and welfare of the beneficiaries (42 CFR 440.260, 441.302(a), and 441.303(a)).

Finding:

South Carolina's Division of Quality Assurance is responsible for conducting a review of waiver monitoring by the Regional Department of Disabilities and Special Needs. The last review was performed in the Fall of 1998. We found that the State of South Carolina has met the above assurance of monitoring as required by 42 CFR 440.260, 441.302(a), and 441.303(a). However, we do have an outstanding concern regarding the frequency of the reviews since we could not find documentation on when the previous review was performed.

The extent of the QA review was limited to plans of service, documentation, and monitoring of services. While these areas are vital in assuring quality for waiver recipients, other components of the program, such as level of care certification, provider agreements / contracts, free choice of providers and reimbursement for waiver services, are equally as important in monitoring quality and access to care.

Recommendation: Through training and/or written instructions, South Carolina should ensure that individuals responsible for monitoring the waiver program understand and adhere to the appropriate timeframes and documentation procedures to ensure full compliance with Federal regulations. The scope of review should be expanded to include all areas of the waiver program.

State's Response: The response to this Factor is twofold: DDSN's internal contract compliance reviews and the independent Medicaid-approved Quality Assurance system.

DDSN has revised its Quality Assurance used to monitor the MR/RD Waiver with a contract compliance review to be effective August 1, 1999. The waiver requirements and other indicators of compliance were completely reviewed and revised as needed to assure that all requirements and indicators were included, clearly stated, and measurable. The scope of the review has been expanded to include all areas of the waiver program. The staff who will conduct the reviews will be provided with specific training regarding the requirements and indicators, the process used to conduct a review, and how to effectively communicate the findings to providers. The Medicaid agency will review and prior approve all waiver training materials. The process for conducting reviews has been revised to enhance their ability to identify and correct deficient areas. These revisions include increases in the number of records reviewed, inclusion of specific criteria used in selecting recipients for review so that a wider variety of recipients is included in the chosen sample, improvements in the communication of review findings, requirements for corrective action plans when compliance is not achieved, follow-up reviews to assure corrective actions are taken, and sanctions when corrections are not made. The Medicaid agency will work with DDSN to ensure oversight of this revised review system.

In addition, the Medicaid agency will ensure that comprehensive monitoring of the waiver is completed through a fully revised and expanded independent QA system. This system will identify and address the quality issues specific to level of care, service planning, appropriateness of waiver services and freedom of choice of providers. The monitoring will include regular on-site visits at each DSN Board to review a statistically valid sample of client records for all service coordinators managing waiver caseloads. The attached preliminary independent Medicaid QA system (Attachment I) further elaborates the revised quality assurance system. Any substantive changes will be reviewed with the HCFA Regional Office.

Mims 0023

HCFA's Response: The Medicaid QA System should include a monitoring component for reimbursement of services. The system should also allow for review of implementation of plans of correction prior to the next scheduled review, if deemed necessary.

Factor B2: Assure that the plans of care are adequate to safeguard the health and welfare of waiver beneficiaries by specifying the provision of necessary waiver and non-waiver services (42 CFR 441.302(a)).

Finding: Based on our review, we found several deficiencies regarding plans of care, hereafter referred to as the plan of services (POS), development and monitoring. Below is a summary of the issues:

(1) The POS included services to be provided and reimbursed through the waiver program that were not covered under the waiver. The general conclusion drawn was that service coordinators used interchangeable terminology for a single service. For example, adult day program was used interchangeably with day habilitation; day habilitation included activities related to prevocational employment; and job coach services were referred to as supported employment. Some cases included discussions about employment plans and training objectives for vocational programs. These activities are not allowable under Medicaid.

Service coordinators, as well as direct service providers, appeared to lack a comprehensive understanding of service definitions and their content as approved under the waiver.

(2) Waiver services were not properly justified in the plan of care. Furthermore, in some cases the waiver services rendered were in direct contradiction to the recipient's wishes. Below are several examples:

- A 72- year old male diagnosed with severe MR and dementia receiving day habilitation services.
- Recipient diagnosed with catatonic schizoplrenia received day habilitation and prevocational habilitation.
- Purchase of closed caption equipment as specialized medical equipment.

(3) Additional needs identified were not always addressed in POS. Service coordinators appeared to be unaware of resources outside of the Department of Disabilities and Special Needs (DDSN) and were often dependent on the client's family for information on services available under Medicaid. Many cases cited the need for dental services, eye examinations, and behavioral health services, but there was no record of any referral activity by the service coordinator.

(4) Plans of service often did not properly identify waiver services, frequency, duration, or providers as required by Federal regulations. In some cases POS were not updated timely.

Recommendation: The State should crossmatch POS, services actually provided and definitions specified in the approved waiver to determine whether: (1) the activities provided and claimed were allowable; and (2) issues identified through individual assessments or monitoring activities were addressed through the POS. Training should be provided to assure that all waiver providers understand and adhere to definitions specified in the approved waiver. The training for service coordinators should include reviews of fundamental policies pertaining to the documentation required for plans of service. Payments made for the provision of activities or services not included in the approved waiver should be recouped.

State's Response: By crossmatching plans of service, the services provided and service definitions, the Medicaid agency Office of Internal Audits will conduct a review of the cases in the compliance review sample to determine if payments were made for the provision of activities or services that were not included in the approved waiver. Recoupment will be made of the federal portion for any payments determined unallowable.

By October 1, 1999, Service Coordinators and supervisory staff will receive training on referring and authorizing waiver services, including appropriate documentation, and proper assessment for the need for services, including the amount, frequency and duration of services in the plan. This training will be conducted by staff members of DDSN. In addition to the training, updated procedural manuals will be provided to all service coordinators by October 1, 1999. In the future DDSN will begin upgrading their automated computer system to include "on-line" planning. This improved automated system, which should be completed by FY 01-02, will

also assist in identifying plans that are due for update, thus preventing plans from expiring. DDSN has also created a new planning document that will aid service coordinators in evaluating and documenting needed services. Furthermore, the revised system used to monitor the MR/RD Waiver includes an indicator to assess whether the plan and services provided were appropriate and allowable.

Along with the training and revised planning document, DDSN has adopted the person-centered planning philosophy which requires the use of an external facilitator in the development of the plan to assure that all needs are identified and addressed when planning. The person-centered planning philosophy stresses the recipient's right to make choices and have his/her choices honored. The role of the external facilitator in planning includes ascertaining the needs of the recipient, assisting as needed in expressing those needs to the professionals involved, and assuring that those needs are honored to the greatest degree possible.

In addition to the previously discussed training, service coordinators and their supervisors will receive technical assistance regarding the resources available in their area as well as written information regarding resources that are available statewide. Prior to implementation the Medicaid agency will review and approve all waiver training materials to assure a consistent and comprehensive presentation.

DDSN's Response:

(1) One specific example (A. McDuffie) noted that interchangeable terminology was used with Adult Education and Day Habilitation. Record review revealed that Adult Education was provided by the school (see attachment at B2).

(2) Review related to the examples of concern to HCFA related to interchangeable terminology revealed that the activities/services provided did meet definition of a waiver service. Terms were not correctly or consistently used; however, a service was provided as defined in the approved waiver.

(3) For the specific examples noted, the records show specific information was included. (See "Waiver Services-Needs" for A. McDuffie, H. Hess at B2).

(4) While we agree with the finding that needs were not

appropriately justified in the plans reviewed, we are concerned with the examples noted in Factor B2 (2) of the report. The first example states "a 72-year old male diagnosed with severe MR and dementia receiving habilitation". Since the definition in the waiver for day habilitation includes "assistance with the retention of self help and adaptive skills" and "enabling the person to maintain his or her maximum functional level" and the plan for this person indicates that assistance was provided in the maintenance of present adaptive skills, socialization skills and learning to manage his behavior, the specific HCFA issue is not clear. Moreover, the level of care criteria for waiver eligibility specifically includes an indicator for needed services to prevent or decelerate regression or loss of current optimal functional status. (See attachment at B2. – Interdisciplinary Team Review for H. Hesse.)

(5) In the final example, the purchasing of closed captioning equipment is questioned. In the waiver, the service is named Specialized medical equipment, supplies and assistive technology. The definition states that "devices, controls, or appliances which enable the recipient to perceive, control or communicate with the environment in which they live" can be funded. Obviously for someone who is deaf, closed captioning equipment enables her to perceive her environment.

(6) Additionally, one example noted that the "POS was not developed/updated timely". A review of the record showed that the plan was updated annually as required. (See Plans of Service for T. Foster dated 1/9/95, 1/5/96, 1/5/97 and 1/5/98 at B2.)

Factor B3: Assure that the services specified in the plans of care necessary to safeguard the health and welfare of the waiver beneficiaries were provided and that waiver beneficiaries have access to appropriate services when needed.

Finding: (1) In many of the cases reviewed, POS development and/or updates did not appear to be based on the needs of the client. Sampled cases provided evidence that development of POS often was "budget driven." Many of the case notes specified aggregate per capita allowances for a specified period of time.

(2) For some cases the needs and service recommendations were not differentiated from the identified "objectives." In these cases, the needs identified were merely summaries of objectives stated in other sections of the plan or the needs section included statements advising to, "see service notes."

(3) The following examples illustrate cases containing documentation of specific incidents which appeared to require further action, but did not include corresponding POS updates or documentation of final resolution.

- Case notes in one record discuss the client having significant problems with bladder control. However, the POS remained the same and indicated "no needs." On this same case, the recipient payment history file indicated that the client was seen in the emergency room. Case notes recorded on the day following the ER visit and future notes, reported "no health problems."

- In one case, notes and service evaluations reported that, not only did it appear that the client was not benefiting from the waiver service, the client had shown significant and consistent regression. In spite of this documented regression, the POS remained unchanged.

- In another case, the notes and POS did not identify health problems needing to be addressed. However, the payment history file showed several claims indicating the client had cardiovascular surgery.

Recommendation: As required by the approved waiver, the State should review plans of service to determine appropriateness and adequacy of services and to ensure that services furnished are consistent with the nature and severity of the individual's disability. Although cost effectiveness is required under Federal regulations, the training recommended in Factors above should emphasize the importance of designing plans to address the needs of the client and avoid the "cookie cutter" approach based on maximum units per person.

State's Response: DDSN's newly created planning document along with its adoption of the person-centered planning philosophy, including the use of external facilitators in planning, will improve the identification of all needs, services and actions to address those needs. Service coordinators have been trained and provided with written training

materials related to the use of the planning document and person-centered practices.

Training will be provided to service coordinators stressing the importance of planning that addresses all of a recipient's needs. This requirement is now part of the revised system for monitoring that was outlined in B1 and will be routinely monitored by DDSN and the Medicaid agency.

In addition, the independent Medicaid QA system will review plans of service to determine timeliness, appropriateness, adequacy of services, and to ensure that services furnished are consistent with the nature and severity of the individual's disability. The Medicaid agency shall ensure staff training emphasizes the importance of designing plans to address the needs of the individual.

Finding B4: Assure that waiver services are provided by qualified providers (42 CFR 441.302(a)(1)).

Finding: The approved waiver specifies licensure and/or certification for providers of waiver services. For those providers that are not required by the State to undergo a formal licensure or certification process, the State has established separate standards. Our review of provider enrollment procedures, service agreements and interviews with State Medicaid and DDSN staff confirmed that the State followed procedures for verification of licensure and certification requirements and all other provider standards.

Factor B5: Assure that board and care facilities covered by Section 1616(e) of the Act in which the HCBW services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR, Part 1394 for board and care facilities (42 CFR 441.302(a)(3)).

Finding: The State has established and implemented standards for 1616(e) facilities. State staff conduct on-sight visits to all such facilities on a periodic basis to ensure that facilities are in compliance with statutory requirements.

ELEMENT C EVALUATION OF NEED PROCESSES

Assure that the State performs and uses individual evaluations and periodic reevaluations of need, which meet regulatory requirements, to assure that waiver services are furnished only to those individuals who would, in the absence of waiver services, require the level of

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care provided in a hospital, NF, or ICF/MR as defined in 1919(a) of the Act, 42 CFR 440.10, 440.40 and 440.150 (42 CFR 441.302(c) and 441.303(c)).

Factor C1: Does the State provide an individual evaluation and reevaluation of the need for the required level of care for each eligible beneficiary for whom there is a reasonable indication that such services may be needed in the near future but for the availability of home and community based services (42 CFR 441.302(c))? Does the State, in fact, use the results of the evaluation / reevaluation in its level of care determination(s)?

Finding: Based on the information in case records, it does not appear that need for institutional care could be substantiated for all clients. While each client had a confirmed diagnosis of mental retardation or related disability, in many of the sampled cases, there did not appear to be a reasonable indication that institutional services would be needed in the near future.

In some cases the assessments stated that the individual was independent in most ADL's and fell into the mild or moderate range of mental retardation. However, the LOC certification and payment history files for these clients indicated severe mental retardation as the diagnosis.

Many of the sampled records included case notes with statements such as, "the client must meet MR to be eligible for waiver services," or "the client needs to have LOC certification to continue waiver participation." While these statements alone are technically correct, it appears that they are placed in the case record to lead the evaluator. Taken in conjunction with other information in the records, in some cases approval of LOC reevaluations appeared to be automatic to allow the client to continue waiver services rather than a valid review of the needs of the client.

Recommendation: State Medicaid and DDSN staff should review the assessment tools and the evaluation process to assure that: (1) procedures accurately identify and document the need for institutional care; (2) performance of evaluations / reevaluations is in accordance with approved methodology; and (3) determinations made through the evaluation process are accurately reflected on certification and billing forms.

Further, ongoing training should be provided to individuals performing evaluations to ensure an understanding and adherence to

the objectives and requirements of the waiver program.

State's Response: The Medicaid agency and DDSN shall fully review the ICF/MR level of care assessment tools and evaluation process to assure that the procedures accurately identify and document the need for institutional care and the performance of evaluations/reevaluations are in accordance with the approved methodology. The independent Medicaid QA system will address the timeliness and quality of LOC determinations by reviewing waiver case records. Any cases with questionable LOC determinations will be referred back to the individual(s) who made the determination for a written explanation to be submitted to the Medicaid-approved QA. If further review is warranted, the case will be referred to a Medicaid contracted independent evaluator. If it is deemed the client no longer meets ICF/MR LOC, the case will be referred to the Medicaid agency for termination from the waiver. The client and responsible party will be notified of the termination and will be informed of their appeal rights.

The Medicaid agency ensures there will be ongoing waiver training provided to staff performing evaluations to improve understanding and adherence to the objectives and requirements of the waiver program. Additionally, for administrative purposes to simplify billing, DDSN's current billing system defaults to the 318.1 diagnosis code which has a description of "severe mental retardation". While the diagnosis code does not affect Medicaid reimbursement, by June 30, 2000, DDSN will make the needed changes to ensure the most definitive diagnosis codes available will be used to appropriately reflect the degree of client mental retardation.

DDSN's Response:

(1) The statements found in the records reviewed were included on the plan or in notes as reminders of the need to request the reevaluation of Level of Care. It would be incorrect to conclude they were designed to influence the evaluator.

(2) Evaluation or reevaluation, per DDSN policy, is a complete and valid review of the person's need for ICF/MR Level of Care for continued waiver eligibility.

HCFA's Response: The State Medicaid Agency should implement a monitoring process to assure that waiver services are furnished only to those individuals who would, in the absence of waiver services, require the level of care provided in a hospital, NF, or ICF/MR as defined in 1919(a) of the Act, 42 CFR 440.10, 440.40 and 440.150 (42 CFR 441.302(c)

and 441.303(c)).

Factor C2: In its evaluation and reevaluation of a person's need for the level of care specified in the approved waiver, does the State apply methods that are consistent with the definitions in 42 CFR 440.10, 440.40, 440.150, as applicable (42 CFR 441.302(c))? Does the State use a comparable level criterion and comparably educated and trained evaluators for candidates in the community as they use for hospital, NF or ICF/MR candidates (42 CFR 441.303(2))?

Finding: The approved waiver specifies that in order to be eligible for waiver services it must be documented that an individual: (1) has a confirmed diagnosis of mental retardation or related disability; AND (2) has needs requiring supervision; AND (3) is in need of services directed toward (a) the acquisition of behaviors necessary to function with as much self-determination and independence as possible or (b) the prevention of deceleration of regression or loss of current optimal functional status. As noted above, it was not always evident that the waiver client met those conditions. Furthermore, it was extremely difficult to determine if the LOC used was comparable to the criteria for institutional care since many records only contained an assertion statement by the evaluator. There was no indication that the evaluator had knowledge of the LOC requirement for an ICF/MR.

In most records, documentation to support the level of care determination was missing or outdated. Psychiatric and other assessments used in completing initial evaluations, continued to be used for reevaluations up to fifteen years after the assessment was completed. In many records reviewed, case notes reported significant events (such as the death of a family member or marked behavior problems) that would appear to indicate the need for a new, or at least an updated, assessment.

Recommendation: As a component of the review of assessment tools and the evaluation process recommended for Factor C1, the State should include a review of the protocol for utilization of assessments / reports from initial evaluations and outside sources in reevaluations and POS revisions. Also, training should be provided to individuals responsible for performing evaluations and reevaluations to ensure an understanding and adherence to requirements specified in the approved waiver and any changes resulting from the State's review of the LOC process.

The specific examples at C2 require explanation. Mr. Stroman has mild mental retardation intellectually and severe mental retardation adaptively. He has bipolar disorder with mood swings. verbal and physical aggression. Although his psychological evaluation was six years old at the time of his initial LOC, his current plan of service and medical information were reviewed. These documents plus the psychological evaluation provided ample, current information regarding behavior, judgement and capabilities, and medical/drug monitoring needs. The reevaluation by DDSN included a review of additional documents: The behavior support plan and the individual program plan to support the continued need for supervision (section 2) and services (section 3).

Mr. Burkett has autism and functions in the profound range of mental retardation intellectually and adaptively. The psychological evaluation was only two years old when DDSN conducted the initial LOC. This report gave ample information regarding his autism, level of mental retardation, behaviors, medical conditions and medications. Subsequent reevaluations were based on the 1991 psychological evaluation plus updated information in the plan of service and documents highlighting involvement of DDSN and other providers.

Regarding the finding of the IPP from 1983, the record indicated that the IPP in question was completed on 3/4/97 (not 1983) as indicated by the "Date of Review". The "Date of Staffing" refers to the staffing held by the agency to determine appropriateness for services. The "staffing" report is attached. (See attachment C2 – Interdisciplinary Team Review for A. McDuffie and staffing report for A. McDuffie.)

Factor C3: Does the State maintain written documentation of all evaluations and reevaluations (42 CFR 441.303(c))?

Finding: The approved waiver specifies that documentation of LOC will be maintained by the service coordinators as part of the client record. Several records reviewed were missing the appropriate documentation. In some cases the records reviewed contained a LOC certification but did not include a copy of the actual LOC assessment. Furthermore, many of the LOC certifications were not properly completed or signed.

Recommendation: The training recommended for Factor C2, should emphasize the importance of following requirements for completion and

documentation of LOC as specified in the approved waiver.

State's Response: Service coordinators and supervisory staff will continue to receive training and written materials that outline the specific record keeping requirements. The review process as outlined under B1 has been revised to include the specific review of the level of care information. Moreover, DDSN will conduct periodic reviews of level of care re-evaluations completed by service coordinators to ensure that the integrity of the process is maintained. In addition, the revised Medicaid-approved QA system will monitor for any additional training needs based on review and findings of waiver case records.

Factor C4: Are those responsible for performing the evaluations and reevaluations those persons described in the approved waiver (42 CFR 441.303(c))?

Finding: As specified in the approved waiver, initial evaluations are completed by an interdisciplinary team; Reevaluations are completed by a Qualified Mental Retardation Professional (QMRP).

Factor C5: Does the State evaluate and/or reevaluate at the times indicated in the approved waiver (42 CFR 441.303(c))?

Finding: The waiver states that initial evaluations should be performed as part of discharge planning for institutionalized individuals and within 30 days of a request for evaluation for individuals being diverted. Reevaluations must be performed, at a minimum, on an annual basis.

Evaluations and reevaluations were not always performed in a timely manner as required by the waiver. In one case reviewed an initial evaluation was not established for sixteen months; in another case there was an eight month gap between the time when the level of care expired and the time LOC was recertified.

Recommendation: Training provided to individuals responsible for performing evaluations and reevaluations should stress importance of compliance with time frames specified in the approved waiver. Since FFP is not available for services provided if a client is not certified as needing institutional level of care, the State should recoup the Federal share of the costs of services provided to individuals during this time.

State's Response: The Medicaid agency Office of Internal Audits shall conduct a review of the cases in the compliance review sample to determine if

payments were made for services provided to individuals that were not certified as needing institutional level of care and recoup the federal portion of any payments determined unallowable.

Service coordinators and LOC evaluators will receive training and written materials by October 1, 1999, outlining the specific timeframes for LOC completion. The automated system currently in place allows for a weekly review of the re-evaluations that are due. The independent Medicaid QA system will conduct periodic waiver case record reviews to assure standards of timeliness and appropriateness for LOC are met. Also, the DHHS Office of Internal Audits will conduct annual reviews to determine if recoupments are necessary based on untimely LOC determinations. Additionally, mandatory and expanded waiver record reviews will be performed by the independent Medicaid QA system in any DSN Boards where a pattern of sub-standard performance is determined. In such cases, corrective action plans will be required from the DSN Board Executive Director and will be subject to approval of the Medicaid agency.

DDSN's Response:

Regarding both examples cited, the lapses in LOC did not occur. The DDSN policy (approved by the state), at the time of the initial review, required that initial level of care evaluations be issued for 90 days. (See Policy dated 8/96 at C5.) Such evaluations were considered valid for one year if enrollment in the waiver or admission to an ICF/MR occurred during the 90 day period. The expiration date on the form corresponds to the 90 day enrollment period, not to the actual level of care expiration date. The policy on the 90 day enrollment period was changed when the state was notified that the requirement for initial evaluation of LOC for waiver admission must be within one month of determination. The policy was changed requiring the expiration date to reflect one year from effective date for initial determinations unless otherwise noted by the evaluator. (See Level of Care Determinations for D. Johnson and R. Moses which were the specific examples cited at C5).

ELEMENT D

BENEFICIARY DUE PROCESS, INFORMING AND FREEDOM OF CHOICE PROTECTIONS

Assure that the State observes the rights of individuals with respect to waiver services in accordance with Federal laws, regulations and the approved waiver.

Due Process - Applications for Waiver Services

Factor D1: Does the State observe due process in handling requests for waiver services in a proper and efficient manner (1902(a)(3), 1915(c)(2)(C), 42 CFR 431.15, 206, 210, and 220, 435.904, 905, 906 and 911, and 441.302(d))?

Finding: The State has established and implemented procedures regarding due process of waiver admission requests in accordance with Federal regulations.

Due Process - Waiver Operations

Factor D2: Does the State observe due process in its operation of the waiver program (1902(a)(3) and 42 CFR 431.206, 210, 211 and 220 and 435.919)?

Finding: The State has established and implemented procedures regarding due process in operating the approved waiver in accordance with Federal regulations.

Beneficiary Informing

Factor D3: Has the beneficiary (or legal representative) who is determined to need the level of institutional care specified in the waiver been informed of the feasible alternatives under the waiver (1915(c)(2)(C) and 42 CFR 441.303(d))?

Finding: The State has established and implemented a procedure to ensure that beneficiaries are informed of alternatives under the waiver. All records reviewed contained "Freedom of Choice Forms." However, not all forms were properly filled out or signed.

Recommendation: Instructions and/or training reiterating the importance of compliance with procedures for informed choice should be provided to those individuals responsible for advising clients of service alternatives and maintaining documentation of choice of institutional or waiver services.

State Response: The Medicaid agency shall ensure that service coordinators and supervisory staff will receive training and written materials by October 1, 1999 stressing the importance of compliance with established procedures for informed choice and service alternatives and documentation of such. Training will be reviewed by the

Medicaid agency prior to implementation. The person centered initiative stresses choice and control of the consumer. This element will be assessed as part of the revised review process outlined in B1.

Factor D4: Does the State give each individual found eligible for the waiver or his or her legal representative free choice of the alternatives available under the waiver including the choice from all qualified providers of each service included in his or her written plan of care, the services of choice, and the option of institutional services (1902(a)(23), 1915(c)(2)(C), 42 CFR 431.51, 441.302(d) and 441.303(d))?

Finding: The approved waiver specifies that recipients may choose and receive services from any available provider. However, in most of the cases reviewed, there was no documentation supporting that free choice of providers was explained to clients or their representatives. Further, the majority of waiver services were provided by local DDSN staff.

Recommendation: The State Medicaid Agency should review procedures for provider enrollment to ensure that all providers meeting criteria specified in the approved waiver have an opportunity to enroll. The State should ensure that, as a partner in the administration of this waiver, the Department of Disabilities and Special Needs, is in compliance with all freedom of choice requirements.

State's Response: The Medicaid agency shall review procedures for provider enrollment to ensure that all providers meeting criteria specified in the approved waiver have an opportunity to enroll with the Medicaid agency. Additionally, the Medicaid agency shall ensure that DDSN is in compliance with all freedom of choice requirements.

Service coordinators will receive training and written materials by October 1, 1999 stressing the importance of offering choice of service providers and documenting that such a choice was offered.

ELEMENT E ADMINISTRATION AND MANAGEMENT

Waiver Services

Factor E1: Assure that the State is providing all the services defined in the approved waiver. The State may provide any of the services specified at 1915(c)(4)(B) of the Act and at 42 CFR 440.180 that have been defined in the waiver and approved by the Secretary.

Finding: The State offers a comprehensive package of services under the

waiver. Nevertheless, our review found that only a limited number of services were provided to the beneficiary (i.e., habilitation). There was evidence that the provision of services was budget driven and, as noted above, limited to services provided by the local DDSN.

Recommendation: As noted in Factor B3, the State should review plans of service to determine appropriateness and adequacy of services and provide training to individuals responsible for POS development and monitoring to ensure that services furnished are consistent with the nature and severity of the individual's disability.

State's Response: The State agrees a comprehensive package of waiver services are available under the MR/RD waiver. Given the small sample size of waiver clients reviewed, it may have appeared that only a limited number of the services were provided to beneficiaries. Service Coordinators and supervisory staff will be trained regarding all available waiver services and will be encouraged to authorize services appropriately based on client need. As noted in the response to Factor B3, the Medicaid agency will require training to the service coordination staff responsible for plans of service development and monitoring to ensure services furnished are consistent with the nature and severity of the individual's disability. Training will be conducted by October 1, 1999.

Factor E2: Assure that the services provided and paid for under the waiver are those defined in the approved waiver (42 CFR 441.301(b)(4)).

Finding: Our review found that services billed did not conform to the definition in the approved waiver or were not properly documented in the POS. As discussed in Factors found in Element B, it appears that some activities provided as "adult day program," day habilitation, prevocational employment, job coach services, and specialized medical equipment, may have exceeded the scope of definition as specified in the approved waiver.

In one case, the record included an invoice for a vehicle modification and listed the responsible party as the habilitation center where the client was receiving day habilitation services. It was difficult to determine whether the vehicle was owned by the client or the habilitation center. We are concerned that the provision of this service under the apparent circumstances was highly improper.

Recommendation: The State should compare POS and services actually provided to determine whether the activities provided and claimed were allowable under the approved waiver. In addition, the State should

ensure that providers are authorized to render the types of services billed and paid. Payments made for services not included in the approved waiver should be recouped.

State's Response: The Medicaid agency Office of Internal Audits will conduct a review of the cases in the sample to determine whether the activities provided and claimed were allowable under the approved waiver. Additionally, the Medicaid agency shall ensure that providers are authorized to render the types of services billed and paid. The federal portion of any payments for services not included in the approved waiver and determined unallowable will be recouped by the Medicaid agency. Additionally, the DHHS Office of Internal Audits will conduct annual reviews of waiver case records to ensure that the federal portion for any inappropriate payments are recouped.

DDSN's Response: The vehicle in question was owned by the recipient's family. The invoice did list the responsible party as the local habilitation provider but also listed, "deliver to" the recipient. (See attachment documentation under E2.) Service notes clearly indicate that the recipient's mother was contacted and asked to arrange a time when her vehicle could be modified. Furthermore, this service has not, to date, been billed to, or reimbursed by, DHHS or Medicaid.

Factor E3: Assure that expanded habilitation services (prevocational, supported employment, and educational services) are provided only to individuals who have been discharged from a NF or ICF/MR, regardless of when the discharged occurred (42 CFR.302(i)(2)).

Finding: The Balanced Budget Act of 1997 deleted the requirement for prior institutionalization as a condition of receipt of expanded habilitation services. Therefore, this Factor is deemed met.

Factor E4: Verify the State's continued intention to serve the number of waiver beneficiaries identified as "C" in the approved waiver.

Finding: The approved waiver indicates that waiver services will be made available to individuals in the target group up to the value of "C" or the number authorized by the State legislature for that time period. As of June 30, 1998, there were 3,650 clients enrolled in the waiver. The maximum enrollment approved was 6,510. As of the date of review, HCFA had not received written notification of the lessor number intended to be served.

Recommendation: As specified in the approved waiver, the State should inform HCFA in writing of any limit which is less than factor C for that waiver

year.

State Response: The Medicaid agency shall inform HCFA in writing of any limit which is less than factor C for any waiver year.

Factor E5: Does the State refuse to offer home and community based waiver services to individuals whose cost of care under the waiver would exceed the cost of institutional care?

Finding: The State has elected the option to refuse to offer waiver services to individuals for whom it is expected the cost of services would exceed the cost of services provided in an ICF/MR. Service cost and utilization estimates are calculated as part of the waiver admission process for each client.

Factor E6: Assure that the State appropriately responds to complaints and grievances.

Finding: The State has procedures in place to address compliance, grievances and, if necessary, provide fair hearings for individuals determined ineligible for waiver services. During the review period, the State received two complaints. In these cases, the State adhered to established procedures in responding to the complaints. However, in one of the cases, the final action was not documented in the case record.

Recommendation: The State should provide training and/or instructions to individuals responsible for the grievance process and service coordinators to ensure that notices of final action are forwarded to the client case record.

State's Response: The Medicaid agency shall ensure training and instructions are provided to individuals responsible for the grievance process and service coordinators, to address the importance of maintaining proper documentation in the case record.

Single State Agency and Proper Delegation of Authority

Factor E7: Does the State Medicaid Agency retain the legal authority to supervise the administration of the waiver program (42 CFR 431.10(b)(2)(I))?

Finding: The approved waiver specifies that the State Medicaid Agency and the State Department of Disabilities and Special Needs are partners in operating the waiver program. The State has developed and

implemented an interagency agreement which delineates roles and responsibilities of each agency.

Factor E8: The agency must not delegate to other than its own officials. authority to exercise administrative discretion in the administration or supervision of the waiver program, or issue policies, rules and regulations on program matters (42 CFR 431.10(b) and (e)).

Finding: The State retains final authority on administration of the waiver program. However, there appears to be some problems with communication between the State agencies. The Medicaid Agency does not appear to have an active role in development or implementation of all policies pertaining to operation of the waiver.

Recommendation: The Medicaid agency Medicaid and DDSN should review the interagency agreement to ensure that roles and responsibilities specified are accurate and actual practices are in compliance with the agreement. Further, the Agencies should review administrative and operating procedures to verify that all policies are approved by Medicaid prior to issuance / implementation. In light of findings noted in Elements B, C and D, the State Agency should expand its role in oversight of the program to ensure compliance with Federal and State Medicaid requirements.

State's Response: The response provided in this document to previous recommendations indicates specific ways in which the Medicaid agency intends to expand its oversight role. Currently, the Medicaid agency and State DDSN waiver staff meet on a monthly basis to discuss waiver concerns and Medicaid policy. We will review the interagency agreement to ensure the roles and responsibilities specified are accurate and actual practices are in compliance with the agreement. The Medicaid agency shall review the administrative and operating procedures of the waiver to verify that all policies have been approved prior to issuance and implementation. The Medicaid agency shall expand its role in the oversight of the program to ensure compliance with Federal and State Medicaid requirements.

Direct Payment

Factor E9: Does the State have provider agreements between the Medicaid agency and each provider furnishing waiver services (42 CFR 431.107)?

Finding: The State has developed waiver-specific provider agreements. These agreements contain standard requirements for participation in the Medicaid program as well as requirements unique to the waiver program. We reviewed a sample of provider agreements for each waiver service. In all cases reviewed, provider agreements were in place prior to the provision of waiver services.

Factor E10: Is payment made directly to the provider of waiver services (42 CFR 447.10)?

Finding: The State has advised that providers under this waiver have agreed to accept reassignment of payment from the Medicaid agency to the DDSN. As noted in Factor D4, the majority of waiver services are provided by local DDSN staff. Therefore, it was difficult to verify that reassignment was voluntary or whether the State had made provisions to make direct payment for providers who did not wish to reassign their rights.

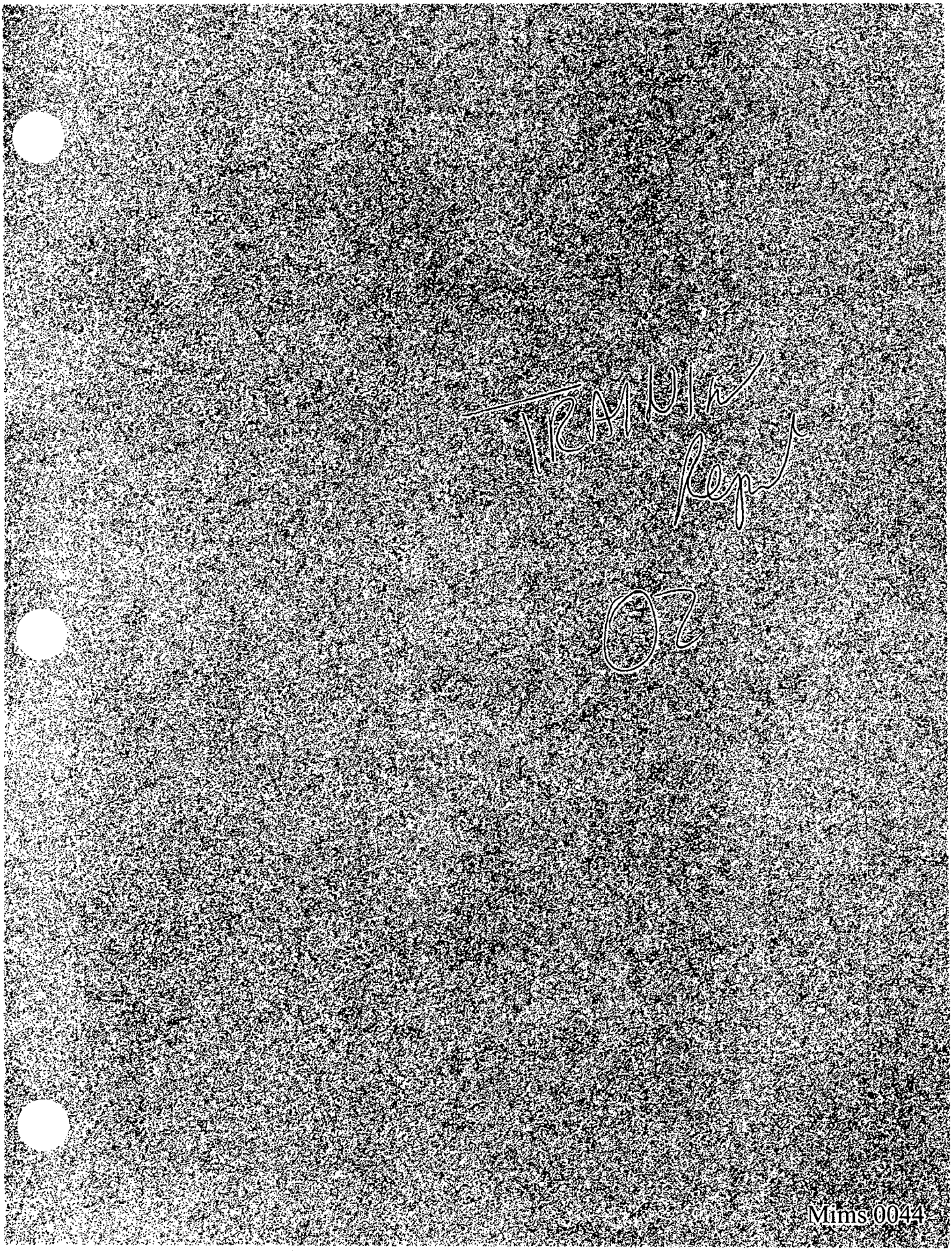
Recommendation: As part of its oversight of the waiver program, the State should review provider contracts and subcontracts and enrollment / referral procedures to ensure compliance with Federal and State contracting requirements. In addition, the State should review the interdepartmental invoice to confirm that State and local agencies are not collecting fees for processing payment for waiver services.

State's Response: The Medicaid agency shall review its contracting process for waiver services, the billing and payment processes for those services, and the enrollment/referral procedures to ensure compliance with Federal and State contracting requirements. Further, the Medicaid agency shall review a sample of provider subcontracts to ensure Federal/State compliance.

DDSN's Response: A majority of the waiver services are provided by local DSN Boards as noted by HCFA. Public Law 44-21-840 recognizes these local DSN Boards as extensions of the DDSN. The Boards are public agencies designated in the law as the administrative, planning, coordinating, and service delivery body for county mental retardation services funded in whole or in part by State appropriations to the DDSN. The DSN Boards meet minimum provider qualifications and standards to provide direct services. In billing for services provided at these local Boards, the DDSN does not add any fees. Moreover, by consolidating the billing, more efficiencies are provided.

For waiver services provided outside the network of the local DSN Boards, the provider of service bills directly to Medicaid. The DDSN does not hinder the providers from billing directly to Medicaid. DDSN adamantly supports consumers' freedom to

choose their providers and services, including providers outside of the DSN Board network.



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To: Ross Robinson
Fm: David H. Kammerer
Re: Employees Actually Trained
Dt: 06/13/02

The following is an update of the training report.
The total employees that are required to have Required Training: **1,093**
The following is the current break down of Babcock Center employees and percentage that are currently trained.

Training for the month of May 2002 *

CPR	148 people	First Aid	148 people	Abuse	175 people
Fire	175 people	Exposure	175 people	DDC-8	104 people

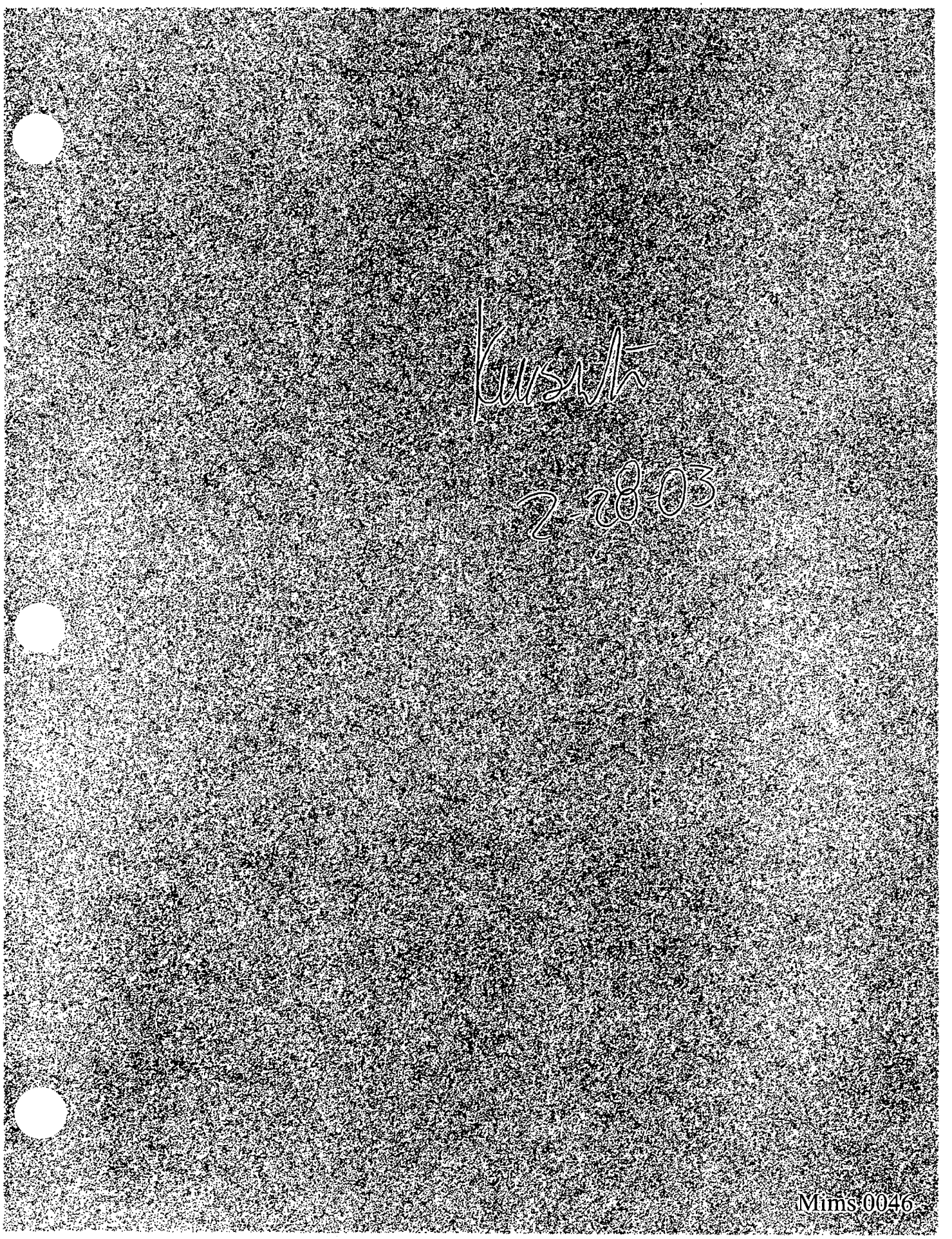
Mandt 141 people (16 hr. course)
Medication Side effects 128 people
Medication Assistance training (8 hr. course) 400 people
* This includes outside boards and CTH Providers.

# of Employees completing Preservice Orientation	**1093**	**100%**
# of Employees completing Required training	**(See below)**	**(See below)**

COMPETENCY	# OF EMPLOYEES TRAINED IN PRESERVICE ORIENTATION	%TRAINED	# OF EMPLOYEES W/ CURRENT CERTIFICATION	% CURRENTLY TRAINED
CPR	1093	100%	776 (840)	71% (77%)
FIRST	1093	100%	955 (1028)	87% (94%)
DEFENSIVE DRIVING	938	100%	778 (830)	83% (89%)
MANDT	1093	100%	619 (785)	57% (72%)
ABUSE	1093	100%	843 (984)	77% (90%)
EXPOSURE CONTROL	1093	100%	798 (988)	73% (90%)
FIRE	1093	100%	757 (987)	69% (90%)
MEDICATION Side Effects	not offered	NA	378 (837)	35% (77%)
Medication Assistance Training	New Course	NA	396 (396)	36%

The above information came from the Completed Competency Course Report for 6/13/02 – 6/30/02. This shows the actual number of employees, the employee names, and the date, the competency was taken. All the names on these lists are current. The numbers in the parenthesis shows the increases in training.

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MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42G068	A. BUILDING _____ B. WING _____	2/28/03

OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGTON I COMMUNITY RESIDEN	160 KENSINGTON RD. COLUMBIA, SC 29203

ID ENT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X4) COMPLETION DATE
26	Continued From page 5 This STANDARD is not met as evidenced by: On the day of the survey based on observation, record review and interview it was determined for 1 of 1 client on the sample (client D) who smokes the facility failed to allow clients to manage their own financial affairs and teach them to do so to the extent of their capabilities. Findings Include: Observation in the residence on 2/24/03 at 4:15 PM revealed staff obtaining cigarettes from a locked cabinet. Further observation revealed staff prompting client D to come out on the patio to have a cigarette. Client D followed the staff person and remained out on the patio until he had smoked two cigarettes. Observation in the residence on 2/25/03 at 7:05 AM revealed client D asking staff for a cigarette. Staff responded "give me a minute". Observation at 7:10 AM revealed another staff member gave client d his cigarette and prompted him to the patio area. Interview with residential staff revealed client D's cigarettes are locked away. Interview with the house supervisor revealed client D's cigarettes are monitored because he does not have enough money to constantly purchase them. Review of the current Behavior Support Program which was not dated revealed client D would smoke in inappropriate places such as the facility and smoke burns were noted on his jacket. Further review revealed a smoking assessment had been completed which revealed client D was not independent in managing his own cigarettes and does not have the money to support a pack per day smoking habit. It was also noted client D could not operate a "childproof" lighter and would create a health risk by burning his clothes and improperly disposing of cigarette butts. Review of the current Individual Program Plan dated 12-17-02 revealed client	W 126	The facility will ensure the rights of all clients. Client D's Smoking Assessment will be reviewed to determine if additional training is needed for Client D to manage his own cigarettes. Client D's Behavior Support Plan will be reviewed to determine if a revision is needed. In the future, the facility will allow clients to manage their own financial affairs and teach them to do so to the extent of their capabilities. Person Responsible: BIS, QMRP, Administrator Projected Completion Date: 3/24/03	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42G068	A. BUILDING _____ B. WING _____	2/28/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GTON I COMMUNITY RESIDEN	100 KENSINGTON RD. COLUMBIA, SC 29203

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Continued From page 6 D has a training program to identify smoking area. review of the objective data revealed client D has met criteria on this objective with 100% independence the past four months. Interview with client d revealed he s unaware he is on a cigarette restriction. Review of nformed consents revealed no current consent or lumian Rights approval for restricting client D's igarettes on the day of the survey.	W 126		
33.420(a)(6) PROTECTION OF CLIENTS RIGHTS ne facility must ensure the rights of all clients. ner the facility must ensure that clients are free on ecessary drugs and physical restraints and e provided active treatment to reduce dependency drugs and physical restraints. is STANDARD is not met as evidenced by: the day of the survey based on record review and erview it was determined for 4 of 4 clients on the nple (clients A, D, E, and H) the facility failed to vide substantial information to demonstrate the d for the use of medications. dings include: iew of the current Individual Program Plan for nt A dated 4/1/02 revealed he has a Behavior port Plan to address inappropriate sexual behavior, sical aggression, inappropriate toileting, ssive-compulsive behavior, and stealing. Further w revealed client A receives Paxil to assist him in aging these behaviors. Continued review revealed Paxil had been increased on 10/14/02 from 20 mg to 40 mg daily. Interview with the nurse revealed sychiatrist increased the Paxil because client A or sleeping and was being combative toward	W 128		

...EFICIENCIES ...RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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...S	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 128	Continued From page 7 another resident. Interview with behavioral staff revealed Paxil was used to address client A's OCD. Further interview revealed Paxil could also be used for sleep. Review of data collected for client A revealed no information available in reference to how little sleep client A was getting per night. Review of the behavior data from February 2002 through December 2002 revealed client A had not had any incidents of inappropriate sexual behavior since April 2002. Client A had had no incidents of physical aggression from Feb. 2002 through December 2002 and this target behavior was discontinued 12/02. Client A did have incidents of inappropriate toileting, 61 in feb., 67 in ... 40 in April, 0 in May, 5 in June, 27 in July, 42 ...ust, 5 in Sept., 11 in Oct., 30 in Nov., and 4 in December 2002. Client A also showed incidents of obsessive-compulsive behaviors. 40 in feb., 104 in March, 38 in April, 0 in May, 81 in June, 11 in July, 49 in August, 8 in Sept., 4 in Oct., 39 in Nov., and 0 in Dec. 2002. Client A showed incidents of stealing, 5 in Feb., 4 in March, 1 in April, 0 in May, 2 in June, 28 in July, 28 in August, 0 in Sept., 3 in Oct., 8 in Nov., and 0 in Dec. 2000. Interview with professional staff confirmed no information in reference to how much sleep client A was receiving was available to the psychiatrist on the day of the increase. Review of the current Individual Program Plan for client A dated 4/1/02 revealed he has a Seizure disorder. Further review revealed client A receives Tegretol 400 mg daily for seizure control. Continued review revealed client A was seen by a Neurologist on 6/20/01. recommendations were to continue same medications and return as needed. Review of the seizure record revealed no seizure activity during the past program year. Interview with the nurse revealed client A has not had a seizure since 1988. Review of the medical section revealed no EEG results to indicate ... seizure activity. Interview with the nurse		The facility will ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. Client A's Behavior Support Plan will be reviewed to determine if he should be on a sleep chart. Appointments have been made for Clients A, D, and E to have an EEG to determine if the seizure medication is needed. Client H was seen by the psychiatrist on 3/10/03 and his medication was discussed at this time. In the future, the facility will provide substantial information to demonstrate the need for the use of medications. Person Responsible: BIS, Nursing, QMRP Projected Completion Date: 3/24/03	

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 8 continued no other information was available on the day of the survey.	W 128		

Review of the current Individual Program Plan for client D dated 12/17/02 revealed he is 59 years old and has a Behavior Support Program to address irregular sleep, disorientation, and delusional behavior. Further review revealed client D receives Inderal, Prozac, Stelazine, Depakote, and Ativan to assist him in managing these behaviors. Continued review revealed client D receives the Depakote for seizures and behavior. Review of the seizure record revealed no such record available. Interview with the nurse revealed client D has not had a seizure since he was ag[illegible]. Further review revealed criteria for target b[illegible] (irregular sleep) was no more than 10 in[illegible]s per month for 6 consecutive months. Review of the data revealed client D has not had 10 incidents of irregular sleep in 11 months (February - December 2002). Review of target behavior (disorientation) revealed the criteria was no more than 20 incidents per month for 6 consecutive months. Review of the data revealed client D has not had more than 11 incidents per month of disorientation from February- December 2002. Review of target behavior (delusions) revealed criteria was no more tan 15 incidents per month for 6 months. Review of the data revealed client D has had no more than 11 incidents of delusional behavior per month from February - December 2002. Continued review revealed client D had met criteria on all behavioral goals and has not had a seizure for over 40 years however, there has been no change to his medication regime with the exception of Ativan being decreased by 1 mg on 12-6-02.

Review of addendum to client D's Individual Program Plan dated 9/24/02 revealed the program team met to discuss client his behavior and sleeping pattern. During this meeting the team agreed to obtain a

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D ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
128	Continued From page 9	W 128		

directors appointment for client H to be seen by the primary physician. Review of admission dated 9/27/02 revealed the team met again to discuss client H's visit to his primary physician. The primary physician recommended client H be placed in a wheel chair and receive one on one staffing until he could be seen by the psychiatrist on 9/30/02. Further review revealed client H was seen by the psychiatrist on 9/30/02 to address aggressive behaviors and irregular sleep patterns. Further review revealed client H was asleep in the wheel chair at this visit. The psychiatrist during this visit prescribed Depakote 500 mg once daily for aggressive behavior, Ambien 10 mg at bed time for sleep for seven days and blood work. Review of the Medication Administration Record for the month of October 2002 revealed client H did not receive either medication prescribed by the psychiatrist. Review of Psychiatrist notes and orders dated 10/14/02 revealed during this visit Depakote 500 mg once daily was increased to Depakote 1000 mg once daily. Interview with the nurse revealed the psychiatrist increased the Depakote based on the blood work presented at this visit. However further interview revealed the physician was unaware client H had not received any of the medication he had previously prescribed. Interview with three professional staff (nurse, administrator, and behavior specialist) revealed the facility was waiting on informed consent before implementing the first psychiatrist order dated 9/30/02. Review of the informed consent revealed the consent had been signed on 9/30/02 by client H's family member and had human rights approval also 9/30/02 for the medication prescribed on this date. However further review revealed no informed consent for Depakote 1000 mg daily. Review of the Medication Administration Record for the month of October 2002 revealed client H received at the most, one dose of Depakote 1000 mg on 10/15/02. Interview with the

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 10 nurse confirmed client H began the Depakote 1000 mg on 10/15/02 and continues on this medication as of the day of the survey. Review of the current Individual Program Plan for client E dated 4/19/02 revealed he has a Seizure disorder. Further review revealed client E receives Phenobarbital 105 mg daily for seizure control. Continued review revealed client E was seen by a Neurologist on 7/30/02. Recommendations were to continue same medications and return as needed. Review of the seizure record revealed no seizure activity during the past program year. Interview with the nurse revealed client E has not had a seizure since h of 1997. Review of the medical section ed no EEG results to indicate current seizure activity. Interview with the nurse confirmed no other information was available on the day of the survey.	W 128		
483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by On the day of the survey based on observation, record review and interview it was determined for 1 of 1 client on the sample (client D) who smokes the facility failed to ensure that clients have the right to retain personal possessions. Findings include: Observation in the residence on 2/28/03 at 11:15 AM revealed staff [illegible]	W 137		

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ME LA:	DEFICIENCIES CORRECTION	(X1) PROVIDER SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ID TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
137	Continued From page 11 cabinet. Further observation revealed staff prompting client D to come out on the patio to have a cigarette. Client D followed the staff person and remained out on the patio until he had smoked two cigarettes. Observation in the residence on 2/25/03 at 7:05 AM revealed client D asking staff for a cigarette. Staff responded "give me a minute". Observation at 7:10 AM revealed another staff member gave client d his cigarette and prompted him to the patio area. Interview with residential staff revealed client D's cigarettes are locked away. Interview with the house supervisor revealed client D's cigarettes are monitored because he does not have enough money to constantly chase them. Review of the current Behavior pport Program which was not dated revealed client D would smoke in inappropriate places such as the facility and smoke burns were noted on his jacket. Further review revealed a smoking assessment had been completed which revealed client D was not independent in managing his own cigarettes and does not have the money to support a pack per day smoking habit. It was also noted client D could not operate a "childproof" lighter and would create a health risk by burning his clothes and improperly disposing of cigarette butts. Review of the current Individual Program Plan dated 12/17/02 revealed client D has a training program to identify smoking area review of the objective data revealed client D has met criteria on this objective with 100% independence the past four months. Interview with client d revealed he is unaware he is on a cigarette restriction. Review of Informed consents revealed no current consent or Human Rights approval for restricting client D's cigarettes on the day of the survey.	W 137	The facility will ensure that clients have the right to retain and use appropriate personal possessions and clothing. Client D's Behavior Support Plan and Smoking Assessment will be reviewed to determine if new training is needed. In the future, the facility will ensure that clients have the right to retain personal possessions. Person Responsible: BIS, QMRP, Administrator Projected Completion Date: 3/24/03	

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ntinued From page 42			
483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: On the day of the survey based on record review and interview it was determined for 4 of 4 clients on the sample (clients A, D, E, and H) the facility failed to maintain a system that assures a full and complete accounting of clients' personal funds. Findings include: eview of the financial records kept in the facility vealed no receipts for purchases made. Interview ith the house supervisor revealed all client receipts e forwarded to the agencies administrative office at e end of each month. Review of Personal Needs ansactions record dated 2/3/03 revealed client lances minus $30.00 personal needs transfer only. other transactions were noted on this document. view of agency checks released to the residence for ents personal needs revealed check amounts up to 0.00 with no direction as to how the money was to ivided or spent. Interview with the house ervisor revealed the facility no longer issues such cks but has changed the way checks are disbursed. ther interview revealed as of December 2002 ity checks now have each client's name and the unt each client is to receive on the check.	W 140 W 149	The facility will establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. A new system is in place that assures a full and complete accounting of clients' personal funds. In the future, the facility will maintain a system that assures a full and complete accounting clients' personal funds. Person Responsible: Supervisor, QMRP Projected Completion Date: 4/15/03	
483.420(b)(2) STAFF TREATMENT OF CLIENTS acility must ensure that all allegations	W 153		

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W 153	(Continued From page 13	W 153		

mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by:

On the day of the survey based on record review and interview it was determined the facility failed to ensure that all allegations of mistreatment as well as injuries of unknown source were reported to the administrator.

Findings Include:

A review of Accident/Injury reports revealed the following:

1/8/03 a client was noted with a bruise area one inch wide on the left leg above the knee. Further review revealed no cause was noted for this injury.

10/1/02 a client was noted with bruises to both knees. No cause was stated for this injury.

8/22/02 a client was noted with a scraped elbow and hands. No cause was stated for this injury.

8/15/02 a client was noted with an abrasion to his forehead. No cause was stated for this injury.

12/??/01 a client was noted with a swollen and tender right arm. No cause was stated for this injury. An interview with professional staff confirmed no investigation had been completed to address any of the above situations.

The facility will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the Administrator, or to other officials, in accordance with State law through established procedures. Staff will be in-serviced on reporting and notifying QMRP of any unknown injuries. In the future, the facility will ensure that all allegations of mistreatment, as well as injuries of unknown source, are reported to the Administrator.

Person Responsible: Administrator
Projected Completion Date: 4/20/03

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(Continued From page 14	W 156		
483.420(d)(4) STAFF TREATMENT OF CLIENTS	W 156	The facility will ensure the results of all investigations are reported to the Administrator, designated representative, or other officials in accordance with State law, within five working days of the incident. All investigations will be completed within five working days. In the future, the facility will ensure that all investigations are completed with five working days. Person Responsible: Administrator Projected Completion Date: 3/24/03	
The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.			
This STANDARD is not met as evidenced by: On the day of the survey based on record review and interview it was determined the facility failed to ensure that all investigations were completed within five working days.			
Findings include:			
Review of Critical Incident dated 11/18/01 revealed a client suffered a left patella fracture. Treatment consisted of a straight leg immobilizer on his left leg and a referral to physician for evaluation for possible surgery. It was noted the injury was caused by the client being in a fight with another client. The client was seen by Orthopedist on 11/20/01 and immediate surgery was recommended. Continued review revealed the results of this investigation were not completed until 12/10/01. Interview with the administrator confirmed the above.			
483.430(e)(2) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
Each client's active treatment program must be designed, coordinated and monitored by a qualified mental retardation professional			
This STANDARD is not met as evidenced by: On the day of the survey based on observation, record			

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Continued From page 15 review and interview it was determined for 4 of 4 clients on the sample (clients A, D, E, and H) the facility failed to ensure each clients active treatment program was integrated, coordinated and monitored by a qualified mental retardation professional. Findings Include: Observation at the work shop on 2/25/03 from 10:45 AM to 11:00 A.M revealed client D seated at his work table. Client D was not wearing dentures or [illegible]sses. Observation from 12:00 PM to 12:20 PM [illegible]d client D eating his lunch client D was not wearing dentures or eyeglasses. Observations in the residence on 2/25/03 from 4:00 PM to 5:00 PM revealed client D again not wearing dentures or eyeglasses. Observations at the residence on 2/26/03 from 6:30 AM to 7:15 AM revealed client D without eyeglasses or dentures. Observations at the day program on 2/26/03 from 10:00 AM to 11:00 AM revealed client D at his work table without eyeglasses or dentures. Review of the current Individual Program Plan for client d dated 12/17/02 revealed client D is edentulous but refuses to wear dentures. Review of training goals for client d revealed no training goal to wear dentures. further review revealed no team discussion or recommendation to address client D refusal to wear dentures. Review of Optometrist examination for client D dated 8/13/02 revealed he has a moderate degree of hyperopia (far sightedness). Recommendations were to wear eyeglasses as needed and return in two years. Interview with the QMRP and the nurse revealed client D's eyeglasses were currently broken. Observation at the day program on 2/25/03 during the lunch meal revealed client H eating his lunch using a [illegible] spoon. Observations on the [illegible] 2/03 of the breakfast meal revealed client H	W 159	The facility will ensure that each client's Active Treatment Program is integrated, coordinated, and monitored by a Qualified Mental Retardation Professional. A meeting will be held to discuss Client D wearing his dentures and eyeglasses. Client H will use a youth spoon at the Day Program and residence. Client A's and D's Behavior Support Plans will be reviewed to determine if changes are needed. An appointment has been made for Client D to have an EEG. Client E will be assessed for sensory stimulation and his training objectives will be re-viewed to determine if revisions are needed. Client H's, and all other residents' training objectives, will be reviewed to determine if revisions are needed. In the future, the facility will ensure each client's Active Treatment Program is integrated, coordinated, and monitored by a Qualified Mental Retardation Professional. Person Responsible: QMRP, Administrator Projected Completion Date: 4/24/03	

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...Continued From page 16	W 159		

consumed his meal using a built up handle teaspoon. Observation of the day program on 2/26/03 revealed client H again used a small maroon spoon when eating his lunch. Review of the current Occupational Therapy assessment dated 4/9/02 revealed client H is to use a youth spoon and fork with built up handle for dining. Interview with day program staff revealed that the maroon spoon is what client H always uses Interview with the QMRP revealed client H is to use a built up handle spoon when dining.

Review of the current Individual Program Plan for client A dated 4/1/02 revealed he has a Behavior Support Plan to address inappropriate sexual behavior, p[illegible] aggression, inappropriate toileting, ob[illegible]e-compulsive behavior, and stealing. Review of the current Behavior Support Plan which was not dated revealed criteria for client A to meet the target behavior of inappropriate sexual behavior had been set. Interview with the QMRP confirmed no criteria had been assigned to the target behavior of inappropriate sexual behavior.

Review of the current Individual Program Plan for client D dated 12/17/02 revealed he has a Behavior Support Plan to address irregular sleep, disorientation, delusion, hallucination, and non-compliance. Review of the current Behavior Support Plan which was not dated revealed only irregular sleep, disorientation, delusions, and hallucinations were target behaviors interventions for staff to implement should these behaviors occur were given however, further review revealed only irregular sleep, disorientation, and delusions were identified as "Behavior Objectives" and data assigned criteria. Review of the data collected recorded data recorded for the months of February 002 through December 2002 on all behaviors listed i... the individual program plan [illegible] ...designed to hallucinations and non-compliance ...

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
159	Continued From page 17 not mentioned at all in the Behavior Program.	W 159		

Review of the current Individual Program Plan for client D dated 12/17/02 revealed he is 50 years old. Further review revealed client D receives Inderal, Prozac, Stelazine, Depakote, and Ativan to assist him in managing inappropriate behaviors. Continued review revealed client D receives the Depakote for seizures and behavior. Review of the seizure record revealed no such record was available. Interview with the nurse on 2/27/03 revealed she would need to obtain the date of client D's last seizure from the ords department. Interview with the nurse on 3/3/03 revealed it was relayed to her that client D has not had a seizure since he was age 12. Client D's Individual Program Plan does not state the above information.

Review of the current Individual Program Plan for client E dated 4/19/02 revealed the speech therapist made a recommendation for client E to be evaluated by an Occupational Therapist for Sensory Stimulation. Further review revealed no Team follow up to this recommendation. Interview with the QMRP revealed she was not sure if the evaluation had been completed but felt it had not. Interview with professional staff on 3/3/03 revealed client E is scheduled to receive a Sensory Stimulation evaluation from the Occupational Therapist in the upcoming week.

Review of residential training goals for client E revealed he has an objective to apply deodorant with 70% independence for 2 consecutive months. Review of the data collected revealed from October 2002 through January 2003 client E has shown no progress on this goal. Further review revealed client E has an objective to evacuate the building when alarm is [illegible] with 90% independence for two consecutive [illegible] of the data collected from

Mims 0059

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42C068	A. BUILDING _____ B. WING _____	2/28/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GTON I COMMUNITY RESIDEN	100 KENSINGTON RD. COLUMBIA, SC 29203

(X4) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued from page 18	W 159		

September 2002 through December 2002 client E showed no progress on this goal even after the goal was revised in November. Continued review revealed lient E has a training objective wear bathrobe with 5% independence for two consecutive months. eview of the data collected revealed from September 002 through December 2002 client E showed no ogress on this goal even after the goal was revised in ovember. Review of training objective to allow staff brush teeth with 90% independence for three nsecutive months revealed client E showed no ogress on this goal from July 2002 through October 02.

[illegible] residential training goals for client H [illegible] has an objective to close blands with 80% [illegible]ce for 3 consecutive months. Review of data collected revealed from March 2002 through ober 2002 client H has shown no progress on this even after the goal was revised in July. Further ew revealed client H has an objective to wear robe 80% independence for two consecutive this. Review of the data collected revealed from mber 2002 through January 2003 client H ed no progress on this goal even after the goal evised in November. Continued review revealed H has a training objective to [illegible] appropriate nt of toilet tissue with 90% independence for two cutive months. Review of the data collected ed from September 2002 through January 2003 H showed no progress on this goal even after the as revised in November. Review of training ive to date the value of coins with 90% [illegible] three consecutive months revealed client H showed no progress on this goal from ber 2002 through January 2003 even after the as revised in November.

...	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	... DATE
...31	Continued From page 19	W 231		
...31	483.440(a)(2)(iii) INDIVIDUAL PROGRAM PLAN	W 231	The facility will ensure that objectives of the Individual Program Plan are expressed in behavioral terms that provides measurable indices of performance. Clients A and D, along with all other individuals on a Behavior Support Plan, will be reviewed to determine if revisions are needed. In the future, the facility will ensure objectives in the Individual Program Plan are expressed in behavioral terms that provides measurable indices of performance. Person Responsible: BIS, QMRP, Administrator Projected Completion Date: 3/24/03	

The objectives of the individual ...plan must be expressed in behavioral terms that provide measurable indices of performance.

This STANDARD is not met as evidenced by:

On the day of the survey based on record review and interview it was determined for 2 of 4 clients on the sample (clients A and D) the facility failed to ensure objectives in the individual program plan were ...essed in behavioral terms that provide measurable ...es of performance.

Findings Include:

Review of the current Individual Program Plan for client A dated ...02 revealed he has a Behavior Support Plan to address inappropriate sexual element, physical aggression, inappropriate toileting, obsessive-compulsive behavior, and stealing. Review of the current Behavior Support Plan which was not dated revealed criteria for client A to meet the target behavior of inappropriate sexual behavior had been set. Interview with the QMRP confirmed no criteria had been assigned to the target behavior of inappropriate sexual behavior.

Review of the current Individual Program Plan for client D dated 12/17/02 revealed he has a Behavior Support Plan to address irregular sleep, disorientation, delusion, hallucination, and non-compliance. Review of the current Behavior Support Plan which was not ...ed revealed only irregular sleep ...disorientation, delusions, and hallucinations were target behaviors, interventions for staff to implement should these behaviors occur were given however, further review ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) MULTIPLE CONSTRUCTION	(X4) DATE SURVEY COMPLETED
	42C068	A. BUILDING _____ B. WING _____	2/28/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TON I COMMUNITY RESIDEN	188 KENSINGTON RD. COLUMBIA, SC 29203

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
ontinued from page 29 clusions were identified as "Behavior Objectives" and were assigned points. Review of the data collected graphed data recorded for the months of February 002 through December 2002 on all behaviors listed in e individual program plan. No measurable criteria as assigned to hallucinations and non-compliance is d mentioned at all in the Behavior Program.	W 231		
3.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN individual program plan must include opportunities for client choice and self-management. S ARD is not met as evidenced by: the of this survey based on observation, record ew and interview it was determined for 2 of 3 ts on the outside (clients E and H) the facility d to provide opportunities for client choice and nanagement. ngs Include: vation at the work shop on 2/24/03 from 9:45 10:15 AM revealed client E seated at his work unengaged. Staff at 10:00 AM prompted client E ese papers. This interaction lasted for less than 2 ute and staff moved to another client. Review of ctive Treatment schedule revealed client E is to aged in work activity during the above time. Interview with 3 program staff on 2/28/03 revealed will work some but not much. Observation the lunch meal revealed client E completed his 12:30 PM and remained seated in dining room ad down on the table until 12:50 PM. nued at the work shop on 2/24/03 from 10:45 10:45 AM revealed client E seated at his work	W 247	The facility will ensure that Individual Program Plans include opportunities for client choice, and self-management. Client E, H, and all other individual, will be offered choices when not engaged in current task. In the future; the facility will provide opportunities for client choice and self-management. Person Responsible: Day Program Manager Projected Completion Date: 4/20/03	

Kabadz Quotes

Nov 03

Mims 0063

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Ref: icfmr-11.12.03

IMPORTANT NOTICE
PLEASE READ CAREFULLY

November 12, 2003

Mr. Gene Marlow
Deputy Executive Director
Clusters of Lexington/Building B
201 Duffie Drive
Lexington, South Carolina 29072

Re: Babcock Center, Clusters Building B – Immediate Jeopardy

Dear Mr. Marlow:

A facility must meet the statutory requirements in Sections 1902(a)(31) and 1905(d) of the Act (42 U.S.C. sections 1396a(a)(31) and 139d(d), respectively) and be in compliance with each of the applicable regulatory Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), established by the Secretary of Health and Human Services at 42 C.F.R. Part 483, Subpart 1 of the Social Security Act, in order to qualify to participate as a ICF/MR in the Medicaid program under Title XIX of the Act.

Survey Findings:
On November 6, 2003, a survey was conducted at your facility by the CMS Federal Survey Team, to determine if your facility was in compliance with Federal requirements for a ICFs/MR participating in the Medicaid program. The survey findings revealed that the facility was not in substantial compliance with the participation requirements **W122, W149, W157 (Condition of Participation: Client Protection), W186, W189 (Direct Care Residential Unit Staff and Staff Training Program), W214 (Comprehensive functional assessment), and that conditions at the facility constituted Substandard Quality of Care and Immediate Jeopardy to the health and safety of clients.** Pursuant to Section 1910(b)(1) of the Act (42 U.S.C.1391(b)(1), the Centers for Medicare and Medicaid Services is canceling your facility's eligibility to participate in Medicaid, effective November 29, 2003.

Mims 0064

Cancellation of Approval of Eligibility to Participate in Medicaid:
As a result of the survey findings, The Centers for Medicare and Medicaid Services is canceling the approval of your facility to participate in the Medicaid program effective on November 29, 2003.

Plan of Correction:
The facility must submit an acceptable, credible allegation to this office within five (5) days of receipt of this notice. The credible allegation must meet the following criteria:

- It must document that the remedial action taken by the facility has removed the deficient practice that constituted the immediate jeopardy to client health and safety; and
- It must demonstrate that the corrective actions have been accomplished between the survey date and the date of the credible allegation.

Please submit your credible allegation by fax to: Joyce Lang, CMS, ICFs/MR Enforcement, at 404-562-7480. Also, you may mail your credible allegation to:

Joyce Lang, ICF/MR Enforcement
The Centers for Medicare and Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

If the credible allegation is timely and acceptable, an unannounced survey will be conducted to confirm removal of the jeopardy and correction of any other outstanding deficiencies. If compliance has been achieved on the revisit, CMS will rescind the cancellation of approval of eligibility for participation in the Medicaid program. If the jeopardy is removed but the facility remains out of compliance, the cancellation of approval may be extended to provide and opportunity to achieve compliance. If the jeopardy is not removed timely the cancellation of approval for eligibility for participation in the Medicaid program will be effective on November 29, 2003.

Reinstatement of Approval Following Cancellation:
When approval to participate in Medicaid is canceled by CMS, the facility's eligibility to participate in the program may not be reinstated unless CMS finds that the reason for cancellation has been removed and there is reasonable assurance that it will not recur. The facility must demonstrate through a reasonable assurance period that it can maintain compliance with all of the statutory and regulatory requirements for at least 90 consecutive days. Compliance with the requirements at 42 C.F.R. Part 483, Subpart 1 will be verified by surveys conducted at the beginning and the end of this period. Before reinstatement, the facility must demonstrate its ability to comply with all pertinent requirements of Title XIX of the Social Security Act. Medicaid eligibility will be reinstated following conclusion of the reasonable assurance period.

Appeal Rights:
If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board, in accordance with 42 C.F.R. Part 498. A written request for a hearing must be filed on later than sixty (60) calendar days from the date of this notice. Such a request, accompanied by a copy of this notice should be forwarded by certified mail directly to:

Jacqueline T. Williams, Chief
Civil Remedies Division
Department of Health & Human Services
Departmental Appeals Board, MS 6132
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

Please forward a copy of your request for an appeal hearing to the Centers for Medicare and Medicaid Services, ICF/MR Enforcement to the address on the letterhead.

Your request for a hearing must identify the specific issues as well as the findings of fact and conclusions of law with which you disagree and explain the basis for contending that the findings and conclusions are not correct. You may be represented at a hearing by counsel at your own expense.

If you have any questions or concerns regarding this notice, please contact Joyce Lang at (404) 562-4025.

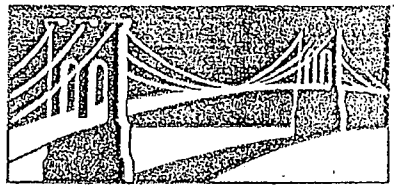
Sincerely,

Joyce Lang (for)

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

Cc: SA
SMA
CO/ICF/MR

Mims 0066



BABCOCK CENTER

November 14, 2003

Ms. Joyce Lang, ICF/MR Enforcement
The Centers for Medicare and Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Dear Ms. Lang:

The CMS Federal Survey Team conducted a survey of Babcock Center's Lexington Clusters facility House B, beginning November 4, 2003 to determine compliance with Federal requirements for ICF/MR participation in the Medicaid program. Based on their findings, the survey team determined that Immediate Jeopardy existed in the area of Client Protection.

Babcock Center is committed to the safety, welfare and protection of persons with disabilities; particularly those individuals supported at the intermediate care level. We have implemented an immediate plan of correction to protect all persons supported at House B at Lexington Clusters.

A credible allegation is attached for your review and approval. Please feel free to contact me if you have any questions or concerns.

Sincerely,

Judith E. Johnson, Ed. D.
Executive Director

Credible Allegation for Lexington Clusters House B

Babcock Center submits this credible allegation in response to the written notification of Immediate Jeopardy determined by the CMS Federal Survey Team during their review of Lexington Clusters November 4, 2003. The following action has been taken to protect the individuals residing in Clusters B as well as to meet the statutory and regulatory requirements set forth under 42 C.F.R. Part 483, Subpart 1:

Staff Coverage: (W122) (W186)

Direct care coverage was increased by one (1) staff to ensure adequate care and protection for each individual in House B. Additionally, Client #1 was placed on one-on-one arm's length staff coverage when in the presence of other clients and visual one-on-one coverage at other times during waking hours.

Client #5 has been placed on one-on-one arm's length coverage when other clients are present and one-on-one visual coverage at other times during waking hours. Due to the aggressive nature of two other clients within the residence, Client #5 will move to another residence November 14, 2003. He will remain on the same level of one-on-one coverage during his observation period in his new residence to ensure he is protected from harm.

Client #7 has been placed on one-on-one arm's length coverage to address his aggression and his sexual behavior, and one-on-one visual coverage when other clients are not present. The specific detail for each client's enhanced coverage is clearly identified in his individual Behavior Support Plan.

Persons Responsible: *The House Manager and Facility Administrator will be responsible for monitoring staff coverage to ensure proper number of personnel are on each shift to carry out each individual's individual program plan.*

Behavior Support: (W 214) (W157)

The Behavior Support Department has completed functional assessments for all residents in Clusters House B in order to identify needs, limitations, and skills deficits. Following the completion of functional assessments, revised Behavior Support Plans were developed, using the analysis of maladaptive behaviors to provide necessary effective interventions focusing on the target behaviors, with clear directions for the implementation of enhanced staffing as necessary. The Director of Behavior Support will obtain the necessary consents and Human Rights Committee approval. The Behavior Support Department will conduct training to ensure all personnel understand and implement the plans consistently. New plans for Clients # 1, 5 and 7 will be implemented by Monday, November 17, 2003.

The Interdisciplinary team will meet weekly to review behavior reports including Behavior Incident Reports, Critical Incidents, and Accident/Injury reports to identify and address any trends that are evident including patterns of victimization and client-to-client incidents. The team will also monitor family/guardian notification for accidents/incidents. Minutes of meetings will be kept at the facility and available for review. Any trends, suspicions, or patterns of victimizations will be investigated and analyzed for further interventions to protect residents from harm.

Persons Responsible: *The Director of Behavior Supports and the QMRP will monitor weekly to ensure Behavior Support Plans are implemented as written and that staff are properly trained to address the behavioral needs of the individuals supported in Clusters House B. The Facility Administrator will monitor weekly meetings and ensure meeting minutes are kept on file and available for review.*

Staff Training: (W149)(W189)

The facility Administrator and Director of Behavior Support will ensure all personnel receive the appropriate training necessary to perform their duties supporting and supervising clients per their individual program plans. This training will include clear instructions for enhanced staffing to ensure each staff performs their roles consistently. This training will also focus on staff's requirement to act when they are aware of or suspicious of incidents of abuse, neglect or injury to clients and trends that may be indicative of victimization. All training will be completed by November 17, 2003.

Persons Responsible: *Director of Residential Services, Administrator and Director of Behavior Supports*

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Refer to: 42G081

November 17, 2003

Mr. Gene Marlow
Deputy Executive Director
Clusters of Lexington/Building B
201 Duffie Drive
Lexington, South Carolina 29072

Re: Babcock Center, Clusters Building B

Dear Mr. Marlow:

On 11/6/03, a survey was completed at your facility by surveyors from the Centers for Medicare and Medicaid Services to determine if your facility was in compliance with the Conditions of Participation (CoPs) for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

Survey Results

The survey findings are reflected on the enclosed Statement of Deficiencies (CMS Form 2567). Your Credible Allegation regarding the Immediate Jeopardy citations was received in the Regional Office on 11/14/03 and is currently being reviewed. A Plan of Correction (PoC) addressing the findings on the CMS 2567 must be submitted within ten (10) calendar days of receipt of this notice. If you have already addressed an issue in your 11/14/03 Credible Allegation, please note this on the PoC. Failure to submit an acceptable PoC by the due date may result in the imposition of additional remedies.

To be considered acceptable, your PoC must contain the following:

- What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place;

Please remember to sign the PoC and submit to:

Joyce Lang, Division of Survey & Certification
Centers for Medicare & Medicaid Services
Long Term Care Enforcement Branch
Sam Nunn Atlanta Federal Center
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

You may fax it to her at (404)562-7480. If you have any questions concerning this letter, please contact Ms. Lang at (404)562-4025.

Sincerely,

Joyce Lang (for)

Sandra M. Pace
Associate Regional Administrator
Division of Medicaid and State Operations

Mims 0071

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Refer to: 42G077initialnotice.doc

November 24, 2003

Bruton Smith Group Home
139 Bruton Smith Rd.
Lexington, SC 29072

Dear Director:

On 11/06/03, a survey was completed at your facility by surveyors from the Centers for Medicare and Medicaid Services to determine if your facility was in compliance with the Conditions of Participation (CoPs) for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

Survey Results

The survey findings are reflected on the enclosed Statement of Deficiencies (CMS Form 2567). A plan of correction must be submitted within ten (10) calendar days of receipt of these survey findings. Failure to submit an acceptable PoC by the due date may result in the imposition of additional penalties.

To be considered acceptable, your PoC must contain the following:

- What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place;

Mims 0072

Please remember to sign the PoC and submit to:

Joyce Lang, Division of Survey & Certification
Centers for Medicare & Medicaid Services
Long Term Care Enforcement Branch
Sam Nunn Atlanta Federal Center
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

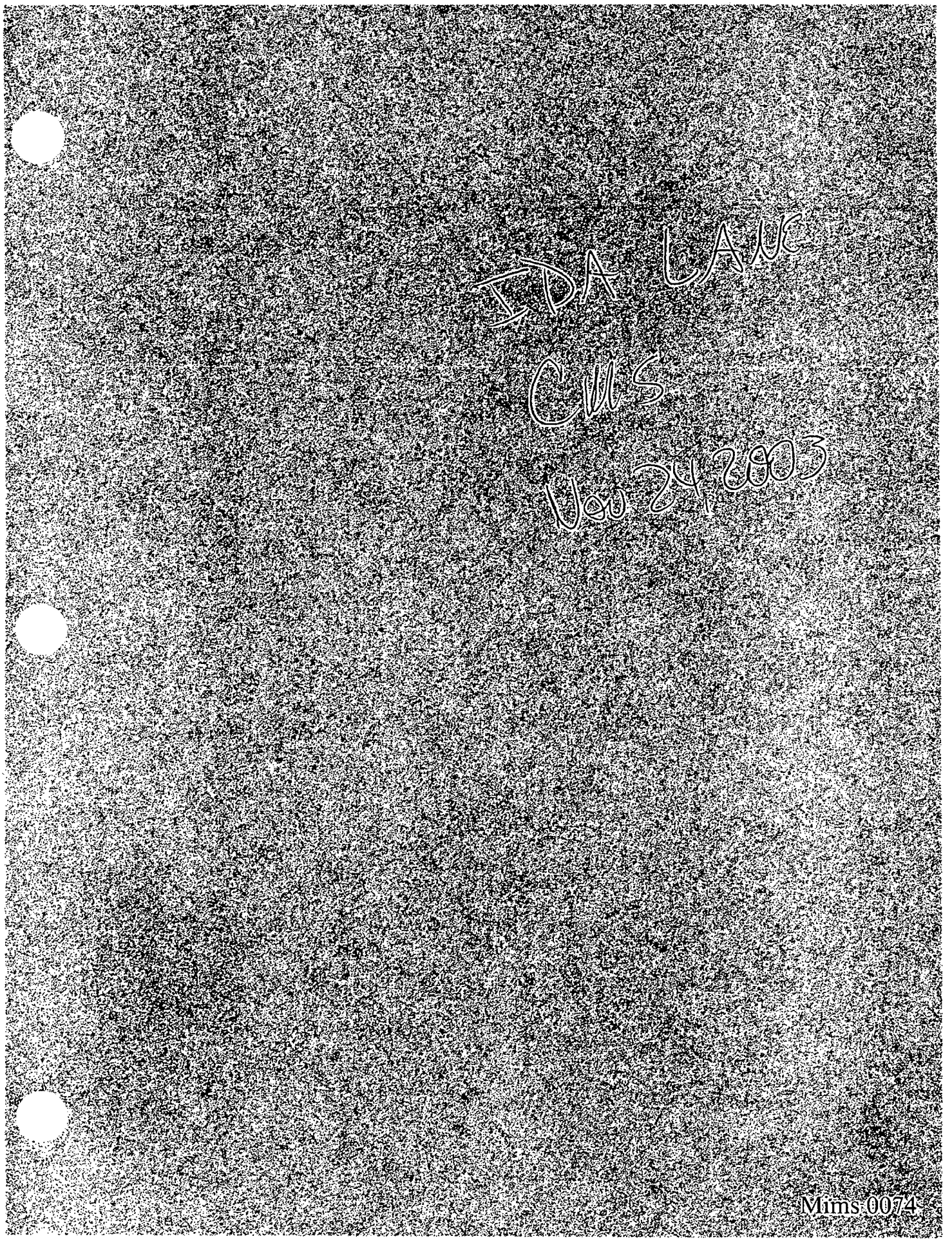
You may fax it to her at (404)562-7480. If you have any questions concerning this letter, please contact Ms. Lang at (404)562-4025.

Sincerely,

Joyce Lang
for

Sandra M. Pace
Associate Regional Administrator
Division of Medicaid and State Operations

Mims 0073



Mims 0074

Babcock Ida Lane II
ICF/MR Team

To: Laverne Dixon and (b)(6)

Cc: Linda Joyce
Amanda Cade

Date: November 24, 2003

Re: Babcock Ida Lane II

Provider #

Federal surveyor (b)(6) QMRP, conducted a complaint investigation at Babcock Industries, Inc. Ida Lane II residence on 11/20/03.

Complaints:

1. **The complainant reported that Client #1 "was admitted to the hospital with arm broken in 6 places" on 11/19/03.**

Findings:

On 11/18/03 at 4:20 PM Client #1's left shoulder and upper arm were observed to be swollen and painful as a direct care staff member assisted in removing Client #1's shirt in preparation for a bath. Client #1 reported he fell at the workshop.

Client #1, a 79 year old male, carries diagnoses of Moderate Mental Retardation, Schizoaffective Disorder, Hypothyroidism, Chronic Eosinophilia Dylensia, and Chronic Brady Cardia. His medications include Zyprexa, Aricept, and Calcium Carbonate.

On 11/20/03 at 3:00 PM Client #1 was interviewed at his residence. He sat in an overstuffed chair. His left arm, in a hard cast from below his shoulder to his hand, was elevated with pillows above his heart. He appeared somewhat drowsy, awakening long enough to talk briefly. When asked, "How did your arm get hurt", his first response was a profane verbal offer of physical assault. When asked again, he said, "I fell this morning getting out of bed." Asked a third time he replied, "I fell in the bathroom at workshop." During the conversation he was asked from different angles about the injury to his arm. The explanation he maintained was that he fell in the bathroom at the day program. He said he was in the bathroom by himself and he got to his feet by himself following the fall.

Mims 0075

On 11/20/03 at 11:00 AM an interview was conducted with the Consumer Advocate, the agency employee responsible for mistreatment investigations. She reported an investigation had been initiated on 11/19/03 but the investigation was in process and not yet completed. She shared copies of the documents she had obtained regarding the injury. She said her initial assessment of the incident was that Client #1 had risen from his seat at the workshop and had gone to the bathroom where he fell. He returned to his table and reported to staff that his arm hurt. The workshop nurse checked his right arm, where he indicated the pain came from, and gave him an arthritis medication for joint pain based on his history of joint pain from arthritis. When he returned home, staff discovered his left arm was swollen and he complained of pain. He was transported to the Urgent Care Center where his X-rays confirmed his left arm was fractured in six places. He was released from the Urgent Care Center and returned to the residence with aftercare instructions to keep the arm immobilized and to be seen by an Orthopod on 11/19/03. On 11/19/03 the Orthopod examined Client #1 and reported the injuries were consistent with a fall that had occurred within 24 to 48 hours. A hanging cast was applied to reduce swelling and to induce alignment. A follow up appointment was made for one week to re-evaluate healing and to consider surgical repair after the swelling had diminished.
The Consumer Advocate reported Client #1's level of supervision need was assessed as "30 minute checks", meaning that he had freedom to move about the residence and the workshop with independence. She said Client #1 also was able to use the restroom independently.
She emphasized that the investigation was not complete, but her initial assessment was leading her to believe the injury resulted from an unfortunate accident with no information suggested staff mistreatment.

On 11/20/03 beginning at 3:15 PM staff members at the residence were interviewed. The House Manager reported Client #1 consistently reported the injury to his arm occurred when he fell in the restroom at the day program on 11/18/03. She said his level of supervision was "Level III" which she described as visual checks every 30 minutes. She said he required staff assistance in using the bathroom because he usually wore adult briefs for incontinence and needed staff assistance in changing them. She said he required 1 on 1 staff assistance when bathing in order to keep him safe.

On 11/20/03 at 4:00 PM a record review was conducted for Client #1. His Single Plan, dated 8/20/03, included "General/Personal Information" which documented "[Client #1's name]'s general accountability is a level III requiring some assistance in self care and thirty minute documentation. [Client #1's name]'s bathing accountability is a Level A, requiring 1 on 1 staffing while bathing." A toileting training objective was being implemented to wipe following bowel movements which staff were to train when toileting in the bathroom. The medical section of the record included no information about bone density concerns for Client #1.

Mims 0076

On 11/20/03 at 4:14 PM an interview was conducted with the facility nurse. The nurse reported being unaware of any bone density issues for Client #1. He elaborated that the prescription for Calcium included in Client #1 medication order would suggest the physician had some concern about bone density.

On 11/20/03 at 4:30 PM the Qualified Mental Retardation Professional (QMRP) was interviewed. When asked about the conflict between the report from the Consumer Advocate that Client #1 used the restroom independently and the House Manager's report that he required staff assistance when using the bathroom, she said she would go to the day program confirm the practice at that location in supporting Client #1 to the restroom. She added that she would call a meeting of Client #1's interdisciplinary team in order to reconsider his support needs across all settings. She said she would conduct monitoring visits at the workshop when Client #1 returns in order to ensure all needed support issues are addressed.

On 11/20/03 at 5:30 PM an interview was conducted with Client #1's sister/legal guardian. She reported Client #1 told her he injured his arm when he fell off the bus upon arriving at the workshop. Client #1's sister expressed concern that he sat at the workshop with a fractured arm for several hours and was transported home before he received medical intervention for the fractures. She reported the doctor told her Client #1's shoulder joint was out of socket and part of the reason for the delay in proceeding with surgery was to allow some time for the shoulder to "get back in place." When advised that Client #1 had given different accounts of the cause of the injury, his sister said, "Most of the things he tells me are credible, but he's afraid of the people at Babcock. When he's afraid, he will sometimes clam up and other times he will say something off the wall." It was Client #1's sister opinion that Client #1 injured his arm falling off the bus upon his arrival at the workshop on 11/18/03.

Results:

The complaint is partially substantiated as Client #1's arm was fractured with multiple fragments. Contrary to the complaint, the fracture was identified on 11/18/03, rather than 11/19/03 and he was not admitted to the hospital. Following a return appointment for evaluation during the week of 11/23/03 a determination will be made regarding appropriate follow up that might include hospital admission for surgical repair.

While discrepancies were identified in the Consumer Advocates report of the level of support Client #1 requires with toileting as compared with the residential staff report, it is not clear this discrepancy was an issue that impacted the injury. Based on Client #1's prescribed level of support he would have had freedom of movement to leave his workstation at the workshop to go to another location within the workshop without staff supervision.

Discrepancies also existed between Client #1's report of the cause of the injury and his sister/guardian's report of what he told her.

It is hoped these discrepancies will be identified and included in the completed investigation. As the investigation was not completed at the time of this review of the incident the results could not be evaluated with respect to thoroughness.

2. Client #1 was beaten with a belt by a 16 year old housemate (Client #2) in May 2002. Client #1's sister/guardian was not notified of the assault.

Findings:

On 11/20/03 at 11:00 AM an interview was conducted with the Consumer Advocate. She reported having no allegation related to this complaint and no investigation. She recalled some information about Client #2 having been involved in assaults against consumers of the resident from which he moved to Wire Road (the residence where Client #1 and Client #2 lived at the time of the incident) but said, "Not at this house."
The Consumer Advocate remembered something from another investigation regarding a belt assault by Client #2 and referred to an investigation involving Client #1 and Client #2. This case involved an alleged rape of Client #1 by Client #2. She provided a copy of the investigation of this incident that documented on 6/13/03 Client #1 alleged that Client #2 "got me last night" in explanation for pain and rectal bleeding. This investigation included an interview with a staff member who was asked if she was aware of any aggressive behavior from Client #2 toward Client #1. She reported that Client #2 had hit Client #1 with a belt. The investigation also included a 6/1/02, time not recorded, Accident/Injury Record that documented, "It was reported that another resident hit [Client #1's name] with a belt causing a sore on his lower back area." The sore was checked by the nurse on 6/3/03, time not recorded, who documented, "Area's red but not bleeding or draining, no treatment given." The Accident/Injury Report form also documented that Client #1's sister/guardian was notified of the incident on 6/3/02 at 12:06 p.m.

On 11/20/03 at 5:30 PM an interview was conducted with Client #1's sister/legal guardian. She reported no one at Babcock Center, neither staff members of the residence or staff from Babcock administration had ever spoken to her regarding the allegation that Client #1 was hit with a belt. She said she became aware of the incident through her attorney.

Results:

This allegation that Client #1 was hit with a belt by Client #2 is substantiated as a staff member report was discovered which alleged that Client #1 had been hit with a belt by Client #2 when both resided at the Wire Road residence. An accident/incident report verified the assault. The allegation that Client #1's sister/guardian was not notified of the incident was not verified, although the sister/guardian reported she had not been notified, the facility reported she had

been notified and presented documentation of the date and time of that notification. As the evidence was contradictory it was not possible to determine that Client #1's sister/guardian was not notified of the incident.

3. Client #1 reported Client #2 raped him, no rape protocol was done, Client #1 received a 2 ½ to 4-centimeter tear in his rectum, which had to be surgically repaired. Staff told the doctor Client #1 fell down. Client #1 reported to staff "that damn boy got me last night." Client #2 admitted getting into bed with Client #1. Client #1 was kept at the same residence with Client #2 for 2 months. Client #1's sister/guardian was not notified of this incident or injury.

Findings:

On 11/20/03 at 11:00 AM an interview was conducted with the Consumer Advocate who reported an investigation had been conducted into the allegation that Client #2 raped Client #1 and a copy of the investigative file was provided. The investigation documented that on the morning of 6/13/02 at the workshop Client #1 complained of pain and was observed bleeding from his swollen rectum. Staff reported he explained the bleeding and swelling by saying, "the damn boy got me last night." Client #1 was referred to the Urgent Care Center where he was interviewed by the investigator. The investigator reported Client #1 said, "the boy came in my room last night." When asked if he knew who this person was he stated "[Client #2's nick name]." When asked what happened Client #1 said he told Client #2 to get out of his room but the boy hurt him, indicating his buttock area. Attempts to gather additional details were not successful.

An evaluation by a physician at the Lexington Urgent Care revealed a 2.5 to 4 centimeter laceration of skin and superficial SQ tissues on the right perianal region. The physician was unable to determine if there was a fistula that extended down to the anal sphincter and was unable to determine if the laceration was the result of trauma or a suppulative rupture. The physician's notes did not indicate a report of the cause of the injury from either the client or the staff. No incident report regarding the allegation was included in the investigative file. There was no information regarding what was reported to the physician at the Urgent Care center regarding the cause of the injury. There was no evidence that a rape protocol had been conducted. The physician placed a clean gauze pack and recommended the area could be washed with Betadine as needed. A referral was made for a surgical evaluation later in the day on 6/13/02. The physician's notes from the initial visit documented that Client #1 was escorted to the appointment by a nurse from Babcock Center and Client #1 was unable to provide any history. The physician's note further documented, "He told them that he had some bleeding and they apparently noticed some bleeding earlier today. There is some question as to whether he may have had trauma to the area. They state that he may have fallen because he commented on this on one occasion." The physician's plan for follow up included, "I suspect this was

either a previous traumatic wound from possibly sitting on something or it could have been an abscess that spontaneously drained and someone just found that he has had drainage from it. I am going to treat it as an open wound and wash it out with hydrogen peroxide and apply dressings. I don't think he needs any antibiotics as there is no induration and this appears clean. He is to follow up with us in one week. He is to have Sitz baths twice daily." No surgical intervention was documented.

On the afternoon of 11/13/02 Client #2 was interviewed. He reported he went into Client #1's bedroom the night before. He stated that he got into bed with Client #1. When asked if he "had sex with [Client #1's name]" he answered, "In the bed." He added that it was "dark outside" when this occurred.

The investigative file included documentation that Client #1's sister/guardian was notified of the incident on 6/13/02. The Consumer Advocate reported she was present when the notification took place in order to be able to provide as much information as possible in the event the sister/guardian had questions about the incident.

On 6/13/02 the interdisciplinary team met and implemented the following interventions in order to provide for the "safety of other clients"; Client #2's level of supervision was changed to "15 minute general accountability", an alarm was set on his door, and staff were directed to "sit in the hallway to monitor his movements." Client #1 was subsequently moved, in August 2003, from the Wire Road residence to Ida Lane II. Asked why the move to another residence was not accomplished immediately, the Consumer Advocate reported there most likely was a delay based on availability of an alternative living setting.

On 11/20/03 at 5:30 PM an interview was conducted with Client #1's sister/legal guardian. She reported no one at Babcock Center, neither staff members of the residence or staff from Babcock administration had ever mentioned the rape of Client #1 to her, "not in all this time have they ever said a word about it." She said she became aware of the incident through her attorney.

Results:

The allegation that Client #2 raped Client #1 is substantiated based on victim and perpetrator statements and physical injury evidence. The allegation that no rape protocol was initiated during the treatment of the perianal rectal laceration is substantiated, although it is not clear if either of the treating physicians were notified of the possibility of the injury resulting from being raped. The allegation that Client #1 suffered a 2½ to 4 centimeter tear to his rectum requiring surgical repair is partially verified. The documentation verified a laceration to Client #1 perianal area that was 2 ½ centimeters in length and 4 centimeters deep. The documentation did not support the allegation that the injury to Client #1' perianal

area required surgical intervention. The allegation that staff told the doctor Client #1 fell down is verified based on the documentation from the surgical consult. No evidence existed that staff reported to either physician that Client #1 reported having been sexually assaulted. The allegation that Client #1's sister/guardian was not notified of the incident was not verified, although the sister/guardian reported she had not been notified, the facility reported she had been notified and presented documentation of the date and time of that notification. As the evidence was contradictory it was not possible to determine that Client #1's sister/guardian was not notified of the incident.

4. Client #1 was found to have an unexplained broken finger

Findings:

On 11/20/03 at 11:00 AM an interview was conducted with the Consumer Advocate who reported an investigation had been conducted into an unknown injury, a broken finger, experienced by Client #1. The investigation documented that Client #1 was observed on 7/21/02 throwing his bedrails around his bedroom and beating on his walls occasionally and saying, "I want out of this hell hole" and "I pray to Jesus to send me to heaven or hell" during a maladaptive behavioral episode. Following the incident staff observed Client #1's right middle finger being bruised and swollen. The staff member who checked the bruised finger said Client #1 did not complain of pain or flinch when she touched the finger. As a result she decided to watch it and monitor for any changes. On 7/22/02, the nurse observed the finger to be more swollen. A referral was made to the Urgent Care center where X-Ray's revealed a fracture to the right middle finger. The investigation suggested the fracture was sustained during the maladaptive behavioral episode involving throwing bed rails and beating the walls.

Results:

The allegation was substantiated.

Ida Lane II
Federal Survey Team Memorandum

To: Laverne Dixon

CC: Linda Joyce
(b)(6)
Amanda Cade

Date: November 28, 2003

Re: Provider #42G139

A complaint investigation was conducted in conjunction with a fundamental survey at the Ida Lane II home in Columbia, South Carolina on November 24 and 25, 2003. The Federal Survey Team was comprised of (b)(6), RN/QMRP, Team Leader, (b)(6), PH.D. Psychologist/QMRP and (b)(6) (b)(6) QMRP. Federal Surveyor (b)(6), QMRP, had conducted a preliminary investigation of the complaint during the week prior to the survey and briefed the team regarding his findings. At the time of the review, eight clients were in residence at the facility. Four individuals were selected as the core sample for the fundamental survey, with Client #1 identified as the individual named in the complaint.

The complaint, received by the Center for Medicare/Medicaid Services on November 19, 2003, alleged, in part, that Client #1 had been "hospitalized with six fractures in his left arm." The complainant further reported that Client #1's sister and family surrogate, suspected abuse or neglect.

Findings:

During the process of observation, record review and interview, the Federal Survey Team did determine that Client #1 sustained a comminuted fracture of the left hummers, at an unknown time on November 17th or November 18th. The fracture of the humerus resulted in the bone being displaced into five fragments. The client reported that he fell while alone in the bathroom at the Pinelake Seniors' Day Program, operated by the Babcock agency. There were no witnesses to corroborate the client's report.

Contrary to the complaint, the fracture was identified on November 18th, rather than November 19th, and he was not admitted to the hospital.

On November 18th, at the day program, at 9:35 AM, Client #1 was reported to be "sleepy," and he told staff he did not "feel good." After lunch, at 12:05 PM, Client

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#1 told staff he couldn't get up from his chair and that his "left shoulder was hurting." The nurse was notified and arrived at the Pinelake Day Program at 12:25 PM. The nurse reported that the client complained of "joint pain" and was using both his right and left arms at the time. Cataflam, 50 milligrams was administered as ordered for pain resulting from osteoarthritis.

On November 18th at 4:15 PM, Client #1 again complained of pain in his left arm and staff noted swelling and bruising as they assisted him to remove his shirt. He was transported to the emergency department at the Providence Hospital Northeast. Client #1 received treatment at the emergency department, returned to his home with the shoulder and arm immobilized, and with orders to be examined by the orthopedic surgical specialist the following day, 11/19/03. The orthopedic surgeon reported that the fracture was consistent with a fall that could have occurred 12 to 24 hours prior to the discovery of the injury. A follow-up examination was scheduled for 11/26/03 to evaluate Client #1's status for surgical reduction [correction] of the fracture.

Although the client has offered different explanations for the injury during separate interviews, he also told each investigator that he fell in the bathroom at the day program.

Client #1 required assistance in the area of personal care and toilet activities, as evidenced by his Individual Habilitation Plan and the reports of direct support staff. Staff at the home claimed that he was supervised each time he used the bathroom. Staff at the day program, however, stated that he used the bathroom independently and assistance was only provided upon his request.

Results:

The Federal Survey Team determined that Client #1 did have opportunities to go the bathroom at the day program and to do so unattended. The Individual Habilitation Plan did not specify the direct supports required by client #1 during toileting and the Qualified Mental Retardation Professional had not coordinated the Individual Habilitation Plan to ensure that the specific support needs for Client #1 were implemented in the home and program environments. See citations at W 159, W 240 and W 249.

Evidence was not sufficient to confirm abuse or neglect. The exact time of the incident and extenuating circumstances (if any) remain unknown. However, the agency's failure to consistently provide the protections and training needs outline in the client's program plan placed him at risk of harm. Therefore, this complaint was substantiated.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
ICF/MR Enforcement
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Ref: 42G139.141.12.08.03

December 8, 2003

Important Notice
Please Read Carefully
Re: Ida Lane II Community Residence

Ms. Adria Davis, Administrator
Ida Lane II Community Residence
124 Ida Lane
Columbia, SC 29203

Dear Ms. Davis:

On November 25, 2003 a complaint investigation and federal fundamental survey was completed at your facility by a CMS, Region IV, Federal Survey Team, to determine if your facility was in compliance with the Conditions of Participation (CoP) for Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The survey findings indicate your facility is not in substantial compliance with the Federal Requirements for participation in the Program.

Survey Findings

The survey findings are reflected on the enclosed Statement of Deficiencies (Form CMS-2567L).

A Plan of Correction (PoC) for the deficiencies identified must be submitted within ten (10) calendar days of receipt of this notice letter. Failure to submit an acceptable PoC by December 18, 2003 may result in further remedies being imposed.

To be considered acceptable, your PoC must contain the following:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

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- Address what measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and

- Include dates when corrective action will be completed.

Please submit your PoC to the attention of Ms. Karen Powell, ICF/MR Enforcement at the address on the letterhead, or you may fax information to 404/562-7540.

When your plan of correction has been accepted, a Region IV, Federal Survey Team will conduct a revisit to your facility to confirm compliance.

If you have any questions concerning this matter, please contact Ms. Karen Powell at (404) 562-7472.

Sincerely,

Karen Powell

for

Sandra Pace
Associate Regional Administrator
Division of Survey and Certification

cc: SC/SA
SC/SMA

Mims 0085

Addendum to CMS 2567 For Ida Lane II Review

(W154)

A. All alleged violations will be thoroughly investigated to include when the incident occurred, the report to the facility Administrator within 24 hours of the incident, and the outcome of the investigation with recommendations to prevent the recurrence.
B. Upon discovery of the incident, the QMRP will notify the facility Administrator and complete the Behavior Incident Report.
C. The investigation will include (a) persons to be notified; (b) interviews with all witnesses, including the client involved, when appropriate; (c) final disposition; (d) plan to prevent the recurrence.

The facility QMRP and Consumer Advocate will monitor monthly to ensure compliance.

Target Completion date: January 21, 2004

(W159)

The QMRP will ensure that all clients' active treatment programs are integrated, coordinated, and monitored.

A. All staff at Ida Lane II and staff at the day program that support the clients will be re-trained on clients' individual program plans.
B. The QMRP will implement training objectives for persons that require assistance with daily living skills such as toileting.
C. The QMRP will observe clients in the residential and day settings weekly to ensure staff assistance is provided as required with documentation be kept on file at the residence.

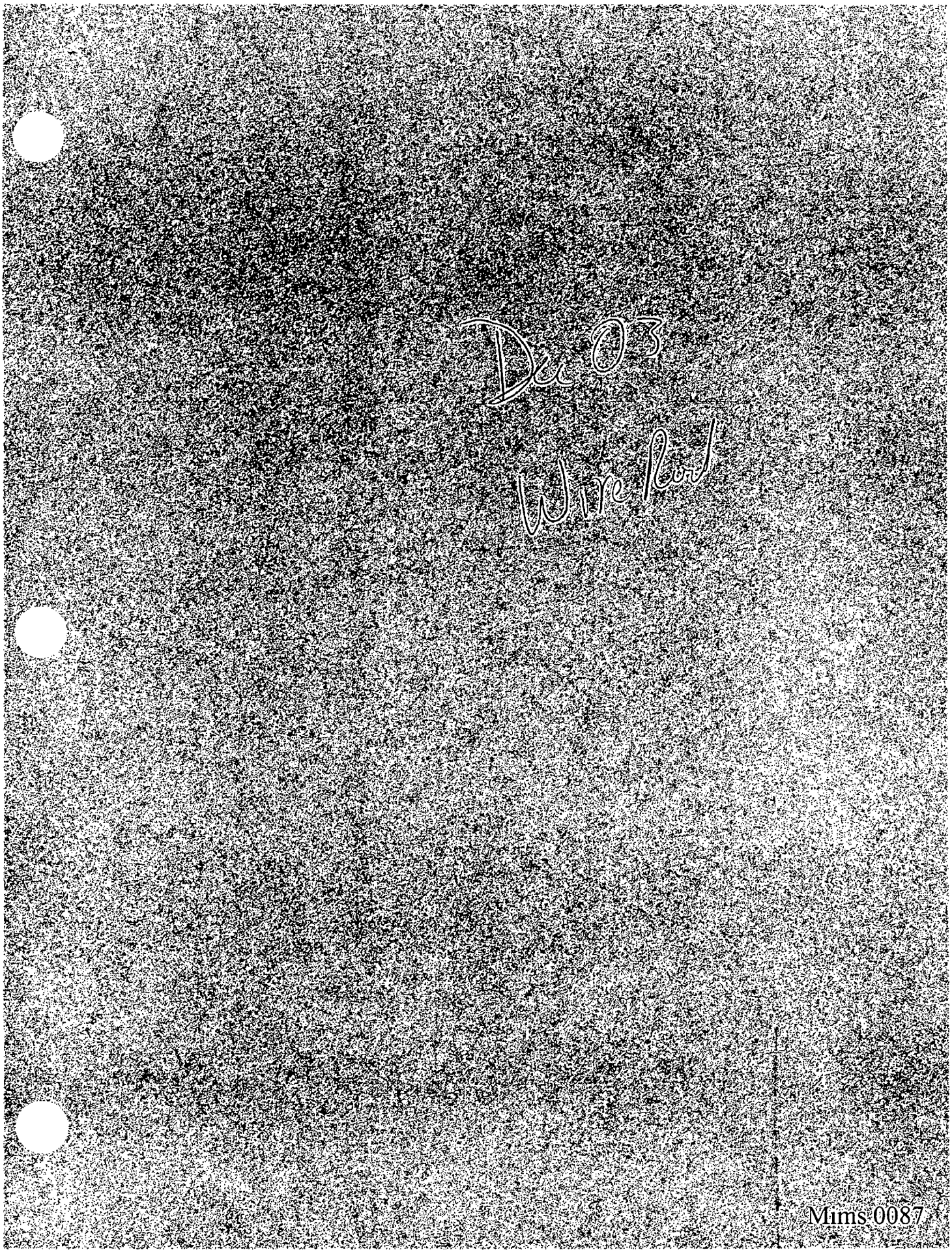
The facility Administrator will monitor to ensure compliance.
Target date: January 20, 2004.

(W240)

The QMRP will ensure the Individual Program Plans contain specific training information to support the clients at Ida Lane II.

A. The clients will be re-assessed in their daily living skills with training objectives implemented that have clear methods identifying how the staff should provide the training. This training will include ways to support clients that are on toileting objectives and monitoring.
B. Staff in residential and day program settings will be trained on changes in objectives so that clients receive consistent support in order to enhance independence.

Mims 0086


Dr. Oz
Mims 0087

WIRE ROAD II
FEDERAL SURVEY TEAM

TO: Laverne Dixon

CC: Linda Joyce
Amanda Cade

From: { (b)(6) }

Date: December 3, 2003

A fundamental survey was initiated in conjunction with a complaint investigation on 12/2/03 at the Wire Road II home, a residential service program operated by the Babcock Center, Inc., in Gilbert, South Carolina. The Federal Survey was comprised of: (b)(6) , RN/QMRP and (b)(6) - QMRP. During the course of the fundamental survey, a client in the core sample, Client #2, was determined to be at risk of potential serious harm. A situation of Immediate Jeopardy was declared.

The survey team first observed Client #2 during his vocational training program at the Clusters Day Program, an entity operated by the Babcock Center, Inc., on 12/2/03, from 10:30 AM to 12:30 PM. During an interview at 11:45 AM, direct support staff assigned to work with Client #2 said staff "feed" Client #2 because, "he chokes". She did not know of any specific instance when he had choked at the day program and was unaware of any assessments or training programs that dealt with eating or swallowing other than the fact that staff assist him in eating.

At noon, lunch was served at the day program. The staff took Client #2's lunch out of an insulated cooler. The lunch included two bologna sandwiches with lettuce (each sandwich was cut into four sections,) a container of potato salad, a container of fruit cocktail and several cookies that were the size of vanilla wafers. During most of the meal the staff asked Client #2 what he wanted to eat next. Client #2 would point to the food he wanted and the staff then fed him the food item selected. When he pointed to the first piece of sandwich, the staff broke one sandwich segment in half resulting in a piece the size of one-eighth of the sandwich. Staff handed him this piece; he put it all in his mouth and ate it. The client was observed to chew the sandwich very slowly and displayed some difficulty swallowing. Client #2 then picked up a ¼-sized piece of the sandwich, put all of it in his mouth and ate it, and again had some difficulty

PENGAD 800-631-6989 DEPOSITION EXHIBIT #14 Johnson 10-8-05

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swallowing. Staff did not intervene. Later in the meal, the staff opened the wrapper of cookies and placed them on the table. Client #2 picked up one cookie, put the whole cookie in his mouth and ate it. As the Client continued to eat, he was observed to tilt his head up and back. Staff did not intervene. Staff then left the room for approximately two minutes, leaving one of the sandwiches cut into fourths and the remaining cookies on the table. During that time, Client #2 picked up a second cookie, put the whole cookie in his mouth, and ate it. At 12:30 PM, at the conclusion of the meal, Client #2 drank his beverage from a cup with a spout lid using both hands to hold the cup up and above his mouth. As the client drank his beverage, his head was tilted up and back.

At Client #2's home, 2:15 pm, the Health Care Services Supervisor stated that Client #2 had problems swallowing and that his food was pureed to prevent choking. The Supervisor stated that nursing staff had noticed some problems with Client #2 swallowing his medications and had requested a speech evaluation. The clinical record for Client #2 was provided and included the following documents:

- An evaluation conducted by a speech pathologist was completed on 1/15/03. It documented a "choking episode" that had occurred three months prior to the evaluation [October of 2002] which had required the use of the Heimlich maneuver. As a part of the evaluation, the speech pathologist observed him in eating a snack of applesauce and finely chopped salad. She reported that Client #2 "exhibited minimal to no chewing". The speech pathologist concluded, "This places him at risk for swallowing any food with texture that could be aspirated and would then create choking potential." The Summary/ Recommendations section stated, "[Client #2] demonstrated insufficient chewing attempts to prepare regular food for safe swallowing. He is at risk for choking unless his food is presented to him in a consistency that would not necessitate any chewing for safe swallowing. It was discussed with staff and nursing that a ground diet is recommended. The nurse stated that she would get the diet ordered on 1/16/03. The following recommendations are made to maximize safe feeding/swallowing: 1. Change diet consistency for food to ground with regular liquids."
- Progress Notes and Orders dated 1/16/03 documented a voice order from the physician for Client #2. The note stated: "Change diet to regular, ground diet with regular liquids."
- An April 1, 2003, Dietician's report stated, "Continue regular diet".
- The Nurses Notes for 10/27/03 for Client #2 referred to the

consistency of his diet and stated, "Regular ground consistency – No larger than a grain of rice is hand over hand fed to prevent choking and packing his mouth".

- The Physician's Order Sheet dated 11/4/03 stated, "Regular – ground consistency – No larger than a grain of rice."
- The Nurses Notes for 11/24/03 for Client #2 referred to the consistency of his diet and stated,"Regular diet with ground consistency – no larger than a grain of rice – use hand over hand feeding to prevent choking and packing his mouth."

During an interview that began at 2:15 PM, the survey team described the noon meal to the Health Care Services Coordinator and the Administrator. The Health Care Services Supervisor stated that she was concerned and the Home Administrator stated that the day program needed to be aware of the diets. Both stated that the night shift staff at Wire Road II prepared the lunches and were responsible for assuring the appropriate consistency. They provided the survey team a copy of the diet instructions for Client #2 posted on the Wire Road II refrigerator for staff to follow. The Health Care Services Supervisor then stated that the diet was ground to the consistency of rice and that she was incorrect when she stated pureed.

At 3:05 PM on 12/2/03, the survey team reviewed a document titled "Mechanical Alterations" which was provided by staff and had been posted on the refrigerator in the Wire Road II kitchen. Client #2's name was next to the word, "Ground". The description provided on the form stated, "Alter to cooked, crumbled ground beef. Must use the food processor. May need to add liquid to get the right consistency." This document also instructed staff as follows: "All food must be mechanically altered before it is put on the table or packed in the lunch boxes. It is the responsibility of staff at the facility to follow the posted diets."

The survey team received a copy of the Client #2's Single Plan (Individual Habilitation Plan) dated 4/3/03, from the Administrator on 12/ 2/03 at 3:30 PM. The "Other Physical/Functional Health" section stated, "Diet: Regular diet". The section titled "Physical Health Needs and Recommendations for Actions" read: "Need: Regular diet".

The same afternoon at 4:10 PM, the Administrator confirmed Client #2's Single Plan (4/3/03) did not include the ground diet, but stated "regular diet."

At 4:00 PM, the Residential Director and the Home Administrator were interviewed. Asked to explain how Client #2 could have been fed a diet that

was not consistent with the physician's order, the staff stated that the 1:1 (direct support staff) assigned to the client should have known the diet was not appropriate and that the residential staff who had prepared the meal should have known the dietary texture was not consistent with the physician's orders. All staff were trained, they added, regarding the special needs of the clients. Quarterly in-service programs were conducted by the Qualified Mental Retardation Professional (QMRP) to ensure that all staff were knowledgeable of individual client needs. Minutes of a "Called Team Meeting," dated 6/9/03, were provided as evidence that staff at the day program had received specific information to provide services for Client #2. The minutes included the following statements: "The team recommended [Client #2] should be admitted into the Clusters Workshop. The team also recommended while in the workshop [Client #2] will have assistance when walking & eating." The meeting was chaired by the QMRP and attended by the Home Administrator, the Day Program Assistant Administrator, and a supervisor from the day program.

When asked how the programs were monitored, the staff replied that the QMRP monitored the day program services on a monthly basis. The team requested documentation to verify that all staff at the home and day program had received training regarding Client #2"s specialized dietary regime.

At 4:30 PM, the Assistant Day Program Director was interviewed by telephone asked what diet Client #2 received at the day program. After looking in the "program book" the staff responded, "[Client #2] gets the same diet as in the house, regular/ground." When asked if the food was ground at the day program, the staff stated that all meals were prepared and "ground" at the home each morning.

At 6:00 PM, the QMRP stated that was aware of the dietary alterations necessary to prevent the risk of choking for Client #2. He reported that there had not been mealtime concerns or choking episodes since Client #2 was enrolled in the day program beginning 6/9/03. The enrollment in the day program followed the client's graduation from high school. When asked to describe the system of monitoring, the QMRP stated that he visited the day program "on an average of once a week," but had not observed a mealtime for Client #2 at that location. When asked how the incident could have been prevented, the QMRP stated that lines of communication needed to be improved.

On 12/3/03 at 10:00 AM, one training record was provided to the team. The record, dated 2/12/03, listed attendance at a 1 ½ hour in-service training program on the topics of: "Mechanical Alterations, Grocery Receipts,

Bonus Card Use, Emergency Food Box-Baby Food for 3 Days and Proper Lunch Containers." Thirty-two attendees were listed from multiple residential facilities operated by the Babcock Center, Inc. Three worked at the Wire Road II residence and none were listed from the day program. No other documentation was provided to verify that any residential and or program staff working with Client #2 were knowledgeable of his individual support needs.

On 12/3/03 at 11:15 AM, the Residential Director and the Home Administrator were notified that a situation of Immediate Jeopardy had been confirmed based on evidence that Client #2 had been placed at significant risk of physical harm and the potential of death from choking on food that was not prepared as recommended by professional assessment and ordered by the physician.

Federal Survey Team Recommendations:

- Based on the failure of the facility to ensure that services were provided to prevent the risk of harm in all programming environments, W 120 is not met.
- Based on the failure of the facility to provide services necessary to prevent physical harm for all clients, W 149 is not met.
- Based on the failure of the facility to ensure that each active treatment program was integrated, coordinated and monitored by the QMRP, W 159 is not met.
- Based on the failure of the facility to provide training that enabled staff to perform their duties effectively and competently, W 189 is not met.
- Based on the failure of the facility to ensure that active treatment services were implemented to meet the crucial support needs of all clients, W 249 is not met.
- Based on the failure of the facility to provide a continuous active treatment program, implemented to meet the crucial support needs, including those related to the health and safety all clients, W 196 is not met and the Condition of Participation: Active Treatment Services, W 195 is not met.

Submitted by:
(b)(6) RN, QMRP

Mims 0092

artment of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Ref: 42G131.ijnot.12.09.03

IMPORTANT NOTICE
PLEASE READ CAREFULLY

December 9, 2003

Ms. Gilda Williams, Administrator
Wire Road II Community Residence
935 Wire Road
Gilbert, South Carolina 29054

Re: Wire Road II Community Residence – Immediate Jeopardy

Dear Ms. Williams:

A facility must meet the statutory requirements in Sections 1902(a)(31) and 1905(d) of the Act (42 U.S.C. sections 1396a(a)(31) and 1396(d), respectively) and be in compliance with each of the applicable regulatory Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded (ICF/MR), established by the Secretary of Health and Human Services at 42 CFR Part 483, Subpart I of the Social Security Act, in order to qualify to participate as a ICF/MR in the Medicaid program under Title XIX of the Act.

Survey Findings:

On December 3, 2003, a fundamental survey with a complaint investigation was conducted at your facility by the CMS Federal Survey Team, to determine if your facility was in compliance with Federal requirements for an ICF/MR participating in the Medicaid program. The survey findings revealed that the facility was not in substantial compliance with the participation requirements and found immediate jeopardy for the following:

- W120, failure of the facility to ensure that services were provided to prevent the risk of harm in all programming environments,
- W149, failure of the facility to provide services necessary to prevent physical harm for all clients,
- W159, failure of the facility to ensure that each active treatment program was integrated, coordinated and monitored by the QMRP,
- W189, failure of the facility to provide training that enabled staff to perform their duties effectively and competently,

Mims 0093

- W195, Condition of Participation: Active Treatment Services,
- W196, failure of the facility to provide a continuous active treatment program, implemented to meet the crucial support needs, including those related to the health and safety of all clients,
- W249, failure of the facility to ensure that active treatment services were implemented to meet the crucial support needs of all clients.

Pursuant to Section 1910(b)(1) of the Act (42 U.S.C.1396i (b)(1), the Centers for Medicare and Medicaid Services is canceling your facility's eligibility to participate in Medicaid, effective December 26, 2003.

Cancellation of Approval of Eligibility to Participate in Medicaid:
As a result of the survey findings, The Centers for Medicare and Medicaid Services is canceling the approval of your facility to participate in the Medicaid program effective on December 26, 2003.

Plan of Correction:
The facility must submit an acceptable, credible allegation to this office within five (5) days of receipt of this notice. The credible allegation must meet the following criteria:

- It must document that the remedial action taken by the facility has removed the deficient practice that constituted the immediate jeopardy to client health and safety; and
- It must demonstrate that the corrective actions have been accomplished between the survey date and the date of the credible allegation.

Please submit your credible allegation by fax to: Ms. Karen Powell, CMS, ICF/MR Enforcement, at 404-562-7540. Also, you may mail your credible allegation to:

Ms. Karen Powell, ICF/MR Enforcement
The Centers for Medicare and Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

If the credible allegation is timely and acceptable, an unannounced survey will be conducted to confirm removal of the jeopardy and correction of any other outstanding deficiencies. If compliance has been achieved on the revisit, CMS will rescind the cancellation of approval of eligibility for participation in the Medicaid program. If the jeopardy is removed but the facility remains out of compliance, the cancellation of approval may be extended to provide and opportunity to achieve compliance. If the jeopardy is not removed timely the cancellation of approval for eligibility for participation in the Medicaid program will be effective on December 26, 2003.

Reinstatement of Approval Following Cancellation:
When approval to participate in Medicaid is canceled by CMS, the facility's eligibility to participate in the program may not be reinstated unless CMS finds that the reason for cancellation has been removed and there is reasonable assurance that it will not recur. The facility must demonstrate through a reasonable assurance period that it can maintain compliance with all of the statutory and regulatory requirements for at least 90 consecutive days. Compliance with the requirements at 42 CFR Part 483, Subpart 1 will be verified by surveys conducted at the beginning and the end of this period. Before reinstatement, the facility must demonstrate its ability to comply with all pertinent

requirements of Title XIX of the Social Security Act. Medicaid eligibility will be reinstated following conclusion of the reasonable assurance period.

Appeal Rights:
If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board, in accordance with 42 CFR Part 498. A written request for a hearing must be filed on later than sixty (60) calendar days from the date of this notice. Such a request, accompanied by a copy of this notice should be forwarded by certified mail directly to:

Jacqueline T. Williams, Chief
Civil Remedies Division
Department of Health & Human Services
Departmental Appeals Board, MS 6132
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

Please forward a copy of your request for an appeal hearing to the Centers for Medicare and Medicaid Services, ICF/MR Enforcement to the address on the letterhead.

Your request for a hearing must identify the specific issues as well as the findings of fact and conclusions of law with which you disagree and explain the basis for contending that the findings and conclusions are not correct. You may be represented at a hearing by counsel at your own expense.

If you have any questions or concerns regarding this notice, please contact Ms. Karen Powell at (404) 562-7472.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

Cc: SA
SMA
CO/ICF/MR

Mims 0095

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEMORANDUM

Date December 9, 2003

From Rose Crum-Johnson, Regional Administrator
Atlanta Regional Office

Subject ALERT: Babcock Center, Wire Road II Community Residence
Provider #42G131

To Office of Strategic Operations

Nature of Alert (highlight ch

- ☐ Critical program developm — needs to be aware of — lead
- ☐ Issue that has received or is
- X Significant Facility issue
- ☐ Issue involving significant c
- ☐ Issue that the Administrator

Summary

Babcock Center, Wire Road II C... Residence, is an 8-bed Intermediate Care Facility for the Mentally Retarded (ICF/MR), located in Gilbert, South Carolina. The Federal Survey Team (FST) initiated a Complaint Investigation/Federal Fundamental Comparative Survey at the facility on December 2, 2003. The FST determined that a client in the core sample, Client #2, was determined to be at risk of physical harm and the potential of death from choking on food that was not prepared as recommended by professional assessment and ordered by the physician. Based on these findings, the FST determined that Immediate Jeopardy existed at W120, W149, W159, W189, W249, W196, and W195, the Condition of Participation 483.440, Active Treatment Services. This is the second Babcock facility to receive a notice of termination. Lexington of Cluster B was terminated on November 29, 2003.

Details

The FST found evidence that this facility did not have systems in place to:

- ensure that services were provided to prevent the risk of harm in all programming environments,
- to provide services necessary to prevent physical harm for all clients,
- to ensure that each active treatment program was integrated, coordinated and

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monitored by the QMRP,
- to provide training that enabled staff to perform their duties effectively and competently,
- to ensure that active treatment services were implemented to meet the crucial support needs of all clients, and
- to provide a continuous active treatment program, implemented to meet the crucial support needs, including those related to the health and safety of all clients.

In addition, the facility failed to consistently provide the staffing they identified as necessary to protect the clients. The Regional Office issued a notice advising the facility that CMS was canceling the approval of the facility to participate in the Medicaid program, effective December 26, 2003, if the jeopardy citations were not corrected by that time.

There has been daily (local) media interest in the investigations of Babcock facilities since the first termination on November 29, 2003.

Talking Points

- The Centers for Medicare & Medicaid Services (CMS) has issued to Babcock Wire Road II Community Residence a notice of termination because of deficiencies found which constituted serious and immediate jeopardy to clients' health and safety.

- Babcock Wire Road II Community Residence, located in Gilbert, South Carolina, is an 8-bed ICF/MR that was surveyed December 2-4, 2003.

- The facility was advised that its Medicaid agreement would be terminated on December 26, 2003, if the problems were not corrected.

- Our first priority is to protect the health and safety of the clients who reside in ICF/MRs.

- CMS only stops Medicaid payments as a last resort, when a facility can't or won't provide the quality care and safe environment that its clients deserve.

Contacts

If you need additional information concerning this matter, please contact Richard A. James at 404-562-7436, or Karen Powell at 404-562-7472.

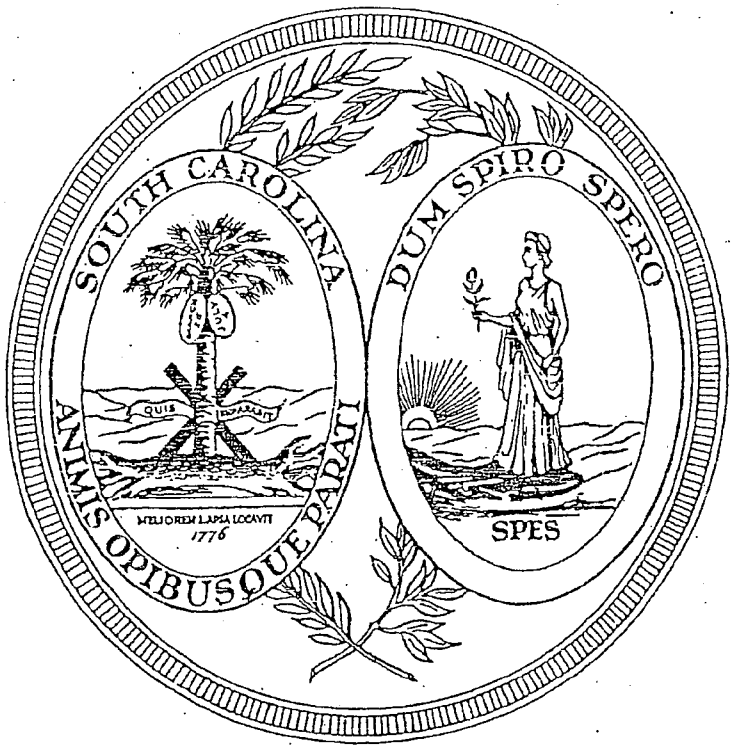
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Megan Stewart, OSORA
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Linda Joyce, CMSO

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2003
Limited Scope Audit

Mims 0098



A Limited Scope Review of Financial, Ombudsman, and Programmatic Issues of Babcock Center, Inc.

Submitted by

South Carolina Department of
Health and Human Services

October 2003

Mims 0099

A Limited Scope Review of Financial, Ombudsman,
and Programmatic Issues of Babcock Center, Inc.
October 2003

EXECUTIVE SUMMARY

In December 2002, the Centers for Medicare and Medicaid Services required that the SC Department of Health and Human Services (DHHS) investigate allegations that had surfaced concerning neglect, abuse, and misuse of funds at the Babcock Center, Incorporated. Babcock is a private, non-profit organization providing services to people with mental retardation and related disabilities and head or spinal cord injuries. Many of the services Babcock provides are funded with Medicaid funds. DHHS has a contract with Babcock and also provides Medicaid funds to Babcock through the SC Department of Disabilities and Special Needs (DDSN), which oversees Babcock's programs. As the state Medicaid agency, DHHS is responsible for the provision of safeguards to ensure the health and welfare of persons receiving care from Babcock and other Medicaid-funded programs. In addition, the DHHS Long Term Care Ombudsman Program is charged with investigating allegations of abuse or neglect in some of the facilities operated by Babcock.

This is a limited scope review. We focused only on the specific allegations that were made concerning Babcock Center, and did not investigate or review the operations of other DDSN facilities for this report. Therefore, we cannot conclude as to whether our findings reflect isolated incidents or are indicative of more systemic problems. The allegations that were substantiated will require corrective actions from both DHHS and DDSN, and may require that new controls be established in the contracts between the two agencies and with Babcock. Due to the findings from this review, DHHS also plans future audits of operations of DDSN, as well as other state agencies that receive significant amounts of Medicaid funds.

A portion of DHHS' review of Babcock Center follows up on findings addressed in a DDSN internal audit of the center. We also limited to the scope of our review to allegations and issues under three categories, as follows:

Financial findings, including:
- Unallowable uses of Medicaid funds;
- Theft of consumer funds;
- Mismanagement of and failure to supervise consumers' personal needs funds; and
- Failure of Babcock Center to follow DDSN's procurement policy.

Abuse, Neglect, and Exploitation findings, including:
- A lack of policy to define and require the reporting of serious resident-on-resident abuse to external authorities;
- Out of 15 allegations investigated, failure to report three incidents of alleged abuse, neglect, and exploitation as required by state law;
- Problems with consumer supervision and a need to ensure adequate staffing;
- Need to improve notification of investigation results; and
- Failure in some instances to follow corrective action plans as originally agreed upon.

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Programmatic findings include:

- Lack of habilitation service provider options beyond local county DSN Board providers due to historical reasons and a very limited number of inquiries from private providers;
- Need to ensure compliance with staffing ratios and to monitor vulnerable clients on a more frequent basis for health and welfare assurances;
- Failure to consistently provide transportation services for one individual;
- Incomplete and untimely service planning provided by Richland/Lexington DSN Board staff for a client;
- Failure to inform one individual (or the legal representative) of the feasible alternatives available under the MR/RD waiver; and
- Failure in one instance to provide due process to inform a waiver applicant of Medicaid appeal rights, freedom of choice and fair hearings.

In addition to the allegations of abuse, neglect, and exploitation that were investigated by the Ombudsman, DHHS had the authority to examine approximately 30 other allegations, of which about half were substantiated or confirmed. In cases involving the unallowable use of Medicaid money, DHHS can order repayment of funds. A repayment schedule has been prepared and is on page 32 of this report.

For allegations involving abuse, neglect, and exploitation of Babcock residents, the results of the investigation have been forwarded to the responsible party of the alleged victim for information and to Babcock. All verified Ombudsman allegations have been referred to the proper regulatory agencies and/or to the Attorney General's Office for future investigation and prosecution.

Within 60 days of receipt of this report, Babcock and DDSN should prepare and submit a plan to DHHS for implementing all recommendations contained in this report. All recommendations must be implemented by March 31, 2004, with priority attention being given to those recommendations affecting health and safety of Babcock consumers. Any new policies, clarifications, plans or other documentation required by the recommendations must also be submitted to DHHS by this time. Failure to take corrective action may result in a withholding of Medicaid funding from Babcock and/or DDSN. Recoupments are due upon notice, which is the date of publication of this report.

A response to the recommendations from the Department of Disabilities and Special Needs, in conjunction with Babcock Center, is included in this report on page 33.

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I. BACKGROUND AND SCOPE

Babcock Center, Inc., is a private, non-profit organization founded in 1970 that serves people with mental retardation, autism, head and spinal cord injuries, and related lifelong disabilities. In order to receive services from the Babcock Center, individuals must be determined eligible for services from the SC Department of Disabilities and Special Needs (DDSN). Babcock Center provides Medicaid services both under a subcontract with the SC Department of Disabilities and Special Needs and directly through a contract with SC Department of Health and Human Services (DHHS). Babcock operates several types of facilities for clients (called residents or consumers):

- Intermediate Care Facility for the Mentally Retarded (ICF/MR) A health-related facility licensed by the state to provide care to persons with mental retardation who do not need care in a hospital or skilled nursing facility.
- Community Residential Care Facility (CRCF) A facility which offers room and board and which, unlike a boarding house, provides or coordinates a degree of personal care or supportive services for individuals who have mental illness or disabilities.
- Community Training Home I (CTH I) A residential placement similar to foster care in a private citizen's home which is licensed and where the caregiver is a contract agency employee. Up to three individuals live in the home and receive personalized care, supervision and training.
- Community Training Home II (CTH II) A home owned or rented by the agency where up to three individuals live. A caregiver may also live in the home or staffing may be provided in shifts.
- Supervised Living Program I and II (SLP I and SLP II) The least restrictive residential placement that still provides staff oversight. Individuals live in apartments, duplexes or other housing and receive staff support and intervention based on personal need. Staff can be on-site or available within three minutes if residents need more supervision.

In addition, Babcock provides other services to DDSN consumers who are eligible under the Mental Retardation and Related Disabilities (MR/RD) Waiver. This is a 1915 (c) waiver which provides a broad range of special home and community-based services to Medicaid eligible individuals with mental retardation or related disabilities to help them live in the community rather than an institution. The allegations investigated for this report involved consumers in all types of Babcock facilities plus the waiver program.

Babcock is part of the network of providers which contract with the Department of Disabilities and Special Needs throughout the state. Babcock is the largest of these providers with a service area that includes Richland, Lexington, Fairfield, and Kershaw counties. In fiscal year 2002 (July 1, 2001, through June 30, 2002), Babcock had an operating budget of $41,496,373, of which 84% was Medicaid funding.

The directive for this investigation arose from numerous allegations filed with both the Centers for Medicare and Medicaid Services (CMS) and DHHS and newspaper publicity surrounding these allegations. The allegations included complaints concerning patient safety and quality of care; abuse, neglect, and exploitation; financial improprieties; and numerous other charges. Many of these allegations had initially been investigated by Babcock consumer advocates and by the Internal Audit Department of the Department of Disabilities and Special Needs, which is responsible for oversight of contractors, including Babcock. The following timeline shows the events leading up to DHHS' involvement in the Babcock investigations:

March 2002: The board of directors at Babcock Center, upon the recommendation of DDSN's state director, requested that the DDSN internal audit department review several areas of Babcock. Other substantive items had been brought to the attention of DDSN's internal audit department by Babcock staff, parents, board members, and DDSN staff and were also reviewed. The DDSN internal audit department reviewed Babcock operations for the period of January 1, 2000, through June 30, 2002.

October 2002: The DDSN internal audit report was completed and provided to Babcock's board. Both Babcock and DDSN agreed to a deadline of January 1, 2003, by which all of the corrective actions noted in DDSN's internal audit report would be completed.

November 2002: A letter from a Complainant was sent to then governor-elect Mark Sanford that detailed numerous allegations and problems at Babcock facilities, and alleged that Babcock and DDSN were not taking necessary corrective actions.

December 2002: The Atlanta Regional Office of CMS requested DHHS to conduct an investigation into allegations related to care provided to Medicaid clients served by the Babcock Center.

*****

DHHS is the State Medicaid Agency as specified in 42 U.S.C. §1396 et. seq. and S.C. Code Ann. §44-6-10 et. seq. to administer the Medicaid program in South Carolina. As part of the administration of the program, the department also administers services under a Medicaid waiver for persons with mental retardation and related disabilities. In addition to DHHS' role as the State Medicaid Agency, it is also the designated State Unit on Aging. This latter designation carries with it the responsibility of the State Long Term Care Ombudsman program. The Ombudsman program, therefore, became involved in the ensuing investigation.

Several sections within DHHS were involved in this report, including the Division of Audits; the Bureau of Senior Services, which houses the Ombudsman program; the Bureau of Long Term Care Services, which administers the waiver program; the Division of Program Integrity; the Bureau of Reimbursement Methodology; and the Office of General Counsel. In addition, the Department of Health and Environmental Control, which serves as the state agency responsible for surveying Intermediate Care Facilities for the Mentally Retarded, reviewed issues related to

its authority. Past survey reports of Babcock facilities were reviewed and a statistical analysis was performed. The statistical analysis revealed the number of deficiencies and violations from 2000 to the present. DHEC's findings are included in this report as an appendix.

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II. FINDINGS AND DETAILED RECOMMENDATIONS

A. FINANCIAL ISSUES

This section addresses the allegations of financial impropriety and mismanagement at Babcock Center, Inc., investigated by the Division of Audits at the South Carolina Department of Health and Human Services. Our review was based on allegations raised in the November 25, 2002, letter from a "Complainant" to then Governor-elect Sanford. Many of the allegations specified in this letter had previously been reviewed by the Internal Audit Department at the SC Department of Disabilities and Special Needs.

Based on the recommendation of DDSN's State Director, on March 28, 2002, the Board of Directors of the Babcock Center, Inc., requested DDSN's Internal Audit Department to perform a review of several areas of Babcock. The specific areas requested to be reviewed included:

- Compliance with DDSN directives regarding oversight of consumers' personal funds and personal property;
- Purchasing practices, including requirements for board oversight and approval;
- Consultant contracts to determine compliance with DDSN policies and prevailing practices;
- Adequacy and physical existence of computer equipment; and
- Use of credit cards, staff travel, and landline and cellular telephone expenses.

In addition, DDSN's Internal Audit Department also reviewed substantive items that were brought to their attention by Babcock staff, parents, board members, DDSN staff, or that were disclosed by the general tests performed during the audit. The scope of their review was January 1, 2000, through June 30, 2002.

The final DDSN internal audit report was provided to Babcock's board on October 29, 2002, and included 29 findings relating to consumers' health and safety, consumers' personal funds and property, personnel and payroll operations, and the Board of Directors. Included were responses from Babcock as to its corrective action plans and anticipated completion dates. Both Babcock and DDSN agreed to an overall deadline of January 1, 2003, by which all of the corrections would be completed. Babcock also was required to report to DDSN their progress on the implementation of corrections monthly, beginning in November 2002. However, Babcock did not complete the corrective actions required by the January 1, 2003, deadline. A number of specific completion dates were amended with DDSN approval. Final review of some of the financial data was on-going by DDSN's Internal Audit Department as of September 2003.

The following allegations were included in the November 25, 2002, letter from the Complainant, and most were initially reviewed by DDSN's Internal Audit Department. We reviewed DDSN's internal audit report and working papers, and also reviewed the corrective actions recommended to and/or taken by Babcock, in order to determine the following:

- Whether reliance could be placed on work already performed to determine the nature and extent of the financial problems;
- Whether DDSN's internal auditors had recommended appropriate corrective actions; and
- Whether DDSN has been adequately monitoring the progress of Babcock's corrective actions to address the findings in the internal audit report.

Theft and Misuse of Consumers' Personal Funds

Documented Instances of Theft

DDSN internal auditors documented two instances of theft of Babcock consumers' personal funds, and we materially agreed with their findings.

- In early October 2001, Babcock Center determined that there was $11,199 in consumer funds at the Lexington Clusters for which a House Supervisor could not account. The theft at the Clusters facility was revealed when a surprise cash count found several hundred dollars of the consumers' cash was missing. The House Supervisor admitted to requesting money to purchase items for consumers from Babcock's finance office and then depositing these funds into his/her own personal bank account.

  Although the DDSN internal auditor directed Babcock to report this theft to local law enforcement on November 26, 2001, it was not reported until February 1, 2002. DDSN internal audit also found that Babcock failed to timely notify the parents/guardians and failed to immediately reimburse the consumers. Finally, Babcock did not terminate the House Supervisor for misappropriation of consumers' personal funds (but did terminate him/her for abandonment of position).

- A House Supervisor at the Wire Road ICF/MR misappropriated $11,373 from the consumers' personal funds. The theft at the Wire Road facility was discovered after an anonymous phone call was received by Babcock's "CARE Hotline." This call reported that a staff member was stealing money from consumers at the Wire Road facility. DDSN internal audit found that residential and finance staff failed to adequately review and monitor the consumers' personal funds. For example, the Wire Road administrator failed to review receipts and reconcile consumers' personal needs funds and ledgers every three months as required. This could have timely detected or possibly prevented the theft. In addition, while the Personal Needs Supervisor from Babcock's finance office supposedly reviewed the receipts at this facility in July 2001, this supervisor too failed to detect the theft. At the time of the DDSN internal audit, unannounced audits were required to be performed at least once a year at all ICFs/MR.

It should also be noted that both cases were turned over to the Attorney General's Office (AG's office) for prosecution, and that Babcock has filed appropriate paperwork for both thefts with the

insurance company that holds their fidelity bond. The fidelity bond is required by the contract between DHHS and Babcock.

Repayment of Consumers' Funds

We determined that Babcock has taken the steps required in its corrective action plan in this area, although some issues were not fully resolved until July 2003, almost two years after the thefts.

- Affected consumers in the Clusters facility were appropriately repaid before July 31, 2002; Medicaid funds were not used to repay the consumers. We also reviewed consumers' bank statements and determined that repaid funds were timely deposited into affected consumers' bank accounts. Most checks were deposited the same day they were received or within three or four days after receipt with the longest period being 12 days, which is not excessive.

- Babcock has repaid all affected Wire Road consumers except one. Babcock has repaid a total of $9,710.37 beginning on August 16, 2002. According to Babcock, one consumer was paid only $600 of the total $2,309 owed him/her because a full repayment would have put the consumer over the Medicaid threshold of $2,000. Based on the consumer's team meeting decision, Babcock will place the additional funds owed this consumer in a pooled trust account for his/her benefit.

- Babcock's corrective action plan also required that retraining of appropriate residential management as well as designated finance staff on proper procedures for monitoring consumers' personal funds be conducted by DDSN's internal audit staff prior to December 31, 2002. We determined that training sessions were held in December 2002.

- Babcock has revised its policies and procedures for managing personal needs in the ICF/MR facilities. These policies include additional procedures to strengthen controls over consumers' personal needs funds. Examples include: checks are no longer sent via inter-office mail; the Finance Director does subsequent reviews of checks written from the personal needs account; a Personal Needs Roamer will visit the ICFs/MR on a regular basis to ensure the House Managers are maintaining monthly paperwork; and a training guide for House Managers has been developed. It should be noted that these controls have not been tested by DHHS.

Missing Receipts for Purchases

Another allegation involving misuse of funds stated that $87,083 in receipts for purchases made by consumers in ICFs/MR facilities were missing. This allegation was identified and verified in the DDSN internal audit report, which stated:

> Consumers' personal funds at the ICF/MRs are not being maintained in accordance with DDSN directive 200-12-DD. It was found that receipts for consumers' purchases totaling $87,083 were missing at 28 of the Center's ICF/MR facilities.

In its response to the DDSN internal audit, Babcock indicated that the center would continue to search for and review all receipts for the ICF/MR programs and would meet a deadline established of November 30, 2002. Babcock then contracted with a number of temporary personnel to review documentation submitted by the ICF/MR facilities. However, DDSN internal audit staff subsequently determined that the work done by the temporary personnel was not reliable.

Because of the dollar amount of the missing receipts, it was determined that DDSN's internal audit department would audit a sample of Babcock consumers' financial records (receipts) at all of the ICFs/MR that had not been already reviewed during the initial audit, and the Attorney General's Office would review the work done by DDSN. Babcock was required to deliver the consumers' financial records to DDSN's Internal Audit Department on February 21, 2003, where they would remain until the audit was complete and the AG's office approved their release. As of the date of this report, DDSN's internal audit staff have completed their review and forwarded their results to the AG's office.

In addition to this review, Babcock formed a workgroup consisting of Babcock employees familiar with Medicaid regulations and reviewed receipts for the period May 1, 2002, through December 31, 2002. DHHS reviewed the workpapers compiled by Babcock's workgroup at three facilities to determine whether this information could be relied upon. After reviewing this work, we had serious concerns with relying on the compiled information. These concerns have been shared with Babcock's finance director and DDSN's internal audit director.

Consumers' Personal Funds Used for Inappropriate Purchases

This allegation was also reviewed by DDSN's internal audit staff, and based on our review we agreed with their finding. The DDSN internal audit report of Babcock stated:

> There were a large number of inappropriate purchases being made with the consumers' personal funds that are funded by Medicaid and are the responsibility of the Babcock Center. Basic needed items such as beds, mattresses, washcloths, towels, bed linens, hygiene supplies, sanitary napkins and related supplies, etc. were purchased by the consumers. When asked, the residential and finance staff stated that the consumers have always paid for these type of items.

In its response to DDSN, Babcock indicated that all consumer expenditures during the past two years would be reviewed, items that were inappropriately purchased would be charged to the Babcock Center, and the consumers would be reimbursed. A target completion date of November 30, 2002, was set.

According to Babcock, a workgroup has completed a two-year look-back of all checks written from the consumers' personal needs bank accounts from December 2000 - December 2002 for inappropriate purchases. However, Babcock did not provide this documentation to us for review after repeated requests. Also, as of July 2003, Babcock has not repaid any consumers. Therefore, we requested that the review of inappropriate purchases be incorporated with the

missing receipts review that had been undertaken by DDSN's internal audit department. DDSN's internal audit director sent us a memorandum dated July 2, 2003, that documented the methodology for reviewing inappropriate purchases. Babcock turned over appropriate information to DDSN in July so that this review may begin. DDSN internal audit department completed this review in October 2003; final repayment schedules for Babcock to reimburse consumers for the inappropriate purchases will be developed shortly after the publication of this report.

RECOMMENDATIONS

1. At the conclusion of the review by the DDSN Internal Audit Department, the Department Of Health and Human Services Division of Audits should review the documentation prepared by DDSN to ensure compliance with Medicaid regulations and with the methodology outlined in the memorandum. Once this is complete, Babcock should develop a repayment schedule to reimburse all affected consumers in a timely manner and should ensure that the consumers' Medicaid and/or SSI eligibility are not affected.

2. The Department of Disabilities and Special Needs should implement a policy to ensure that providers' employees responsible for handling consumer funds are properly trained in accounting of consumers' funds. Since there is significant staff turnover, this training should be included in the orientation for new hires whose duties include this job function.

Improper Use of Medicaid Funding.

Use of Medicaid Funds for Severance Pay

The former Babcock Chief Executive Officer (CEO) was paid $120,000 for severance pay plus benefits using Medicaid funds. We found that the severance package paid to the former Babcock CEO was an unallowable use of Medicaid funds. The severance agreement was signed by Babcock's board chairperson in February 2002 and was subsequently ratified by the full Babcock board in October 2002. According to Babcock's current board chair, this agreement was approved by Babcock's board in February 2002, although this approval was not formally documented in the board minutes.

In Babcock's FYE 6/30/02 Medicaid cost report, Babcock claimed the severance pay costs as allowable costs. According to Medicaid policies, severance pay would be an allowable expenditure as long as it was a necessary and proper cost of operating patient care facilities. In addition, there must be an obligation for payment of severance pay, the severance pay

arrangement must be an accepted business practice in the health care field, and the amount involved must be reasonable to be allowable. We determined that the former Babcock CEO's severance package was not an allowable cost for Medicaid reimbursement because (1) the Babcock Center did not have a severance policy at the time of the dismissal of the CEO, and (2) the severance payments were not properly developed as required under Medicaid cost principles.

Because the costs of severance pay, fringes and insurance premiums paid to the former CEO are not expenditures reimbursable for Medicaid, they must be removed from allowable costs. The amount to be removed from allowable costs for the period March 1, 2002, to June 30, 2002, is calculated as follows: $42,791.54 severance pay, $3,273.55 payroll tax fringes, and $1,828.10 insurance premiums for a total of $47,893.19. (See schedule on page 32).

Erroneous Payments

One allegation involved a $1.3 million error in payments to Babcock. We determined that the $1.3 million was an adjustment from DDSN to Babcock for changes in reimbursable costs as a result of the closing of the Pinelake ICF/MR facility. When the Pinelake ICF/MR closed, 44 consumers were moved to a different care service setting. Pinelake had been under a direct contract with DHHS for Medicaid reimbursement. However, these consumers were moved to settings where their costs would be reimbursed through DDSN. Transferring the consumers from Pinelake to other facilities took several months, and since Babcock did not timely report the change in residential placement, DDSN's payment system did not adjust from a direct DHHS reimbursement to reimbursement through DDSN. This resulted in an underpayment of $1.3 million to Babcock Center, which was identified by DDSN and reconciled in the following quarter. (DHHS has no recommendations relating to this issue because it is unlikely that Babcock will in the future close another facility that serves a large number of consumers.)

Other Uses of Medicaid Funding

There were several other allegations made about improper uses of Medicaid funds that, upon review by DHHS, were determined to be allowable expenditures. These allegations included:

- Babcock uses Medicaid funds to pay approximately $120,000 a year in salaries for three consumer advocates. We determined that the payment of consumer advocates salaries and fringe benefits are allowable Medicaid expenditures based upon our review of the position descriptions. Babcock's consumer advocates are responsible for following up on all consumer concerns and quality of care issues as they relate to the health, safety, and rights of consumers served by Babcock Center.

- Babcock uses Medicaid funding to pay a pharmacy consultant $25,000 a year to provide professional advice related to administration, storage, etc. of medication. This is an allowable Medicaid expenditure. Babcock has a current contract with its pharmacy

consultant who performs general supervision of pharmaceutical services for all consumers in Babcock's ICF/MR, CTH II, and CRCF facilities.

- Under this year's contract, Babcock is being paid more than $1 million for empty beds. We were unable to substantiate this amount because more specific information was not provided by the complainant. However, we determined that bed reservation is an allowable expenditure for Medicaid payment and authorized by the SC State Plan The ICF/MR bed hold policy is intended to promote frequent and informal leaves from the facility for family and community visits, trips, activities, or vacations, while also ensuring continuing availability of a client's bed. The leave must be prescribed by the attending physician, and cannot exceed eight days per month.

In addition, it was alleged that Medicaid funds were used to pay two staff members who worked almost entirely for the Babcock Foundation. However, DDSN internal auditors determined that state funds, not Medicaid, were used to pay the Babcock Foundation employees and included this finding in the Babcock internal audit report, as follows:

> Babcock Center is incurring inappropriate costs and using State funding to pay the salaries and fringe benefits for Babcock Center Foundation's two employees. One employee works full-time and the other, the Executive Director (ED), works part-time (20-25 hours weekly).

Because state funding was used to pay the salaries of the two employees in question, DHHS does not have jurisdiction concerning this allegation.

RECOMMENDATIONS

3. The Department of Health and Human Services Bureau of Reimbursement Methodology should remove $47,893.19 for severance pay from allowable Medicaid costs applicable to Babcock's FYE 6/30/02 cost report during its annual desk audit/cost settlement process (which is currently in process). Babcock should ensure that 100% of all severance pay, applicable payroll tax, and all health insurance premiums paid for previous employees receiving severance pay are removed from allowable costs on all 6/30/2003 Babcock Medicaid cost reports. This would apply to ICF/MR cost reports submitted to DHHS and applicable cost reports submitted to DDSN.

4. In addition, the Department of Disabilities and Special Needs should amend the applicable FYE 6/30/02 cost reports to remove the allocated portion of the related severance pay costs reported by Babcock. DDSN should also exclude the allocated portion of the related severance pay costs reported by Babcock during the preparation of its FYE 6/30/03 cost reports.

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5. If the Department of Disabilities and Special Needs wishes to provide for severance payments to subcontractor executives, then it should ensure that any severance payments are properly developed and allowable under Medicaid cost principles.

6. As part of the follow up audit of Babcock, Department of Disabilities and Special Needs internal audit staff should review and test a sample of Babcock's long-term care/mental retardation facilities to ensure that Babcock is in compliance with the state's bed hold policy and that leaves of absence are properly documented. If possible, DDSN should determine the annual cost to Medicaid of following the state's bed hold policy. A copy of DDSN's follow up audit report should be sent to DHHS Division of Audits.

Payment Methodology and Staffing Ratios

Pay Bands

The original complaint letter expressed numerous concerns over staffing ratios at Babcock facilities, and whether the Medicaid funds to provide for adequate staff were being used for that purpose. Inadequate staffing was alleged to be a factor in the lack of proper supervision of consumers, which was one of the causes of resident-to-resident abuse and negligence. (The allegations involving resident-to-resident abuse and negligence by Babcock staff were reviewed by the DHHS staff with the Long Term Care Ombudsman's program. Their findings and recommendations are in Section B of this report.)

Different facilities operated by Babcock have different staffing ratios. For example, in one supervised living residence, two staff members provided supervision/transportation for 12 residents (a one to six ratio), while the ratio at another supervised living residence was one to sixteen. Staffing ratios are based on the level of care needed by individual consumers. Funds to pay for consumers needs are provided by DDSN through "pay bands," or a capitated system, which provides a mechanism to identify the resources available on an annual basis for the consumer. The annual band payment is a daily rate multiplied by 365. This is in many ways the same as DHHS paying daily rates to various nursing homes or residential care providers that include services covered by the daily payment. The cash is provided to the DSN Boards a month in advance for almost all services so as to assure that there are sufficient resources available to meet consumers' needs in a timely manner.

For new consumers, band levels are supposed to be determined using a variety of need assessments which are incorporated into the consumer's service plan. The information collected determines the level of care needed for the individual consumer: the greater the level of care, the higher the staffing ratio and hence, the higher the band payment. The various payment levels are

based on historical cost reports that identify the cost of services for the various levels of need. (A letter from DDSN's Deputy State Director, describing the band payment system, is in Appendix D.)

We determined that the band payment system is an allowable reimbursement method provided that:

- DDSN can ensure that this system meets consumers' individual needs;
- Levels of care and care plans are not based solely on where a consumer lives; and
- DDSN has adequate documentation to tie band levels to actual costs of services delivered.

While DDSN uses the band payment system to budget allocations to Babcock, it is reimbursed for Medicaid expenditures based on cost reports submitted to DHHS.

Accounting for the Use of Outlier Funding

In cases where consumers' circumstances and needs are substantially higher than the average, Babcock is given additional funding equal to the difference in the consumer's approved budget and the consumer's band amount (as defined above). This is called "outlier funding," and can be used when consumers need one-on-one care.

One concern was that, if some consumers were funded to receive one-on-one care, how were the alleged incidents of abuse and neglect able to occur? Were these consumers, in fact, receiving the one-on-one care? We reviewed Babcock's plans of care for two consumers referenced in the allegation. Although one-on-one care was prescribed for the two consumers, Babcock's documentation to show that both consumers received one-on-one care as required in their care plans was not 100% complete. For example, staff notations documenting supervision at five-minute intervals were not always complete.

Babcock received interim payments for FY 2002 from DDSN for $27,254 and $94,224 for outlier funding for each consumer, respectively. These amounts are in addition to the $65,567 Babcock received from the band system for *each* consumer. Thus, Babcock received a total of $92,821 and $159,791, respectively, in Medicaid funds to care for these consumers.

In addition, DDSN should not pay extra funds for one-on-one care unless medical and/or behavioral need is documented by a physician or qualified professional, requested in writing from a provider, and approved by DDSN. In order to determine if DDSN followed internal funding methodology, we reviewed DDSN's Service Tracking System (STS) and outlier funding requests submitted by Babcock for these consumers. Babcock's outlier funding request supported that one consumer was medically approved for outlier funding for FY 2000 only, and that this funding would not automatically roll to FY 2001 or FY 2002. Babcock's outlier funding request supported that the other consumer was medically approved for outlier funding for FY 2000 and FY 2001 only, and that this funding would not automatically roll to FY 2002.

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However, the STS indicates that both consumers continue to receive outlier funding. The "End Date" on STS for both consumers is shown as "00000000," meaning that a termination date has not been established. This means that both consumers will continue receiving outlier funding until such time as an "end date" is keyed into STS.

We determined that DDSN has been obtaining verbal confirmation from providers that consumers who receive outlier funding continue to have the medical and/or behavioral conditions requiring the increased funding. Because of the significant dollar amounts of outlier funding, we believe that providers should justify annually a consumer's continued medical and/or behavioral need for greater services. This continued need should be documented in the consumer's file and signed by a physician or other qualified individual.

RECOMMENDATIONS

7. The Department of Disabilities and Special Needs should work with Babcock to develop and implement an adequate system of accountability to assure that consumers are receiving one-on-one care if this level of service is required in the consumer's plan of care. DDSN should ensure that Babcock's accountability system is capable of tracking Medicaid funding to show that Medicaid funds approved for one-on-one care for a particular consumer were actually utilized by Babcock for that purpose.

8. The DHHS Division of Audits should audit the pay band system to ensure that it follows all federal and state requirements; that funds allocated for consumers are used to meet their needs; and that cost reports submitted by DDSN continue to justify reimbursements claimed.

9. DDSN should expand its outlier status procedures to include steps that should be followed by providers to request continuing outlier funding for their consumers. Additionally, DDSN should expand outlier status procedures to include steps providers should follow if a Medicaid consumer's need changes (increase or decrease) before the annual outlier request has been submitted and approved.

10. DDSN should ensure that providers have appropriate documentation to support the consumers' need for outlier funding and one-on-one care. DHHS and DDSN should develop guidelines that outline retention requirements for one-on-one accountability records and other documentation and should share this information with their providers.

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Procurement Policy Not Followed & Other Contractual Issues

Purchase of Chairs

Babcock purchased $100,000 worth of chairs for ICF/MR facilities in the spring of 2001 with state and Medicaid dollars. The Babcock board was not consulted or informed, and no bids were taken to comply with DDSN's procurement policy for DSN boards, which is similar to the SC Procurement Code. The DDSN internal auditors included this instance in their report, and based on our review we concur with their finding. According to DDSN auditors, Babcock Center had a single purchase order issued December 18, 2000, for 718 new chairs for the ICFs/MR priced at $107.90 each plus sales tax. The total purchase cost was $81,345.70. Only one vendor was contacted. Babcock Center's policy allowed each chair to be considered a single item purchase; since each chair cost less than $1,500, competitive quotes were not required. However, Babcock Center's procurement policy was not in compliance with DDSN's procurement policy. Had DDSN's procurement policy been followed, the single purchase rule would have applied. Babcock would have had to solicit written quotes submitted as sealed bids from at least ten qualified sources since the purchase exceeded $25,000. The procurement would have had to have been advertised at least once. Babcock has since changed its procurement policy to adhere to the single purchase rule.

Computer Consultant

A computer consultant was working with Babcock without a contract and was paid $120,000 per year. DDSN internal audit also reviewed this allegation, and we agree with their finding that the allegation is correct. Babcock Center had an unwritten contract with an outside company at a cost of $124,200 per year to provide technical support for its computer software and hardware. These services were procured without soliciting proposals from potential contractors. However, in early September of 2002, the former computer consultant was hired as the IT manager for Babcock.

Other Allegations

There were several other allegations involving contracts and other procurement issues. However, we determined that most of these allegations were unfounded or not substantiated. These included the following:

- DDSN improperly handled the award for a contract for a quality assurance review. We determined that this allegation is incorrect. Due to the estimated value of the contract, DDSN worked with the SC Budget and Control Board, Procurement Services Division, Materials Management Office (MMO) to award this contract and followed the requirements of the Procurement Code, including issuing a Request for Proposal (RFP).

- DDSN has a contractual relationship with a former DDSN State Director who is also involved with MENTOR and First Health. Based on our review it was determined that

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the former DDSN State Director is working as a temporary, part-time employee for DDSN and does not have a contractual relationship with DDSN. His/her role is to work with new DSN executive directors and boards who need technical assistance in the areas of management and operations.

- A current Babcock board member is benefiting financially by his/her relationship with DDSN. Based on our review it is concluded that this allegation is unsubstantiated. The board member is not a vendor of DDSN.

- Babcock did not properly follow DDSN procurement policy in hiring a new external auditor. Based on our review it was determined that Babcock appropriately followed DDSN procurement policy with respect to this transaction. Babcock placed an invitation to bid for audit services in May 2002 for a three-year contract, through FY 04-05. Six CPA firms submitted proposals, which were evaluated by the members of Babcock's finance committee. It was noted that Babcock's board minutes did not reflect the ratification of the awarding of the audit services contract. Although Babcock's board may have approved the contract award as recommended by the finance committee, this approval was not formally documented in the board minutes. Payment for auditing services is an allowable Medicaid expenditure.

RECOMMENDATIONS

11. The Babcock Center, Inc., Board of Directors should ensure that approval of all future contract awards is documented in the board minutes and should add this requirement to their procurement policy.

12. The Department of Disabilities and Special Needs should ensure that Babcock follows the requirements of DDSN's procurement policy and should consider imposing penalties if these policies are not followed.

Other Issues of Concern

Failure to Maintain Medicaid Eligibility

A consumer lost Medicaid eligibility in August 2001 due to the conservator refusing to provide income information. Based on our review it was determined that this allegation was correct. A consumer lost Medicaid eligibility from August 1, 2001, through December 1, 2001, because the conservator failed to provide income information to the Richland County Department of Social Services (DSS). Notices were sent to the conservator several months before the consumer's Medicaid eligibility was discontinued, and notices continued to be sent after eligibility was lost. Notices were sent by Richland County DSS, DDSN, and Babcock to the conservator, an attorney for the conservator, and to a Probate Judge requesting authority for Babcock to receive the

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income information on the consumer's behalf so that his/her Medicaid eligibility would not be discontinued. On April 5, 2002, the income information was received, and the consumer's Medicaid eligibility was reinstated as of December 1, 2001.

We concluded that Babcock and DDSN took appropriate action for the benefit of the consumer to obtain required income information in an effort to safeguard the consumer's Medicaid eligibility. These efforts resulted in the consumer loosing only four months of Medicaid eligibility. We determined that Medicaid was not billed for the four months this consumer was ineligible.

DHHS also reviewed the personal needs account activity for the consumer for August-December 2001. No exceptions were noted from this review. The consumer is receiving $30 in SSI monthly and is earning $70 monthly in income.

Consumer's Checking Account Overdrawn

One consumer reported that his/her checking account was overdrawn; someone had been able to make an automatic withdrawal in the amount of $300 from his/her account. We determined that the $300 withdrawn out of this consumer's account was done with his/her knowledge. This consumer has a telephone in his/her room and supplied his/her checking account number to obtain a credit card with a fee of $299. This was done without the knowledge of the consumer's guardian and staff at the CTHII where the consumer lives. The $299 fee was charged to the consumer's bank account on October 4, 2002, causing the bank account to be overdrawn and an overdraft fee of $27. The bank mailed notification of the overdraft to the CTHII, and another $27 overdraft fee was posted to the consumer's bank account on October 7, 2002. The house manager contacted the credit card company, which cancelled the consumer's credit card, and the $299 charge was reversed on October 15, 2002. The house manager also contacted the bank, which forgave one of the overdraft fees on October 18, 2002. We concluded that this matter was handled in a proper and timely manner.

Falsifying Time Records

One consumer reportedly watched staff falsify time records by clocking in and out for each other. We were unable to address this allegation, since more specific information was not provided by the complainant. Babcock's time card policy contained in their Employee Handbook was reviewed to determine whether sufficient controls were in place to prevent or deter employees for clocking in and out for each other. In addition, we spoke with a staff member of Babcock's human resources department to determine what supervisory review was done to employee time cards. Employees are required to use a time clock when clocking in and out for work and are responsible for the hours reported on their time cards. Supervisors record the hours worked by their employees from the time cards and submit this information and the employees' time cards to the Babcock administrative office for processing. Supervisors are reviewing the hours reported by their employees on their time cards to ensure the employees are being paid for the hours they worked.

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B. ABUSE, NEGLECT, AND EXPLOITATION OF BABCOCK RESIDENTS

This section addresses the allegations of abuse, neglect, and exploitation of Babcock Center residents that were investigated by the Long Term Care Ombudsman Program with assistance from the Program Integrity Unit. The Ombudsman investigated allegations involving:

- Resident death as a result of neglect;
- Resident-to-resident abuse;
- Staff-to-resident abuse and inappropriate conduct by staff;
- Failure to report abuse, neglect, and exploitation;
- Medication errors;
- Restrictions on freedom of choice; and
- Failure to maintain adequate staffing.

The purpose of the Ombudsman's involvement in this review was threefold:

- Under both state law (The SC Omnibus Adult Protection Act) and federal law (the Older Americans Act), the Ombudsman is required to investigate complaints made by or on behalf of individuals who reside in facilities operated or contracted for operation by the Department of Disabilities and Special Needs (DDSN).

- Although the majority of the allegations involving Babcock Center had been investigated appropriately by the Consumer Advocate Unit and appropriate action had been recommended, there were concerns that in some instances Babcock Center did not follow up with corrective actions as recommended by the consumer advocates.

- Approximately 15 allegations of abuse, neglect, and/or exploitation were investigated in this report. It was determined that three of these incidents were not reported to the responsible party and/or to the Ombudsman Program as required.

Information related to Ombudsman investigations is exempt from disclosure under the SC Freedom of Information Act, and, unless consent is obtained, disclosure of individually identifiable information is prohibited under both state and federal laws. Therefore, we did not include many details as to the nature of the allegations but rather have focused this part of the review on recommending improvements for the future.

Findings and Recommendations

The Ombudsman Program investigated a total of 33 allegations that included physical abuse, medical neglect, financial exploitation, failure to report, medication errors, restrictions on freedom of choice, failure to maintain adequate staffing, resident-to-resident abuse, and

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inadequate supervision. Many of the cases involved more than one complaint. It was found that most of these allegations had already been investigated by the Babcock Center and appropriate action had been recommended. The investigations or re-investigations for this report included interviews with the resident's responsible party and with Babcock Center staff, as well as a review of the Babcock Center's internal investigations, appropriate hospital records, and all applicable facility documentation. It was then determined if appropriate reporting to and follow-up with law enforcement or other state agencies had been carried out. Our investigative findings were forwarded to the responsible party of the alleged victim and to Babcock Center. All verified allegations not previously reported have also been referred to the proper regulatory agencies for action, and/or to the Attorney General's office for investigation and prosecution. We also sent closing letters regarding any investigations or re-investigations to the responsible parties and the facility.

Because of the findings that involved the health, safety and welfare of Babcock Center consumers, attempts were made to determine the factors that contributed to these problems and recommend corrective actions. The problems that were identified generally fell into the categories of abuse, neglect and exploitation; resident-to-resident abuse; failure to report critical incidents; inadequate staffing and supervision; failure to follow up with the responsible parties; and failure to follow corrective action plans. We have suggested interventions that would help prevent these occurrences in the future. Failure to adequately address these problems could raise serious questions about Babcock Center's ability to provide for the day-to-day safety and welfare of its clients.

Resident-to-Resident Abuse

While DDSN has a policy that requires reporting of all critical incidents internally, there is not a policy that requires the reporting of serious instances of resident-to-resident abuse to the Ombudsman Program or to Adult Protective Services (at the Department of Social Services). There has been no policy in this area because the Omnibus Adult Protection Act (OAPA) does not include altercations or acts of assault between vulnerable adults as physical abuse. However, since the safety of these vulnerable individuals is at stake, serious incidents of resident-to-resident abuse should be reported to external parties. In addition, resident-to-resident abuse could be an indication of negligent supervision on the part of Babcock staff.

It should be noted that the system for reporting resident-to-resident abuse could be confusing to law enforcement, the public, and facility staff. Under the S.C. Omnibus Adult Protection Act, a resident of a facility is considered a vulnerable adult. However, under the same law, physical abuse does not include altercations or acts of assault between vulnerable adults. As a result, facility staff could sometimes be confused about reporting abuse or acts of violence when the perpetrator is another resident. Currently, the S.C. Attorney General's Office does not investigate resident-to-resident abuse as specified under the OAPA. Therefore, we recommend that the S.C. Adult Protection Coordinating Council conduct a thorough review of and

recommend changes to South Carolina's system for reporting abuse, neglect, exploitation, and altercations and acts of assault between vulnerable adults.

In the interim, all serious allegations of resident-to-resident abuse or altercations between residents in DDSN facilities should be reported to the Ombudsman Program or to Adult Protective Services (according to the type of facility where the incident occurred). The Ombudsman Program and DSS should follow-up on the most serious incidents to determine if adequate supervision was being provided to these vulnerable individuals.

In addition, although DDSN has written procedures for transitioning new admissions, it lacked formal, written procedures to address issues of transition and training when a consumer is transferred from one Babcock Center facility to another. Consumer safety can be endangered when certain residents are transferred to a new facility where they do not know the staff, and the staff does not know the residents' previous history or problems. DDSN could use its admissions policy for transitioning new residents except in cases of emergency. In addition, relocation procedures should take into account freedom of choice for consumers whenever possible.

Failure to Report Abuse, Neglect, and Exploitation

Of 15 allegations of abuse, neglect, and/or exploitation investigated, one instance was identified where Babcock Center failed to report the allegation to the Ombudsman as required, and two instances were identified where Babcock failed to report to the clients' responsible party. Since the Ombudsman's Office plays such a critical role in the protection of vulnerable adults, even one failure to report an incident is a critical area which needs to be addressed by DDSN and Babcock.

The Omnibus Adult Protection Act defines the responsibilities for reporting abuse, neglect and exploitation of vulnerable adults. DDSN policy also specifies that all suspected abuse, neglect, or exploitation must be reported to state or local law enforcement agencies and to the Ombudsman Program or DSS within 24 hours. Serious cases of physical abuse with injury or severe neglect must be reported immediately.

DDSN Directive 534-02-PD, *Procedures for Reporting, Investigating, and Preventing Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency*, has outlined this requirement in detail. The directive also states that local and state law enforcement agencies may investigate an allegation of abuse, neglect, or exploitation, but that a referral to law enforcement does not relieve DDSN or contract provider agencies from also reporting the allegation to the Ombudsman or DSS.

Finally, in several of the Babcock facilities visited by ombudsman investigators during the month of January 2003, notices were not properly displayed for reporting abuse, neglect, and exploitation. Under the Omnibus Adult Protective Act, DDSN and its contractors must prominently display notices about the mandates for reporting abuse, neglect and exploitation.

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The notices outline the penalties for not reporting and the penalties for intimidating or threatening a person cooperating with an investigation. The posters should contain the phone number and address of the State and Regional Long Term Care Ombudsman Program and local law enforcement. Posters may be requested from the Long Term Care Ombudsman Program. This directive has been in place since the Omnibus Adult Protective Act was enacted in 1993. However, it was found that the posters had not been properly displayed in all Babcock Center facilities.

Problems with Staffing and Consumer Supervision

Although policy directives state that DDSN's provider agencies will conduct quarterly visits, no directives were identified for conducting ***periodic unannounced*** visits to community residential locations during evening and nighttime hours. DDSN should ensure that sufficient staffing is being provided in accordance with agency standards and consumer needs. DDSN must also ensure that adequate supervision is being provided according to the resident's care plan. These unannounced visits should begin immediately and should also be made a part of DDSN's policies and procedures.

In one instance Babcock Center failed to provide one-on-one supervision for a high-needs individual. *(This finding was also discussed in part A: Financial Issues.)* Intensive supervision is needed by some DDSN consumers whose safety (or when the safety of others) would be at risk if not supervised appropriately. DDSN consumers who are funded to receive one-on-one supervision should be supervised as specified in their plans of service. Supervision is also needed when consumers are allowed to attend off-site activities.

Another contributing factor to concerns about consumer safety was the lack of written procedures for requesting medical assistance during emergency situations. In one emergency situation, the on-call nurse could not be reached by staff and did not return emergency messages in a timely manner. Staff should have been instructed to contact EMS or call 911 immediately when nursing staff are unavailable.

It should be noted that the SC Ombudsman asked the Attorney General's office to determine if there was neglect on the part of the on-call nurse who failed to respond to the emergency messages. In October 2003, the AG's office determined that neglect had <u>not</u> occurred.

Need to Improve Notification of Investigative Outcomes

DDSN did not have a policy directive in place that requires the consumer's responsible party to be notified ***in writing*** of the outcome of Babcock's internal investigations. Babcock's practice has been to notify responsible parties by telephone of the results of abuse or neglect investigations. A new policy directive should be implemented for all DDSN and Babcock

Center facilities that requires closure letters when an internal investigation is conducted and the case has been resolved. The closure letter should state that the investigation was conducted in accordance with the Omnibus Adult Protection Act; state the reason for the investigation; explain what the investigation included; and state whether the allegation or complaint was verified. A copy of the closing letter should be sent to the family or responsible party for the resident. A copy of the letter should also be forwarded to the Ombudsman Program as part of the investigation documentation.

Failure to Follow Corrective Action Plans

When complaint investigations were conducted by the Babcock Center and allegations were substantiated, recommendations were made to provide for the safety and welfare of the consumer and to help prevent the future occurrence of another incident. However, Babcock Center staff failed in some instances to follow up or act on the recommendations. A new policy directive should be implemented by Babcock Center to assure that all recommendations outlined in the internal investigations are completed as specified. DDSN should also develop a procedure to follow up on all internal investigations to determine that recommendations were carried out and documentation was forwarded to the appropriate investigative entities for the record.

Also, in order to assure that investigations are properly conducted and that recommendations and corrective actions resulting from investigations are implemented, DHHS has re-assigned a State Office Ombudsman Investigator to oversee all complaints from facilities operated or contracted for operation by DDSN. Responsibilities will include reviewing all internal investigations and conducting any follow-up investigations when required. Investigations may also be conducted by the DHHS Ombudsman when requested by the resident and/or responsible party, or if it has been determined that an independent investigation is required

RECOMMENDATIONS

13. The Ombudsman and the Department of Disabilities and Special Needs should define "serious resident-to-resident abuse." Then DDSN should implement a directive in all its facilities that requires all serious allegations of resident-to-resident abuse or altercations between residents be reported to the Long Term Care Ombudsman Program or to DSS Adult Protective Services (according to the type of facility where the incident occurred).

14. The S.C. Adult Protection Coordinating Council should conduct a thorough review of and recommend changes to South Carolina's system for reporting abuse, neglect, exploitation, and altercations and acts of assault between vulnerable adults.

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22. DDSN should ensure that Babcock Center is required to follow-up on recommendations and/or corrective action plans on all internal investigations, and the action plan should be made a part of the consumer record. The Department of Health and Human Services should amend its contracts with DDSN to require that DDSN ensure contractor compliance with corrective actions in a timely manner. Failure to ensure contractor compliance should result in DHHS withholding future Medicaid reimbursements from DDSN.

C. PROGRAMMATIC ISSUES: MEDICAID HOME AND COMMUNITY BASED WAIVER

This section addresses the allegations and complaints concerning Babcock Center's compliance with requirements of the Medicaid waiver program. The Mental Retardation and Related Disabilities (MR/RD) waiver provides a broad range of special home and community-based services to Medicaid eligible individuals with mental retardation or related disabilities to help them live in the community rather than an institution. DDSN subcontracts with Babcock Center to provide home and community-based waiver services. Under its memorandum of agreement with DDSN, DHHS is the final authority and makes all final decisions regarding all matters related to the administration of the MR/RD waiver.

The investigation included a review of case record information, interviews with recipients/responsible parties and appropriate DDSN staff, and the analysis of claims information. The complaints and issues addressed were centered around the health, safety, and welfare of consumers; provider standards, qualifications, and accessibility; quality assurance and outcomes; consumer rights related to due process, fair hearing, appeals and freedom of choice.

Specific allegations about problems with the waiver program came from Babcock consumers, their guardians or responsible parties, and other sources including the complaint letter of November 2002. DHHS Medicaid waiver program staff within the Bureau of Long Term Care Services reviewed these allegations. It should be noted that we reviewed only the specific allegations and complaints involving individuals in the waiver program, and did not evaluate DDSN or Babcock's other programs or compliance with Medicaid waiver requirements in general.

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Health, Safety and Welfare of Consumers

We investigated five cases involving allegations of abuse and neglect of consumers which occurred due to insufficient staffing levels and supervision of staff. Two out of these five allegations were substantiated.

State law requires that DDSN establish minimum standards of operation for the care, training, or treatment of the populations it serves. DDSN has established residential habilitation standards for Community Training Home Level II (CTH II) at a minimum of one caregiver to four clients. In addition, waiver services require adequate levels of staffing to meet consumer needs. In the two substantiated cases, both waiver recipients resided at CTH II facilities. This may indicate that current policies and procedures either were not followed or were not adequate to prevent incidence of abuse and/or neglect. Along with minimum standards of operation, DDSN through its oversight system needs to ensure that Babcock is following the standards developed by DDSN.

DDSN has established a minimum requirement of at least every three months (90 days) for Service Coordination staff to contact a waiver participant to monitor the usefulness and effectiveness of all waiver funded services, including an assessment of the quality of services provided. Due to the potential vulnerability of some waiver participants, however, the minimum time span of 90 days may not be sufficient to ensure residential or day habilitation staff are providing quality care and supervision.

Lack of Provider Choice

We reviewed issues surrounding a lack of service provider options other than the local Disabilities and Special Needs (DSN) Boards. There were five cases investigated for this allegation. The majority of MR/RD waiver services provided by the DSN Boards are habilitation services including Supported Employment, Prevocational Habilitation, Residential Habilitation and Day Habilitation. DDSN, by policy, offers waiver recipients a choice of other local county DSN boards for these habilitation services.

However, other than for MR special needs populations (i.e. dually diagnosed, conduct disorders, etc.), there are no other private provider options available at this time for residential habilitation waiver services in the Richland-Lexington county area. This may be due to the following reasons:

- Through subcontracts with DDSN, the county DSN boards have historically provided the vast majority of the waiver services. Based on state/federal reports, over 85% of waiver services have been provided by the county DSN boards and billed by DDSN.
- There is an identified lack of private providers for habilitation services.

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- Previously, DHHS has received a very limited number of inquiries from private providers seeking to provide respite and habilitation waiver services. While private providers have been given written information related to the waiver service qualifications, they have not applied to be Medicaid providers.

In addition, to increase available choices, DDSN has offered a Request for Proposal (RFP) to allow private providers to subcontract and provide services through the local county DSN boards, who would then become the private provider's fiscal intermediary for billing to DDSN.

However, CMS is reviewing the RFP to determine whether this arrangement would be appropriate as a means to recruit and reimburse private providers. Private providers should have the opportunity for independence from the DDSN organizational network. Under the terms of the current MR/RD waiver, all service providers have the option to bill the Medicaid state agency (DHHS) direct or use DDSN as a fiscal intermediary for their reimbursement. The waiver states:

> The Medicaid agency will make payments directly to providers of waiver services. Providers may voluntarily reassign their right to direct payments to the ... South Carolina Department of Disabilities and Special Needs. Providers who chose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method: The Medicaid agency will make payments to providers of waiver services through an approved MMIS.

Service Not Provided

In one case we investigated, it was alleged that DDSN subcontracted providers had not met the standard that required them to provide appropriate transportation to and from services. Under the terms of the waiver, appropriate transportation services must be provided as a component part of all the habilitation waiver services.

> Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

In the case we investigated, we found that DDSN did not ensure that a consumer was provided transportation to the job site on the days when the Job Coach provided the supported employment services. The waiver does not require recipients to be provided transportation to the work site other than the day the Job Coach is present. This case is currently the subject of an administrative appeal. DDSN will be required to refund the payments made for supported employment for this individual, or otherwise comply with the Hearing Officer's resolution of the matter. Also, a bigger issue is whether DDSN is adequately ensuring that consumers have regular transportation to job sites that are in the private sector. However, an analysis of this issue was beyond the scope of this report.

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Plan of Services

We investigated one allegation involving plans of service and confirmed that a Medicaid waiver participant was identified as having an incomplete and inadequate plan of service. Plans of service are a critical component of a consumer's care. Services are authorized and delivered based on the plan of care. If a service is not identified as a need in the plan, it cannot be funded with Medicaid. The waiver requires that plans of service be reviewed and completed on an annual basis.

In the incident we reviewed, a consumer's plan of service, dated November 26, 2001, was due for review. Staff from the Richland/Lexington DSN board (which provides case management to Babcock consumers) held a meeting in November 2002 to determine the new plan of service, but the consumer's legal guardian was not present at the meeting. There were several attempts to contact the guardian, but he did not attend the meeting to ensure the consumer was adequately represented. A final plan was not developed with the guardian and fully approved until January 7, 2003. Therefore, DDSN should be required to refund the federal share of $4,646 for waiver services provided during the time the consumer did not have an up-to-date plan of service (11/26/02-1/7/03).

Also, the individual's plan of service from November 26, 2001, identified behavior support needs. The behavior support plan took seven months to develop (until June 6, 2002), was incomplete, and was also not signed by the responsible party or legal representative.

We also investigated two other related allegations that respite services were not provided due to budget constraints, and that behavior support services were terminated without notification. In the first case the individual was not enrolled in the Medicaid MR/RD waiver program; in the second case the individual was not receiving behavior support services through the Medicaid MR/RD waiver program. Both individuals were receiving services supported with state funds. Therefore DHHS had no jurisdictional authority over these allegations.

Consumer Rights

We reviewed several allegations related to due process, fair hearing, appeals and freedom of choice for consumers. These included:

- Applicants/recipients for Medicaid services were not properly informed of waiver options and appeal rights under the terms of the waiver. There was one case investigated for this allegation.
- Medicaid appeal rights were not provided upon waiver termination.

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- Residential staff had inappropriately revealed personal medical information, and there were no designated location(s) where staff and recipients could discuss privileged health information.

We found documentation to support that a waiver applicant was not provided appeal rights or timely determination of waiver eligibility. Under the terms of the waiver, individuals must be informed, offered choice, and provided appeal rights. The waiver states the following:

> As part of the Service Coordinator's assessment and service planning visit, individuals and responsible parties are provided with adequate information to make an informed decision as to where the individual's care will be received. Service planning addresses problems and feasible solutions. It also includes as exploration of all resources utilized by the client, both formal and informal, as well as those waiver services which may be available to meet the individual's needs and those needs which cannot be met.
>
> When an individual is determined to be likely to require a level of care, the individual or his or her legal representative will be informed of any feasible alternatives under the waiver; and given the choice of either institutional or home and community-based services.
>
> The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

According to DDSN, it is working to clarify its policy for how waiver recipients should be informed of waiver options, freedom of choice, and appeal rights, and also to provide service coordination staff with training on this policy. In the meantime DDSN has sent a letter to provide additional guidance to all waiver recipients.

Regarding the second allegation, DDSN did have documentation to support that Medicaid appeal rights were provided upon notification that waiver services were being terminated. There was one case investigated for this allegation. For the third allegation, we could not confirm that DDSN staff had inappropriately shared personal health information. There was not a designated administrative area to be used specifically for sharing privileged health information at the residence.

RECOMMENDATIONS

23. The Department of Disabilities and Special Needs should ensure that Babcock is meeting the current required residential standards. In addition, DDSN should review the current residential habilitation standards and minimum caregiver staffing levels to determine if supervision and oversight are sufficient and appropriate to ensure an individual's health and safety.

Mims 0127

24. DDSN should develop a plan to increase the frequency of Service Coordination staff contact (telephone/face-to-face) with vulnerable clients.

25. Both DDSN and DHHS should increase efforts to identify potential private providers, develop capacity among the private sector to deliver services to disabled individuals, and remove any barriers to competition. DDSN should inform private providers of their right to receive direct payment from the state Medicaid agency.

26. DDSN should ensure transportation services are provided by their subcontracted entities for all habilitation services as required under the terms of the waiver. DDSN should issue a policy clarification to subcontracted providers and service coordination staff confirming the extent to which transportation services are a required component part of supported employment.

27. DDSN should issue a policy clarification to waiver service coordination staff specifying that plans of service are not considered complete until the consumer's responsible party or legal guardian has participated in the planning meeting. The policy should require that their participation in the planning meeting be documented, possibly by having the responsible party or guardian sign the plan. DHHS should recoup the cost of waiver services provided when a plan of service is not completed within 12 months.

28. DDSN should provide training to service coordination staff on informing, choice, and Medicaid appeal and hearing rights for Medicaid waiver applicants and recipients.

Mims 0128

III. CONCLUSION

Most of the findings in this report involve failure to follow existing policies, ensure corrective actions, and adequately supervise consumers. Because we limited our review only to the specific allegations that had been made about Babcock Center, we cannot conclude as to whether our findings reflect isolated incidents or are indicative of more systemic problems. In any case, DDSN's ability to monitor and oversee Babcock Center (and other providers) is of critical importance to ensure consumer safety and compliance with rules and regulations. To this end, DDSN has created an external quality review and contract compliance process that is beginning its second year of operation. The contractor for this process is First Health. DDSN should ensure that First Health's quality assurance operations include:

- An analysis of trends and patterns among service providers;
- Identification of system-wide weaknesses;
- A determination of best practices worthy of replication;
- Areas where policy is weak or nonexistent;
- Identification of needed training; and
- Ability to levy sanctions for non-compliance.

Many of the recommendations in this report could be incorporated into a stronger quality assurance process. Also, in order to fulfill its administrative oversight responsibilities, DHHS needs greater information about subcontractors providing Medicaid services. This should include DDSN internal audits related to Medicaid, all quality assurance reports conducted by First Health and other external groups, and documentation of follow-up, corrective actions, and recoupments. Both agencies need to work together to ensure regular and improved communication. At a minimum, additional requirements for information and improved assurance could be put into DHHS contracts with DDSN and Babcock.

RECOMMENDATIONS

29. The Department of Disabilities and Special Needs should review quality assurance efforts and determine how they might be strengthened. When possible, the recommendations in this report should be incorporated into the quality assurance agreement with First Health.

30. DHHS should obtain and regularly review copies of internal audit, quality assurance, and follow-up reports related to DDSN's Medicaid subcontractors and services.

31. DHHS should review its contracts with DDSN and Babcock to ensure they contain appropriate provisions for quality assurance and that DDSN shares this information with DHHS.

Mims 0129

IV. REPAYMENT SCHEDULE

Based on the DHHS interagency task group reviews, DDSN is required to repay the federal share of the $6,656.00 overpayment of Medicaid funds. Additionally, the Babcock Center and DDSN must amend the amount reported as allowable costs in their applicable cost reports for fiscal year ending June 30, 2002 (FY02). The following schedule outlines the amounts to be recouped or adjusted to allowable costs for FY02 by area. The second schedule reflects Babcock's liabilities to its' consumers. Report page numbers that correspond to each disallowed item are noted in parenthesis.

	Recoupment*	Adjustment to allowable costs (FY02)
Disallowed severance package paid to Babcock's former CEO (Page 11)		$47,893.19**
Disallowed for waiver services performed when the consumer did not have an up to date plan of service (Page 28)	$ 6,656.00	
Totals	**$ 6,656.00***	**$47,893.19**

* *Recoupments are due upon notice. FFP amount due from DDSN equals $4,646.55.*

** *Babcock must also exclude the severance pay related costs during the preparation of its FYE 6/30/03 cost reports. DDSN must also exclude the allocated portion of the related severance pay reported by Babcock during the preparation of its applicable FYE 6/30/03 cost reports.*

SCHEDULE OF CONSUMER REPAYMENTS

Babcock Obligation/Liabilities to Consumer

Consumers Personal Funds theft at Wire Road – Liability due to the consumer (Pages 7-8) ($11,373.00 - $9,710.37)	$ 1,662.63
Consumers Personal Funds missing receipts at 28 ICF/MR facilities – Liability due to the consumer (Pages 8-9)	$87,083.00
Total Babcock Obligation/Liabilities to Consumer	**$88,745.63**

Mims 0130

V. DDSN's and Babcock Center's Response to the Report Findings

As this report states, many of the findings that have been substantiated in the DHHS report were previously identified and substantiated in DDSN's Internal Audit Report of Babcock Center issued October 29, 2002. Babcock's corrective action plan to address these previously identified findings in the DDSN audit was approved and is being monitored by DDSN. There were 62 corrective actions required by DDSN's previous audit. Babcock has completed all corrective actions with one exception as of this date. The exception is due to the requirement that the Attorney General's Office must review and approve the plan of correction for that finding.

Many of the findings and recommendations raised in the DHHS report are issues identified previously by DDSN management and the Babcock Center's board of directors as a result of DDSN's audit of Babcock Center. Babcock Center staff have been and are still working to correct these issues. While corrective action has been taken, compliance through management reviews and oversight will continue.

Beyond the findings identified in the DDSN audit, there are additional findings which will require corrective action. Both DDSN and Babcock Center are committed to taking appropriate corrective steps.

The issue of resident-to-resident abuse for all vulnerable populations including persons with disabilities and special needs is a very serious issue. Even though the SC Code of Laws does not address this issue, DDSN has had a policy in place for years requiring reporting of these incidents from service providers to DDSN. DDSN is very willing to work with the DHHS Ombudsman to help determine what constitutes serious allegations of resident-to-resident abuse and add a new requirement of reporting to external authorities.

As identified in this report the practice of verbally reporting results of investigations to families/responsible parties will be strengthened by providing a written report. Similarly, in addition to the approval contained in the annual plan, individuals requiring additional supports will have those needs documented in writing. Also, information posters describing procedures for reporting abuse, neglect and exploitation will be moved from the office areas of the consumers' homes to a more prominent location in the general living areas.

Babcock has provided additional information to DDSN regarding findings related to 15 allegations of abuse, neglect, and/or exploitation. This report determined that 3 of the 15 were not reported appropriately; the information from Babcock supports that there were actually two, one where the family was not notified and one in which the DHHS Ombudsman was not notified. However due to the vulnerable nature of the consumers served, each failure to report, especially to the Ombudsman, is a critical incident that must be corrected.

As stated previously, both DDSN and the Babcock Center are committed to making any necessary corrections that are identified in this report. These corrections will be implemented as identified by our joint response to the recommendations below.

DDSN's and Babcock Center's Response to the Recommendations:

1. DDSN's Internal Audit has completed its review and will coordinate with DHHS's Division of Audits regarding its work. DDSN will ensure that Babcock reimburses the affected consumers in a timely and appropriate manner.

2. Training for handling consumer funds will be a requirement to be incorporated in orientation for new hires whose duties include this job function.

3. Babcock will coordinate with the DHHS's Bureau of Reimbursement Methodology to remove the unallowed cost related to severance pay in the FYE 6/30/02 cost reports. Babcock will ensure the final cost reports for FYE 6/30/03 exclude these costs as well. It should be noted that while the report correctly states that the Babcock Center's Board of Directors approved the severance pay in February 2002 without documenting the board action, it does not note that formal action was taken by the board on October 22, 2002 to formally document this action in the board minutes.

4. DDSN will amend the FYE 6/30/02 cost reports to remove the allocated portion of the related severance pay cost reported by Babcock. DDSN will exclude this cost from the FYE 6/30/03 cost reports.

5. DDSN will instruct providers that if severance payments are made they must be properly developed and allowable under Medicaid cost principles.

6. Internal Audit at DDSN will review and test Babcock's facilities for compliance with the state's bed hold policy regarding proper documentation of leaves of absence and will forward a report to DHHS.

7. DDSN and Babcock will ensure there is a system of accountability to assure one-on-one care is provided per individuals' plans of care and that the expenditures for this care are properly documented in the Medicaid cost reports.

8. DDSN will work with DHHS in any review of the pay bands. DDSN developed this funding system to increase choice of services and providers for consumers and to assure needs are funded. All cost are documented in the Medicaid cost reports submitted to DHHS per federal and state requirements.

9. Future requests for continuing outlier funding will be justified in writing. Procedures will be submitted to DHHS's Division of Audits for review. The procedures will include requirements for requesting and changing outlier status.

10. Providers who receive outlier funding will be required to maintain documentation in support of this level of need and will maintain these records per Medicaid guidelines.

Mims 0132

11. Babcock Center's Board of Directors will ensure that board minutes reflect approval of contract awards approved by the board. Babcock will add this requirement to their procurement policy.

12. DDSN will monitor through compliance reviews and audits that DDSN's procurement policy is followed by Babcock and will disallow any documented additional cost from non-compliance of the policy in the Medicaid cost reports.

13. DDSN will work with the Ombudsman at DHHS to define serious allegations of resident-to-resident abuse or altercations and will ensure that this definition is used in determining the reporting of these incidences to the DHHS Ombudsman or to DSS's Adult Protective Services as appropriate. As noted previously, these incidents were reported internally only since state law does not address this issue at all.

14. DDSN agrees that the state law regarding reporting abuse, neglect, exploitation, and altercation and acts of assault between vulnerable adults needs clarifying. The agency will work with the S. C. Adult Protection Coordinating Council regarding this issue.

15. DDSN's admissions policy will be utilized for transitioning current residents between Babcock Center facilities except in an emergency.

16. DDSN procedures will be reviewed to ensure all suspected abuse, neglect, or exploitation allegations reported to law enforcement are also reported to the DHHS Ombudsman or DSS's APS as appropriate within time requirements of state law and policy directives.

17. DDSN will ensure that its facilities prominently display notices about the mandates for reporting abuse, neglect, and exploitation in the common areas of residences as opposed to the office areas which has been the practice for many years.

18. Providers will be instructed by DDSN to conduct periodic unannounced visits to all of their residential locations across all shifts, including weekends, to assure sufficient staffing and supervision per the residents' care plans. As of February 2003, Babcock initiated monthly unannounced accountability visits.

19. DDSN will instruct all providers to ensure that one-on-one supervision is provided according to approved care plans and that the supervision is documented in the plans. The First Health compliance review will include a sampling of staffing time records and care plans to ensure proper levels of supervision are being provided.

20. Babcock implemented a new emergency contact system effective January 21, 2003 that includes calling 911 and EMS. Training has been implemented and emergency numbers are provided to the staff of each residence. Babcock has provided documentation to DDSN that the nurse involved with the situation identified in this report received disciplinary action.

Mims 0133

21. All DDSN facilities and contract providers will be required to prepare written closure letters when an internal investigation covered by OAPA is completed and the case resolved. The letter will include the following: the investigation was conducted in accordance with the Omnibus Adult Protection Act; the reason for the investigation; an explanation of what the investigation included; and whether the allegation or complaint was verified or not verified. Copies of the closure letters will be sent to the family or responsible party for the resident involved in an investigation and to DHHS's Ombudsman. Previously, Babcock staff contacted families by telephone concerning investigations.

22. DDSN will ensure through compliance reviews and audits that Babcock follows-up on all recommendations and/or corrective action plans on all internal investigations. Any action plans will be part of the consumer record where appropriate.

23. DDSN will ensure through the compliance review process that Babcock is meeting the current required residential standards and consumers' needs per the consumers' plans. The MR/RD Medicaid Waiver requires adequate levels of staffing for the consumers in the waiver to meet the consumers' needs. For this reason most of the residential settings have more than the minimum caregiver staffing ratios. Regarding one of the report's findings, Babcock has provided DDSN information that one of the two incidents of insufficient staffing levels and supervision is not supported based on documentation that Babcock had 3 staff on duty on the third shift completing their accountability checks per the consumers' plans. The necessary corrective action regarding the incident that occurred per this report did not include adding additional staff. Consumer safety is and will continue to be of primary importance.

24. DDSN will require monitoring by service coordination staff more frequently than 90 days for the most vulnerable waiver recipients which will be identified in the individuals' service plans.

25. DDSN issued the Qualified Provider Request for Proposal through the Budget and Control Board to actively recruit additional providers. They will be paid the rate approved in their proposals. DDSN will continue to seek additional providers as recommended since it matches the agency's goal of consumers having additional choices of providers. All private providers will be informed of their right to receive direct payment from DHHS. There have always been many services billed directly to DHHS by private providers. In the last few years the number of private providers for all of DDSN services has expanded significantly. The largest increase has been in the case management and early intervention areas. However, as identified in this report, prior to the QPL there were not many private providers of habilitation services funded under the waiver even though private providers received information regarding providing services.

26. DDSN will ensure through policy clarification that transportation services are provided by Babcock and other providers of habilitation services, including supported employment, per the terms of the MR/RD Medicaid Waiver.

Mims 0134

27. DDSN will ensure through the compliance review process that the Richland/Lexington DSN Board complies with the current policy that plans of service are not complete until the consumer's responsible party or legal guardian has participated in the planning meeting. This participation should be documented.

28. DDSN staff previously addressed these issues by informing all consumers' responsible parties and all service coordinators statewide in writing regarding waiver choice and appeal and hearing rights due to concerns expressed by DHHS staff at monthly coordinating meetings. A brochure was also created to be handed out by the service coordinator to every person applying for services explaining these rights. DDSN disagrees with the report's determination that a waiver applicant was not provided appeal rights or timely determination of waiver eligibility. DDSN's information supports that when all information needed for eligibility determination was provided, a final determination of eligibility was made. When eligibility was previously denied based on the information provided, appeals of the decisions were made. However, as has been stated above, all individuals applying for services are now given a brochure detailing their rights at the time of application.

29. DDSN will continue to review its quality assurance efforts and make improvements that strengthen them. As identified in this report, beginning in July 2002 DDSN has taken a new approach to quality assurance by contracting with an independent organization separate from the agency in order to remove any conflict of interest in quality assessments. Now that it is in its second year, the process has been modified and bolstered by data and information gathered the first year. We intend to build on this success by continuing to improve the process each year.

30. DDSN staff will share information regarding audits and assurance reviews with DHHS staff at regularly scheduled meetings.

31. DDSN's commitment to quality assurance is demonstrated by the contracting of quality assurance reviews to an independent third party entity. DDSN will share the information provided with DHHS staff at regularly scheduled meetings.

Mims 0135

Appendix A – LETTER FROM CMS

Services
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid
Region IV

Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909.

December 2, 2002

Mr. Bill Prince, Director
Department of Health and Human Services
1801 Main Street
P. O. Box 8206
Columbia, South Carolina 29202-8206

Dear Mr. Prince:

We have been made aware of allegations of abuse, neglect and misuse of Medicaid funds for individuals receiving services through the South Carolina Home and Community Based Waiver for Individuals with Mental Retardation or Related Disabilities. The allegations are specifically related to the Babcock Center. We understand that members of your Community Long Term Care staff have been discussing these issues and the recent audit with staff from the Department of Disabilities and Special Needs (DDSN).

In accordance with regulations at 42 CFR 441.302, as a condition of waiver approval, States must assure necessary safeguards have been taken to protect the health and welfare of persons receiving services under the waiver. While DDSN serves as the operating agency for the waiver, as the administering agency DHHS is ultimately responsible for the waiver as well as other services provided under the Medicaid program such as ICF/MR. Therefore, we are requesting that you investigate all allegations of neglect, abuse and misuse of funds. Your investigation should include direct interviews with clients, family members and/or legal guardians. Please provide us with a copy of findings and corrective action plans (including specific timelines) to address any problems cited. Further, please provide a description of the procedures you will employ to ensure corrective actions are completed.

We share your commitment for quality waiver services and are confident that your staff will succeed in working with DDSN to address these concerns. If we may be of assistance, please contact Tandra Hodges at (404) 562-7409.

Sincerely,

Rhonda Cottrell
Associate Regional Administrator
Division of Medicaid and Children's Health

Appendix B: DEFINITIONS AND LEGAL AUTHORITY

Appeal/Fair Hearing: The administrative proceeding specified in SC Code R. 126-150 et seq. by which any entity aggrieved by a final action or determination regarding the SC Department of Health and Human Services may contest the action.

Assessment: A method of determining a consumer's current long term care needs through the use of a comprehensive standard instrument.

Babcock Center, Incorporated (Babcock or Babcock Center): A private, non-profit organization founded in 1970 serving people with mental retardation, autism, head and spinal cord injury, and related lifelong disabilities. In order to receive services from the Babcock Center, individuals must be determined eligible for services from the SC Department of Disabilities and Special Needs. Babcock Center provides Medicaid services either under a subcontract with the SC Department of Disabilities and Special Needs or directly through a contract with SC Department of Health and Human Services.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services. CMS administers the Medicare program, Medicaid program, and State Children's Health Insurance Program.

Client Funds (also known as personal needs allowance/consumer funds): Funds received or retained by a resident for personal expenses and sometimes deposited and held in an account administered by a facility for the convenience of the individual.

Community Residential Care Facility (CRCF): A facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal care for a period of time in excess of 24 hours for two or more persons, 18 years old or older, not related to the licensee within the third degree of consanguinity. Included in this definition is any facility (other than a hospital), which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities. These facilities may be referred to as "assisted living" provided they meet the above definition of a community residential care facility.

Community Training Home I (CTH I): A residential placement similar to foster care in that a private citizen's home which is licensed and where the caregiver is a contract agency employee. Up to three individuals live in the home and receive personalized care, supervision and training.

Community Training Home II (CTH II): A home owned or rented by the agency where up to three individuals live. A caregiver may also live in the home or staffing may be provided in shifts. This model differs from the Community Training Home I placement because, if the caregiver changes, residents will not have to move.

Mims 0137

Appendix B, cont.: DEFINITIONS AND LEGAL AUTHORITY

Consumer: A person with a disability who utilizes health and/or social services. Also referred to as a recipient or resident.

Cost Report: The report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicaid program.

Disabilities and Special Needs Board (DSN Board): A local Board which has been established pursuant to S.C. Code Ann. §44-21-810 et seq., the members of which are appointed by the Governor or through the County Council authority and which provides, under contract with the SC Department of Disabilities and Special Needs (DDSN) and SC Department of Health and Human Services (DHHS), comprehensive community services to eligible residents of a geographic service area designated by DDSN.

Federal Financial Participation (FFP): Any funds, either title or grant, from the Federal government.

Freedom of Choice: The right of a Medicaid recipient to receive services from any willing provider of those services who meet all applicable standards and qualifications.

Head and Spinal Cord Injury (HASCI) Waiver: A 1915 (c) Medicaid waiver that addresses the long term needs of persons with Head and/or Spinal Cord Injuries.

Home and Community-Based Waiver: A special Medicaid program operated under Section 1915 (c) which allows the provision of a special package of approved services to a defined target population with long term care needs.

Intermediate Care Facility for the Mentally Retarded (ICF/MR): A health related facility which meets the requirement for state licensure to provide care to persons with mental retardation who do not need care in a hospital or skilled nursing facility.

Long Term Care Ombudsman Program (LTCOP): Authorized by the federal Older Americans Act and the S.C. Omnibus Adult Protection Act, the Long Term Care Ombudsman Program investigates any problem or complaint on behalf of any interested party or any client, patient, or resident of defined facilities.

Memorandum of Agreement (MOA): A legal document that binds two or more parties outlining their scope of responsibilities one to the other.

Mims 0138

Appendix B, cont.: DEFINITIONS AND LEGAL AUTHORITY

Mental Retardation and Related Disabilities (MR/RD) Waiver: A 1915 (c) waiver which provides a broad range of special home and community-based services to Medicaid eligible individuals with mental retardation or related disabilities to help them live in the community rather than an institution.

Omnibus Adult Protection Act (OAPA) {S.C. Code Ann §43-35-5 et seq.}: Provides for a system of adult protection in South Carolina and clarifies the roles and responsibilities of the agencies involved. The Act provides a mechanism for problem resolution and interagency coordination to address continuing needs of vulnerable adults and uniformly defines abuse, neglect, and exploitation in all settings. The Act clarifies reporting procedures for allegations of abuse, neglect and exploitation and provides procedures for emergency protective custody. The Act also defines the role of the court in the adult protection system and provides for civil and criminal penalties for abuse, neglect, and exploitation.

Policies: The general principles by which the SC Department of Health and Human Services (DHHS) is guided in its management of the Title XIX program, as further identified by DHHS promulgations and by state and federal rules and regulations.

Provider: Any individual, group, institution, or state agency delivering services to Medicaid recipients and receiving payment for those services.

Recoupment: Funds previously paid to a provider of Medicaid services or sub-grantee of the State's Medicaid Program in error or determined, by post-payment review, to have been improperly paid and returned to the Department or withheld from payments owed to the provider or sub-grantee.

Request for Proposal (RFP): A written or published solicitation issued by an authorized procurement officer for proposals to provide supplies or services, which ordinarily result in the award of the contract to the responsible bidder making the proposal determined to be most advantageous to the State. The award of the contract must be made on the basis of evaluation factors which must be stated in the RFP. From SC Code Ann. §11-35-310(28).

Sanction: A penalty imposed in accordance with SC Code Ann. R 126-400 et seq. of the Department's regulations.

Service Coordinator: A professional who assists Medicaid clients in accessing appropriate and available services. Also known as a case manager.

Service Plan: A document which provides a comprehensive review of a consumer's problems and strengths. Goals are set based on the consumer's identified needs, and interventions are specified to meet those needs. Also referred to as a plan of care.

Mims 0139

Appendix B, cont.: DEFINITIONS AND LEGAL AUTHORITY

Service Tracking System (STS): The Service Tracking System is DDSN's system for tracking information about the individuals applying for and receiving services. STS collects intake, eligibility, waiting list, service assignment, and service delivery data for billing and reporting purposes. The STS is primarily maintained by the staff assigned to coordinate services for individuals requesting/receiving services from DDSN.

SC Department of Disabilities and Special Needs (DDSN) The State agency that plans, develops, coordinates and funds services for South Carolinians with the severe, lifelong disabilities of mental retardation and related disabilities, autism, traumatic brain injury, spinal cord injury and similar disabilities.

SC Department of Health and Environmental Control (DHEC): The State health agency. Section 1864(a) of the Social Security Act directs the Secretary of Health and Human Services to use the help of State health agencies when determining if health care institutions meet provider certification to receive Medicaid reimbursement. 42 CFR part 488 sets forth that the State health agency performs surveys to support its certifications.

SC Department of Health and Human Services (DHHS): The State Medicaid agency as specified in 42 U.S.C. §1396 et. seq. and S.C. Code Ann. §44-6-10 et. seq. to administer the Medicaid Program in South Carolina and also functions as the State Unit on Aging.

SC Department of Mental Health (DMH): The State Mental Health Agency which serves adults, children, and their families affected by serious mental illnesses and significant emotional disorders.

SC Department of Social Services (DSS): The State agency authorized by the Omnibus Adult Protection Act of the South Carolina Code of Laws, to investigate all reports of abuse, neglect and financial exploitation of children and adults living in the community (non-institutionalized) and provide services. Services are provided to meet the adults' basic needs and to ensure their safety.

SC State Budget and Control Board: The SC State Budget and Control Board plays a key role in the general management of state government. This institution is unique to South Carolina and provides a broad array of services to other parts of the public sector as well as administrative and regulatory functions. The State Procurement Office (SPO) is responsible for the procurement of all goods and services for South Carolina not provided by the Information Technology Management Office (ITMO) or the Office of the State Engineer (OSE). The SPO issues solicitations, maintains statewide term contracts, and assists agencies with their procurement of goods and services. The Materials Management Office (MMO) is part of the SPO and handles contract awards for goods and services not procured through the ITMO and OSE.

Appendix B, cont.: DEFINITIONS AND LEGAL AUTHORITY

Supervised Living Program I (SLP I): The least restrictive residential placement which still provides staff oversight. Individuals live in apartments, duplexes or other housing and receive staff support and intervention based on personal need.

Supervised Living Program II (SLP II): Similar to the Supervised Living Program I, except residents need more supervision. Staff are on-site or available within three minutes (they usually live in another section of a duplex or apartment).

Title XIX: The Title of the Social Security Act dealing with Medicaid. Codified at Title 42 of the United States Code, Chapter 7, subchapter XIX (42 U.S.C. §1396 et seq.)

Appendix C: REVIEW CONDUCTED BY SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

On December 20, 2002, representatives from the SC Department of Health and Human Services met with representatives of the South Carolina Department of Health and Environmental Control, Bureau of Certification. The purpose of the meeting was to share a letter to Governor Mark Sanford dated November 25, 2002, by an individual who had been associated with the Babcock Center. The Babcock Center is a non-profit organization providing residential/vocational/health services to individuals with developmental disabilities. Included with the letter was a 32-page narrative identifying 57 issues of concern with the rights and care of the individuals receiving services from the Babcock Center. The SC Department of Health and Human Services requested the Bureau of Certification to assist in investigation of those facilities that fall under its jurisdiction.

The information provided was copied and a preliminary review of the Babcock Center's Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) was done. It was identified that the Babcock Center provided ICFs/MR services within 30 homes. It became clear early in the investigative process that the Bureau of Certification had two tasks related to the documented concerns. They were to:

1) Investigate specific individuals/issues identified in the Babcock Center ICFs/MR and;
2) Investigate Babcock Center's ability to provide services, within certified ICFs/MR, in light of the 57 concerns identified by the complainant.

Identified deaths, abuse, neglect and/or mistreatment within ICFs/MR

The SC Department of Health and Environmental Control's Bureau of Certification review of the concerns identified within the narrative centered around three issues:

1) Death of clients while under Babcock Center's ICFs/MR level of care;
2) Abuse and/or neglect of identified individuals under the ICFs/MR level of care; and
3) Theft and misuse of consumers' personal funds.

Investigation of concern 1 and 2 fall within the authority of the SC Department of Health and Environmental Control's Bureau of Certification and will be addressed in the following summary. The financial concerns related to allegations centered in ICFs/MR were addressed in this report by the DHHS fiscal team.

Appendix C, cont.: REVIEW CONDUCTED BY SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

On October 1, 1996, the Health Care Finance Administration introduced a new ICF/MR inspection (survey) protocol. This protocol identified/rearranged survey tasks to be completed while a state surveyor is onsite. Task 2 required the state surveyor to review the facility systems to prevent abuse, neglect and mistreatment and to resolve complaints. This would include any client deaths that may have occurred.

Identified client deaths within ICFs/MR

The complainant and additional documentation collected since December 2, 2002 identified 5 individuals who passed away while under the care of the Babcock Center. Review of facility survey information and interview with the state surveyors revealed all five deaths (using the 1996 protocol) were reviewed by state surveyors during annual or follow-up recertification surveys. Three of the clients died during a hospital stay with the remaining two passing away in their home. The ages of the individuals range from 50 to 76 years old. There were no citations or indications of facility misconduct in relation to the identified deaths based on available information.

Of the five facilities surveyed, a citation was identified in one facility in relation to one (of the five) clients. That citation was based on the individual's refusal of medication and the lack of facility response to assist the client in overcoming this difficulty.

New information was identified through this multi-agency investigation in relation to one of the deaths that occurred in 2001. Due to the impact this information may have on an accurate determination, it was decided to conduct onsite re-investigations of the five identified deaths. In addition, the scope of death investigation was expanded, based on available information, to include the total number of known deaths throughout the ICFs/MR in the Babcock system. A total of eleven deaths (in nine ICFs/MR) were identified since 7/1/01.

The investigation of ten of eleven deaths revealed there was no indications of facility misconduct in relation to the identified deaths. During the investigation of the one death that occurred on 5/4/03, citations were made in reference to facility compliance with the federal regulations for ICFs/MR. These citations did not substantiate neglect.

One death investigated (of the eleven) brought about citations of non-compliance with Federal Medicaid regulations for ICFs/MR. This death, which occurred in 2001, through re-investigation of the situation revealed neglect was substantiated. The citations identified are currently under review for facility accountability.

Mims 0143

Appendix C, cont.: REVIEW CONDUCTED BY SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

(In other words, Babcock Center in the year 2000 had an average of 7.0 standard citations per facility surveyed. An average of .06 condition level citations per facility was also identified or 1 condition cited per 16.5 facilities surveyed).

The percentage of the total number of facilities/standards cited/conditions cited of the state was compiled. It revealed that for the years 2000 and 2001, the percentage of standards and conditions cited were less than the percentage of facilities Babcock Center operates of the total facilities of the state. However, the percentage of standards and conditions cited during 2002 was greater than Babcock Center's facility percentage. The percentages are provided below:

2000			2001			2002		
Facility %	Standard %	Condition %	Facility %	Standard %	Condition %	Facility %	Standard %	Condition %
22.45	20.05	12.50	21.99	21.85	17.95	20.49	25.26	41.18

(In other words, Babcock Center in the year 2000 made up 22.45 % of the facilities surveyed, 20.05 % of all standards cited and 12.50 % of all condition level citations made during that year).

If a facility, through a recertification survey, has citations identified non-compliant, the facility is given an opportunity to present a plan of correction (POC) to the survey agency. Based on an acceptable POC, the survey agency may recommend the facility be recertified with the attachment of an Automatic Cancellation Clause (ACC) date. The state survey agency must follow-up, in some manner, on all citations. If evidence is identified that indicates a citation (one citation is all that is needed) is not corrected, then the state survey agency will recommend that the ACC date be invoked, or identified as the date the facility must show compliance or become decertified and lose funding. The percentage of Babcock facilities with an invoked ACC is greater than the facility percentage for the state. Review of data from the past three years revealed Babcock Center's percentage of state facilities with standards identified on a follow-up visit that were not corrected and had their ACC invoked.

2000		2001		2002	
Facility %	Invoked ACC %	Facility %	Invoked ACC %	Facility %	Invoked ACC %
22.45	42.42	21.99	54.84	18.33	54.55

(In other words, Babcock Center in the year 2000 made up 22.45 % of the facilities surveyed and 42.42 % of all invoked ACCs made during that year).

One strategy to increase facility accountability is to recommend a reduced contract period from 12 months to 6 months. The state survey agency uses this if a facility has condition level

Appendix C, cont.: REVIEW CONDUCTED BY SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

citations two years in a row. Over this past year, Babcock Center has had 2 of the 30 ICFs/MR to have a 6 month contract recommended due to Condition level citations over two consecutive recertification surveys.

Another strategy to increase accountability is to perform multiple certified ICFs/MR visits at the same time focused on an issue common to all facilities to be surveyed. In December 2002, while conducting an annual survey, a surveyor identified day program staff providing attention to individuals from the facility that the surveyor was observing. It seemed that other clients, who were not living at the facility the surveyor was surveying, were not getting the attention they needed. The surveyor generated a memo to file outlining the concerns he had. Because of this, the Bureau of Certification made simultaneous unannounced visits to 7 ICFs/MR that feed into this day program. Based on observation, interview and verified by record review, 5 ICFs/MR were not in compliance with federal standards. These citations were provided to the facilities for plans of correction. Future surveys will continue to evaluate compliance with the tags associated with care and services provided at day programs

DHEC Certification Recommendations

The Babcock Center must insure that each facility be able to timely access information and provide all documentation of abuse, neglect, mistreatment, or unusual occurrences that impact on client health/safety for the time frame identified. That would include information for individuals who no longer reside at the facility.

Mims 0145

Appendix D: LETTER FROM DDSN

June 24, 2003

William L. Wells, CPA
Deputy Director
Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Dear Mr. Wells:

At our meeting on June 17, 2003, you requested in writing several of the issues that were discussed concerning the way DDSN pays their local DSN boards versus the way DDSN is reimbursed from DHHS.

DDSN's payment system to the DSN boards was changed to accommodate our consumers in two important ways: (1) To respond to their needs as they are identified in their service plans and, (2) To facilitate flexibility in choice of service and service provider. The funding band approach provides a mechanism to identify the resources available on an annual basis for the consumer and his/her planning team. The cash is provided to boards a month in advance for almost all the services so as to assure that there are sufficient resources available to meet consumers' needs in a timely manner. This is only done for the DSN boards, and those grandfathered in as DSN boards such as Babcock Center. They act as the fiscal agent for the resources which are tied to individual consumers. The county DSN boards are created as public entities to plan, administer, provide or arrange services for DDSN eligible consumers per South Carolina Code 44-20-375. They are the single point of entry into DDSN's system and act just as a county office does at DSS or DHEC. Therefore, DDSN and state law treats them as an affiliated organization.

Mims 0146

Appendix D, cont.: LETTER FROM DDSN

Having the band payment available as an annual rate paid monthly in advance improves cash flow and assures availability for reimbursing a private entity if the consumer chooses another provider. The band payment is simply a daily rate multiplied by 365 days to identify the total annual resources available to the consumer to meet his/her needs. This is in many ways the same as DHHS paying daily rates to various nursing home providers or residential care providers that include many services covered by the daily payment. In addition, the federal government required DDSN to bundle a number of services when the residential and day habilitation services were created for the MR/RD Waiver.

For new consumers, band levels are determined using a level of care instrument called ICAP or information gathered from a variety of needs assessments which are incorporated into the plan. The information collected determines the level of care needed for the individual consumer. The various payment levels are based on historical cost reports that identify the cost of services for the various levels of need. Using real cost information helps to ensure that sufficient funds are available to provide the needed services. In addition, DDSN's independent quality assurance contractor reviews the service plans and accompanying documentation and even performs consumer satisfaction surveys as an additional measure to assure needs are identified and the appropriate services are performed.

The process starts with DDSN making a month's advance payment to the DSN boards for consumers whether or not they are Medicaid eligible or the service is Medicaid reimbursable. For DDSN, Medicaid is a revenue source and DDSN up fronts the service delivery dollars using State dollars appropriated to DDSN by the General Assembly. These dollars pay for services rendered during the month. By the 5th working day of the next month, the DSN boards report the units of service provided as determined by the DHHS contract with DDSN. DDSN then bills DHHS for Medicaid eligible services delivered and DHHS reimburses DDSN usually by the end of that next month, almost two months after DDSN has already paid for the services. Since the DSN boards are affiliated organizations each is required to submit to DDSN Medicaid cost reports which are incorporated into Medicaid cost reports for DDSN services. See Attachments A and B which explain cash flow and timeframes.

When the services are billed to DHHS for Medicaid reimbursement the service matches DDSN's contract with DHHS in terms of units and rates of service. The cost reports either support the reimbursement or settlements occur.

Each private provider still bills the service and is reimbursed after the service is provided at a set rate as is normal for private providers. Their costs and units are included when appropriate within DDSN's cost reports if the DDSN system reimburses them.

Appendix D, cont.: LETTER FROM DDSN

This funding system is basically the same system regarding the DSN boards as existed when the various Medicaid contracts were created. Management at DHHS over the years has recognized that the DSN boards are DDSN's county entities. Changes have been incorporated to increase and encourage more choice for consumers, both for services needed and providers available to render services.

These changes have been discussed over several years. The KPMG Peat Marwick July 1998 audit of the South Carolina health and human services agencies discussed the change in payment methodologies on pages 7-8, introducing more consumer choice on pages 7-9, and more flexibility through the waiver on pages 7-10 (please see Attachment C). In addition, these changes have been discussed at meetings where the previous directors of DHHS were in attendance. They have been explained at many DDSN Commission Meetings with DHHS program staff attending. And they have been discussed at meetings between the two agencies' programmatic staff.

I believe this covers many of the issues we discussed at the meeting. If you need any further information, please call me.

Sincerely,

Bill Barfield
Deputy State Director

BB/sjd

Attachments

Mims 0148

2004 CMS

Mims 0149

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEMORANDUM

Date: March 13, 2004

From: Alfreda Walker, Survey and Certification Branch Manger

Subject: **Response to Babcock Center Complaints (Ms. Patricia Harrison)**

To: **Linda Joyce**

Responses to Ms. Patricia Harrison's Complaints as they relate to the Federal Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The Federal surveys were conducted form the time frame of June 2003 through March 13, 2004.

The original written complaint from Ms. Harrison contained fifty-three Complaint Allegations. However, the Federal team only focused on those complaints related to the ICF/MR Federal Program. Although there were other allegations contained in the original complaint they are addressed in a separate report form the Division of Medicaid and Children's Health.

Federal surveys were conducted in the following Babcock ICF/MR facilities, Wire Road I and II, Camden I and II, Lexington Clusters, A, B, D, E, and F, Burton Smith Group Home and Ida Lane I and II. The following Allegations are written as they appeared on the original complaint:

I. Complaint Allegation #4- Failure to comply with Adult Protection Act/report abuse, failure to hold management accountable for not reporting abuse.

"$11,000.00 was stolen from 8 ICF/MR consumers at house B at Clusters in early October, 2001...."

A. Findings:

On November 4, 2003, at 11: 30 a.m., the Federal team requested the facility provide, all information pertaining to fiscal audits conducted by the Department of Developmental Disabilities and Special Needs (DDSN). The allegation referred to the date of October 2001. The facility staff was not able to produce an audit of October 2001. But reported an audit existed for the date of August 19, 2002. On November 4, 2003, at 7:00 p.m., the survey team was presented a report entitled South Carolina

Department of Disabilities and Special Needs Internal Audit Report 03-01, of Babcock Center, Inc. The audit report included a section entitled "Consumers' Personal Funds and Property, Unaccounted for Consumer Funds at the Lexington ICF/MR Clusters," that documented $11, 199.00 in consumer funds at the Lexington Clusters for which a House Supervisor could not provide any knowledge of how these funds were spent. The audit report also documented the facility's failure to properly investigate the incident of theft, and the reporting of the incident. In addition, the report did not include information about the amount of money that was stolen to the South Carolina Department of Disabilities and Special Needs. There was no written documentation of how the facility failed to take appropriate disciplinary action against the House Supervisor. In addition, there was not any written documentation, of how the facility failed to refer the incident to the local law enforcement agency, in a timely manner for the completion of a criminal investigation. The facility also failed to notify the parents/guardians of the incident and failed to reimburse the consumers. The "Action Plan" of the facility reported corrective action of "All consumers affected were reimbursed by July 31, 2002." There was no information included or excluded from the Audit Report which would suggest a "cover up" of the theft of client funds.

On November 5, 2003, at 4:30 p.m., a review of the financial records for sampled clients, and an interview with the current House Manager, who maintained the financial records, of all money transactions, was conducted by the Federal surveyor at approximately 10:30 a.m. The manager explained the current financial process for maintaining client funds. There should be documentation of all deposits and withdrawals from the client's accounts. Written statements and receipts of the client's purchase(s) should support these withdrawals. All cash money for clients is maintained in a safe located inside the residence. The facility conducts ongoing audits of clients' money on hand by matching current money on hand with withdrawal request and receipts. The review of this system by the survey team revealed no missing money.
The Federal surveyor did not find any documented evidence of $6,000.00 stolen from eight (8) clients residing in Wire Road and the Clusters.

The remainder of the allegations listed in Allegation #4 will be addressed in a separate report by the Medicaid Branch of Region IV.

Allegation: The allegation was substantiated by the State Survey Agency. The ICF/MR survey substantiated that the allegation was corrected and the monies were reimbursed

B. "Clusters is a hot spot of abuse."

Findings:

The Federal survey teams conducted surveys of Cluster A, Cluster B, Cluster D, Cluster E and Cluster F. The findings related to Abuse/Neglect are as follows:

Cluster "A"

On July 24, 2003 through July 26, 2003, the Federal survey team conducted a full survey of Cluster "A." On July 23, 2003, at 9:20 a.m., the Federal team reviewed the Abuse Investigations conducted by the facility from July 2002 through July 24, 2003. This review revealed the failure of the facility to develop and implement policy and procedures that required immediate reports to the administrator and a thorough investigation of all injuries of unknown source. The facility's incident reports indicated that there were four injuries of unknown source. The incident reports lacked documentation of an investigation of the incident by the facility. Interview with the facility administrator revealed the Qualified Mental Retardation Professional (QMRP) was responsible for filling out the required incident form. However, based on a review of the information presented by the federal surveyor, the administrator admitted that the QMRP had not completed this task as required. The administrator further informed the federal surveyor that incidents were not always reported immediately to her and that staff judgement was used about whether an incident should be reported to her. In addition, the administrator explained that there was no policy developed on how the investigation of injuries of unknown source would be conducted.

On July 23, 2003, at 2:05 p.m., the federal survey team reviewed two agency policies concerning abuse, neglect and mistreatment. The policy entitled, Policy Abuse, Neglect, or Exploitation: Prohibition of and Employee Reporting Responsibilities: Procedures for Reporting, Investigating, and Preventing Abuse, Neglect, or Exploitation of People Receiving Services and Supports, and Reporting of Critical Incidents. Both were dated July 22, 2003. Neither of the two policies contained written documentation, that required reporting of all injuries of unknown source immediately to the administrator; nor was any documentation found to require a thorough investigation of all injuries of unknown source.

As stated above, upon review of the facility's incident reports the federal team determined that there were four injuries of unknown source, and no thorough investigation of these injuries. The injuries were as follows:

- Injury report dated June 2, 2003, at 8:45 a.m. for sampled Client #3 stated "Right side of face (lower jaw) swollen." The injury was reported to the nurse on June 2, 2003 at 9:00 a.m. and the physician was notified. The remainder of the incident report was left blank, and no other investigated findings were documented.

- An injury report dated March 12, 2003, at 5:55 p.m., for Client #3 stated, "Nurse says her left ankle is swollen. Sending to Urgent Care for x-rays (sic)." There was an additional statement by the staff "I don't know anything that happened to the client. Nurse was passing meds (and) said [Client #3]'s

ankle was swollen. She wants her to go to urgent care. Charge person was also notified." The remainder of the incident report was left blank. There were no other investigated findings or written documented staff statements attached.

- An injury report dated April 8, 2003, at 3:30 p.m., for Client #5 stated, "Old bruise already there. On old bruise skin was pulling off." The nurse signed the report on April 8, 2003. There were no further investigative findings or staff statements attached.

- An injury report dated June 5, 2003, at 11:30 p.m., for Client #5 stated, "On the bottom of her foot there is a big blue bruise found on client foot at 11:30 p.m. " The nurse was called and she signed the report at 11:40 p.m. There were two other statements by direct care staff attached. On June 5, 2003 one staff stated, "Staff called me in [Client #5]'s room. Went in room, There was a bruise on [Client #5]'s foot. Called nurse and charge person (remainder of statement illegible). The second statement was dated June 5, 2003 and said, "When I was changing [Client #5]'s pamper, saw her left foot was blue under the bottom, and foot, leg swollen at 11:40 p.m." There were no further investigative findings or staff statements attached.

Cluster "B"

The Federal survey team performed a review of the facility's Abuse Investigation on November 4, 2003 through November 6, 2003 a full survey of Cluster "B" was conducted by the Federal team. On November 4, 2003, at 1:30 p.m. the Federal team reviewed abuse investigations conducted by the facility. The documentation was for the time frame of November 1, 2002 through November 4, 2003. This review revealed the facility's failure to develop, and implement policy and procedures related to abuse/neglect. The policy did not address how the facility would ensure how sufficient behavioral and staff interventions to protect clients from assaults and injuries. Specifically, there was no procedure of how clients would be protected from injury resulting from client to client aggression. In addition, the facility failed to implement a system that included identifying perpetration and victimization trends. There was no written documentation that the facility conducted functional analysis of maladaptive behaviors in order to develop effective behavioral strategies affecting seven (7) of eight (8) clients currently residing in Cluster "B." Based on these findings, it was determined that Immediate Jeopardy existed. An ***Immediate Jeopardy is defined by the Federal Codes of Regulations 42. CFR as, "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident."*** The Jeopardy identified by the Federal survey team, resulted from the facility's failure to ensure clients were not neglected, and placed at risk from other clients living in the home. Specifically, the Federal team was able to identify one client as a frequent victim of other client's aggression. In addition, the facility

failed to develop and implement policies and procedures to assure that three (3) of five (5) injuries of unknown origin were immediately reported to the Director of the facility.

On November 4, 2003 at 1:30 p.m. a review was conducted of the agency policy on abuse. The policy included a section entitled, Acts of Assault Between People Receiving Services which documented, "Reporting requirements pursuant to the state laws do not apply to altercations or acts of assault between people receiving supports protected by these laws except as noted below. However, corrective/preventive action should be taken to protect and intervene whenever people receiving services may be harming themselves or others. All injuries should be thoroughly reviewed and appropriate action taken to prevent similar occurrences. Failure to provide proper supervision to prevent people receiving services from assaulting each other could be a form of neglect if the employee fails to intervene or provide proper supervision when they clearly have a duty to do so. Each situation will be reviewed and if it is determined that the employee failed to provide appropriate supervision which resulted in risk to the life safety of the person receiving services, the incident should be reported as suspected neglect and investigated by established procedures as outlined in this policy and in compliance with state law."

The federal team conducted a review of incident reports on November 4, 2003; this review revealed 29 incidents of client-to-client aggression within the time frame of November 1, 2002 through November 4, 2003. Examples included:

- November 19, 2003- Client #2 kicked Client #1 in the mouth; this resulted in Client #1 biting through his upper lip.
- October 5, 2003, 2:45 p.m.- Client #1 hit Client #4.
- October 3, 2003, at 11:50 a.m.- Client #7 was scratched and hit by Client #6, receiving a split lip.
- September 22, 2003- The Qualified Mental Retardation Professional noted that a large scratch was found by staff on Client #8's arm, date and perpetrator unknown.
- September 13, 2003 at 5:20 p.m.-Client #8 attacked by Client #7 with a shoe.
- September 13, 2003 at 5:20 p.m.-Client #5 was pushed down by Client #7, which caused an abrasion to Client #5's left knee.
- September 13 2003, 3:35 p.m.- Client #7 became self-abusive after a physical altercation with Client #1.

- September 6, 2003, 2:00 p.m.- Client #8 scratched Client #6 on his face and right arm.

- September 6, 2003, 4:15 p.m.- Client #5 pushed by Client #1. Red marks and bruising noted.

- August 25, 2003, 11:10 a.m.- Unknown Client at the workshop stabbed Client #7 in the neck with a pen, laceration noted.

- August 9, 2003, 12:35 p.m.- Client #1 bit Client #5 on his right shoulder, bite marks noted.

- July 26, 2003, 9:30 a.m.- Client #7 attempted to bite an unknown Client, which caused injury to his mouth.

- July 26, 2003, 9:30 a.m.- Client #7 scratched Client #5. Scratches noted on Client #5's back and chest.

- July 1, 2003, 8:57 a.m.- Client #5 was bitten by a female Client at the workshop and required seven stitches.

- June 30, 2003, (time unknown)- Client #7 bit Client #5 on his calf, bite marks noted.

- May 10, 2003 7:15 a.m. Client #5 pushed by an unknown Client. Client #5 sustained a bruise on his right knee.

- April 23, 2003, 4:45 p.m. Client #5 attempted to bite Client #1. Client #1 responded by biting Client #5. Client #5 had bite marks on his left knee.

- On April 10, 2003, 7:30 p.m.-Unknown Client hit Client #5. Client #5 sustained red marks to [his] back.

- March 11, 2003, 5:29 p.m.- Client #1 pushed Client #5, causing an abrasion to Client #5's right elbow.

- January 29, 2003, 1:25 p.m.-Another Client, while at the workshop, hit Client #5 with a chair.

- December 19, 2002, 6:40 p.m.- Client #1 bit Client #7 causing bite marks on Client #7's left ankle.

- December 18, 20003, 4:55 p.m.- Client #1 pushed a Client no longer residing in the home.

- December 13, 2002, 4:55 p.m.- Client #7 hit a Client no longer residing in the home, cutting his head.

- December 13, 2002, 7:32 a.m.- Client #7 hit Client #5 on his back.

- December 13, 2002, 7:35 a.m.- Client #7 hit a Client no longer living in the home on the head.

- December 13, 2003, 7:37 a.m.- Client #5 or a Client no longer living in the home bit Client #7 causing red marks on Client #7's back and a cut on Client #7's thumb.

- December 9, 2002, 8:30 a.m.- Client #1 kicked Client #5, causing an abrasion to Client #5's right knee.

- November 15, 2002, 4:59 p.m.- Client #1 pushed by Client #2, cutting his head.

- November 15, 2002, 5:15 p.m.- Client #1 bit a Client no longer residing in the home on the right arm causing bite marks.

Client #1

Client #1 was responsible for nine (9) incidents and Client #7 was responsible for 8 incidents. There were four (4) incidents in which the perpetrator was not identified on the incident report. Five (5) incidents identified five (5) other clients #2, #4, #5, #6, and #8 living in the home as perpetrators. There were two (2) other instances, in which the perpetrators were not clients living in the home.

All twenty-nine (29) incidents resulted in injuries to the victim. Client #5 was identified as the victim of assault in fourteen (14) of the twenty-nine (29) incidents. The primary perpetrators of these assaults were Client #1 (5) incidents and Client #7 (4). In three (3) of three (3) incidents to Client #5 the perpetrator was unknown. In two (2) of the instances, the perpetrator was not a person living in his home.

The Behavior Support Plan (BSP) for Client #1, dated September 17, 2002, identified the maladaptive behaviors to include; "Physical aggression: defined as any action with the intent of causing harm to another person, including biting, kicking, hitting, etc., Verbal Aggression: any verbalization intended to cause harm to another person to include screaming, cursing, name-calling, etc.", "Self abuse", Hallucinations", "Non-cooperation", and "Inappropriate sexual behavior. The BSP did not include a functional analysis of the maladaptive behaviors. The intervention focus of the BSP relied primarily on 1 on 1 staff support that was to be in place during waking hours. The plan did not include a description of what the 1 on 1 staffing would entail or how it was to be implemented in the home. The data for Client #1's aggression for the time period November 2, 2003 through September 2003, revealed he had exhibited 249

physically aggressive incidents. Documentation of these incidents of physical aggression included:

- November 5, 2002, 5:15 p.m.- Client #1 bit another client on the right arm causing bite marks.
- December 9, 2002, 8:30 a.m.- Client #1 kicked another client causing an abrasion to the right knee.
- December 23, 2002 4:55 p.m.- Client #1 pushed another client to the floor resulting in a wound to the top of his head requiring 5 sutures to close.
- March 11, 2003, 5:29 p.m.- Client #1 pushed another client causing an abrasion to the right elbow.
- May 26, 2003, 7:30 p.m.- Client #1 pushed another client from his walker to the floor, resulting in a wound to his forehead requiring 8 sutures to close.
- August 9, 2003, 12:35 p.m.- Client #1 bit another client on his right shoulder, bite marks noted.
- September 6, 2003, 4:15 p.m. Client #1 pushed another client causing red marks and bruising.

On November 4, 2003 at 11:00 a.m. a review was conducted of the investigations of abuse, neglect and mistreatment conducted by the facility between the period of November 4, 2002 and November 4, 2003. Of the eight investigations completed during that time frame. One (1) documented report, did not include evidence of reporting immediately to the Director, an abusive incident between a staff member and client. This case, labeled "[Client #1's name] August 15, 2003," involved a staff member, who on August 11, 2003, at 6:30 a.m. observed the lead staff member of the facility, become upset with Client #1 because he was taking too long to eat his breakfast. The staff member took Client #1's food away, and Client #1 began crying and asked the staff member to give him back his food. The staff member escorted Client #1 down the hallway, but Client #1 resisted. The staff member then stated to the client, "I know you didn't just hit me." The staff member grabbed Client #1 by the neck and put him against the wall. Client #1 continued to resist and the staff member hit him on the arm with his fist then proceeded to take Client #1 to his room where he was heard crying.

The investigative file noted the allegation was not reported until November 14, 2003. The file documented that when questioned the staff member reporting said he did not report the incident immediately, because he was scared due to the staff member's position within the residence.

Mims 0157

On November 5, 2003 at approximately 9:00 a.m., a review was conducted of an abuse investigation of Client #1. The abuse file entitled, (Client #1's name), documented that an employee who resigned her employment on September 23, 2002, reported to the Assistant Director during an employment exit conference that she observed a staff member hit Client #1 with a wooden paper towel holder with force. Later, on the same shift 3 p.m. to 11p.m, the same staff member was observed to hit Client #1 again while giving him a bath. The dates of these incidents were not documented. Interviewed Client #1 on the day of the incident, the client confirmed that the staff member hit him. The investigation report documented this statement; "The allegation of physical abuse against [the alleged perpetrator's name] is substantiated. [The alleged perpetrator's name] will be terminated based upon a substantiated case of abuse." On September 28, 2002, the employee was terminated.

On October 1, 2002, another staff member reported that Client #1 told her he was "going to lie and get all the guys fired in the house." On the basis of this report the investigative case was re-opened and Client #1 was re-interviewed.
An Addendum Report included with the investigation resulted in a determination that the substantiation of abuse against the alleged perpetrator was rescinded. This decision was based on a determination that Client #1 was unreliable and an absence of "bruises or marks to indicate abuse."

The Addendum Report did not include documentation of recognition that another staff member initially reported this incident, and was not by Client #1. There was no information regarding a re-interview with the reporting party or a determination that the initial report of this incident was not credible.

- An investigation report documented that on July 6, 2003, at 4:15 p.m. Client #1 was discovered with large abrasions/bruises on his chest. The Director of Nursing documented the bruises appeared to have been caused by a belt or a wire looped object: as the bruises matched the shape of the handle of a fly swatter as evidenced by photographs of a fly swatter held over the bruises on Client #1's chest. Client #1 reportedly offered differing explanations of the cause of the bruises. He stated, he did not know how the bruises occurred. He said I could have fell, scratched himself, someone could have kicked him, someone could have punched him or maybe he was hit by an unknown person with a metal object while in the hallway. The investigation included recognition that Client #1 was assigned 1: 1 staffing prior to, the discovery of the bruises. The staff members assigned to provide 1: 1 staffing prior to the discovery of the bruises reported having no information about how the bruises might have been caused.
  The investigation resulted in a determination that abuse was substantiated with an unknown perpetrator.

On November 4, 2003, at 9:00 a.m. the federal surveyor observed the staff member assigned to provide 1:1supervision for Client #1. During this observation, staff responded to four telephone calls between 9:00 a.m. and 10:00 a.m. The telephone

was located in the entry hall of the facility, thus, requiring the staff member to leave the living room to answer the telephone. Client #1 was left unattended, as he sat on the couch in the living room. This also left the client out of arm's length of the assigned staff member, as required by the prescribed behavior program.

The Federal surveyor interviewed Client #1's assigned staff member on November 4, 2003, at 11:00 a.m. When asked how he prevented Client #1 from assaulting others he said, "I try to keep him within an arm's length, pull him away by his back if he tries to attack anyone and redirect him. These interventions work sometimes." He continued by stating, " Client #1 usually picked on Client #5." The Federal surveyor then asked the staff member if the residence, in his opinion was a safe place for clients to live. He responded by saying, "Well, there are a lot of fights."

On November 5, 2003, at 10:00 a.m., an interview was conducted with another direct care staff member assigned 1:1 to Client #1. When asked how he prevented Client #1 from assaulting others he stated, " I've known him for over three years and I can usually talk him down if he is upset." I keep Client #1 within arms length and use redirection sometimes when he becomes upset. The Federal surveyor asked the staff to describe the behavior interventions prescribed in Client #1's BSP, and he said, "No, not exactly, it's been altered some." He also stated "Problems come up with Client #1 when staff are inconsistent in how they respond to him. Staff on the 3-11 shift do it a little different".

On November 4, 2003, at approximately 2:00 p.m., the federal surveyor also conducted an interview with the Behavior Supervisor. This staff member was assigned as the behavior specialist for clients in Cluster Building B. During this interview, the Behavior Supervisor stated the psychological assessments and behavior plans did not contain a functional analyses of the client's behaviors.

He further explained the correct method of physical management to prevent Client #1 from assaulting others did not include a procedure of pulling him away by his back as explained by the residential staff member. The Behavior Program Supervisor stated "...staff members received initial and ongoing training on BSP's and physical intervention techniques approved by the agency."

Client #5

The following incident of injury of unknown source for Client #5 was as follows:

- May 10, 2003, Client #5 was found to have a bruise on his right knee. A sentence written by an unknown person states "[Client #5's name] was pushed by another client and fell to the ground. There was no documentation of when, where, or how the incident occurred.

On November 4, 2003, beginning at 10:45 a.m., reviews were conducted of the records of Clients #1, #5 and #7. The Behavior Support Plan (BSP) for Client #5, the

primary victim of assaults, focused on staff prompting the client to avoid assaults, by avoiding conflict with other clients. The Behavior Support Plan (BSP) for Client #5 did not include a functional analysis of behavior.

The Behavior Supervisor further stated he had not conducted an analysis of the client-to-client assaults to determine if a particular client was being victimized. He stated he often observed Client #5 frequently "in the wrong place at the wrong time." He was sometimes assaulted when he approached other clients engaged in maladaptive behavior(s). This often times resulted in him being assaulted." When asked if he believed Client #5 was safe in his residence, the Behavior Supervisor said, "I won't go out on a limb and say nothing's going to happen to him. But in a meeting during the previous week regarding problems in the Clusters Building B, the management team determined the need for additional staffing. The home had been running on bare minimum staff, and the one on one requirement for two clients residing in that home could not always be maintained."

On November 4, 2003, at 4:45 p.m., the Consumer Advocate for Babcock Center was interviewed, and explained that she primarily investigated "Critical Incidents." According to her these incidents, require hospitalization, police involvement, staff abuse or neglect, or financial exploitation. When asked whether she was aware of the level of client-to-client abuse in the home she replied. "That house is tough, the staff have their hands full." When asked if she was aware of Client #5's being targeted by his peers, the Consumer Advocate stated "we all fall in to the mind trap of saying, oh, that's just [Client #5' name]. If they had to document every behavior of his, that is all they would be doing. We need people to come in and tell us what we're missing because we're just not seeing it now."

Client #7

The BSP for Client #7 identified the maladaptive behaviors to include physical aggression defined as any action with the intent of causing harm to another person, including biting, kicking, hitting, etc. The BSP did not include a functional analysis of the targeted behavior. Per the Interdisciplinary team meeting held on October 31, 2003, Client #7 was placed on 1:1 staffing ratio on that day for unrelated sexual behavior and not for his aggression. The data for Client #7's aggression for the time period November 2002 to September 2003, revealed he had exhibited 223 aggressive incidents. Examples of the documentation of these incidents of physical aggression included:

- December 13, 2002, 4:55 p.m.- Client #7 hit another client resulting in a laceration to his head.

- June 30, 2003, (time unknown), Client #7 bit another client on the calf of his leg, bite marks noted.

- July 26,2003, 9:30 a.m.- Client #7 scratched another client resulting in scratches noted on his back and chest.

- September 13, 2003 5:20 p.m.- Client #7 "attacked" another client with a shoe.

- July 30, 2003, at 8:15 a.m., the facility staff found Client #7 with a cut over his left eye. The staff notified the facility nurse, who treated the cut with soap and water then covered it with a band-aid. The QMRP noted "[Client #7's name] may have accidentally fell and bump (sic) his head." On August1, 2003 the Director signed the "Administrative Review" portion of the report and documented, "client bumped his head." There was no further documentation of additional investigation of how the scratch to the eye area occurred.

The federal surveyor asked the BPS if he was aware of the frequency of targeted behaviors for Client's #1, #5, and #7. He responded and said," The data collection system was not capable of trend analysis. And only recorded the frequency of maladaptive behavior(s)."

Client #8

November 4, 2003 at 10:00 AM, during a review of the "Accident/Injury Records", five (5) incidents were identified for which a thorough investigation had not been completed for Client #8. Those incidents included:

- September 21,2003, a scratch was discovered on Client #8's neck. Staff documented "a scratch mark on left side of the neck which appears to be old due to color. There was no documented evidence of the date or time this mark could have occurred."

- September 22, 2003, the Qualified Mental Retardation Professional (QMRP) noted, "it appears that [Client #8] may have scratched himself as usual." On October 7, 2003, the Director signed the "Administrative Review" portion of the report and also noted, "mark is old." There was no documented evidence of additional investigation.

On November 5, 2003, at 8:30 a.m. an interview was conducted with the Director of Babcock Clusters. She reported being aware of staffing problems in the home, particularly since two clients were identified as needing 1:1 staffing. She reported when a determination was made to add one additional staff member to the staffing pattern of the home. A part of her action plan was to assign the new staff member to the 12:00 a.m. to 8:00 a.m. shift. She further identified the required staffing minimums by shift as; 4 staff for the 8 a.m. to 4:00 p.m. shift; 4 staff for the 4:00 p.m. to 12:00 a.m. shift; and 3 staff for the 12:00 a.m. to 8:00 a.m. shift. The Director also stated she was aware that the Behavior Support Plans did not include and were not developed from functional analyses of maladaptive behaviors, and no trends analysis

on assaultive behaviors had been completed by facility staff. She also said, she was aware of assaults between clients in the home and the Behavior Support Plans needed improving.

On November 5, 2003, at approximately 9:00 a.m., the Federal surveyor reviewed the staffing patterns of Cluster "B" for the time period from October 2, 2003, through November 1,2003. They were as follows:

- On the day shift (8:00 a.m. to 4:00 p.m.) 1 person under staffed 20 of 31 shifts.
- On the evening shift (4:00 p.m. to 12:00 a.m.) 1 person under staffed 18 shifts.
- On the overnight shift (12:00 a.m. to 8:00 a.m.) one person under staffed 3 of 31 shifts.

Based on the findings of the above incidents, it was determined that actual harm had occurred to Client #5, and based on the current interventions employed by the agency, including inadequate behavior support plans, there is a likelihood for potential harm to occur again. It was also determined that facility was aware of the impact of Client #1 and #7's behavior on the other clients, specifically Client #5. There was no documented evidence of the facility's actions to intervene in reducing or eliminating the behaviors. In addition, the facility failed to ensure the staffing ratios as identified to keep people safe.

On November 4, 2003, 10:00 a.m. a review of the Accident/Injury Records conducted by the Federal team revealed three (3) injuries of unknown source. There was no written evidence of immediate notification to the Director. Those included:

- November 22, 2002, Client #7 was found to have a "swollen and blue" left big toe. No documentation existed as to how the toe was injured. The Director documented being notified of the injury on November 25, 2002.
- December 23, 2002, Client #3 was found to have a laceration on the heel of his left foot. There was no documentation of the Director being notified of the injury.
- September 21,2003, a nurse noted that Client #8 had "red scratch marks below ear about one inch long". There was no documentation as to how the scratches occurred. The Director documented being notified of the injury on October 7, 2003.

November 16, 2003, 3:00 p.m., an interview with the Assistant Director confirmed that all allegations of abuse, neglect and mistreatment and all reports of injuries of unknown origin are supposed to be reported immediately to the Director. She could

offer any explanation for the absence of policy to support standard practice within the agency or for the failure of facility staff to immediately report incidents identified above.

November 4, 2003, at 1:00 p.m., the Federal surveyor was provided a copy of the "Reporting of Critical Incidents" policy dated August 26, 2003. The policy, defined critical incidents to include, "accidents that result in serious injury", and "significant acts of aggression by or against supported persons". The policy did not define "serious" injuries or "significant" acts of aggression.

The policy further documented, "The first response person...will initiate and complete an initial investigation within 24 hours. The results of the investigation will be reported immediately to the House Manager and the QMRP(Qualified Mental Retardation Professional)/Coordinator as well as the responsible Administrator or Residential Director." The policy did not include a requirement for all injuries of unknown origin to be reported immediately to the Director. The Consumer Advocate confirmed that all injuries of unknown source should be reported immediately to the Director.

Clusters "D"

A federal survey of Cluster "D" was conducted on July 29, 2003 through July 30, 2003. The survey revealed no written evidence of non-compliance with federal regulatory requirements of failing to implement, investigate or report any abuse/neglect during the time frame of July 2002 through July 29, 2003.

Clusters "E"

A federal survey of Clusters "E" was conducted on September 15, 2003 through September 17, 2003. Based on observations, record and staff, client and family interviews. The federal survey team determined that the facility did not demonstrate non-compliance of developing, implementing or reporting any abuse/neglect incidents as required by federal regulations.

Clusters "F"

A federal survey of Clusters "F" was conducted on July 24, 2003 through July 25, 2003. The survey findings documented no non-compliant deficient practice of the federal regulatory requirements of developing, implementing or reporting abuse/neglect of any clients residing in the facility.

Allegation: Not substantiated for Clusters D, E, F; partially substantiated for Cluster B.

II. Allegation #5- Failure to protect consumers from repeated beatings, failure to report negligent supervision to Ombudsman, lack of accountability in funding outlier services: the case of Ed M.

A. Failure to protect consumers from repeated beatings

Findings:

The Federal survey teams conducted an investigation of all Abuse Investigation reports of Clusters A, B, D, E, and F, in addition to surveys of Wire Road I, Wire Road II, Ida Lane I, Ida Lane II, Horrell Hill, Burton Smith Group Home and Camden I. Based on the investigation of these Intermediate Care Facilities for the Mental Retarded (ICF's/MR. The team did not find any documented evidence, of ***repeated beatings by a staff***, as stated in the allegation. However, the team did confirm one (1) incident of abuse. This abusive act occurred September 2002. Example:

- On November 5, 2003 at approximately 9:00 a.m., a review was conducted of an abuse investigation of Client #1. The abuse file entitled, (Client #1's name), documented that an employee who resigned her employment on September 23, 2002, reported to the Assistant Director during an employment exit conference that she observed a staff member hit Client #1 with a wooden paper towel holder with force. Later, on the same shift, 3 p.m. to 11p.m.the same staff member hit Client #1 again while giving him a bath. The dates of these incidents were not documented. However, Client #1 was later interviewed on September 23, 2002, by the facility staff about the two reported incidents. The client confirmed that the staff member hit him. The investigation report documented this statement "The allegation of physical abuse against [the alleged perpetrator's name] is substantiated. [The alleged perpetrator's name] will be terminated based upon a substantiated case of abuse." On September 28, 2002, the employee was terminated.

The following two investigations of mistreatment did not allege abuse but were identified as accidental injuries that were investigate to determine if staff could have taken an active part in the injury or could have taken action to prevent the injuries.

- On March 23, 2003 at 7:30 a.m. Client #1 was in his bedroom bending over to pick up his soiled clothes from the floor. As he raised himself, his head struck the corner of his dresser, resulting in a laceration over his right eye. An initial nursing assessment at the facility resulted in a transfer to the Urgent Care Center, where the wound was closed with three (3) sutures. The investigation included a report from the 1:1 staff member assigned at the time of the incident that he was inside Client #1's room, "standing right beside him," when the accident occurred. He reported, "It happened so quickly" there was nothing he could do to prevent Client #1 from hitting his head. The administrative response by the agency to this investigation concluded, while there was an obvious injury to the client, there was no conclusive information to confirm

abuse by an employee. In addition, the agency's investigation documented there was no evidence to determine if the staff could have taken action to prevent the injury.

- May 13, 2003, at 10: 15 p.m., Client #1 "jumped off the van and ran into the house" and hit his head on the fireplace, resulting in a laceration over his left eye. An initial nursing assess at the facility resulted in a transfer to the Urgent Care Center, where the wound was closed with five (5) sutures. The investigation included a report from the 1:1 staff member, assigned at the time of the incident. According to the staff, Client #1, "...snatched away from me slipped and hit his head against the brick wall in the Great Room." The administrative response, by the agency of this investigation, determined the existence of an injury of Client#1. The client received the necessary medical care. There was no evidence to prove physical abuse or intent of abuse by the staff to the client. The facility staff member's written description, of the incident was supported by the physician's report, from the Urgent Care Center. The physician stated in his report that, the lacerations occurred as a result of trauma to the head by a blunt object. The agency concluded that the injury was not the result of staff abuse, and there was no evidence to support the prevention of the injury.

On November 5, 2003, at approximately 4:00 p.m. the Federal team conducted an interview with the Behavior Program Supervisor. The purpose of the interview was to determine, how the facility identified clients who continued to be assaulted, does the facility define an accident versus an assault, and how does the facility protect clients during the investigation of allegation(s) of abuse. The Behavior Supervisor explained that staff members are required to report all client injuries, regardless if they suspect abuse. These injuries are reported by completing an Accident/Injury Report. The reports are reviewed and a determination is made regarding Serious Injury, Critical Injury. Based on the type of injury, the information is reviewed by the agency and an investigation is conducted. This method provides the agency and the residential facility (Clusters A, B, C, Camden I and II) with the names of the clients who, based on incident reports, are considered targets of abuse. The next step is to determine if this is client to client abuse, or if it is staff to client abuse, or an accident caused by the client. If in the case of client to client abuse, the Behavior Program Supervisor will request the development and implementation of a written behavior support plan, to reduce the aggressive behavior(s). In the event of staff to client abuse, the staff is first suspended, pending the investigation of the incident, and if the staff is found guilty of the abuse, the staff member is terminated. The clients are protected from more abuse, through the suspension of the staff during the investigation of the incident. If it is determined that the client may have caused the injury/accident, the client is given whatever treatment necessary, and an investigation of what possibly caused the accident/injury is completed. The Supervisor further stated the facility, to his knowledge, had not defined the difference between an assault and an accident.

The Federal team conducted surveys of eleven ICF/MR facilities from the month of June 2002 through February 2004. Based on the team's investigation there was evidence of the facility providing one-on-one supervision for two clients, residing in Cluster "B." The Federal team determined that the facility's one-on-one supervision was inadequate because it could not ensure clients were not neglected and placed at risk from other clients living in the facility.

Findings:

- On November 4 through 6, 2003, the Federal team observed at least four (4) incidents of client to client aggression in the presence of one-on-one staff. The Federal team gathered supporting information to determine how the facility provided protection of clients against client to client aggression.

- On November 4, 2003, at approximately 1: 00 p.m., a review was conducted of the Abuse Investigation(s) conducted by the facility within the time frame of November 4, 2002 through November 3, 2003. This review revealed twenty (20) investigations of mistreatment involving various clients in Cluster "B."

- On November 4, 2003, at 1:30 p.m. a review was conducted of the agency's policy on abuse. The policy included a section entitled, Acts of Assault Between People Receiving Services which documented, "Reporting requirements pursuant to the state laws do not apply to altercations or acts of assault between people receiving service supports protected by these laws except as noted below. However, corrective or preventive action should be taken to protect and intervene whenever people receiving services may be harming themselves or others. All injuries should be thoroughly reviewed and appropriate action taken to prevent similar occurrences. Failure to provide proper supervision to prevent people receiving services from assaulting each other could be a form of neglect if the employee fails to intervene or provide proper supervision when they clearly have a duty to do so. Each situation will be reviewed and if it is determined that the employee failed to provide appropriate supervision which resulted in risk to the life and safety of the person receiving services, the incident should be reported as suspected neglect and investigated by established procedures as outlined in this policy and in compliance with state law."

- On November 4, 2003, the Federal team interviewed the Behavior Supervisor, who acknowledged the facility's employment of additional staff to provide one-on-one staff supervision. The Behavior Supervisor explained the development of behavior support plans for clients who were identified by the facility as displaying aggressive behavior(s) toward client(s). These plans outlined the responsibilities and implementation of the one-on-one staff member. However, in Cluster "B," the Supervisor, having knowledge of the many incidents of client to client abuse, acknowledged during this interview, that the facility was often

"...running on bare minimum staff and the one-on-one requirement for two clients residing in that home could not always be maintained."

- On November 5, 2003, the Federal team conducted an interview with the Director of the Babcock Clusters. According to the Director, the agency was aware of staffing problems in Cluster "B," and decided to add additional staff to provide on-on-one supervision. The agency assigned four (4) for the 8:a.m. to 4:00 p.m. shift; four (4) for the 4:00 p.m. to 12:00 a.m. shift; and three (3) staff for the 12:00 a.m. to 8:00 a.m. shift. This additional staff was added to the facility, effective immediately, upon the completion of all behavior programs written, requiring one on-one-supervision.

- The Federal team reviewed incident reports for the time frame of November 1, 2002 through November 4, 2004. This review revealed twenty-nine (29) incidents of client to client aggression.

- The Federal team's observations confirmed a lack of knowledge and implementation of the client's behavior support plan, to reduce client to client abuse. Based on this evidence and written documentation of incident reports and the facility's knowledge of increase client to client aggression over a period of June 2002 through November 5, 2003. The Federal team cited deficient practice of Client Protections at the level of ***actual harm.***

Results of Allegation: Substantiated

III. Allegation # 6- Failure to report abuse and failure to protect consumers/employees from violent consumers: Case of A.J.

Babcock employee, Linda LaCroix, was injured when consumers D.J. threw furniture at her early in January 2002.

Findings:

The Federal survey team conducted an investigation of all Accident/Injury reports, as well as facility incident reports from the time frame of June 2002 through November 2003, to validate the complaint allegation(s). Based on the surveys conducted by the Federal team, the team could not validate any specific incidents, of client aggression toward staff.

In addition, the ICF/MR survey process directs the surveyor to focus attention on the client and the services provided to the client. In the case of Linda LaCroix, the Federal team could not confirm validation of the complaint. However, the team reviewed all Incident Reports of all eleven surveys. Based on the surveyors reviews

there were no incidents of client to staff aggression. But there was documented evidence of client to client and staff to client. This information is contained in Allegations #4 and 5.

Results of Allegation: Unsubstantiated

IV. Allegation #7- Death of resident, failure to provide medical treatment, falsification of records failure to do accountability checks, failure to report negligent supervision to Ombudsman: James B.

James died from GI bleeding. Management protecting some staff to cover up lack of staff supervision for residents, who have medical problems.

Findings:

The Federal team conducted eleven surveys of Babcock Agency's ICF/MR facilities. These facilities included Ida Lane I and II, Butron Smith Group Home, Wire Road I and II, Camden I and II and Clusters A, B, C, D, E and F. During the survey of the ICF/MR facilities, there was no evidence to confirm the failure of the facility to report any negligent supervision to the Ombudsman. In addition, the Federal team did not find any documented evidence regarding the case of James B., as alleged in the complaint.

Results of Allegation: Unsubstantiated

V. Allegation #8 – Failure to report sexual assault/failure of law enforcement to investigate, failure to report negligent supervision to Ombudsman, lack of choice in residential providers: case of Eddie W.

Findings:

The Federal team conducted twelve surveys of Babcock Agency's ICF/MR facilities. These facilities included Ida Lane I and II, Burton Smith, Clusters A, B, C, D, E and F Wire Road I and Wire Road II and Camden I and Camden II. There was no evidence to confirm the facility's failure to report sexual assault, failure to report sexual assault to law enforcement for investigation, or failure to report negligent supervision to Ombudsman. There was also a lack of evidence, to confirm the facility failed to provide clients with choices of community residential placement and providers. In addition, the Federal team did not find any documented evidence regarding the case of Eddie W. as alleged in the complaint.

But reported an audit existed for the date of August 19, 2002. On December 3, 2003, at approximately 2:20 p.m., the survey team was presented a report entitled South Carolina Department of Disabilities and Special Needs Internal Audit Report 03-01, of Babcock Center, Inc. The audit report included a section entitled "Consumers' Personal Funds and Property, Unaccounted for Consumer Funds at the Lexington ICF/MR Clusters," that documented $600.00 in consumer funds at the Wire Road for which a House Supervisor could not provide any knowledge of how these funds were spent. The audit report also documented the facility's failure to properly investigate the incident of theft, and the reporting of the incident. In addition, the report did not include information about the amount of money that was stolen to the South Carolina Department of Disabilities and Special Needs. There was no written documentation of how the facility failed to take appropriate disciplinary action against the House Supervisor. In addition, there was no written documentation, of how the facility failed to refer the incident to the local law enforcement agency. The report did not indicate if this incident was referred in a timely manner, for the completion of a criminal investigation. The facility also failed to notify the parents/guardians of the incident and failed to reimburse the consumers. The "Action Plan" of the facility reported corrective action of "All consumers affected were reimbursed by July 31, 2002." There was no information included or excluded from the Audit Report which would suggest a "cover up" of the theft of client funds.

On December 3, 2003, at 4:30 p.m., a review of the financial records for sampled clients, of Wire Road and an interview with the current House Manager, who maintained the financial records, of all money transactions, was conducted by the Federal surveyor at approximately 4:30 p.m. The manager explained the current financial process for maintaining client funds. There should be documentation of all deposits and withdrawals from the client's accounts. Written statements and receipts of the client's purchase(s) should support these withdrawals. All cash money for clients is maintained in a safe located inside the residence. The facility conducts ongoing audits of clients' money on hand by matching current money on hand with withdrawal request and receipts. The review of this system by the survey team revealed no missing money.

The Federal surveyor did not find any documented evidence of $600.00 stolen from eight (8) clients residing in Wire Road.

Allegation: Unsubstantiated.

XXX. Allegation #32-Failure to comply with HIPAA.

Allegation #33-DDSN and Babcock have interfered with consumer's right to legal counsel, failure to provide eligibility determination in a timely fashion: the case of SP.

Allegation #34- Arbitrary determination of eligibility for services.

Allegation #35- Failure of Service Coordination to inform families of home and community based waiver service options.

Allegation #36- Respite Care

Allegation #37- HASCI services.

Findings:

The Federal survey team conducted eleven surveys of ICF/MR facilities for the time frame of June 2003 through November 2003. The team was not able to validate any of the above allegations. The federal regulations for the ICF/MR program do not require investigation of arbitrary determination of eligibility for services, coordination of informing families of home and community based waiver service options as stated in the complaint. However if community placement is recommended by the Interdisciplinary Team, the ICF/MR federal regulations directs the surveyors, to investigate the process used by the facility to discharge the client from the facility to the community. The Federal team did not investigate Respite Care, or HASCI services, due to a lack of regulatory requirements, for such an investigation. This information is contained in the Medicaid State Plan.

Although the Federal team did not substantiate the allegation of the facility to inform families of home and community based wavier services, the team was able to gather information pertaining to community placement. Based on record review and interviews with clients and facility staff, the team cited the facility for failure to discharge a client, who was not in need of continued ***Active Treatment*** services. The following is an example of the team's findings:

Client #4 is a 33-year-old male who has resided in the Wire Road 1 facility since July 18, 2001. Record review for Client #4 conducted on July 23, 2003 at 10:00 a.m., indicated that he was admitted to Wire Road from a large facility. Client #4 had two previous small group home placements that "...were unsuccessful due to aggressive and destructive behaviors," according to the Behavior Support Plan, that was implemented October10, 2001, and reviewed on May 9, 2003 by the Human Rights Committee. Client #4 is his own legal guardian, and his adoptive parents are his surrogate consent makers for medical procedures. He was not registered to vote but expressed interest in doing so. According to the Behavior Support Plan, Client #4 had the following diagnoses: Moderate Mental Retardation; Intermittent Explosive Disorder; Depressive Disorder; Borderline Hypertension; and Acute Intermittent Porphoria. The Behavior Support Plan also stated that Client #4 was prescribed Paxil, which a review of the physician's orders confirmed. Client #4 was home on his day off on July 22, 2003, as his job at a garbage collection site was on Mondays, Wednesdays and Fridays, and every other weekend. Client #4 earned close to minimum wage for this work, according to time studies provided by his employer.

Record review on July 23, 2003 at 10:00 a.m., of records supplied by his job coach, indicated that Client #4 was very good at his job and functioned independently in his job tasks.

At approximately 8:20 a.m., Client #4 introduced himself to the Federal surveyor. He was friendly, smiling and said that he did not need to be at the facility because he was "too smart." During the survey entrance conference on July 22, 2003 at 10:00 am, the Residential Director described Client #4 as "independent in most Activities of Daily Living (ADL). During observations on July 22, 2003 at 12:00 Noon, Client #4 was conversant, alert and verbal. Later, the surveyors observed Client #4 in the evening. There was no observations of assisting Client #4 with either bathing grooming or dressing.

Although Client #4 was not observed making any purchases, he informed the surveyor of a recent request and purchase of videotapes (of a sexual nature), for his personal viewing in his bedroom. When asked what he liked to buy, Client #4 said that he purchased "S-E-X tapes" with his money. These purchases were confirmed by review of the financial records and also by review of the Human Rights Committee meeting minutes. Further interview, with the Behavior Specialist, confirmed that the videos had been obtained.

Client #4 was cheerful and smiled as he spoke. When he was complimented on his smile and very white teeth, Client #4 agreed stating that "if you don't take care of your teeth- then no more teeth."

During the same interview, when asked if he was going to go make his lunch, Client #4 stated that the staff prepare all of the meals in the home, but that he "like to cook, I cook good, but we can't cook here." Client #4 then explained that he cooked meals at home and had cooked at other facilities, prior to admission to Wire Road. He continued, by explaining his capability to prepare sandwiches and knowledge of how to use a microwave. He enjoyed using the microwave because he likes to eat microwave "popcorn."

Client #4 also expressed his desire to move to a Community Training Home (CTH, a small waiver home) and was close to accomplishing this move. When asked by the surveyor what he needed to do to be able to move, he said "my behaviors." He explained he had problems with anger in the past, but now, "...the guys [his house-mates] get on me but, I just laugh and walk away. They aren't worth getting myself into trouble. This isn't helping me." He further stated that "living with eight guys- it can stress you out. Eight is just too many."

On July 22, 2003 at 2:30 p.m. approximately 3:00 p.m., the Behavior Specialist assigned to the home was interviewed. He stated Client #4 "has come a long way" in terms of his participation and his behavior." He contributed the client's employment in the community as the most positive influence on his behavior. The Behavior Specialist continued by stating, "his incidents of aggression and 'non-compliance" had

decreased "significantly." Record review on July 22, 2003 at 4:00 p.m., of the incident reports documented no serious behavioral incidents involving Client #4. A second interview with the House Manager on July 23, 2003 at 9:30 a.m., confirmed that Client #4's independent functional ability as well as a reduction in aggressive behaviors.

On July 23,2003, at 10: 00 a.m. a record review for Client #4 was conducted. The documentation contained in the record also confirmed the independent level of functioning for Client #4. Based on an assessment for the following functional skills; The Community Living Skills Assessment Basic 1, dated January 6, 2003, Recreational/Leisure Skill Assessment dated January 6, 2003. Sexual Behavior Inventory. Additionally, Client #4 was assessed on the Community Living Skills Assessment 1, Intermediate and Community Living Skills Assessment, Advanced, and there were additional areas in which Client #4 was found to be independent.

Therefore, the Federal team determined that the facility failed to discharge the client, who functioned independently, to the community.

Allegation #38-History of failure to report and prevent abuse: the Jennings case.

Findings: The individual identified here had been discharged from the ICF/MR program prior to the initiation of the survey process.

Allegation #39-Unreported beatings and sexual assault of 78 year old client: case of James J.

Findings:
Client James J., is referred to as Client #1 in this investigation.

The Federal team entered Ida Lane II on November 18, 2003, at approximately 3:45 p.m. The team's findings are as follows:

- On November 18, 2003, at 4:20 p.m., Client #1's left shoulder and upper arm were observed by the Federal surveyor, to be swollen and painful, as a direct care staff member assisted in removing the client's shirt, in preparation for a bath. According to the client he fell at the workshop. Client #1,is described as a 79 year old male, who has diagnoses of Moderate Mental Retardation, Schizoaffective Disorder, Hypothyroidism, Chronic Eosinophilia Dylensia, and Chronic BradyCardia. His medications included Zyprexa, Aricept, and Calcium Carbonate.

- On November 20, 2003, at 3:00 p.m., Client #1 was interviewed at his residence. He sat in an overstuffed chair. His left arm, was in a hard cast from below his shoulder to his hand. His hand was elevated with several pillows above his heart.

He appeared somewhat drowsy, awakening long enough to talk briefly. When asked, "How did your arm get hurt"? he stated, "I fell this morning getting out of bed." When asked a second time he replied, "I fell in the bathroom at the workshop." During the conversation, the Federal surveyor asked additional questions regarding the incident. The client repeated, he fell in the bathroom at the day program. He described the incident by explaining he was in the bathroom by himself and fell. Client #1 gave no specific details explaining how he fell. When asked by the Federal surveyor, if he was running and fell the client did not respond. When asked if he was walking and perhaps his legs became weak and he fell, he continued to respond by stating "I fell in the bathroom." He concluded his statement by explaining how he got to his feet by himself after his fall without any assistance.

- On November 20, 2003, at 11:00 a.m., an interview was conducted with the Consumer Advocate. She reported an investigation had been initiated on November 19, 2003 but was not completed. She provided the team with copies of the written documents obtained regarding the injury. The initial assessment of the incident documented that Client #1 stood up from his seat at the workshop, and walked to the bathroom where he fell. He returned to his table and reported to staff that his arm hurt. The workshop nurse checked his right arm, where he indicated the pain came from, and gave him arthritis medication for joint pain. The client has a history of joint pain from arthritis. When he returned home, staff discovered his left arm was swollen and he complained of pain. He was transported to the Urgent Care Center where X-rays confirmed his left arm was fractured in six places. He was released from the Urgent Care Center and returned to the residence with aftercare instructions to keep the arm immobilized. His next scheduled appointment to check the medical condition of his arm by an Orthropod was November 19, 2003. On November 19, 2003, the Orthropod examined Client #1 and reported the injuries were consistent with a fall that occurred within 24 to 48 hours. A hanging cast was applied to reduce swelling and to induce alignment. A follow up appointment was made for one week to re-evaluate healing, and consider surgical repair after the swelling had diminished. The Consumer Advocate reported Client #1's level of supervision was assessed as "30 minute checks". According to the Advocate this level of supervision allowed the client freedom to move about the residence, the workshop, and use the bathroom independently. She also emphasized that, although the investigation was not complete, her initial assessment was leading her to believe the injury resulted from an unfortunate accident. There was no information to suggest staff mistreatment.

- On November 20, 2003 beginning at 3:15 p.m., staff members at the residence were interviewed. The House Manager reported Client #1 consistently reported the injury to his arm occurred when he fell in the restroom at the day program on November 18, 2003. She explained the various levels of supervision and Client #1's level, was "Level III." Level III was described as visual checks every 30 minutes. She further explained that the client also required staff assistance in

using the bathroom. This was necessary because he usually wore adult briefs for incontinence and required staff assistance in changing them. She said he required 1:1 staff assistance when bathing in order to keep him safe.

- On November 20, 2003, at 4:14 p.m., the Federal surveyor conducted an interview with the facility nurse. The nurse reported being unaware of any bone density issues for Client #1. However, he did elaborated how the prescription for Calcium, would suggest the physician had some concern about bone density.

- On November 20, 2003, at 4:30 p.m., the Qualified Mental Retardation Professional (QMRP) was interviewed. When asked about the conflict between the report from the Consumer Advocate, regarding independent use of the restroom and the report from the House Manager, who expressed that the client needed staff assistance when using the bathroom. The QMRP was unaware of any difference between the two descriptions. However, to resolve the conflict said she would confirm the client's level of on independence through assessment and observation. To accomplish this, a team meeting would be held and the results of the assessments would be discussed.

- On November 20, 2003, at 5:30 p.m., The Federal team conducted an interview with Client #1's sister/legal guardian. She reported Client #1 told her he injured his arm when he fell off the bus upon arriving at the workshop. Client #1's sister, expressed concern that he sat at the workshop with a fractured arm for several hours and was transported home, before he received medical intervention for the fractures. She reported the doctor told her Client #1's shoulder joint was out of socket and part of the reason for the delay in proceeding with surgery was to allow some time for the shoulder to "get back in place." When advised that Client #1 had given different accounts of the cause of the injury, his sister said, "Most of the things he tells me are credible, but he's afraid of the people at Babcock. When he's afraid, he will sometimes clam up and other times he will say something off the wall." It was Client #1 sister's opinion that he injured his arm falling off the bus upon his arrival at the workshop on November 18, 2003.

Results of Allegation: Unsubstantiated. The investigation by the facility was not complete, due to gathering additional information from other staff members and clients. However, the Federal team cited ***Immediate Jeopardy as defined by the Federal Codes of Regulations 42. CFR as, A situation in which the provider's noncompliance with one or more requirements of participation has caused, serious injury, harm, impairment or death to a resident."*** The Jeopardy identified by the Federal survey team, resulted in from facility's failure to ensure clients were not neglected, and placed at risk from harm.

B. Client #1 was beaten with a belt by a 16 year old housemate (Client #2) in May 2002. Client #1's sister/guardian was not notified of the assault.

Findings:

On November 20, 2003, at 11:00 a.m., the Federal team conducted an interview with the Consumer Advocate. She reported having no allegation related to this complaint and no investigation. She recalled some information about Client #2 having been involved in assaults against consumers of the residence from which he moved to Wire Road (the residence where Client #1 and Client #2 lived at the time of the incident) but said, "Not at this house." The Consumer Advocate remembered something from another investigation regarding a belt assault by Client #2, and referred to an investigation involving Client #1 and Client #2. This case involved an alleged rape of Client #1 by Client #2. She provided a copy of the investigation of this incident that documented on June 13, 2003, Client #1 alleged that Client #2 "Got me last night". The investigation included an interview with a staff member, who was asked if she was aware of any aggressive behavior from Client #2 toward Client #1. She reported that Client #2 hit Client #1 with a belt. However, the Accident/Injury Record, dated the same date, June 3, 2003, documented, "...another resident hit [Client #1's name] with a belt, causing a sore on his lower back area." The sore was checked by the nurse on June 3, 2003, time not recorded, who documented, "Area's red but not bleeding or draining, no treatment given." The Accident/Injury Report form also documented that Client #1's sister/guardian was notified of the incident on June 3, 2003 at 12:06 p.m.

- On November 20, 2003, at 5:30 p.m. interview with Client #1's sister/legal guardian was conducted. She reported no one from Babcock Center, neither staff members of the residence or staff from Babcock administration, ever spoke to her regarding the allegation that Client #1 was hit with a belt. She said she became aware of the incident through her attorney.

- The Allegation that Client #1 was hit with a belt by Client #2 was substantiated. The team was able to obtain a written report that alleged Client #1was hit with a belt by Client #2, when both resided at the Wire Road residence. An accident/incident report verified the assault. The allegation that Client #1's sister/guardian was not notified of the incident was not verified. The facility staff, and House Manager, informed the Federal surveyor that the sister was notified of the belt incident. There was written documentation provided to validate notification of sister. The sister/legal guardian informed the Federal surveyor that the facility did not notify her of the incident. As the evidence was contradictory it was not possible to determine that Client #1's sister/guardian was not notified of the incident.

D. Client #1 reported Client #2 raped him, no rape protocol was done, Client #1 received a 2 ½ to 4-centimeter tear in his rectum, which had to be surgically repaired. Staff told the doctor Client #1 fell down. Client #1 reported to staff "that damn boy got me last night." Client #2 admitted getting into bed with Client #1. Client #1 was kept at the same residence with Client #2 for 2 months. Client #1's sister/guardian was not notified of this incident or injury.

Findings:

- On November 20, 2003, at 11:00 a.m., an interview was conducted with the Consumer Advocate who reported an investigation had been conducted into the allegation that Client #2 raped Client #1 and a copy of the investigative file was provided. The investigation documented on the morning of 6/13/02 at the workshop, Client #1 complained of pain and was observed bleeding from his swollen rectum. Staff reported he explained the bleeding and swelling by saying, "the damn boy got me last night." Client #1 was referred to the Urgent Care Center where he was interviewed by the investigator. The investigator reported Client #1 said, "the boy came in my room last night." When asked if he knew who this person was he stated "[Client #2's nick name]." When asked what happened Client #1 said he told Client #2 to get out of his room but the boy hurt him, indicating his buttock area. Attempts to gather additional details were not successful.

- An evaluation by a physician at the Lexington Urgent Care revealed a 2.5 centimeter to 4 centimeter laceration of skin and superficial SQ tissues on the right peri-anal region. The physician was unable to determine if there was a fistula that extended down to the anal sphincter and was unable to determine if the laceration was the result of trauma or a suppulative rupture. The physician's notes did not indicate a report of the cause of the injury from either the client or the staff. No incident report regarding the allegation was included in the investigative file. There was no information regarding what was reported to the physician at the Urgent Care center regarding the cause of the injury. There was no evidence that a rape protocol had been conducted. The physician placed a clean gauze pack and recommended the area could be washed with Betadine as needed. A referral was made for a surgical evaluation later in the day on June13, 2002. The physician's notes from the initial visit documented that Client #1 was escorted to the appointment by a nurse from Babcock Center was unable to provide any history. The physician's note further documented, "He told them that he had some bleeding and they apparently noticed some bleeding earlier today. There is some question as to whether he may have had trauma to the area. They state that he may have fallen because he commented on this on one occasion." The physician's plan for follow up included, "I suspect this was either a previous traumatic wound from possibly sitting on something or it could have been an abscess that spontaneously drained and someone just found that he has had drainage from it. I am going to treat it as an open wound and wash it out with hydrogen peroxide and apply dressings. I don't think he needs any antibiotics as there is no induration and this appears clean. He is to follow up with us in one week. He is to have sitz baths twice daily." No surgical intervention was documented.

- On the afternoon of November 13, 2002 Client #2 was interviewed. He reported he went into Client #1's bedroom the night before. He stated that he got into bed

with Client #1. When asked if he "had sex with [Client #1's name]" he answered, "In the bed." He added that it was "dark outside" when this occurred.

- The investigative file included documentation that Client #1's sister/guardian was notified of the incident on June13, 2002. The Consumer Advocate reported she was present when the notification took place in order to be able to provide as much information as possible in the event the sister/guardian had questions about the incident.

- On June 13, 2002 the interdisciplinary team met and implemented the following interventions in order to provide for the "safety of other clients"; Client #2's level of supervision was changed to "15 minute general accountability", an alarm was set on his door, and staff were directed to "sit in the hallway to monitor his movements." Client #1 was subsequently moved, in August 2003, from the Wire Road residence to Ida Lane II. Asked why the move to another residence was not accomplished immediately, the Consumer Advocate reported there most likely was a delay based on availability of an alternative living setting.

- On November 20, 2003 at 5:30 p.m, an interview was conducted with Client #1's sister/legal guardian. She reported no one at Babcock Center, neither staff members of the residence or staff from Babcock administration had ever mentioned the rape of Client #1 to her. "Not in all this time have they ever said a word about it." She further stated, she became aware of the incident through her attorney.

- The allegation that Client #2 raped Client #1 is substantiated based on victim and perpetrator statements and physical injury evidence. The allegation that no rape protocol was initiated during the treatment of the perianal rectal laceration is substantiated, although it is not clear if either of the treating physicians were notified of the possibility of the injury resulting from being raped. The allegation that Client #1 suffered a 2½ to 4 centimeter tear to his rectum requiring surgical repair is partially verified. The documentation verified a laceration to Client #1 perianal area that was 2 ½ centimeters in length and 4 centimeters deep. The documentation did not support the allegation that the injury to Client #1' perianal area required surgical intervention. The allegation that staff told the doctor Client #1 fell down is verified based on the documentation from the surgical consult. No evidence existed that staff reported to either physician that Client #1 reported having been sexually assaulted. The allegation that Client #1's sister/guardian was not notified of the incident was not verified, although the sister/guardian reported she had not been notified, the facility reported she had been notified and presented documentation of the date and time of that notification. As the evidence was contradictory it was not possible to determine that Client #1's sister/guardian was not notified of the incident.

E. Client #1 was found to have an unexplained broken finger

Findings:

- On November 20, 2003 at 11:00 a.m., an interview was conducted with the Consumer Advocate who reported an investigation had been conducted into an unknown injury, a broken finger, experienced by Client #1. The investigation documented that Client #1 was observed on July 21, 2002, throwing his bedrails around his bedroom and occasionally beating on his walls occasionally and saying, "I want out of this hell hole" and "I pray to Jesus to send me to heaven or hell" during a maladaptive behavioral episode. Following the incident staff observed Client #1's right middle finger was bruised and swollen. The staff member who checked the bruised finger said Client #1 did not complain of pain or flinch when she touched the finger. As a result she decided to watch it and monitor for any changes. On July 22, 2002, the nurse observed the finger to be more swollen. A referral was made to the Urgent Care Center where x-ray's revealed a fracture to the right middle finger. The investigation suggested the fracture was sustained during the maladaptive behavioral episode involving throwing bed rails and beating walls.

- The Federal team determined that the Allegation of Client #1 having a broken in his finger was substantiated.

Results of the Allegation: Substantiated.

Allegation #40- Repeated beatings of Clients at Clusters: the case K.D.

Allegation #41-Failure to provide legal representation: CAH

Allegation #42- Physical abuse of clients by staff: R.O. and S.B.

Allegation #43-Problems with consumer advocacy system at the Babcock Center.

Allegation #44-Requiring school records to prove MR.

Allegation #45- Failure to provide meaningful work/training opportunities for consumers, failure to provide needed service of transportation and costs of programs.

Allegation #46-Physical abuse and financial exploitation of Clusters Resident: case of Kyle T.

Findings:

Client #1, in this finding is Kyle T.

The Federal survey teams conducted surveys of Cluster A, Cluster, Cluster B, Cluster D, Cluster E and Cluster F. The findings related to Abuse/Neglect. For the purpose of answering Allegation #46, Kyle T. is referred to as Client #1. The names of the other clients in this team finding remain anonymous for protection of client privacy and confidentiality. The finding is as follows.

Cluster "B"

The Federal survey team performed a review of the facility's Abuse Investigation on November 4, 2003 through November 6, 2003 a full survey of Cluster "B" was conducted by the Federal team. On November 4, 2003, at 1:30 p.m. the Federal team reviewed abuse investigations conducted by the facility. The documentation was for the time frame of November 1, 2002 through November 4, 2003. This review revealed the facility's failure to develop, and implement policy and procedures related to abuse/neglect. The policy did not address how the facility would ensure how sufficient behavioral and staff interventions to protect clients from assaults and injuries. Specifically, there was no procedure of how clients would be protected from injury resulting from client to client aggression. In addition, the facility failed to implement a system that included identifying perpetration and victimization trends. There was no written documentation that the facility conducted functional analysis of maladaptive behaviors in order to develop effective behavioral strategies affecting seven (7) of eight (8) clients currently residing in Cluster "B." Based on these findings, it was determined that Immediate Jeopardy existed. An ***Immediate Jeopardy is defined by the Federal Codes of Regulations 42. CFR as, "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident."*** The Jeopardy identified by the Federal survey team, resulted from the facility's failure to ensure clients were not neglected, and placed at risk from other clients living in the home. Specifically, the Federal team was able to identify one client as a frequent victim of other client's aggression. In addition, the facility failed to develop and implement policies and procedures to assure that three (3) of five (5) injuries of unknown origin were immediately reported to the Director of the facility.

On November 4, 2003 at 1:30 p.m. a review was conducted of the agency policy on abuse. The policy included a section entitled, Acts of Assault Between People Receiving Services which documented, "Reporting requirements pursuant to the state laws do not apply to altercations or acts of assault between people receiving supports protected by these laws except as noted below. However, corrective/preventive action should be taken to protect and intervene whenever people receiving services may be harming themselves or others. All injuries should be thoroughly reviewed and appropriate action taken to prevent similar occurrences. Failure to provide proper supervision to prevent people receiving services from assaulting each other could be a form of neglect if the employee fails to intervene or provide proper supervision when they clearly have a duty to do so. Each situation will be reviewed and if it is determined that the employee failed to provide appropriate supervision which resulted

in risk to the life safety of the person receiving services, the incident should be reported as suspected neglect and investigated by established procedures as outlined in this policy and in compliance with state law."

The federal team conducted a review of incident reports on November 4, 2003; this review revealed 29 incidents of client-to-client aggression within the time frame of November 1, 2002 through November 4, 2003. Examples included:

- November 19, 2003- Client #2 kicked Client #1 in the mouth; this resulted in Client #1 biting through his upper lip.
- October 5, 2003, 2:45 p.m.- Client #1 hit Client #4.
- October 3, 2003, at 11:50 a.m.- Client #7 was scratched and hit by Client #6, receiving a split lip.
- September 22, 2003- The Qualified Mental Retardation Professional noted that a large scratch was found by staff on Client #8's arm, date and perpetrator unknown.
- September 13, 2003 at 5:20 p.m.-Client #8 attacked by Client #7 with a shoe.
- September 13, 2003 at 5:20 p.m.-Client #5 was pushed down by Client #7, which caused an abrasion to Client #5's left knee.
- September 13 2003, 3:35 p.m.- Client #7 became self-abusive after a physical altercation with Client #1.
- September 6, 2003, 2:00 p.m.- Client #8 scratched Client #6 on his face and right arm.
- September 6, 2003, 4:15 p.m.- Client #5 pushed by Client #1. Red marks and bruising noted.
- August 25, 2003, 11:10 a.m.- Unknown Client at the workshop stabbed Client #7 in the neck with a pen, laceration noted.
- August 9, 2003, 12:35 p.m.- Client #1 bit Client #5 on his right shoulder, bite marks noted.
- July 26, 2003, 9:30 a.m.- Client #7 attempted to bite an unknown Client, which caused injury to his mouth.
- July 26, 2003, 9:30 a.m.- Client #7 scratched Client #5. Scratches noted on Client #5's back and chest.

- July 1, 2003, 8:57 a.m.- Client #5 was bitten by a female Client at the workshop and required seven stitches.

- June 30, 2003, (time unknown)- Client #7 bit Client #5 on his calf, bite marks noted.

- May 10, 2003 7:15 a.m. Client #5 pushed by an unknown Client. Client #5 sustained a bruise on his right knee.

- April 23, 2003, 4:45 p.m. Client #5 attempted to bite Client #1. Client #1 responded by biting Client #5. Client #5 had bite marks on his left knee.

- On April 10, 2003, 7:30 p.m.-Unknown Client hit Client #5. Client #5 sustained red marks to [his] back.

- March 11, 2003, 5:29 p.m.- Client #1 pushed Client #5, causing an abrasion to Client #5's right elbow.

- January 29, 2003, 1:25 p.m.-Another Client, while at the workshop, hit Client #5 with a chair.

- December 19, 2002, 6:40 p.m.- Client #1 bit Client #7 causing bite marks on Client #7's left ankle.

- December 18, 20003, 4:55 p.m.- Client #1 pushed a Client no longer residing in the home.

- December 13, 2002, 4:55 p.m.- Client #7 hit a Client no longer residing in the home, cutting his head.

- December 13, 2002, 7:32 a.m.- Client #7 hit Client #5 on his back.

- December 13, 2002, 7:35 a.m.- Client #7 hit a Client no longer living in the home on the head.

- December 13, 2003, 7:37 a.m.- Client #5 or a Client no longer living in the home bit Client #7 causing red marks on Client #7's back and a cut on Client #7's thumb.

- December 9, 2002, 8:30 a.m.- Client #1 kicked Client #5, causing an abrasion to Client #5's right knee.

- November 15, 2002, 4:59 p.m.- Client #1 pushed by Client #2, cutting his head.

- November 15, 2002, 5:15 p.m.- Client #1 bit a Client no longer residing in the home on the right arm causing bite marks.

Client #1

Client #1 was responsible for nine (9) incidents and Client #7 was responsible for 8 incidents. There were four (4) incidents in which the perpetrator was not identified on the incident report. Five (5) incidents identified five (5) other clients #2, #4, #5, #6, and #8 living in the home as perpetrators. There were two (2) other instances, in which the perpetrators were not clients living in the home.

All twenty-nine (29) incidents resulted in injuries to the victim. Client #5 was identified as the victim of assault in fourteen (14) of the twenty-nine (29) incidents. The primary perpetrators of these assaults were Client #1 (5) incidents and Client #7 (4). In three (3) of three (3) incidents to Client #5 the perpetrator was unknown. In two (2) of the instances, the perpetrator was not a person living in his home.

The Behavior Support Plan (BSP) for Client #1, dated September 17, 2002, identified the maladaptive behaviors to include; "Physical aggression: defined as any action with the intent of causing harm to another person, including biting, kicking, hitting, etc., Verbal Aggression: any verbalization intended to cause harm to another person to include screaming, cursing, name-calling, etc.", "Self abuse", Hallucinations", "Non-cooperation", and "Inappropriate sexual behavior. The BSP did not include a functional analysis of the maladaptive behaviors. The intervention focus of the BSP relied primarily on 1 on 1 staff support that was to be in place during waking hours. The plan did not include a description of what the 1 on 1 staffing would entail or how it was to be implemented in the home. The data for Client #1's aggression for the time period November 2, 2003 through September 2003, revealed he had exhibited 249 physically aggressive incidents. Documentation of these incidents of physical aggression included:

- November 5, 2002, 5:15 p.m.- Client #1 bit another client on the right arm causing bite marks.
- December 9, 2002, 8:30 a.m.- Client #1 kicked another client causing an abrasion to the right knee.
- December 23, 2002 4:55 p.m.- Client #1 pushed another client to the floor resulting in a wound to the top of his head requiring 5 sutures to close.
- March 11, 2003, 5:29 p.m.- Client #1 pushed another client causing an abrasion to the right elbow.
- May 26, 2003, 7:30 p.m.- Client #1 pushed another client from his walker to the floor, resulting in a wound to his forehead requiring 8 sutures to close.

- August 9, 2003, 12:35 p.m.- Client #1 bit another client on his right shoulder, bite marks noted.

- September 6, 2003, 4:15 p.m. Client #1 pushed another client causing red marks and bruising.

On November 4, 2003 at 11:00 a.m. a review was conducted of the investigations of abuse, neglect and mistreatment conducted by the facility between the period of November 4, 2002 and November 4, 2003. Of the eight investigations completed during that time frame. One (1) documented report, did not include evidence of reporting immediately to the Director, an abusive incident between a staff member and client. This case, labeled "[Client #1's name] August 15, 2003," involved a staff member, who on August 11, 2003, at 6:30 a.m. observed the lead staff member of the facility, become upset with Client #1 because he was taking too long to eat his breakfast. The staff member took Client #1's food away, and Client #1 began crying and asked the staff member to give him back his food. The staff member escorted Client #1 down the hallway, but Client #1 resisted. The staff member then stated to the client, "I know you didn't just hit me." The staff member grabbed Client #1 by the neck and put him against the wall. Client #1 continued to resist and the staff member hit him on the arm with his fist then proceeded to take Client #1 to his room where he was heard crying.

The investigative file noted the allegation was not reported until November 14, 2003. The file documented that when questioned the staff member reporting said he did not report the incident immediately, because he was scared due to the staff member's position within the residence.

On November 5, 2003 at approximately 9:00 a.m., a review was conducted of an abuse investigation of Client #1. The abuse file entitled, (Client #1's name), documented that an employee who resigned her employment on September 23, 2002, reported to the Assistant Director during an employment exit conference that she observed a staff member hit Client #1 with a wooden paper towel holder with force. Later, on the same shift 3 p.m. to 11p.m, the same staff member was observed to hit Client #1 again while giving him a bath. The dates of these incidents were not documented. Interviewed Client #1 on the day of the incident, the client confirmed that the staff member hit him. The investigation report documented this statement; "The allegation of physical abuse against [the alleged perpetrator's name] is substantiated. [The alleged perpetrator's name] will be terminated based upon a substantiated case of abuse." On September 28, 2002, the employee was terminated.

On October 1, 2002, another staff member reported that Client #1 told her he was "going to lie and get all the guys fired in the house." On the basis of this report the investigative case was re-opened and Client #1 was re-interviewed.
An Addendum Report included with the investigation resulted in a determination that the substantiation of abuse against the alleged perpetrator was rescinded. This

decision was based on a determination that Client #1 was unreliable and an absence of "bruises or marks to indicate abuse."

The Addendum Report did not include documentation of recognition that another staff member initially reported this incident, and was not by Client #1. There was no information regarding a re-interview with the reporting party or a determination that the initial report of this incident was not credible.

- An investigation report documented that on July 6, 2003, at 4:15 p.m. Client #1 was discovered with large abrasions/bruises on his chest. The Director of Nursing documented the bruises appeared to have been caused by a belt or a wire looped object: as the bruises matched the shape of the handle of a fly swatter as evidenced by photographs of a fly swatter held over the bruises on Client #1's chest. Client #1 reportedly offered differing explanations of the cause of the bruises. He stated, he did not know how the bruises occurred. He said I could have fell, scratched himself, someone could have kicked him, someone could have punched him or maybe he was hit by an unknown person with a metal object while in the hallway. The investigation included recognition that Client #1 was assigned 1: 1 staffing prior to, the discovery of the bruises. The staff members assigned to provide 1: 1 staffing prior to the discovery of the bruises reported having no information about how the bruises might have been caused.
  The investigation resulted in a determination that abuse was substantiated with an unknown perpetrator.

On November 4, 2003, at 9:00 a.m. the federal surveyor observed the staff member assigned to provide 1:1supervision for Client #1. During this observation, staff responded to four telephone calls between 9:00 a.m. and 10:00 a.m. The telephone was located in the entry hall of the facility, thus, requiring the staff member to leave the living room to answer the telephone. Client #1 was left unattended, as he sat on the couch in the living room. This also left the client out of arm's length of the assigned staff member, as required by the prescribed behavior program.

The Federal surveyor interviewed Client #1's the assigned staff member on November 4, 2003, at 11:00 a.m. When asked how he prevented Client #1 from assaulting others he said, "I try to keep him within an arm's length, pull him away by his back if he tries to attack anyone and redirect him. These interventions work sometimes." He continued by stating, " Client #1 usually picked on Client #5." The Federal surveyor then asked the staff member if the residence, in his opinion was a safe place for clients to live. He responded by saying, "Well, there are a lot of fights."

On November 5, 2003, at 10:00 a.m., an interview was conducted with another direct care staff member assigned 1:1 to Client #1. When asked how he prevented Client #1 from assaulting others he stated, " I've known him for over three years and I can usually talk him down if he is upset. I keep Client #1 within arms length and use redirection sometimes when he becomes upset. The Federal surveyor asked the staff

to describe the behavior interventions prescribed in Client #1's BSP, and he said, "No, not exactly, it's been altered some." He also stated "Problems come up with Client #1 when staff are inconsistent in how they respond to him. Staff on the 3-11 shift do it a little different".

On November 4, 2003, at approximately 2:00 p.m., the federal surveyor also conducted an interview with the Behavior Supervisor. This staff member was assigned as the behavior specialist for clients in Cluster Building B. During this interview, the Behavior Supervisor stated the psychological assessments and behavior plans did not contain a functional analyses of the client's behaviors.

He further explained the correct method of physical management to prevent Client #1 from assaulting others did not include a procedure of pulling him away by his back as explained by the residential staff member. The Behavior Program Supervisor stated "...staff members received initial and ongoing training on BSP's and physical intervention techniques approved by the agency."

Client #5

The following incident of injury of unknown source for Client #5 was as follows:

- May 10, 2003, Client #5 was found to have a bruise on his right knee. A sentence written by an unknown person states "[Client #5's name] was pushed by another client and fell to the ground. There was no documentation of when, where, or how the incident occurred.

On November 4, 2003, beginning at 10:45 a.m., reviews were conducted of the records of Clients #1, #5 and #7. The Behavior Support Plan (BSP) for Client #5, the primary victim of assaults, focused on staff prompting the client to avoid assaults, by avoiding conflict with other clients. The Behavior Support Plan (BSP) for Client #5 did not include a functional analysis of behavior.

The Behavior Supervisor further stated he had not conducted an analysis of the client-to-client assaults to determine if a particular client was being victimized. He stated he often observed Client #5 frequently "in the wrong place at the wrong time." He was sometimes assaulted when he approached other clients engaged in maladaptive behavior(s). This often times resulted in him being assaulted." When asked if he believed Client #5 was safe in his residence, the Behavior Supervisor said, "I won't go out on a limb and say nothing's going to happen to him. But in a meeting during the previous week regarding problems in the Clusters Building B, the management team determined the need for additional staffing. The home had been running on bare minimum staff, and the one on one requirement for two clients residing in that home could not always be maintained."

On November 4, 2003, at 4:45 p.m., the Consumer Advocate for Babcock Center was interviewed, and explained that she primarily investigated "Critical Incidents."

According to her these incidents, require hospitalization, police involvement, staff abuse or neglect, or financial exploitation. When asked whether she was aware of the level of client-to-client abuse in the home she replied. "That house is tough, the staff have their hands full." When asked if she was aware of Client #5's being targeted by his peers, the Consumer Advocate stated "we all fall in to the mind trap of saying, oh, that's just [Client #5' name]. If they had to document every behavior of his, that is all they would be doing. We need people to come in and tell us what we're missing because we're just not seeing it now."

Client #7

The BSP for Client #7 identified the maladaptive behaviors to include physical aggression defined as any action with the intent of causing harm to another person, including biting, kicking, hitting, etc. The BSP did not include a functional analysis of the targeted behavior. Per the Interdisciplinary team meeting held on October 31, 2003, Client #7 was placed on 1:1 staffing ratio on that day for unrelated sexual behavior and not for his aggression. The data for Client #7's aggression for the time period November 2002 to September 2003, revealed he had exhibited 223 aggressive incidents. Examples of the documentation of these incidents of physical aggression included:

- December 13, 2002, 4:55 p.m.- Client #7 hit another client resulting in a laceration to his head.
- June 30, 2003, (time unknown), Client #7 bit another client on the calf of his leg, bite marks noted.
- July 26,2003, 9:30 a.m.- Client #7 scratched another client resulting in scratches noted on his back and chest.
- September 13, 2003 5:20 p.m.- Client #7 "attacked" another client with a shoe.
- July 30, 2003, at 8:15 a.m., the facility staff found Client #7 with a cut over his left eye. The staff notified the facility nurse, who treated the cut with soap and water then covered it with a Band-Aid. The QMRP noted "[Client #7's name] may have accidentally fell and bump (sic) his head." On August1, 2003 the Director signed the "Administrative Review" portion of the report and documented, "client bumped his head." There was no further documentation of additional investigation of how the scratch to the eye area occurred.

The federal surveyor asked the BPS if he was aware of the frequency of targeted behaviors for Client's #1, #5, and #7. He responded and said," The data collection system was not capable of trend analysis. And only recorded the frequency of maladaptive behavior(s)."

Client #8

November 4, 2003 at 10:00 AM, during a review of the "Accident/Injury Records", five (5) incidents were identified for which a thorough investigation had not been completed for Client #8. Those incidents included:

- September 21,2003, a scratch was discovered on Client #8's neck. Staff documented "a scratch mark on left side of the neck which appears to be old due to color. There was no documented evidence of the date or time this mark could have occurred."

- September 22, 2003, the Qualified Mental Retardation Professional (QMRP) noted, "it appears that [Client #8] may have scratched himself as usual." On October 7, 2003, the Director signed the "Administrative Review" portion of the report and also noted, "mark is old." There was no documented evidence of additional investigation.

On November 5, 2003, at 8:30 a.m. an interview was conducted with the Director of Babcock Clusters. She reported being aware of staffing problems in the home, particularly since two clients were identified as needing 1:1 staffing. She reported when a determination was made to add one additional staff member to the staffing pattern of the home. A part of her action plan was to assign the new staff member to the 12:00 a.m. to 8:00 a.m. shift. She further identified the required staffing minimums by shift as; 4 staff for the 8 a.m. to 4:00 p.m. shift; 4 staff for the 4:00 p.m. to 12:00 a.m. shift; and 3 staff for the 12:00 a.m. to 8:00 a.m. shift. The Director also stated she was aware that the Behavior Support Plans did not include and were not developed from functional analyses of maladaptive behaviors, and no trends analysis on assaultive behaviors had been completed by facility staff. She also said, she was aware of assaults between clients in the home and the Behavior Support Plans needed improving.

On November 5, 2003, at approximately 9:00 a.m., the Federal surveyor reviewed the staffing patterns of Cluster "B" for the time period from October 2, 2003, through November 1,2003. They were as follows:

- On the day shift (8:00 a.m. to 4:00 p.m.) 1 person under staffed 20 of 31 shifts.

- On the evening shift (4:00 p.m. to 12:00 a.m.) 1 person under staffed 18 shifts.

- On the overnight shift (12:00 a.m. to 8:00 a.m.) one person under staffed 3 of 31 shifts.

Based on the findings of the above incidents, it was determined that actual harm had occurred to Client #5, and based on the current interventions employed by the agency, including inadequate behavior support plans, there is a likelihood for potential harm to occur again. It was also determined that facility was aware of the impact of Client

#1 and #7's behavior on the other clients, specifically Client #5. There was no documented evidence of the facility's actions to intervene in reducing or eliminating the behaviors. In addition, the facility failed to ensure the staffing ratios as identified to keep people safe.

On November 4, 2003, 10:00 a.m. a review of the Accident/Injury Records conducted by the Federal team revealed three (3) injuries of unknown source. There was no written evidence of immediate notification to the Director. Those included:

- November 22, 2002, Client #7 was found to have a "swollen and blue" left big toe. No documentation existed as to how the toe was injured. The Director documented being notified of the injury on November 25, 2002.

- December 23, 2002, Client #3 was found to have a laceration on the heel of his left foot. There was no documentation of the Director being notified of the injury.

- September 21,2003, a nurse noted that Client #8 had "red scratch marks below ear about one inch long". There was no documentation as to how the scratches occurred. The Director documented being notified of the injury on October 7, 2003.

November 16, 2003, 3:00 p.m., an interview with the Assistant Director confirmed that all allegations of abuse, neglect and mistreatment and all reports of injuries of unknown origin are supposed to be reported immediately to the Director. She could offer any explanation for the absence of policy to support standard practice within the agency or for the failure of facility staff to immediately report incidents identified above.

November 4, 2003, at 1:00 p.m., the Federal surveyor was provided a copy of the "Reporting of Critical Incidents" policy dated August 26, 2003. The policy, defined critical incidents to include, "accidents that result in serious injury", and "significant acts of aggression by or against supported persons". The policy did not define "serious" injuries or "significant" acts of aggression.

The policy further documented, "The first response person...will initiate and complete an initial investigation within 24 hours. The results of the investigation will be reported immediately to the House Manager and the QMRP(Qualified Mental Retardation Professional)/Coordinator as well as the responsible Administrator or Residential Director." The policy did not include a requirement for all injuries of unknown origin to be reported immediately to the Director. The Consumer Advocate confirmed that all injuries of unknown source should be reported immediately to the Director.

Based on the Federal team's observations during the days of the survey, the written evidence of incident reports and confirmation of the agency's lack of knowledge of increased client to client aggression for the time frame of June 2002 through November 2003. The Federal team cited the deficient practice of Client Protections at the level of *actual harm.*

Allegation #47-Failure to maintain Medicaid eligibility of incapacitated client: the case of Walter P.

Allegation #48- Improper use of state and Medicaid dollars through purchases which do not comply with state regulations.

Allegation #49-Problems with the Babcock Foundation.

Allegation #50-Contracts with former employees. DDSN State Director.

Allegation #51- Involvement of P&A

Allegation #52-Confidentiality of preliminary of DDSNN audit.

Allegation #53- Hiring new external auditor.

The Federal survey team conducted eleven surveys from the month of June 2002 through January 2004. The investigation of these facilities was guided by ICF/MR federal regulations. However, the allegations listed above are not contained in these regulatory requirements. Therefore, the team was unable to substantiate or not substantiate the complaint allegations.

Additional Findings:

The original complaint listed Fifty-three allegations of concern. This report contains information resulting from the Federal surveys conducted by the Federal survey team. The Federal team conducted twelve surveys and identified other areas of concern, not identified in the original complaint that was cited at the Immediate Jeopardy Level. The finding is as follows:

The Federal team entered Wire Road I on December 2, 2003 and conducted a Federal survey. The team cited Immediate Jeopardy on December 3, 2003 after observations of the lunch meal. The following is the finding:

- The survey team first observed Client #2 during his vocational training program at the Clusters Day Program, an entity operated by the Babcock Center, Inc., on December 2, 2003, from 10:30 a.m. to 12:30 p.m. The team conducted an interview at approximately 11: 45 a.m. with the direct support staff, assigned to work with Client #2. According to the staff, Client #2 requires assistance with feeding, because "he chokes". She was unaware of any specific instance when he

had choked, at the day program. She continued by stating a lack of knowledge of any assessments or training programs conducted for Client #2, to detect any difficulty with eating or swallowing. She was only aware of other Day Program Staff advice to assist client when eating.

- The team observed the lunch meal at approximately 12:00 p.m. at the day program. The staff took Client #2's lunch out of an insulated cooler. The lunch included two bologna sandwiches with lettuce (each sandwich was cut into four sections,) a container of potato salad, a container of fruit cocktail and several cookies that were the size of vanilla wafers. During most of the meal the staff asked Client #2, what he wanted to eat next. Client #2 would point to the food he wanted and the staff then fed him the food item selected. When he pointed to the first piece of sandwich, the staff broke one sandwich segment in half resulting in a piece the size of one-eighth of the sandwich. Staff handed him this piece; he put it all in his mouth and ate it. The client was observed to chew the sandwich very slowly and displayed some difficulty swallowing. Client #2 then picked up a ¼-sized piece of the sandwich, put all of it in his mouth and ate it, and again had some difficulty swallowing. Staff did not intervene. Later in the meal, the staff opened the wrapper of cookies and placed them on the table. Client #2 picked up one cookie, put the whole cookie in his mouth and ate it. As the Client continued to eat, he was observed to tilt his head up and back. Staff did not intervene. Staff then left the room for approximately two minutes, leaving one of the sandwiches cut into fourths and the remaining cookies on the table. During that time, Client #2 picked up a second cookie, put the whole cookie in his mouth, and ate it. At 12:30 p.m., at the conclusion of the meal, Client #2 drank his beverage from a cup with a spout lid using both hands to hold the cup up and above his mouth. As the client drank his beverage, his head was tilted up and back.

- On December 2, 2003 at 2:15 p.m., at Client #2's home, the Health Care Services Supervisor stated that [Client #2] had problems swallowing. His food is pureed to prevent choking. The Supervisor also explained, nursing staff noticed some problems with Client #2 swallowing his medications. Based on these observations, the nurses requested a speech evaluation. The clinical record for Client #2 was provided and included the following documents:

  a. An evaluation conducted by a speech pathologist was completed on January 15,2003. It documented a "choking episode" that occurred three months prior to the evaluation [October of 2002] that required the use of the Heimlich maneuver. As a part of the evaluation, the speech pathologist observed him, eating a snack pack of applesauce and finely chopped salad. She reported that Client #2 "exhibited minimal to no chewing". The speech pathologist concluded, "This places him at risk for swallowing any food with texture that could be aspirated and would then create choking potential." The Summary/ Recommendations section stated, "[Client #2] demonstrated insufficient chewing attempts to prepare regular food for safe swallowing. He is at risk for choking. His food should be prepared in a consistency that would not

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necessitate any chewing for safe swallowing. The house staff and the nursing was informed of the prescribed diet, "ground", by the speech pathologist. The nurse stated that she would get the diet ordered on January 16, 2003. The following recommendations are made to maximize safe feeding/swallowing: Change diet consistency for food to ground with regular liquids."

b. Progress Notes and Orders dated January 16,2003, documented a voice order from the physician for Client #2. The note stated: "Change diet to regular, ground diet with regular liquids."

c. An April 1, 2003, Dietician's report stated, "Continue regular diet".

d. The Nurses Notes for November 27, 2003, for Client #2 referred to the consistency of his diet and stated, "Regular ground consistency - No larger than a grain of rice. Use hand over hand technique to fed client, to prevent choking and packing his mouth".

e. The Physician's Order Sheet dated November 4, 2003, stated, "Regular - ground consistency - No larger than a grain of rice."

f. The Nurses Notes dated November 24, 2003 for Client #2 referred to the consistency of his diet and stated, "Regular diet with ground consistency - no larger than a grain of rice - use hand over hand feeding to prevent choking and packing his mouth."

- On December 2, 2003, at 2:15 p.m., the survey team described the noon meal served at the Day Program, to the Health Care Services Coordinator and Administrator. The Health Care Services Supervisor stated she was concerned about the lunch meal. The Home Administrator stated the day program should be aware of clients' diets. They both explained how the night shift staff, at Wire Road II, prepared the lunches and were responsible for assuring the appropriate consistency. The survey team was provided a copy of the diet instructions for Client #2. These instructions were also posted on the Wire Road II refrigerator for staff to follow. The Health Care Services Supervisor, after reading the posted instructions stated the diet was ground, to the consistency of rice, and she was incorrect when she stated pureed.

- On December 2, 2003, at 3:05 p.m., the survey team reviewed a document entitled "Mechanical Alterations" which was provided by staff and had been posted on the refrigerator in the Wire Road II kitchen. Client #2's name was next to the word, "Ground". The description provided on the form stated, "Alter to cooked, crumbled ground beef. Must use the food processor. May need to add liquid to get the right consistency." This document also instructed staff as follows: "All food must be mechanically altered before it is put on the table or packed in the lunch boxes. It is the responsibility of staff at the facility to follow the posted diets."

- The survey team received a copy of the Client #2's Single Plan (Individual Habilitation Plan) dated April 3, 2003, from the Administrator on December 2,203, at 3:30 p.m. The "Other Physical/Functional Health" section stated, "Diet: Regular diet". The section titled "Physical Health Needs and Recommendations for Actions" read: "Need: Regular diet". The same afternoon at 4:10 p.m., the Administrator confirmed Client #2's Single Plan (April 3,2003) did not include the ground diet, but stated "regular diet."

- On December 2, 2003, at 4:00 p.m., the Federal surveyor conducted an interview with the Residential Director and the Home Administrator. The Federal surveyor asked both staff members to explain the problem with serving Client #2 the wrong diet. The staff stated the 1:1 (direct support staff) assigned to the client, after observing the incorrect lunch meal was packed, should not have served the meal to the client. In addition, the staff who prepared the meal should have known the dietary texture was not consistent with the physician's orders. All staff was trained, regarding the special needs of the clients. The facility staff was provided Quarterly in-service programs, conducted by the Qualified Mental Retardation Professional (QMRP). The purpose of the in-service training was to ensure staff knowledge of individual client needs. Minutes of a "Called Team Meeting," dated June 9, 2003, were provided as evidence that staff at the day program had received specific information to provide services for Client #2. The minutes included the following statements: "The team recommended [Client #2] should be admitted into the Clusters Workshop. The team also recommended while in the workshop [Client #2] will have assistance when walking & eating." The meeting was chaired by the QMRP and attended by the Home Administrator, the Day Program Assistant Administrator, and a supervisor from the day program. When asked how the programs were monitored, the staff replied that the QMRP monitored the day program services on a monthly basis. The team requested documentation to verify that all staff at the home and day program had received training regarding Client #2"s specialized dietary regime.

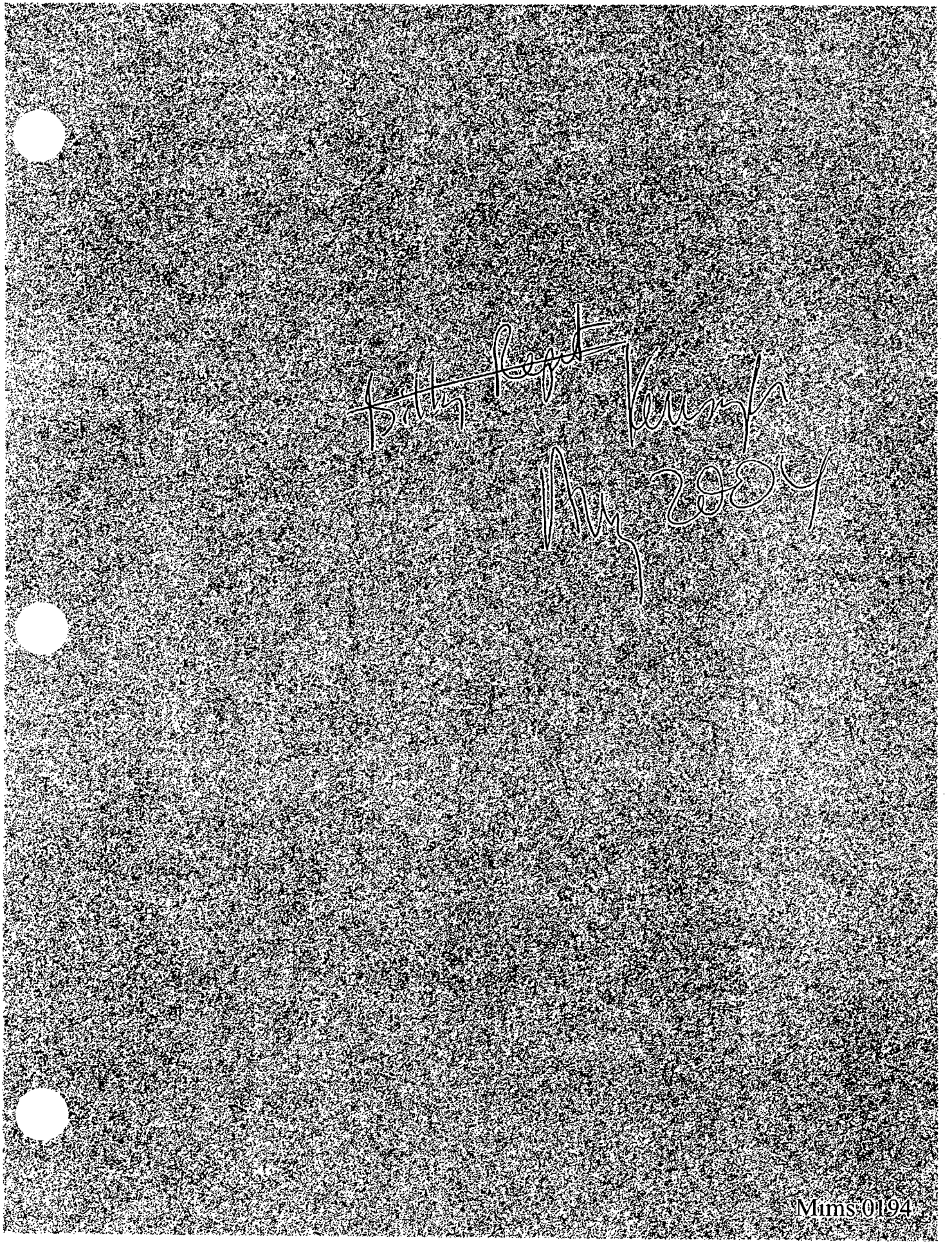
- On December 2, 2003, at 4:30 p.m., the Assistant Day Program Director was interviewed by telephone by the Federal team. The team asked the Director what diet Client #2 received at the day program. After looking in the "program book" the staff responded, "[Client #2] gets the same diet as in the house, regular/ground." When asked if the food was ground at the day program, the staff stated that all meals were prepared and "ground" at the home each morning.

- On December 2, 2003, at 6:00 p.m., the QMRP stated that was aware of the dietary alterations necessary to prevent the risk of choking for Client #2. He reported that there had not been mealtime concerns or choking episodes since Client #2 was enrolled in the day program beginning June 9, 2003. When asked to describe the system of monitoring, the QMRP stated he visited the day program "on an average of once a week," but had not observed a mealtime for Client #2 at

that location. When asked how the incident could have been prevented, the QMRP stated that lines of communication needed to be improved.

- On December 3, 2003, at 10:00 a.m., one training record was provided to the team. The record, dated February 12, 2003, listed attendance at a 1 ½ hour in-service training program on the topics of: "Mechanical Alterations, Grocery Receipts, Bonus Card Use, Emergency Food Box-Baby Food for 3 Days and Proper Lunch Containers." Thirty-two attendees were listed from multiple residential facilities operated by the Babcock Center, Inc. Three worked at the Wire Road II residence and none were listed from the day program. There was no additional documentation presented to the Federal team that verified the attendance of any residential and or program staff to any other training who was assigned to Client #2that was knowledgeable of his individual support needs.

- On December 3, 2003, at 11:15 a.m., the Residential Director and the Home Administrator were notified that a situation of Immediate Jeopardy. The Jeopardy was cited based on evidence that Client #2 had been placed at significant risk of physical harm and the potential of death from choking on food that was not prepared as recommended by professional assessment and as ordered by the physician.


Mims 0194

Record Review of Behavioral and Residential Data
August 17, 2004

Name: Billy Cothran
BOB: 10/18/40
Residence: Babcock Center's Kennsington I ICF/MR
Functioning Level: Intellectual: Profound Adjudicated Incompetent
Adaptive: Profound

Medical Diagnosis:
Profound Mental Retardation
Blind
Behavior Disorder
Bipolar Disorder
Impulse Control
History of Anemia
History of Constipation
Arthritis

Background:

Billy Cothran is a 63 year old male first admitted to Babcock Center on 4/7/98. Institutionalized since 9/11/52 at Whitten Center he appeared normal until the age of 8 months. No known cause was identified with his mental retardation. Profoundly retarded, IQ testing revealed a quotient of 15 (Stanford Binet, 1984). Vineland adaptive testing revealed that this client operated at a social age of 2.91 years.

Currently available records show a psychiatric diagnosis of Behavior Disorder and Bipolar Disorder. Impulse Control has been considered in addition. Psychiatric impressions of his diagnosis have varied with his symptoms. Psychotropic medications, according to the latest available records, include Sinequan and Zyprexa. Behaviorally, a long history of eye digging, nose digging, and rectum digging have been reported. Self abusive behaviors have been severe enough to result in hospitalization in the past after certain psychotropic reductions. Medically, medical progress notes and his previous Single Plan (2003) reveal a further medical diagnosis of arthritis and blindness. He uses a wheelchair per Physical Therapy evaluation (12/19/03).

Billy currently lives in an ICF institutional setting with seven other residents. He has displayed the following behaviors: nose digging, eye digging, rectal digging, removing clothing, rolling on the floor "up at night", and inappropriate urination. For 2003, targeted behaviors exceed 183 episodes per months. Requested behavior data was incomplete for 2004, but graphing suggested 614 episodes of nose digging through June 2004. This would be an increase in this behavior over 2003 numbers by over 25%. The numbers for 2004 are presented with some caution because Babcock Center

has not provided all of the requested information for 2004. This includes an incomplete Single Plan and no current Behavior Support Plan has been provided. Other behaviors listed by 2004 graphs did not include numbers needed for analysis. A further review of 2003 records showed Billy tearful and frequently rolling on the floor. Other harmful behaviors included head banging, whether accidental or intentional, along with frequent inappropriate urination, e.g., in his chair, on the floor, in the bed, and in the bath tub. There were four elopement related BIR'.s for 2003, i.e., attempts to leave the residence resulting in an alarm being triggered. Two episodes of fecal smearing appeared for the year. Over 38 nursing notes, behavior incident reports, and QMRP reports refer to urinary regression and the need for prompting with bladder habits since admission. Behavior incident reports refer to bed wetting, urination on the floor, his chair, and in the bath. There has been one episode of Billy pulling off his toe nail. Incomplete 2004 data showed a slight decrease in urination.

Since admission to Babcock and through December 2003, Behavior and accident reports show that Billy has been assaulted by other clients at a rate of 3 to 4 reported attacks per year. Accident reports during that time period also include 18 incidents of mostly unknown cause, i.e., there were no witnesses as to the cause.

A behavior support plan and the psychotropic medications Sinequan and Zyprexa noted were used to alter behavior. Behavior interventions included positive attention for appropriate behaviors. Matter of fact explanation when correcting target behaviors was encouraged. A behavior support plan addendum stressed prevention and increased staff involvement. Redirection was encouraged to alternative activities to avoid reinforcing inappropriate behaviors. Staff interaction was also encouraged to allow for reasonable attention. Zyprexa was increased in fall of 2003 with a reported decrease in behaviors.

Current Situation:

Requested 2004 data is incomplete. Psychotropic medication review notes refer to an improvement in behavior, however, a review of the one behavior whose numbers were reported show a trend in nose digging that will reflect an over all increase of 50% by the end of December 2004 if not successfully addressed. As mentioned above, six months of this behavior are already 25 % greater in number than the entire year of 2003. Episodic data sheets for inappropriate toileting were not provided per the Behavior Support Plan Addendum for 2003.

Need for Enhanced Staffing:

Billy's inappropriate behaviors show a significant increase for 2003. He has demonstrated a vulnerability to assault by aggressive clients due to his blindness. These injuries in the past have resulted contusion, scratches, falls including being pushed into the residential fire place.

A major concern expressed in behavior incident reports, nursing summaries and various behavior documents has been various episodes or inappropriate urination. A number of these wetting incidents have occurred in bed, in Billy's lounge chair, on the floor, and in the shower. Since 1998, nursing summaries have continuously referred to the need to prompt Billy to evacuate both his bowels and bladder.

A review of Accident/Injury Reports from 4/7/98 through 8/18/03 revealed 18 episodes listed for this time period. This is mentioned as an indicator of the need for enhanced supervision for this client. Carpet burns, scratches, bruises, and even a cut above the eye have been noted in these documents. Most of those injuries were of an unknown origin. A 9/1/01 injury report noted that blood was found on his tee shirt. This was attributed to hemorrhoids (Note that Billy has a targeted behavior involving anal stimulation).

Enhanced staffing will encourage prompting with bladder and bowel habits as has been recommended in nursing summaries and review. Staff should be assigned in order to minimize accidents with unnecessary impediments to Billy's freedom. Attention should be given in order to allow positive social reinforcement for behaviors opposite targeted behaviors.

PROPOSED LIVING SITUATION:

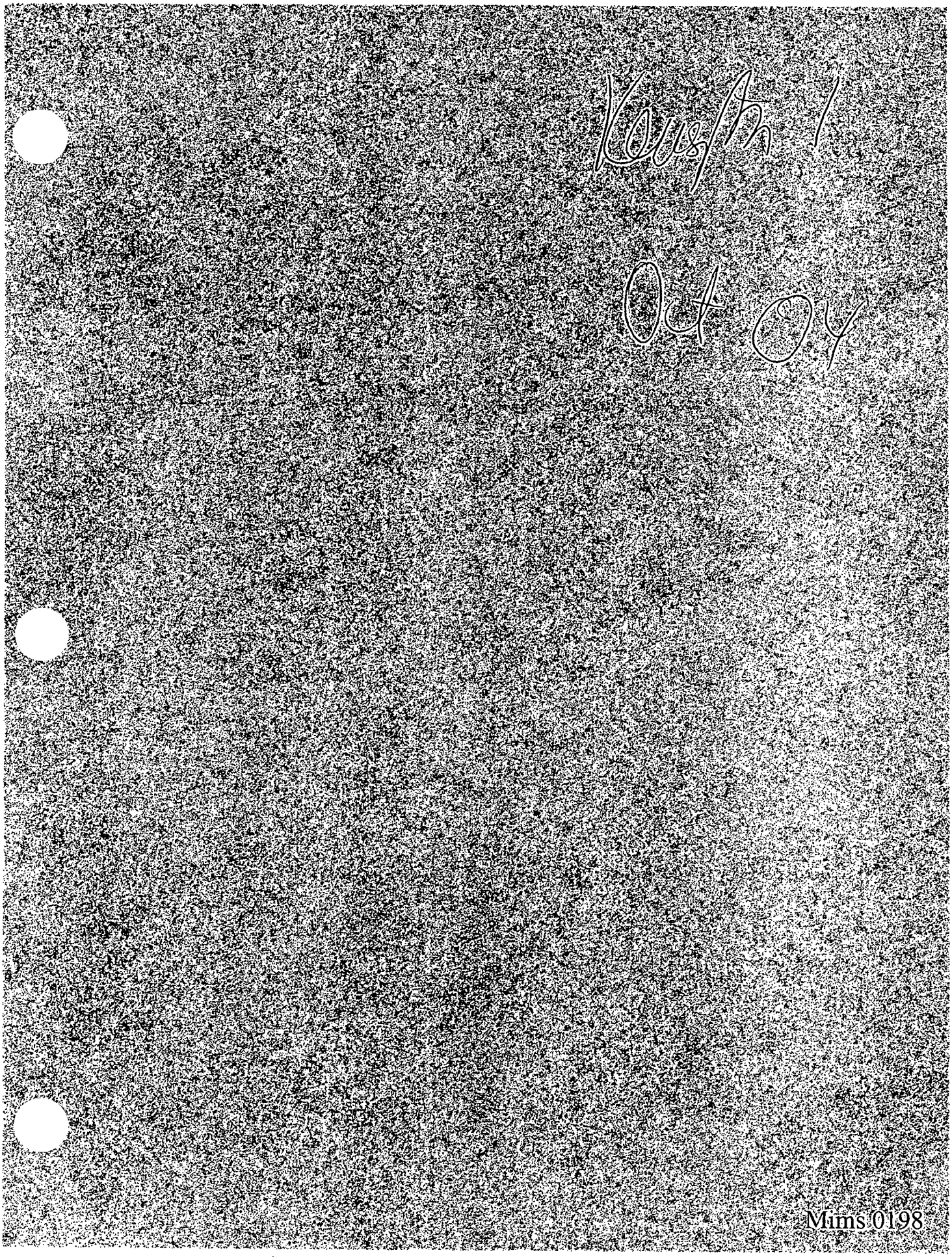
Efforts under development include placement in a CTH II setting with non-aggressive clients. Enhanced staffing should be based on need with an emphasis on waking hours. Transportation needs should be included in this assessment.

Further development of this proposal should be made in cooperation with Lutheran Family Services, the Richland/Lexington Disability and Special Needs Service Coordinator, and in cooperation with the guardians of Billy.

Respectfully submitted.

T. J. Cuddington

Timothy J. Cuddington, M.Ed.


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Department of Health & Human Services
Sam Nunn Atlanta Federal Center
Centers for Medicare & Medicaid Services
Division of Survey and Certification
65 Forsyth Street, S.W. Suite 4T20
Atlanta, Georgia 30303-8909



October 13, 2004

Mr. Gene Marlow
Deputy Executive Director
Babcock Center Administration
500 Rivermont Drive
Columbia, South Carolina 29210
Fax: 803-799-1238

Re: Kensington I Group Home 42G068 – Immediate Jeopardy

Dear Mr. Marlow:

On October 6 - 11, 2004, representatives of the Centers for Medicare and Medicaid Services conducted a fundamental survey in conjunction with a complaint investigation at Kensington I, an Intermediate Care Facility for the Mentally Retarded (ICF/MR), located in Columbia, South Carolina. The survey team informed the facility director on October 7, 2004 that conditions within Kensington I Group Home posed an immediate jeopardy to the health and safety of clients. Specifically, the facility does not meet the requirements of Section 1905(d) of the Social Security Act and the Condition of Participation for ICFs/MR of Client Protections (42CFR 483.420).

This letter is to inform you that we have determined that the conditions found do, in fact, pose **Immediate Jeopardy** to the health and safety of clients. A summary of findings, which constitute the immediate jeopardy, are enclosed. Please note that there may be a supplemental listing of noncompliance that did not rise to the level of immediate jeopardy included in the final CMS-2567.

The facility must submit an acceptable credible allegation to this office within five (5) working days of receipt of this notice that demonstrates removal of the Immediate Jeopardy threat, or the Centers for Medicare and Medicaid Services will terminate your participation in the Medicaid program. Failure to correct the immediate jeopardy within twenty-three (23) days of the date of the survey will result in your termination. Termination will be effective **November 3, 2004.**

Please note that this letter does not constitute formal notice of termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination is warranted, we will provide you with a separate formal notification of that determination.
If you have removed the Immediate Jeopardy or achieved compliance, please advise us immediately by faxing your allegation of compliance to:

Joyce Lang, ICFs/MR Enforcement
The Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909
Fax: (404) 562-7480

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To be considered acceptable, your allegation of compliance must include your planned action to correct the deficiencies and the expected completion date. It must be specific and realistic, stating exactly how the deficiency was or will be corrected. The allegation of compliance must also identify what measures will be put into place to ensure that the deficient practice does not recur and how the corrective action(s) will be monitored.

If your allegation of compliance is found to be acceptable by the Regional Office, a revisit will be conducted before the termination date. If the Centers for Medicare and Medicaid Services determines that the reasons for termination continue, the effective date of the termination will remain November 3, 2004 , and you will be so informed in writing. If corrections have been made to remove the Immediate Jeopardy and if total compliance has been achieved, the termination procedures will be halted, and you will be notified in writing. If the threat has been removed, but compliance with all the conditions of participation has not been achieved, additional time may be granted for correction.

If you wish to appeal this determination, you may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 CFR 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. If you choose to do so, please submit a hearing request (accompanied by a copy of this letter), directly to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Jacqueline T. Williams, Chief
330 Independence Avenue, S.W.
Cohen Building - Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. Counsel may represent you at your own expense. However, please be advised that a provider is not entitled to a formal hearing prior to termination, but only after adverse action actually take place.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

Enclosures: Immediate Jeopardy Findings

cc: CO ICF/MR
State Survey Agency (with Enclosures)
State Medicaid Agency (with Enclosures)

Kensington I
Immediate Jeopardy Summary

October 12, 2004

A fundamental survey was initiated in conjunction with a complaint investigation at Kensington I, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) operated by the Babcock Center, Inc., from October 6 through October 11, 2004. The fundamental survey was extended to a full survey on October 7, 2004. The complaint, received by the Centers for Medicare & Medicaid Services, alleged the death of an individual (Client #5) on September 25, 2004, was a result of choking on food served at the facility.

During the course of the investigation and survey, the Federal Survey Team identified circumstances that placed the remaining seven residents of the home at potential risk of serious harm. On October 7th at 8:00 AM the Region IV Office was notified and agreed with the findings. The Central Office concurred. At 1:25PM on October 7th, the Home Administrator was notified that an immediate jeopardy had been declared based on the failure of the facility to ensure the protection of all clients by failing to thoroughly investigate the death a client and, further, to provide protection for all clients pending the results of the investigation. Additionally, the observations of the needs of the seven men who were living at the facility led to an immediate concern regarding their safety at mealtimes. The need for monitoring to prevent choking was evident for four of the men (Clients # 3, #4, #6 and #8). All seven of the men (Clients #1, #2, #3, #4, #6, #7 and #8) had physician's orders for individualized diets; each mechanically altered to ensure safe consumption. Evidence indicated certain staff had not consistently prepared and served diets in accordance with the physicians' orders. This evidence was considered to be a critical issue regarding the effectiveness of staff training to prepare specialized diets. The number of staff assigned to prepare and monitor mealtimes, particularly on weekend days was considered insufficient to ensure all of the men could dine safely. During weekdays, three staff were routinely scheduled during the two meals served at the residence, breakfast and dinner. On the weekend days, only two staff had been scheduled when all three meals were served at the residence. This staffing pattern was not considered adequate to ensure the safety of all of the men during mealtimes.

The Home Administrator was also informed that, based on serious concerns regarding compliance with the Conditions of Participation: Client Protections and Facility Staffing, the survey would be extended to a full survey, and include all eight Conditions of Participation.

Based on the findings of the Federal Survey Team, recommendations were made to the Region IV Office to find the facility not in compliance with W122, the Condition of Participation: Client Protections. Additionally, deficient practices were identified

resulting in the recommendation to cite standards W149, W154, W155, W186, W189, W474 and W485.

Findings:

On October 6, 2004, beginning at 11:50 AM, the Babcock Center, Inc. "Internal Investigation Report of Alleged Abuse, Neglect or Exploitation," dated September 27, 2004, regarding the death of Client #5 was reviewed. The report described the chronology of events as follows:

"[Client #5,] resident of the Kensington I ICF/MR, began choking after leaving the dinner table on September 25, 2004. The staff began the Heimlich maneuver and called 911. [Client #5] collapsed to the floor and staff began chest compressions and CPR. EMS arrived and began working on [Client #5]. He was transported to Richland Memorial Hospital. [Client #5] was pronounced dead at 2:13 pm. It was reported that the cause of death was cardiac arrest. On September 27, 2004, a verbal report of autopsy finding suggested that there were chunks of food found in [Client #5's] trachea. According to the nutrition progress noted dated 8/26/03, [Client #5] is on a mechanically altered pureed diet. Based on this information, an investigation for possible neglect was initiated. This was reported to the Attorney General's Office. [Investigators] from the Attorney General's Office, began an investigation."

The "Internal Investigation Report of Alleged Abuse, Neglect or Exploitation," dated September 27, 2004, recorded the time of the incident as 2:00 PM on September 25th and the actual allegation of suspected neglect was recorded as 3:00 PM on September 27, 2004.

On September 25, 2004 (at a time not documented) the agency received written statements from each of the two employees who were present during the incident. Both of the written statements described a choking episode immediately following a meal. Both of the written statements described the use of the Heimlich maneuver and CPR and the response of the emergency medical services.

According to the Consumer Advocate, who was the internal investigator for the Babcock Center, Inc., no further investigation was conducted until September 27th, when the preliminary report of the autopsy was received. The Consumer Advocate reported information received from a Licensed Practical Nurse (LPN) who was present at the emergency room was the basis for concluding (on the day of Client #5's death, September 25th) that additional investigation was not necessary. That information was recorded in a written statement by the LPN (at a time not documented) on September 25th. The statement read, in part: "ER Physician talked with me and he felt [Client #5] had a massive MC (massive coronary). They suctioned [Client #5] and then at 2:13 p they announced he had expired." No further investigation was initiated based on the LPN's written statement.

Mims 0202

On September 27th, the second day following the death, interviews with the two employees present during the incident were completed by investigators of the Attorney General's Office at 3:00 PM. At that time, the incident was officially reported as possible neglect by the Babcock Center Inc. and the investigation was deferred to the Attorney General's Office. One of the two employees was placed on administrative leave and the second employee returned to duty at the Kensington I residence at 4:00 PM on September 27th. The conclusion contained in the agency report was: "Due to insufficient information, this investigator cannot draw a conclusion as to whether or not neglect occurred. This investigator does not have immediate access to the hospital records or autopsy records. The Attorney General's Office is investigating this allegation and will provide results to Babcock Center. Therefore, Babcock Center will defer the conclusion of this incident to the Attorney General's Office."

The report documented the decision to place one of the two employees on administrative leave pending the outcome of the internal investigation. The report did not document the rationale for allowing the second employee to return to duty prior to the completion of the investigation. The Consumer Advocate reported no further interviews were conducted following the interviews conducted by the Attorney General's Office, prior to authorizing one employee to return to duty at 4:00 PM on September 27th. The Consumer Advocate explained that the employee who returned to duty was not considered to be responsible for any aspect of potential neglect in the death of Client #5, whereas "criminal charges" may be filed by the Attorney General's Office against the employee who was placed on administrative leave.

The two employees, who were on duty on the day of Client #5's death, September 25th, were interviewed individually by investigators of the Attorney General's Office at 2:00 PM and 3:00 PM on September 27th. The report of the interviews was reviewed beginning at 12:25 PM on October 6th. Neither interview, as recorded, could confirm whether the consistency of the food prepared and served to Client #5 on the day of his death was the pureed consistency ordered by the physician. Both of the employees worked the remainder of the shift, and left the facility at 4:00 PM on September 25th. Time records provided indicated leave status for both employees on September 26th was "Annual Leave."

On October 7 at 5:45 PM, the Senior Residential Director reported the second employee had also been removed from duty based on the determination of immediate jeopardy. She provided a copy of a "Corrective Action Report" dated October 7th. The report read: "During an incident whereby a consumer went into distress at Kensington I facility, you were one of the staff on duty. Due to the inconclusive nature of the investigation you are hereby placed on Procedural Suspension until further notice. This is effective 10/7/04."

During observations at the residence during the evening meal on October 6th (a Wednesday) at 5:40 PM, all of the seven men who lived at the home were served meals that were mechanically altered to ensure that food could be ingested safely and without risk of choking. Three direct support staff were on duty. Four of the seven men (Clients

#3, #4, #6 and #8) were closely monitored by the staff who assisted them to eat their meals at a safe pace.

Evidence received during the initial document review of the death of Client #5 revealed that only two staff members were on duty at the time of the incident, despite the need for monitoring for five of seven men present for the mid-day meal on September 25th (a Saturday).

Staffing schedules for the home provided by the Home Administrator verified that three direct support staff were routinely scheduled in the home during breakfast and dinner Monday through Friday. The weekend schedules showed two staff on duty during mealtimes on Saturdays and Sundays during the prior month. The Home Administrator reported that only two staff were on duty on the day of Client #5's death and said that coverage had been considered sufficient since one of the eight men was away from the facility for the weekend.

Based on the needs of the men during the mealtime observation, two direct support staff members were not considered to be a sufficient staffing complement to ensure safety for all of the men during mealtimes.

Staff training was considered to be a critical component of the situation of immediate jeopardy based on the statement of the employee who prepared the food served to Client #5 on September 25th. The employee who prepared the meal reported that he put a grilled cheese sandwich into the food processor and then scraped "the sticky sandwich out of the processor and mixed it with bean and bacon soup." By the employee's description, he did not process the soup/sandwich mixture together to a pureed consistency as ordered for Client #5. The employee further stated that he had prepared that same meal in the same manner on other occasions and was therefore not following the protocol for preparation of Client #5's diet. A statement of the second employee said she "saw [Client #5's] bowl and the sandwich had been placed in the soup," because, "the color of the soup was lighter due to the bread." There was no clarification of that statement as to when the second employee "saw the sandwich in the soup," and the report did not document the second employee's description of the texture of sandwich/soup mixture, e.g., pureed, thick or lumpy. Although she stated she saw the mixture in the bowl, the report did not say she was asked to describe the consistency of the mixture.

Based on the information provided regarding the circumstances of the death of Client #5, the facility failed to take appropriate actions to ensure client protections, particularly related to thoroughly investigating the critical incident and providing protections for all clients during the process of investigation. Observations, interviews and document reviews conducted on October 6 and 7, 2004, provided evidence that mechanically altered diets were not consistently prepared as ordered to meet the developmental needs of all of the men living at Kensington I. The reported actions of staff in preparing mechanically altered diets indicated that staff training had not been effective. Further, evidence was sufficient to conclude that direct support staff were not assigned in sufficient numbers to supervise mealtimes at the facility on weekend days.

Mims 0204

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42G068	A. BUILDING 01 - KENSINGTON I COMMUNI B. WING _____	11/23/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON I COMMUNITY RESIDEN	100 KENSINGTON RD. COLUMBIA, SC 29203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 02307 Recertification Survey Ms Katrina Rivers, QMRP (803) 256-3360 KGR K3 Building 0101 K6 06-06-83 K7 2000 Existing K8 Small ICFMR under Board and Care K9 Acceptance of a Plan of Correction Facility Rated Prompt, E-Score 1.46 During the recertification survey conducted on this date, the facility did not comply with 42 CFR 483.70(j). This was evidenced by the following K-Tags which correspond to NFPA's 101, Life Safety Code (LSC) and codes referenced by the LSC.	K 000		
K0029	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Any hazardous area that is on the same floor as, and is in or abuts, a primary means of escape or a sleeping room is protected by one of the following means: (a) Protection is an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than ¾ hour.	K0029		

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SC DEPARTMENT OF HEALTH REGULATION

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X John D. D— | X Administrator | 12/17/04

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

Mims 0205

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/7/2004
FORM APPROVED
OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
42 G068	A. BUILDING _____ B. WING _____	11/19/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NSINGTON I COMMUNITY RESIDEN	100 KENSINGTON RD. COLUMBIA, SC 29209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: On the day of the survey observation, interview, and record review revealed that the facility failed to ensure that the governing body exercised sufficient operating direction over the day program to ensure that adequate maintenance was carried out. Findings included: Observation on 11/17/04 at 12:35 PM at the day program in the men's bathroom in the lower area revealed that there was no door on the handicap accessible stall. Further observation revealed that the towel dispenser was broken, that there was a hole in the wall beside the sink, and another break behind the door, stained ceiling tiles, and that the walls were scarred and in need of painting. Interview with the day program administrator at the time revealed that she did not know why there was no door on the stall. Interview at the time with day program staff #13 revealed that there had never been a door on the stall "since I've been here." Interview with day program staff #15 at 12:45 PM confirmed that the towel dispenser was broken. Observation on 11/18/04 at 10:45 AM at the day program in the seniors' area room 203 revealed rust stains on door, stained ceiling tiles, and that the walls	W104	W104 The facility will ensure the governing body must exercise general policy, budget, and operating direction over the facility. 1. The governing body will ensure adequate maintenance at the Day Program. 2. Support Services will replace or repair the broken soap dispenser, repair holes in the wall and replace stained ceiling tiles. 3. Scarred walls will be repainted. 4. The governing body will be submitting a capital application for engineering and financing in the future to address leaks, proper lighting, etc. Person(s) Responsible: Director of Support Services Projected Completion Date: 2/19/2005 RECEIVED DEC 17 2004 DIVISION OF PROFESSIONAL & HEALTH REGULATION	

OR. ATORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X Administrator X 12/17/04

lency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other is provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following these documents are made available to the facility. If deficiencies are cited, an approved Plan of correction is requisite to continued program participation

Vams 0206

SPARTMENT OF HEALTH AND HUMAN SERVICES
F ERS FOR MEDICARE & MEDICAID SERVICES

(X1) OF DEFICIENCIES OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42G068	A. BUILDING _____ B. WING _____	11/19/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENSINGTON I COMMUNITY RESIDEN	100 KENSINGTON RD. COLUMBIA, SC 29203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 104	Continued From page 1 were scarred and in need of painting. Interview with the day program administrator on 11/18/04 at 11:20 AM revealed that work orders had already been submitted for these and other repairs. Review of work orders revealed the following work orders: 5/25/04--andillary building needs painting. 5/11/04--,holes in bathroom walls need to be repaired; 6/4/04--ceiling tiles need to be replaced in all areas; 8/14/04--holes in both ladies and men's bathroom need repairing; 11/4/04--paper towel dispenser is not working. The administrator also produced another document dated 9/21/04 that listed 22 work orders that had been submitted. It also stated that the day program had "ceiling leaks, walls that need repairs/painted, A/C that leaks on floor, improper lighting in workshop and senior program rooms." The workshop was not receiving adequate maintenence.	W 104		
/ 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: On the day of the survey observation and interview revealed that the facility failed to ensure that clients had privacy during the care of personal needs for 3 out of 4 sample clients	W130		

Mims 0207

2005 Carolina Medical Review

Mims 0208

EXECUTIVE SUMMARY

Review of Babcock Center, Inc.
Compliance with Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

Carolina Medical Review
January 18, 2005

At the request of the South Carolina Department of Health and Human Services (DHHS), Carolina Medical Review (CMR), the federally designated quality improvement organization for the state of South Carolina, completed an administrative/operational review of Babcock Center, Inc. (Babcock) as a follow up to surveys conducted by the Center for Medicare and Medicaid Services (CMS). The results of the CMS surveys had placed several Babcock facilities in immediate jeopardy. CMR specifically performed the assessment on behalf of DHHS for an indication of the status of Babcock in meeting the conditions of participation in the Medicaid Program as required by federal regulations. CMR initiated and completed the assessment during the fourth quarter of CY2004. The Executive Summary serves to briefly outline findings of the review and the attached reporting grid lists the conditions of participation and specific details of review results and determinations.

The CMR evaluation of Babcock consisted of three phases, including a desk review of selected documents and materials, a limited client file review and a residential facility review. The CMR review team completed the three phases at the respective CMR and Babcock administrative offices in Columbia, SC, and the thirteen residential facilities in the counties of Richland, Lexington, Fairfield and Kershaw. An overview of the results of this review is as follows.

I. Desk Review

CMR requested selected materials and documents from the Babcock, Inc. administrative offices for completion of the desk review portion of this evaluation. The requested desk review materials were delivered by Gene Marlow, Babcock Deputy Executive Director, on November 8, 2004. Following review of the documents at CMR offices, Lisa Bearden, Ph.D., CMR Medicaid Programs Manager, and Sandi Owens, CMR Assistant Medicaid Programs Manager, arranged to review additional materials at the Babcock administrative offices during the months of November and December. In addition, the CMR review team interviewed Babcock staff about issues that arose from the desk review. At this time, addition materials necessary for completion of the evaluation were also requested for review. A summary of findings from the desk review is as follows:

1. There is no comprehensive set of policies and procedures for the administration of programs and other aspects of business (CFR 483.410, a through c). When questioned about required policies, administrative staff indicated that they did not know about those policies that are required under the Conditions of Participation. Specific examples of missing policies and/or procedures that impact the integrity of the programs include a lack of direction on disciplinary actions toward staff, no procedural statement concerning when items are required from residences for documentation of client financial records, no policy on appropriate aspects for client records, and a confidentiality policy that only addresses release of protected health information with other reference to the confidentiality of client information and how that information is handled within the Babcock organization. The Deputy Executive Director indicated to CMR reviewers that Babcock refers to SCDDSN policies for guidance and has not "felt the need" for a comprehensive set of administrative policies and procedures. When asked about the vast number of staff with multiple disciplinary actions who appear to receive excellent employee evaluations, the Human Resource Director stated that "that shouldn't happen" and that Babcock does not use progressive discipline steps. It should be noted that one staff member had 13 disciplinary reviews, with several indicated as "Written Warning." This same staff member was eventually found guilty of client exploitation. The miscellaneous policies that were reviewed lacked clear dates of regular revision or review.

2. Although one responsibility of the Babcock Board of Directors is to provide the CEO with an annual written evaluation on his/her performance, no documentation of such evaluation was referenced in any Board meeting minutes reviewed. (CFR 483.410, a)

3. During the review of Client Abuse and Neglect Cases, several files were found to include other client documents that were unrelated to the case. Indeed, one example of mingling client information included an internal memo from one administrative staff to another concerning knowledge of an abuse allegation of another client. It should be noted that there was no file on that specific allegation. When asked about this situation, the Deputy Executive Director stated that he had "no idea how that happened." He then stated that a file would be started even though the memo was dated from a prior month. (CFR 483.410, c)

4. Although abuse and neglect files reference actions that are to take place concerning follow up, there is no documentation that the follow up actually occurred. In addition, there is no policy statement that addresses consistency among investigations. (CFR 483.420, d)

5. A review of staff training logs revealed that some staff has not been trained at a frequency indicated by administrative staff. (CFR 483.430, b and e)

6. Workshop forms have no documentation to detail the exact nature of activities and rely simply on codes such as "crafts," "singing/music," etc. The Director of Vocational Supports stated that staff only uses codes for activities because that is all that is required by the Department of Labor. He stated that there are no files that provide further information concerning activities. During the client file review, CMR staff found that client files do not contain information of how work activities tie back into the overall training of Babcock clients. Further, some files showed clients paid for only one hour or

less of work activity at day programs or workshops, without documentation as to what occurred during the remaining time at the respective programs. (CFR 483.440, a)

7. Although a complete chart was requested for review by CMR, the Babcock Center organizational chart that was provided only reflected administrative staff and did not include direct care staff who work with clients in the homes or other programs. Therefore, CMR was unable to completely assess organizational structure and administrative accountability.

II. Client File Review

The following items contain general comments regarding deficiencies noted during the client file review which was conducted during visits to selected residential facilities. Dr. Bearden and Ms. Owens completed the file reviews. A total of twelve files were reviewed with two files from six group homes included. The residences included for purposes of this review segment were Camden I and II, Kensington I and II, Kitty Wake and Leaning Pines. A brief summary of findings is as follows:

1. There is a consistent organization to all files. Content, however, varies widely within each home and among the different clients. (CFR 483.410, c6)
2. Client files were found in unsecured locations in all homes visited. (CFR 483.410, c2)
3. Several client files had no signatures recorded on the signature sheet. (CFR 483.410, c4)
4. Some team meetings were missing signatures. (CFR 483.410, c4)
5. Explanatory legends were missing from records at three group homes. (CFR 483.410, c5)
6. Client Financial Records were not found in the charts reviewed although Babcock administrative staff indicated that financial records would be located at the residences in client charts. Residential staff indicated that all financial records are located "at Rivermont." House managers were unable to discuss financial documentation with reviewers. (CFR 483.420, b1 and b2)
7. One client file contained the personal layaway tickets of a house manager. When questioned about this, the manager stated, "Don't worry about that. That's MY stuff." (CFR 483.420, b1 and b2)
8. There was limited documentation of a concerted effort to encourage participation of family members, guardians or other related individuals in client activities. (CFR 483.420, c)
9. There was no or very minimal documentation of outside activities in multiple records reviewed. (CFR 483.420, c5)
10. Records reviewed at Leaning Pines lacked documentation of activities for approximately two months. When questioned, staff stated that they "quit all that since [they] knew they were going to be a CTH II" facility. (CFR 483.420, c5)
11. Clients in Leaning Pines and Kitty Wake have no assessment indicating that changing the home from an ICF to a CTH II is appropriate. In fact, the latest and current assessments have all of the clients classified at the ICF/MR level. (CFR 483.440, b4)

12. Annual assessments do not appear to be completed. Instead, staff only initial and redate old evaluations. (CFR 483.440, f2)
13. There was no demonstrated continuity of care or understanding by staff concerning respective information contained in the various client charts (i.e. main, medical, and training). (CFR 483.410, c6)

III. Residential Facility Review

Unannounced visits to Babcock residential facilities were conducted by Dr. Bearden, Ms. Owens and Joy Slocum, CMR Behavioral Health Review Specialist. Visits were made during the early morning as well as afternoon and early evening hours in order to observe staff to client interactions and the conduct of various daily routines. Several trends relative to a failure to comply with applicable state licensing regulations were observed throughout the program's operations. Numerous items needing improvement, correction, or repair were observed throughout the facilities that were visited. While some of these items are noted in the specific, detailed part of the report, trends observed and summarized here are intended to provide a brief overview of the results of the site visits:

1. Personal identification was requested from the reviewers by staff at only four locations, indicating lack of compliance with HIPAA requirements. Even though staff did not require proper identification of the CMR team, they readily volunteered confidential information including information about client families, resident health, behavioral characteristics, and other client specific data. In addition, records and other information regarding residents were being maintained in locations that were not locked or secured so that the information was accessible or readily visible to anyone visiting the location. (CFR 483.410, b and c)
2. Potentially harmful agents were observed to be unlocked and accessible to residents throughout the program creating potential hazards within the homes. Examples of these potentially harmful agents included laundry detergent, bleach, dish sanitizing powder, dish detergent, and cleaning products. Supporting this concern was the review of one client incident report that actually documented the consumption of an unknown amount of a cleaning agent by a group home resident. (CFR 483.410, b)
3. Trash cans were not covered in kitchens during times that food was being prepared in the majority of the locations. Tops of the trash cans were removed while meal preparation was in progress. (CFR 483.410, b)
4. Buckets of standing mop water and bags of trash were observed unattended in hallways in many of the homes. (CFR 483.410, b)
5. While it was noted that efforts have been made to repair and upgrade some locations, approximately half of the locations remaining were in need of major repairs or upgrading. Doors in some facilities had been damaged to the point of splintering, with damaged, rotting or chipped molding around floors. Some homes were in severe need of repairs to walls due to holes, mars, or scrapes and were in need of fresh interior paint that could be easily cleaned. Some homes were in need of replacement of the kitchen cabinets due to wear and tear. Flooring had tears or holes in the surfaces. (CFR 483.470, f3)

7. The supply of frozen foods in some residences was low or nearly non-existent. (CFR 483.410, b)

8. Some overhead fluorescent bulbs were burnt out and some lamps in resident rooms were either unplugged or did not work. (CFR 483.410, b and CFR 483.420, a)

9. Food in the refrigerators was not labeled for contents nor dated. Personal drinks were not labeled and were often uncovered where observed in freezers and refrigerators throughout the locations that were visited. At times, food that had been prepared for the meal to be served was uncovered. (CFR 483.470, l)

10. Active programming was observed occurring at Kensington I, Rabbit Run and Horrell Hill. Other locations appeared to be functioning in a 'maintenance mode' (i.e., getting residents prepared for going off to the day program, getting residents ready for a meal, ready for bed, etc.). Residents, particularly those who were in wheelchairs or who were non-verbal, were observed placed in living rooms in front of the television. (CFR 483.440, a)

11. Residents who had what appeared to be widely disparate care needs were observed particularly at Fair Avenue, Nazareth Road, Ida I and Ida II, Kensington I and Kensington II, and Carter Street. For example, Fair Avenue had four male residents. One resident was classified as functioning within the mild range of mental retardation but required much direct and physical assistance and intervention from staff as he had cerebral palsy with severe contractures of his limbs. This location also housed a resident with severe behavioral aggression as evidenced by a 6" oblong dent in the newly painted wall in the hallway. The surveyor was informed that this facility had just been reclassified in December, 2004 as a Community Training Home. Numerous residents throughout the facilities used wheelchairs and slept in hospital beds. Several of the locations had special equipment necessary for showering and bathing some of the residents. This is a concern in that several homes are being reclassified without documentation of client needs assessment for appropriate placement and in consideration of fire and safety standards. (CFR 483.470, a)

12. Sanitation of facility linen was compromised throughout the locations that were visited by the storage of other types of equipment, storage of unclean linens, or by failing to keep the doors of the linen closets closed. (CFR 483.410, b)

13. Staff work schedules provided by the agency did not reflect locations or hours for individuals designated as QMRP's (qualified mental retardation professionals). Only one such individual was encountered in the home at the time of the survey. (CFR 483.430, b)

Summary and Recommendations

As stated above, the CMR assessment of Babcock Center, Inc. was for the purposes of establishing a general determination regarding compliance with the federally required conditions of participation as a Medicaid provider for ICF/MR services. Each condition of participation was reviewed in relation to materials submitted by Babcock executive or administrative staff, or as part of on site residential facility visits, including client file and programmatic observations coupled with staff interviews and facility examination. The attached grid details results by CFR designation.

Mims 0213

Due to time constraints, some aspects of business and programming were not reviewed in detail. In addition, the review team only conducted residential visits during the day hours and not when clients are scheduled for sleep time. The CMR review team focused on those conditions that were potentially the most harmful if found deficient, therefore some conditions of participation, such as those related to contracted services, were not examined in detail.

In consideration of review findings, CMR cannot provide assurance to DHHS that Babcock Center, Inc. is meeting the minimal conditions of participation in the Medicaid program as required by federal regulations. Specifically, the main concerns are as follows:

1) Although there is some level of organizational structure in place, staff at both direct care and administrative levels were unable to clearly demonstrate a consistent understanding of role, responsibility and accountability;
2) An apparent lack of active treatment and programming for residents of Babcock facilities; and
3) Residential facility reclassification from ICF/MR to CTH II without documentation that appropriate level of care assessment of clients has been completed.

Mims 0214

REPORTING GRID

Review of Babcock Center, Inc.

Compliance with Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

Carolina Medical Review
January 18, 2005

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
483.410	Governing Board and Management				
	Governing Body (GB)				
	1. The facility must identify an individual or individuals to constitute the governing body of the facility. The governing body must- • Exercise general policy, budget, and operating directions over the facility; • Set the qualifications (in addition to those set by State law) for the administrator of the facility; and • Appoint the administrator of the facility.	X			• Babcock has a Board of Directors which, according to the Constitution and Bylaws of Babcock Center, Inc., shall consist of at least 12 members. • General Rules and Regulations of this board were provided. • The President/CEO shall be selected and appointed by the board. • The President/CEO manages the day-to-day administration and operation of the agency, subject to policies adopted by the board. • At least annually, the board will provide the President/CEO with a written evaluation of his/her performance and a salary review. No reference to this requirement was found in the Board of Directors meeting minutes provided by Babcock executive staff for review by CMR. • The copy of the Constitution and Bylaws reviewed was not dated. • The copy of the Bylaws submitted by Babcock executive staff in materials requested by CMR for the desk review indicate the original Board of Directors appointed in 1975 with no modifications and with the latest Bylaws amendment dated 2001. • There was no mention of the frequency with which meetings will be held. "Meetings of the Board of Directors shall be held at such times and places and with such notice as fixed by it". • There were no specific requirements for Board membership and no specific responsibilities or job requirements outside of those indicated in the Constitution and Bylaws.
	Organized Governing Board Structure				

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
					• During review of residences, CMR staff observed overflowing trash cans and articles of trash on the ground around trash cans at several facilities. Also during a review of one facility (Leaning Pines), garbage collectors emptied the cans, but left trash on the ground surrounding the group home. • In the Babcock Disaster Preparedness Plan, a reference is made to the overloading of extension cords. The use of extension cords in licensed facilities is prohibited by state regulations. • An unlocked cabinet was in the garage of this same facility containing hazardous materials such as poisons and cleaning fluids. Other residences had potentially harmful agents in unlocked cabinets and accessible to clients. • During the site visits, CMR staff personal identification was only verified twice by staff at four locations. • Personal identification was requested from the reviewers by staff at only four locations, indicating lack of compliance with HIPAA requirements. • Potentially harmful agents were observed to be unlocked and accessible to residents throughout the program creating potential hazards within the homes. Examples of these potentially harmful agents included laundry detergent, bleach, dish sanitizing powder, dish detergent, and cleaning products such as "Odorban" and "Fabuloso", as well as a jar of over-the-counter skin cream called "Sween". Supporting this concern was the review of one client incident report that actually documented the consumption of an unknown amount of a cleaning agent by a group home resident.
	Client Records Ch				
	1. The facility must develop and maintain a recordkeeping system that includes a separate record for each client and that documents the client's health care, active treatment, social information, and protection of the client's rights.		X		• Review of records at Kitty Wake, Leaning Pines and Kensington II found that each client had a separate record. It should be noted that, although the records were organized similarly, the content was inconsistent among those records reviewed with some records missing elements listed on the content pages. • Files at two homes that have been changed from ICF to CTH II (Kitty Wake and Leaning Pines) have client assessments that are current and indicate that the clients are still at the ICF level.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
					documentation from September to December of 2004. Staff indicated that they stopped documenting because they knew they were changing from ICF to CTH level of care.
	2. The facility must keep confidential all information contained in the clients' record, regardless of the form or storage method.		X		• Dietary information identifying resident names was publicly accessible as it was posted on the bulletin board in the kitchen at 1118 Nazareth Road. Additionally, resident records were observed on an unsecured bookshelf in a public area off the living room at this facility. • Resident records were observed to be unlocked and accessible at Carter Street, Kensington I, Rabbit Run, and Woodlawn. • Staff readily shared resident health, behavioral and family information with reviewers throughout the sites. • Records for most group homes reviewed were kept in unlocked cabinets. In addition, in two homes half of a client bedroom was converted into an office for staff and contained confidential client records and other proprietary information.
	3. The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if a minor) or legal guardian.	X			• There is a Policy for Protection of the Privacy of Protected Heath Information, effective date April 14, 2003. • Noted in this policy is that all employees shall be trained on this policy during orientation and annually thereafter. • This policy refers to "applicability" to the Board of Directors, but no confidentiality documentation was located for Board members.
	4. Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.		X		• Record review at several homes (e.g. Leaning Pines) revealed no signatures recorded on the signature sheet in the client record.
	5. The facility must provide a legend to explain any symbol or abbreviation used in a client record.		X		• A legend was not found in records reviewed at Kitty Wake, Leaning Pines, and Kensington II.
	6. The facility must provide each identified residential living unit with appropriate aspects of each client's record.		X		• There is no policy and procedure regarding the appropriate aspects for each client record; however it appeared that all records were arranged in a similar manner. Each client had three binders (main, medical, and training) with indexes in the front of each binder. As noted above, there is great variability in record content unrelated to individual client characteristics. Interviews at three facilities revealed a lack of understanding of relevant information flow among staff using the three types of client binders. For example, direct care and house management staff appeared not to know about client information in the medical binders and nursing staff could not demonstrate an understanding of information contained in the

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	Services Provided Under Arrangement with Outside Source				
	1. If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.	X			• Babcock executive staff provided CMR with copies of vendor/professional staff contracts for those services provided by contract employees. CMR did not include a detailed assessment of these contracts for purposes of this review other than to document their respective existence.
	2. The agreement must- • Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and • Provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart.	X			• See above. In addition, licenses of professional contract staff were provided to the reviewers by Babcock executive staff.
	3. The facility must assure that outside services meet the needs of each client.			X	• See above.
	4. If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment that are specified in 483.470 (a) through (g), (j) and (k).			X	• See above.
	Condition				
	1. The facility must be licensed under applicable State and local laws.	X			• Babcock executive staff provided copies of group home licenses.
483.420(a)	**Client Protections**				
	1. The facility must ensure the rights of all clients. Therefore, the facility must – • Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility; • Inform each client, parent (if the client is a minor), or legal guardian of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment; • Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process; • Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities; • Protect each client from physical		X		• None of the residents have an opportunity to learn to manage their finances as all such duties are managed through individuals who work at the corporate office location. Individual facility staff was unable to discuss resident finances due to lack of information. • In the Kensington II and Woodlawn locations, resident privacy and sleeping space was compromised with offices for staff. • At Nazareth Road, one resident's behaviors involved going into other resident's rooms and sometimes wearing other resident's clothing. This resident, while unsupervised, was indeed observed putting on another resident's socks while she was in the other resident's room. • One resident, who was in a wheelchair at Ida II, did not have socks on his feet during an early morning visit. When questioned, staff reported "he just takes them off." • A fluorescent overhead resident bedroom light was flickering.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
					about specific client financial activities. There appears to be a strong disconnect between the group home staff and the administrative offices. • Two house managers (Kensington and Kitty Wake) were unable to discuss in detail those financial activities that are listed in their respective job descriptions. • In one client file at Kensington II, a staff member had personal layaway tickets. When questioned by the reviewer, she simply said "Don't worry about that. That's MY stuff." • Client Financial Records were not found in records reviewed. • Residential staff did not follow procedures as described by the administrative financial staff interviewed. Activities were not documented each time money was added or used from the money envelope located in each client file and there were multiple old requisitions found in client files reviewed. When asked about this, financial staff stated that the requisition "must not have been needed and therefore would not be submitted." • There is no written procedure or policy that ensures the integrity and appropriate documentation addressed in the house manager training completed by the financial staff as discussed with CMR.
	2. The client's financial record must be available on request to the client, parents (if a minor) or legal guardian.		X		According to Babcock administrative staff, the client financial records could be found in the client files maintained in the facilities. No client financial records were found during review of client records. CMR requested client financial records from a staff member at Kensington II who informed the reviewer that those records were kept at the administration building on Rivermont Drive. On 12/29 and 12/30 the administration office of Babcock Center was again visited and client financial records were again requested and not received. • An interview with financial staff included a discussion of training that is provided to house managers. • Financial staff was unable to provide a CMR reviewer with an explanation of codes and/or the process used for billing DHHS for reimbursement. • This same staff did, however, walk the CMR reviewer through the computer documentation of client accounts.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	1. Promote participation of parents (if a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;	X			• A letter inviting family members to the Individual Program Plan meeting was found in one record reviewed at Kensington II.
	2. Answers communications from clients', families, and friends promptly and appropriately;		X		• No documentation was found during the review.
	3. Promote visits by individuals with a relationship to the client at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;		X		• No documentation was found during the review.
	4. Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of the client's and other clients' privacy;	X			• One record reviewed at Kitty Wake disclosed several documented contacts by family members.
	5. Promote frequent and informal leaves from the facility for visits, trips, or vacations; and		X	X	• The review of client records on 12/21/04 at Leaning Pines found documentation of community activities for one client. Only three activities were documented for the year 2004. • At Kensington II one record had no outside activities documented.
	6. Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to serious illness accident, death, abuse, or unauthorized absence.	X			• CMR found evidence of parent or guardian notification of incidents on the incident reports kept in the Consumer Advocacy office.
	Staff Treatment of Clients				
	1. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. • Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment. • Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet. • The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.	X			• Babcock has a policy titled Abuse, Neglect, or Exploitation: Prohibition of and Employee Reporting Responsibilities, Procedures for Reporting, Investigating, and Prevention Abuse, Neglect, or Exploitation of People Receiving Services and Supports. • During the period 11/01/02 – 11/24/04, Babcock had a total o 85 reported cases of abuse.
	2. The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.		X		• Although abuse and neglect files reference actions that are to take place concerning follow up, there is no documentation that the follow up actually occurred. In addition, there is no policy statement that addresses consistency among investigations.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	while the investigation is in progress.				
	4. The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and if the alleged violation is verified, appropriate corrective action must be taken.	X			• A review of incident report files of abuse found that in cases of substantiated abuse, the staff member involved was terminated and in-service training on Babcock's abuse and neglect policy was held at the facility involved.
483.430	Condition of Participation: Facility Staffing				
	Qualified Mental Retardation Professional				
	1. Each Client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who- • Has at least at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and is one of the following: o A doctor of medicine or osteopathy. o A registered nurse. o An individual who holds at least a bachelor's degree in a professional category such as occupational therapist, physical therapist, psychologist, social worker, speech-language pathologist or audiologist, professional recreation staff, dietitian or a human services professional.	X			• Babcock does employ individuals who hold the job title of QMRP. A detailed assessment of the personnel files for this staff however was not completed for purposes of this study.
	Professional Program Services				
	1. Each Client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff must work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.		X		• One surveyor who visited a total of thirteen (13) sites during both early morning hours between 6:30 AM and 8:30 AM, and afternoon to evening hours from approximately 3:00 PM to 7 PM, only met one staff member at Horrell Hill who reported that she held the position of a QMRP (qualified mental retardation professional.) Staff who reported that they held positions as "house managers" were observed at: Carter Street, Rabbit Run, Woodlawn, and Bruton Smith Road. • One administrator arrived at Nazareth Road during the time of the site visit. She reported that she was newly hired as of November, 2004 and had worked in this field in another state, noting that the system in South Carolina was "very different." She was observed working on a laptop computer in an office area. • During on site visits to Leaning Pines, staff and clients were

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	2. The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.	X			• It appears that Babcock employs enough staff, but there is evidence that they are not conducting programs as needed for the clients under their care.
	3. Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.		X		• In reviewing the client records, there appeared to be little involvement in developing and revising the client treatment plans. This was evident by incomplete single plans, no documentation of interdisciplinary team participation, and untimely revisions or updates for treatment plans.
	4. Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.	X			• Babcock has a staff development department which provides ongoing staff training.
	5. Professional program staff must be licensed, certified, or registered as applicable to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in 483.410 (b), must meet the following qualifications: • Occupational Therapist or Occupational Therapy assistant: an individual must be eligible for certification as an occupational therapist/occupational therapy assistant by the American Occupational Therapy Association or another comparable body. • Physical Therapist: an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body. • Physical Therapy assistant: an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body. • Psychologist: an individual must have at least a master's degree in psychology from an accredited school. • Social Worker: an individual must- o Hold a graduate degree from a school of social work accredited or approved by the Council on	X			• CMR did not conduct a detailed review of the credentials of all staff categories. It does appear that those personnel records reviewed had the appropriate credential contained in them. In addition, contract personnel are used in several of the categories listed in this condition of participation and executive staff provided CMR with copies of those agreements.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	college or university accredited or approved by the Council on Social Work Education or another comparable body. • Speech-Language Pathologist or Audiologist an individual must- o Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or o Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification. • Professional Recreation staff member: an individual must have a bachelor's degree in recreation or specialty areas such as art, dance, music or physical education. • Professional dietitian: an individual must be eligible for registration by the American Dietetics Association. • Human Services professional: an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology). If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of this paragraph of this section are not required- • Except for qualified mental retardation professionals; • Except for the requirements of this section concerning the facility's provision of enough qualified professional program staff; and • Unless otherwise specified by State licensure and certification requirements.				
	1. The facility must not depend upon the clients or volunteers to perform direct care services for the facility.	X			
	2. There must be responsible direct care staff on duty and awake			X	• CMP conducted residential visits during the day and night

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	emergency, in each defined residential living unit housing - • Clients for whom a physician has ordered a medical care plan; • Clients who are aggressive, assaultive or security risks; • More than sixteen clients; or • Fewer than sixteen clients within a multi-unit building.				to be asleep.
	3. There must be a responsible direct care staff person on duty on a twenty four hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing- • Clients for whom a physician has not ordered a medical care plan; • Clients who are not aggressive, assaultive or security risks; and • Sixteen or fewer clients			X	• No visits were conducted during client sleep hours.
	4. The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.	X			• Although direct care staffing numbers appear to be adequate, the high volume of unexplained injuries may indicate a need for more complete monitoring of those residential facilities where individual clients experience multiple injuries.
	Direct Care (Residential Living Platform)				
	1. The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.	X			• Staffing levels appear adequate though individual programming does not appear to be occurring as expected for this population and respective training needs.
	2. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.			X	• CMR did not review residential facilities when clients were scheduled for sleep.
	3. Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients; • For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2. • For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4. • For each defined residential living unit serving clients who function within the range of mild retardation the		X		• At Nazareth Road with seven (7) residents present in the facility, the nurse placed her hand behind a resident's head in the kitchen to prevent the resident from initiating a behavior of banging her head on the cabinets as the resident was waiting to be given her soda after work. (This resident was reportedly deaf, blind, with many inappropriate behaviors and was classified as functioning within a profound range of mental retardation.) Direct care staff other than the van driver, were late arriving to this facility at the time of this visit so residents had already come into the home. • During an early morning visit, only two direct care staff were on duty at Kensington II with eight (8) residents, Ida I with eight (8) residents, and Ida II with eight (8) residents each

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
					• Residents who had what appeared to be widely disparate care needs were observed particularly at Fair Avenue, Nazareth Road, Ida I and Ida II, Kensington I and Kensington II, and Carter Street. (Ex: Fair Avenue housed four male residents. One resident was classified as functioning within the mild range of mental retardation but required much direct and physical assistance and intervention from staff as he had cerebral palsy with severe contractures to his limbs. This location also housed a resident with severe behavioral aggression as evidenced by a 6 " oblong dent in the newly painted wall in the hallway. The surveyor was informed that this facility had just been reclassified in December, 2004 as a Community Training Home.) • Nazareth Road had one resident who was deaf, blind and self-abusive. This location had multiple residents with various behavior problems.
	4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.	X			
	Staff Training				
	1. The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	X			• See above (Professional Program Services # 4)
	2. For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.	X			• Babcock employees are required to complete the Basic and Intermediate level of Mandt training during orientation and at the direction of the employees' supervisor, this course is required annually. • The Mandt system is a comprehensive training system for managing people. The basic level is designed for those who interact on a daily basis with people who, for the most part are cooperative. Intermediate level is for employees who interact with clients who may become uncooperative and/or confused. The advanced levels are designed for employees who interact with clients who have a history of being, or likely to become, physically aggressive to themselves or others.
	3. Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.			X	• CMR reviewers were not able to verify at this time.
	4. Staff must be able to demonstrate the skills and techniques			X	• Not verified during this review.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
483.440(a)	Active treatment services				
	Active treatment				
	1. Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward- • The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and • The prevention or deceleration of regression or loss of current optimal functional status.		X		• While direct care staff were familiar with the name of the day program each resident attended, none of the staff who were interviewed could provide any information about the content and goals for their residents in the day program. • At Nazareth Road, one resident took two showers and flooded the floor of one bathroom, while she was unattended. This same resident also walked throughout the house with a towel only partially covering her lower body. During the majority of this visit, staff members were noted to be in other areas of the house, not necessarily with residents who were engaged in self-initiated activities throughout the facility. The atmosphere at this location was very chaotic and disorganized. • At Wire Road II, residents were seated in a semi-circle around the television with "Judge Greg." • At Ida II, residents were seated around the television while staff attended to other matters during the early morning. Staff who were present were not always able to keep residents in their view as they completed morning duties. • At Ida II, one of the residents who was non-verbal, was seated in a wheelchair and was seated in front of the television in the morning. This resident was noted to have been chewing on the middle of a hand towel that was in his mouth. As this surveyor approached him, he became very excited and agitated. Staff was not in the same room at the time. When the staff member was asked about the use of the towel, she informed the surveyor that "his mother wants us to use it so that he won't chew his clothing." Upon further questioning, the staff member responded that this problem and method had not been formally written as part of the resident's program plan. This surveyor then urged the staff member to initiate a program review with the appropriate program staff to explore appropriate referrals through a speech therapist and/or physician in order to obtain other more appropriate means of dealing with this resident's behavior. • While active programming was observed occurring at Kensington I, it should be noted that Kensington I had been

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
					from Quality Assurance had been present during this observation. Active programming was also noted at Rabbit Run and Horrell Hill. The majority of other locations appeared to be functioning in a 'maintenance mode' i.e. getting residents prepared for going to the day program; getting residents ready for a meal, ready for bed, etc. Residents, particularly those who were non-verbal and/or in wheelchairs, were found to have been placed in living rooms in front of the television. • CMR found inadequate documentation that active treatment was being conducted in all records reviewed.
	2. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.			X	• No clients whose records were reviewed appeared to be independent.
	S.L. Admissions, Transfers, and Discharges				
	1. Clients who are admitted by the facility must be in need of and receiving active treatment.		X		• Records lacked evidence of clients receiving active treatment.
	2. Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.			X	• According to staff in facilities visited, client records are "thinned" and old records archived. For this reason, admission records were not available. Therefore, this standard could not be scored. • A pre admission evaluation was found in one record reviewed. The admission decision for this client appeared appropriate.
	3. The preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.		X		• One pre admission evaluation was reviewed. The client's likely benefit from placement in the facility was not documented. • In general, client's assessments of all types were not regularly redone and staff simply dated and initialed old assessments stating that they were still accurate.
	4. If the client is to be either transferred or discharged, the facility must- • Have documentation in the client's record that the client was transferred or discharged for good cause; and • Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except emergencies).		X		• During the visit to Ida I, one male resident informed this surveyor that he was being transferred in the near future to one of the facilities in Blair "in order to be closer to his mother." He reported that his mother lived in West Columbia. He was anxious to be with some of his "friends" at that location. It is unknown what criteria or assessments were used in arriving at the decision to transfer this individual.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
					facilities had changed level from an ICF facility to a CTH II home. In all records reviewed, the clients were certified as needing ICF level of care. There was no documentation to indicate the clients had been transferred to a different level of care.
	5. At the time of discharge, the facility must- • Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if a minor) or legal guardian, provide a copy to authorized persons and agencies; and • Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.			X	• No discharge summaries were reviewed.
	Individual Program Plan(s)				
	1. Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to – • Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c) (3) of this section; and • Designing programs that meet the client's needs.	X			• Although client files did contain individual program plans for residents, the documentation of relevant information concerning progress issues and specific skills with purpose was very weak.
	2. Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.	X			• Documentation of meaningful dialogue for team planning was not evident although the records did include several staff categories. • Signatures were missing from a variety of client records regarding team meetings.
	3. Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed, to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must- • Identify the presenting problems and disabilities and where possible their causes; • Identify the client's specific developmental strengths; • Identify the client's specific developmental and behavioral management needs; • Identify the client's need for services without regard to	X			• Initial assessments were present in client files.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community and as applicable, vocational skills.				
	4. Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c) (3) of this section, and the planned sequence for dealing with those objectives. These objectives must- • Be stated separately, in terms of a single behavioral outcome; • Be assigned projected completion dates; • Be expressed in behavioral terms that provide measurable indices of performance; • Be organized to reflect a developmental progression appropriate to the individual; and • Be assigned priorities.	X			• Although present, individual program plans are weak and not detailed for outcomes.
	5. Each written training program designed to implement the objectives in the individual program plan must specify: • The methods to be used; • The schedule for use of the method; • The person responsible for the program; • The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives; • The inappropriate client behavior, if applicable; and • Provisions for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.	X			• See above comments on program plans. This area should be assessed in greater detail.
	6. The individual program plan must also: • Describe relevant interventions to support the individual toward independence. • Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found. • Include, for those clients who lack them, training in	X			• See above comments.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	(including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. • Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied and a schedule for the use of each support. • Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible. • Include opportunities for client choice and self-management.				
	7. A copy of the client's individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if a minor) or legal guardian.	X			• Plans are available to staff and records indicate that others may also gain appropriate access.
	Program Implementation				
	1. As soon as the interdisciplinary team formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.			X	• Due to time constraints of this review, program implementation was not assessed in enough detail to score. The recommendation is that a more focused review of active programming be completed at a later date.
	2. The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.			X	• See above.
	3. Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.			X	• See above.
	Program Documentation				
	1. Data relative to accomplish the criteria specified in the client individual program plan objectives must be documented in measurable terms.			X	• For purposes of this review, CMR did not complete a detailed assessment of this condition. Documentation in a variety of areas is weak.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	contributed to an overall understanding of the client's ongoing level and quality of functioning.				
	(c) Program Monitoring and Planning				
	1. The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including but not limited to situations in which the client- • Had successfully completed an objective or objectives identified in the individual program plan; • Is regressing or losing skills already gained; • Is failing to progress toward identified objectives after reasonable efforts have been made; or • Is being considered for training towards new objectives.			X	• Not assessed during this review.
	2. At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.		X		• Annual assessments do not appear to be completed. Instead, staff only initial and redate old evaluations.
	3. The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to – • Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that in the opinion of the committee involve risks to client protection and rights; • Insure that these programs are conducted only with the written informed consent of the client, parent (if a minor), or legal guardian; and • Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes need to be addressed.			X	• Not assessed during this review.
	4. The provisions of paragraph (f) (3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees. State law or regulations provided for equivalent			X	• CMR was unable to assess this condition during this review.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	client protection and consultation.				
488.450	Client Behavior and Facility Practices				
	Facility Practices Conducive to Client Dignity				
	1. The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures must- • Promote the growth, development and independence of the client; • Address the extent to which clients choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible; • Specify client conduct to be allowed or not allowed; and • Be available to all staff, clients, parents of minor children, and legal guardians.		X		• Babcock Center does not have a policy for the management of conduct between staff and clients. • According to Babcock this issue is addressed in the Babcock Center, Inc. Employee Handbook, revised July 2004, page 9. These sections indicate mandated for conduct between Babcock Center's employees and its consumers as well as their support and treatment by the staff.
	2. To the extent possible, clients must participate in the formulation of these policies and procedures.			X	• CMR was unable to assess this condition during this review.
	3. Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.			X	• CMR was unable to assess this condition during this review.
	Management of Inappropriate Client Behavior				
	1. The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures must be consistent with the provisions of a-1 of this section. These procedures must- • Specify all facility approved interventions to manage inappropriate client behavior; • Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive; • Insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and • Address the following: o the use of time-out rooms, o the use of physical restraints, o the use of drugs to manage inappropriate behavior, o the application of painful or noxious stimuli,		X		• Babcock does not have a policy and procedure related to management of inappropriate client behavior. • CMR was given a copy of the Behavior Support Plan Manual which lists the purpose as the following: "To describe the position of Babcock Center as it relates to the practice of Psychological Services and individuals needing behavior support." This Behavior Support Plan manual does address the use of Time Out rooms, physical restraints, use of medications for behavior support, and use of noxious procedures. Although time out rooms, etc., are addressed, staff indicated to the review team that these methods are not used.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	o the staff members who may authorize the use of specified intervention, o A mechanism for monitoring and controlling the use of such interventions.				
	2. Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.			X	• This condition was not reviewed in enough detail to render a determination at this time.
	3. Techniques to manage inappropriate client behavior must never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.	X			• This is listed in the Behavioral Support Plan manual under practices which are prohibited in the treatment or management of inappropriate behavior.
	4. The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with 483.440 (c) (4) and (5) of this subpart.	X			• This is located in the Behavior Support Plan.
	5. Standing or as needed programs to control inappropriate behavior are not permitted.	X			• This is addressed in the Behavior Support Plan
	Time-out Rooms (c)				
	1. A client may be placed in a room from which egress is prevented only it the following conditions are met: • The placement was a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus emergency placement of a client into a time-out room is not allowed); • The client is under the direct constant visual supervision of designated staff; and • The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.			X	• According to staff interviewed, Babcock does not use time out rooms; however the use of time out rooms is addressed in the Behavioral Support Plan manual. Therefore, this condition must be assessed in greater detail to render a determination.
	2. Placement of a client in a time-out room must not exceed one hour.			X	• See above.
	3. Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.			X	• See above.
	4. A record of time-out activities must be kept.			X	• See above.
	Physical Restraints (d)				
	1. The facility must employ physical restraints only-			X	• CMR did not evaluate compliance with this condition during this review.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	applied; • As an emergency measure, but only absolutely necessary to protect the client or others from injury; or • As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.				
	2. Authorization to use or extend restraints as an emergency must be - • In effect no longer that 12 consecutive hours; and • Obtained as soon as the client is restrained or stable.			X	• See above.
	3. The facility must not issue orders for restraint on a standing or as needed basis.			X	• See above.
	4. A client place in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage must be kept.			X	• See above.
	5. Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.			X	• See above.
	6. Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed, and a record of such activity must be kept.			X	• See above.
	7. Barred enclosures must not be more than three feet in height and must not have tops.			X	• See above.
	1. The facility must not use drugs in doses that interfere with the individual client's daily living activities.			X	• CMR did not assess this condition for compliance during this review.
	2. Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team and used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behavior for which the drugs are employed.			X	• See above.
	3. Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the			X	• See above.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	and the drug regimen review requirement in 483.460(j), for desired responses and adverse consequences by facility staff; and • Gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.				
483.460	Health Care Services				
	Physician Services (c)				
	1. The facility must ensure the availability of physician services 24 hours a day.	X			• Client files indicated physician availability by community physicians.
	2. The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan must be integrated in the individual program plan.			X	• CMR did not assess at this time.
	3. The facility must provide or obtain preventive and general medical care as well as annual physical examination of each client that at a minimum include the following: • Evaluation of vision and hearing. • Immunizations using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. • Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed. • Tuberculosis control, appropriate to the facilities population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.	X			• Client files indicated appropriate general medical assessments.
	4. To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.			X	• CMR did not assess compliance with this condition.
	Physician Participation in Individual Program Plan (d)				
	A physician must participate in -				
	1. The establishment of newly admitted client's initial individual	X			• Client files indicate that this occurs

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	2. If appropriate, physicians must participate in the review and update of the individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.	X			• Client files indicate that this occurs.
	Nursing Services				
	The facility must provide clients with nursing services in accordance with their needs. These services must include-	X			• Nursing services are available by both Babcock employees and contract nurses.
	1. Participation as appropriate in the development, review, and update of the individual program plan as part of the interdisciplinary team process.			X	• CMR did not review compliance with this condition.
	2. The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.			X	• CMR did not review compliance with this condition.
	3. For those clients certified as not needing a medical care plan , a review of their health status which must – • Be by direct physical examination; • By a licensed nurse; • Be on a quarterly or more frequent basis depending on client need; • Be recorded in the client's record; and • Result in any necessary action (including referral to a physician to address client health problems).			X	• CMR did not review compliance with this condition.
	4. Other nursing care as prescribed by the physician or as identified by client needs; and			X	• CMR did not review compliance with this condition.
	5. Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to – • Training clients and staff as needed in appropriate health and hygiene methods; • Control of communicable diseases and infections, including the instructions of other personnel in methods of infection control; and • Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.			X	• CMR did not review compliance with this condition.
	Nursing Staff				
	1. Nurses providing services in the facility must have a current	X			• Babcock executive staff provided CMR with documents

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	services sufficient to care for clients health needs including those clients with medical care plans.				verifying compliance with this condition.
	3. The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.	X			• Babcock executive staff provided CMR with documents verifying compliance with this condition.
	4. If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or on-site consultation to the licensed practical or vocational nurse.	X			• Babcock executive staff provided CMR with documents verifying compliance with this condition.
	5. Non-licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons.			X	• CMR did not address this condition during this review.
	[illegible] Dental Services (c)				
	1. The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.	X			• Client files showed evidence of dental services provided by community dentists.
	2. If appropriate, dental professionals must participate, in the development, review and update of the individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.			X	• CMR did not review at this time.
	3. The facility must provide education and training in the maintenance of oral health.			X	• CMR did not review at this time.
	Comprehensive Dental Diagnostic Services (d)				
	Comprehensive dental diagnostic services include-			X	• CMR did not review dental diagnostic services for purposes of this review.
	1. A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the clients oral condition, not later than one month after admission to the facility (unless the examination was completed with 12 months before admission).			X	• See above.
	2. Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease; and			X	• See above.
	3. A review of the results of examination and an entry of these results in the client's dental record.			X	• See above.
	Comprehensive Dental Treatment (e)				
	The facility must ensure comprehensive dental treatment services that include-			X	• CMR did not review in detail dental services and treatment for purposes of this evaluation.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	a-day basis by a licensed dentist; and				
	2. Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.			X	• See above.
	Documentation of Dental Services				
	1. If the facility maintains an in-house dental service, the facility must keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.			X	• See above.
	2. If the facility does not maintain an in-house dental service, the facility must obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.			X	• See above.
	Documentation of Dental Services				
	1. If the facility maintains an in-house dental service, the facility must keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.			X	• See above.
	2. If the facility does not maintain an in-house dental service, the facility must obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.			X	• See above.
	Pharmacy Services (01)				
	1. The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.	X			• Babcock uses contract pharmacy services and documentation in client files indicates regular review by a pharmacist.
	Drug Regimen Review (01)				
	1. A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.			X	• Compliance with this condition was not assessed during this review.
	2. The pharmacist must report any irregularities in client's drug regimens to the prescribing physician and interdisciplinary team.			X	• See above.
	3. The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record.			X	• See above.
	4. An individual medication administration record must be maintained for each client.			X	• See above.
	5. As appropriate the pharmacist must participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.			X	• See above.
	Drug Administration (01)				
	The facility must have an organized system for drug administration that identifies each drug up to the point of administration. The system must assure that-			X	• CMR did not assess compliance with this condition during this review.
	1. All drugs are administered in compliance with the physician's			X	• See above.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	orders;				
	2. All drugs, including those that were self-administered, administered without error;			X	• See above.
	3. Unlicensed personnel are allowed to administer drugs only if State law permits;			X	• See above.
	4. Clients are taught how to administer their own medications if the interdisciplinary team determines that self administration of medications is an appropriate objective, and if the physician does not specify otherwise;			X	• See above.
	5. The client's physician is informed of the interdisciplinary team's decision that self-administration of medication is an objective the client;			X	• See above.
	6. No client self-administers medications until he or she demonstrates the competency to do so;			X	• See above.
	7. Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law; and			X	• See above.
	8. Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.			X	• See above.
	[illegible]				
	1. The facility must store drugs under proper conditions of sanitation, temperature, light, humidity, and security.	X			• The review of residential facilities indicated compliance with this condition.
	2. The facility must keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self administer drugs in accordance with 483.460 (k) (4) may have access to keys to their individual drug supply.		X		• A container of "Sween Cream" was observed unsecured on a nightstand of a female resident at Nazareth Road. This facility primarily provides care for residents in the profound and severe ranges of mental retardation.
	3. The facility must maintain records of the receipt and disposition of all controlled drugs.			X	• CMR did not review this condition at this time.
	4. The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedule II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 *et seq.*, as implemented by 21 CFR part 308).			X	• CMR did not review this condition at this time.
	5. If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs.			X	• Babcock does not maintain a licensed pharmacy.
	[illegible]				
	1. Labeling of drugs and biologicals must- • Be based on currently accepted professional principles and practices; and			X	• CMR did not review compliance with this condition.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	• Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable				
	2. The facility must remove from use- • Outdated drugs; and • Drug containers with worn, illegible, or missing labels			X	• CMR did not review compliance with this condition.
	3. Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician			X	• CMR did not review compliance with this condition.
	[illegible]				
	1. If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.			X	• CMR did not review compliance with this condition.
	2. If the laboratory chooses to refer specimens for testing to another lab, the referral lab must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.			X	• CMR did not review compliance with this condition.
483.470	[illegible]				
	[illegible]				
	1. The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.		X		• Residential visits to seven facilities indicated that residents of different levels and care needs were housed in the same facilities. • Residents who had what appeared to be widely disparate care needs were observed particularly at Fair Avenue, Nazareth Road, Ida I and Ida II, Kensington I and Kensington II, and Carter Street. For example, Fair Avenue had four male residents. One resident was classified as functioning within the mild range of mental retardation but required much direct and physical assistance and intervention from staff as he had cerebral palsy with severe contractures of his limbs. This location also housed a resident with severe behavioral aggression as evidenced by a 6" oblong dent in the newly painted wall in the hallway. The surveyor was informed that this facility had just been reclassified in December, 2004 as a Community Training Home. Numerous residents throughout the facilities used wheelchairs and slept in hospital beds. Several of the locations had special equipment necessary for showering and bathing some of the residents. This is a concern in that several homes are being reclassified without documentation of client needs assessment for appropriate placement and in consideration of fire and safety standards.
	2. The facility must not segregate clients solely on the basis of	Y			

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders, etc., with other comparable social and intellectual development.				based on the basis of physical disabilities.
	(b) Bedrooms.				
	1. Bedrooms must- • Be rooms that have at least one outside wall; • Be equipped with or located near toilet and bathing facilities; • Accommodate no more than four clients unless granted a variance under paragraph (b) (3) of this section; • Measure at least 60 square feet per client in multiple client bedrooms and at least 80 square feet in single client bedrooms; and • In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.	X			• Residential reviews indicated compliance with this standard.
	2. If a bedroom is below grade level, it must have a window that- • Is usable as a second means of escape by the client(s) occupying the room; and • Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.			X	• CMR did not review compliance with this condition.
	3. The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified mental retardation professional- • Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and • Documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.			X	• CMR did not review compliance with this condition.
	4. The facility must provide each client with- • A separate bed of proper size and height for the convenience of the client; • A clean comfortable mattress;	X			• The mattress in one client's room at Nazareth Road was sagging. • In general, while most of the facilities were warm, blankets on resident beds were not observed throughout the program.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	• Functional furniture appropriate to the client's needs and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.				comforters. • At Carter Street, heavy plastic from the manufacturer but that was torn was still maintained on the box springs of one client's bed. Staff explained that this plastic "kept the bed" dry. This same type of plastic was observed in use on the box spring of a client at Kensington I.
	Storage Space in Bedroom(s)				
	The facility must provide-				
	1. Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-bed activity is a threat to health and safety; and	X			• Residence visits confirmed compliance with this standard.
	2. Suitable storage space, accessible to clients, for personal possessions, such as TV's, radios, prosthetic equipment and clothing.	X			• Residence visits confirmed compliance with this standard.
	Toilet/Bathroom(s)				
	The facility must-				
	1. Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;	X			• Residence visits confirmed compliance with this standard.
	2. Provide for individual privacy in toilets, bathtubs, and showers; and	X			• Residence visits confirmed compliance with this standard.
	3. In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110^0 Fahrenheit.			X	• Compliance was not assessed during this review.
	Heating and Ventilation(s)				
	1. Each client bedroom in the facility must have – • At least one window to the outside; and • Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.	X			• Residence visits confirmed compliance with this standard.
	2. The facility must- • Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and • Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.	X			• Residence visits confirmed compliance with this standard.
	Floors				
	The facility must have-				
	1. Floors that have a resilient, nonabrasive, and slip-resistant surface;	X			• Residence visits confirmed compliance with this standard.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	2. Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and	X			• Residence visits confirmed compliance with this standard.
	3. Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.		X		• At Carter Street, a hole in the surface of the flooring was observed in the middle of one client's room. • Carpeting was frayed and worn in various locations at Rabbit Run. • The floor in the day room of Bruton Road was soiled.
	Space and Equipment				
	The facility must have-				
	1. Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan.		X		• Various sites needed repairs to walls, molding, doors, door frames, kitchen cabinets, and new paint. While it was noted that efforts have been made to repair and upgrade some locations, approximately half of the locations that were visited were in need of major repair or refurbishing. Doors in some facilities had been damaged to the point of splintering; molding around floors was damaged, rotting or chipped. Some homes were in need of repairs to walls due to holes, mars, scrapes and were in need of fresh interior paint that could be easily cleaned. Some homes were in need of replacement of the kitchen cabinets due to wear and tear. Flooring had tears or holes in the surfaces.
	2. Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.			X	• Compliance was not assessed during this review.
	3. Provide adequate clean linen and dirty linen storage areas.		X		• At Nazareth Road, two wheelchairs were observed stored in the linen closet. A port-a-potty was also being stored in the linen closet at Ida II. • At Carter Street, two male resident's soiled clothing was stored in an open laundry basket inside their closet. Soiled resident clothing was also observed being stored in this manner at Wire Rd. II. • At Carter Street and Horrell Hill, the linen closets had a 'musty odor' as though blankets had been used, then put back into the closet prior to washing them. • The door to the linen room was open at Rabbit Run, Ida I and Ida II, Wire Road II at the time of this survey.
	Emergency Preparedness				
	1. The facility must develop and implement detailed [illegible]	X			

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.				21, 2004 which addresses all potential emergencies.
	2. The facility must communicate, periodically review, make the plan available, and provide training to the staff.	X			• A copy of this plan is kept in each facility • New employees receive disaster preparedness training during their orientation.
	Evacuation Drills				
	1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to • Ensure that all personnel on all shifts are trained to perform assigned tasks; • Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and • Evaluate the effectiveness of emergency and disaster plans and procedures.			X	• CMR did not assess compliance with this condition in enough detail to render a determination. It should be evaluated at a later date for all residences.
	2. The facility must- • Actually evacuate clients during at least one drill each year on each shift; • Make special provisions for the evacuation of clients with physical disabilities; • File a report and evaluation on each evacuation drill; • Investigate all problems with evacuation drills, including accidents, and take corrective action; and • During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies chapter of the Life Safety Code.			X	• CMR did not assess compliance with this condition in enough detail to render a determination. It should be evaluated at a later date for all residences.
	3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any line-in and relief staff they utilize.			X	• CMR did not assess compliance with this condition in enough detail to render a determination. It should be evaluated at a later date for all residences.
	Fire Protection (I)				
	1. General • Except as otherwise provided in this section, the facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 200, for incorporation by reference in accordance with 5 U.S.C. 552 (a) and 1 CFR part 51.		X		• There was no evidence that monthly checks of fire extinguishers were being done by staff at Nazareth Road as the last check for one extinguisher was documented 9/04. Also, the door to the fire extinguisher in the hall was broken. • At Nazareth Road, there was no warning sign posted re: oxygen in use in one client's room. Also, at Horrell Hill, when one resident's door was open, the warning sign for 'oxygen in use' was hidden from view and the door was propped open most of the time. • At Carter Street, the emergency lighting in the hall of the left side of the resident's sleeping area was inoperable and was

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	• The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC. • A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).				loose from the wall. When this item was shown to a staff member, she asked, "What is it for?"
	2. Exceptions for all facilities • Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility. • If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC. • The facility must be in compliance with the following provisions beginning on March 13, 2006: o Chapter 19.3.6.3, exception number 2. o Chapter 19.2.9, Emergency Lighting.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	3. Facilities that meet the LSC definition of a health care occupancy • After consideration of State survey agency recommendations, CMS may waive for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met: o The waiver would not adversely affect the health and safety of the clients. o Rigid application of specific provisions would result in an unreasonable hardship for the facility.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	[redacted]				
	The facility must-				
	1. Use lead-free paint inside the facility ; and				
	2. Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.				
	[redacted]				
	1. The facility must provide a sanitary environment to avoid sources and transmission of infections. There must be an active		X		• Throughout the sites, the majority of the staff did not keep lids on the trash cans in the kitchen during food preparation

1445

Mims 0245

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	infection and communicable disease.				bedroom area of Kensington II. • The bathroom sink in the resident's area was stopped up and had standing water in it at Kensington II. Also, the toilet had not been flushed from a BM and no toilet paper was available. • At Nazareth Road, interior dinette chairs, one with BM on the seat, had been placed outside on the patio at the time of this visit. • Staff at Nazareth Road were observed dumping mop water in the yard at the corner of the patio. • Buckets with standing mop water were observed at: Kensington I, Kensington II and outside at Nazareth Road. • Pantry shelves were heavily soiled with splash and food debris at Nazareth Road. • There were numerous observations of open and uncovered, unidentified personal drinks, being stored in freezers and refrigerators throughout the program. Some were in aluminum cans; others were in cups provided by commercial fast food establishments. • Two boxes of single service plastic eating utensils were observed open and not secured in the pantry at Nazareth Road. • A resident bathroom in the left wing at Carter Street was observed with a wet washcloth left in the sink, a towel on the floor, and urine and feces on the toilet seat. • The right wing resident bathroom at Carter Street did not have paper towels for individualized drying of hands and no toilet paper was available. • No toilet paper was available in the resident's bathroom at N. Fair Avenue nor Kensington I. • No pump soap was available at the bathroom sinks in the resident areas of Woodlawn. • At Kensington I, a bag of trash was observed on the floor in the hallway. • At Kensington I, a staff member was observed handling clean eating utensils by putting her hands on the ends that people put into their mouths. • 'Port-a-potties' were observed being stored in the hallways, resident bedrooms or in clean linen rooms at: Horrell Hill, Rabbit Run, and Ida II.

Mims 0246

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
					meat that was thawing in the refrigerator. • At Nazareth Road, one client's bedroom floor was soiled with debris and her trash can was full. • All air returns throughout Carter Street were heavily soiled with accumulated dust and debris. Also, the resident floors in the right wing of this site were soiled with accumulated debris. • Food in the refrigerators was not labeled for content identification nor dated. Personal drinks were not labeled and often uncovered containers were observed in freezers and refrigerators. At times, food that had been prepared for the meal being served was uncovered. • Babcock Center has an infection control manual dated 06/17/1993. According to this manual, policies and procedures related to the infection and control program are reviewed annually and as needed. No evidence of this review found. • According to executive staff at Babcock, they are in the process of revising this manual.
	2. The facility must implement successful corrective action in affected problem areas.	X			• None were found during residential visits.
	3. The facility must maintain a record of incidents and corrective actions related to infections.	X			• Records of incident reports were requested and, according to staff, Babcock had no incidents reported.
	4. The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.	X			• Noted in the employee health requirements, the employee must be free of obvious communicable disease.
[illegible]	[illegible]				
	1. Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.			X	• CMR did not assess compliance with this condition in enough detail to render a determination. It should be evaluated at a later date for all residences.
	2. A qualified dietitian must be employed full-time, part-time, or on a consultant basis at the facility's discretion.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	3. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	4. The client's interdisciplinary team, including a qualified dietitian and physician, must prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	5. Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	6. Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	[illegible]				
	1. Each client must receive at least three meals daily, at regular times comparable to normal mealtimes in the community with • No more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast; and • Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under the above bullet.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	2. Food must be served- • In appropriate quantity; • At appropriate temperature; • In a form consistent with the developmental level of the client; and • With appropriate utensils.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	3. Food served to clients individually and uneaten must be discarded.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	[illegible]				
	1. Menus must- • Be prepared in advance; • Provide a variety of foods at each meal; • Be different for the same days of each week and adjusted for seasonal changes; and • Include the average portion sizes for menu items.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	2. Menus for food actually served must be kept on file for 30 days.			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	[illegible]				
	The facility must-			X	• CMR did not assess compliance with this condition in enough detail to render a determination.
	[illegible]				

CFR	STANDARD	MET	NOT MET	N/R	COMMENTS
	deficits in dining areas, unless otherwise specified by the interdisciplinary team or a physician.				
	2. Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;				
	3. Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client;				
	4. Supervise and staff dining rooms adequately to direct self-help dining procedures to assure that each client receives enough food and to assure that each client eats in a manner consistent with his or her developmental level; and				
	5. Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.				

Mims 0250

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42G068	A. BUILDING _____ B. WING _____	R 03/08/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON I COMMUNITY RESIDEN	100 KENSINGTON RD. COLUMBIA, SC 29203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: NOT CORRECTED: INADEQUATE OR NO ACTION BY PROVIDER On the day of the survey observation, interview, and record review revealed that the facility failed to ensure that the governing body exercised sufficient operating direction over the day program to ensure that adequate maintenance was carried out. Findings included: Observation at the day program on 3/7/05 at 11:07 AM revealed that although a door had been put on the adapted toilet stall, it had not been painted. The hole in the wall in the men's bathroom had been patched and roughly spackled, but not sanded and painted. The break behind the door was still present. A paper towel dispenser had been put up. It did not work. The bathroom still needed painting. Some stained ceiling tiles needed replacing. Room 203 still had rust stains on the floor. It still needed repainting and ceiling tiles replaced. Interview with the day program administrator on 3/7/05 at 12:10 confirmed that these repairs had not been made. She also confirmed that the [illegible]	W 104	W104 The facility will ensure the governing body exercises general policy, budget, and operating direction over the facility. a. The hole in the wall in the men's bathroom will be repaired. b. The bathroom and door on bathroom stall will be painted. c. A new operable paper towel dispenser is up in the bathroom. d. The break behind the door will be repaired. e. The stained ceiling tiles in the bathroom and classroom will re-placed. f. Room 203 rust stains on the floor will be repainted. g. In the future, the facility will ensure that the governing body exercises sufficient operating direction over the Day Program to ensure that adequate maintenance is carried out. Person(s) Responsible: Day Program Manager Projected Completion Date: 4/15/05	

RECEIVED
MAR 30 2005
BUREAU OF [illegible]
SC DHEC/HEALTH REGULATION

(X6) SIGNATURES OF DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X7) DATE
X [signature]	X Administrator X	3/29/05

...ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other ...uards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following ...te of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following ...te these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Mims 0251

High Arts

Mims 0252

BOARD:
Elizabeth M. Hagood
Chairman
[illegible] Kent
[illegible]airman
Howard L. Brilliant, MD
Secretary

D H E C

PROMOTE PROTECT PROSPER

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

BOARD:
Carl L. Brazell
Louisiana W. Wright
L. Michael Blackmon
Coleman F. Buckhouse, MD

April 29, 2005

FEDERAL EXPRESS

Dr. Judy Johnson, Executive Director
Babcock Center
500 Rivermont Drive
Columbia, South Carolina 29210

Re: Kensington I Community Residence

Dear Dr. Johnson:

To participate as a provider of services in the Medicaid Program an Intermediate Care Facility for the Mentally Retarded one must meet all provisions of section 1905 (g) of the Social Security Act; be in compliance with each of the Conditions of Participation established by the Secretary of Health and Human Services; and be free of hazards to the health and safety of the residents.

The South Carolina Department of Health and Environmental Control assists the Centers for Medicare and Medicaid Services by surveying intermediate care facilities and other providers of services to determine whether they continue to meet the requirements of Medicaid.

On **April 27, 2005** we conducted a second follow-up visit at your facility. Two (2) standards were found not corrected nor had acceptable progress been made in correcting these deficiencies since the time of the recertification survey, and two (2) additional standards were cited.

We are recommending, as this is non-compliance on the second revisit, termination in the Medicaid Program effective April 30, 2005.

Sincerely,

Arthur I. Starnes, Director
Division of Certification

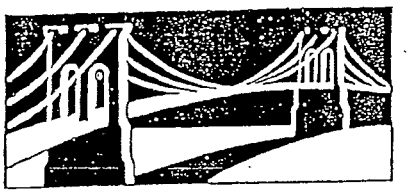
AIS/REC/eak

cc: HHS

Enclosures

Mims 0253

[illegible] DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL



BABCOCK CENTER

3 May 2005

Dear Parents/Family Members:

As a follow-up to the telephone call you received yesterday, I believe it is important for you to have this information in writing from me.

On April 29, 2005, the SC Department of Health and Human Services (DHHS) was notified by the SC Department of Health and Environmental Control (DHEC) that Babcock Center had failed to correct deficiencies found during their annual certification review of Medicaid Standards at Kensington I ICF/MR. DHEC has recommended that our Medicaid funding be terminated as of April 30, 2005. DHHS has informed us to that our Medicaid agreement has been terminated due the failure of Kensington I to meet the federally mandated Medicaid participation requirements. We have been directed to begin planning for relocating the residents.

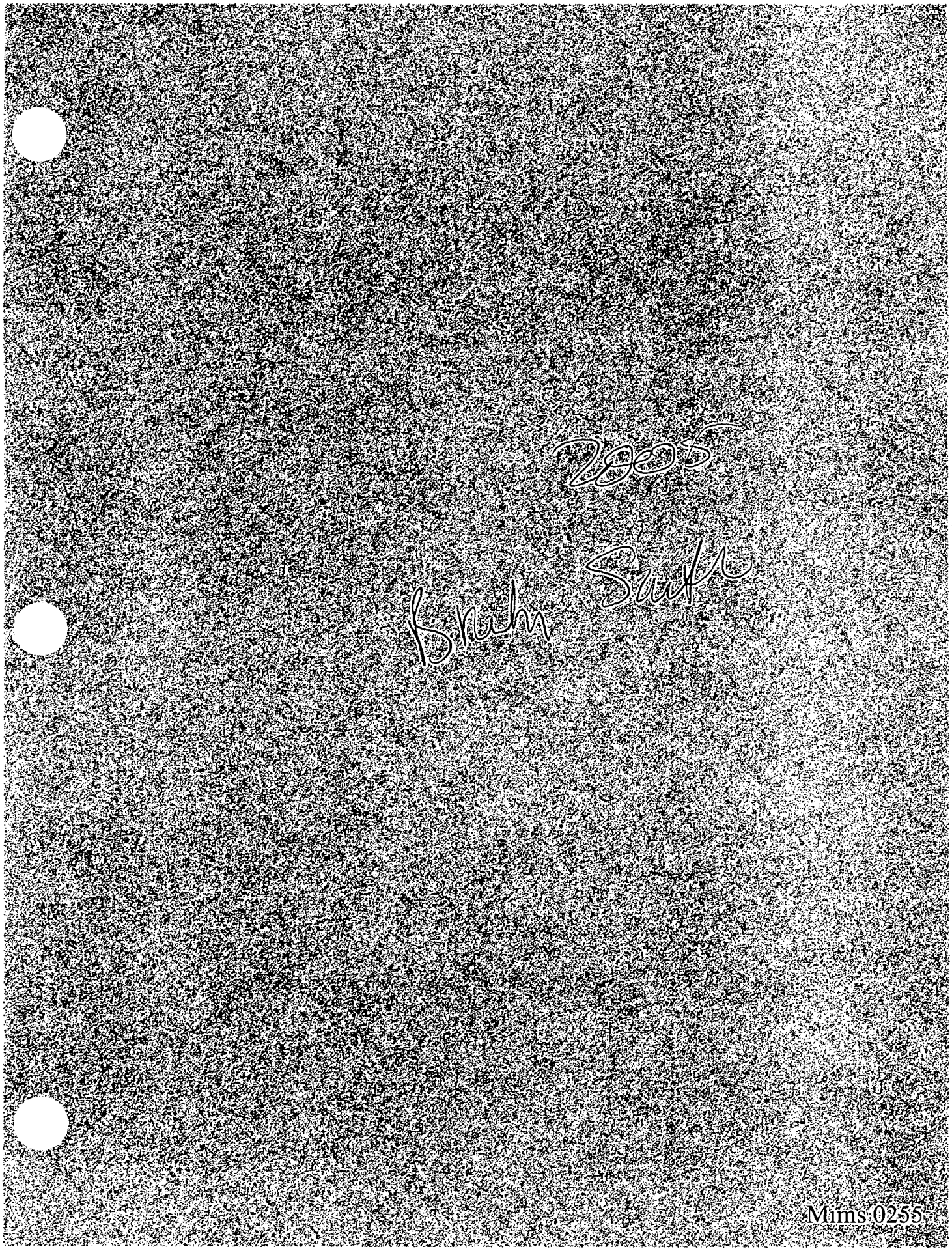
You should know that the two Medicaid Standards determined as not being in compliance by DHEC are not life-threatening. There are no health, safety or accountability issues involved. Essentially, on April 27, 2005, the DHEC surveyor found that documentation by Babcock staff was insufficient to justify the psychiatrist's increase of a medication for one person whom he has treated for at least a year. The fact that our psychiatric consultant based his decision on his interview with the consumer, not just on residential documents, leads us to the decision that we will appeal the action to terminate funding.

The appeal procedure may require several months. Please be assured that, regardless of the outcome, your family member will continue to receive residential services. We will keep you informed and consult you on alternative locations as a contingency plan should relocation become necessary.

I apologize for the concern this information must cause you. We did not expect the DHEC finding nor the DHHS decision. If you have any questions about the telephone call or this letter, please call me, Gene Marlow or Dorothy Goodwin.

Sincerely,

Judy E. Johnson, Ed.D.
Executive Director


Deeds
Study
Blah
Mims 0255

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

corrected sent 5-24-05

May 20, 2005

CERTIFIED MAIL

Dr. Judy Johnson, Executive Director
Babcock Center
500 Rivermont Drive
Columbia, South Carolina 29210

Re: Bruton Smith Community Residence, Medicaid Provider # 0822NH

Dear Dr. Johnson:

The Department of Health and Human Services (DHHS) has received notification from the South Carolina Department of Health and Environmental Control (DHEC) that on a follow-up survey conducted April 27,2005 that Bruton Smith Community Residence was again found to be out of substantial compliance with the requirements for participation in the Medicaid program. The following deficiencies initially cited on your annual survey of December 10, 2004, remained uncorrected and without acceptable progress toward corrections:

W-209	483.440(c)(2)	Individual Program Plan
W-263	483.440(f)(3)(ii)	Program Monitoring and Change

These deficiencies have not been deemed to pose immediate jeopardy to the health and safety of your facility's residents.

Under the terms of the relevant provider contract between the Department of Health and Human Services and the Department of Disabilities and Special Needs, your facility's qualification to participate as a Medicaid provider of Intermediate Care Services for the Mentally Retarded

Division of Community & Facility Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2590 Fax (803) 255-8209

Mims 0256

(ICF/MR) is specifically made contingent upon your maintaining appropriate certification. As a result of the most recent survey findings as discussed in the DHEC correspondence, your facility has not yet qualified for continued certification. DHEC has formally recommended that DHHS invoke the automatic cancellation clause for Bruton Smith Community Residence effective May 31, 2005. DHHS accepts this recommendation from DHEC.

Should you fail to achieve adequate compliance before May 31, 2005, please be advised that as of that date Medicaid will no longer be able to pay for the care of residents at your facility. Current residents whose care is funded by Medicaid would have two choices: (1) remain in your facility under another source of payment (e.g., on a private basis); or (2) move to another ICF/MR that is certified to participate as a Medicaid provider. If a decision is made to relocate residents, federal regulations allow for the continuation of Medicaid funding (including federal financial participation) for a maximum of thirty (30) days while reasonable efforts are made to transfer residents to other facilities or to alternate care. [42 C.F.R. 441.11.] This limited continuation of funding is only available for residents admitted prior to the effective date of the termination.

You are required to notify all patients seeking admission to the facility of the potential termination and that continuing payments under the Title XIX Medicaid program are contingent upon the successful and timely resolutions of the cited deficiencies and the achieving of substantial compliance with federal participation requirements. DHHS will be providing the general public with notice of the impending termination through a notice published in a local newspaper prior to the effective date of the termination.

The federal regulations governing the administration of the Medicaid Program afford an ICF/MR specific appeal rights with respect to termination. [42C.F.R. 431, Subpart D.] In order to invoke these appeal rights, your facility would be required to file a written request for a hearing within sixty (60) days of the receipt of this notice. [42C.F.R. 431.153(d).] Such a request for an appeal should be submitted to the following address:

South Carolina Department of Health and Human Services
Division of Appeals and Hearing
Post Office Box 8206
Columbia, South Carolina 29202-8206

Federal financial participation (FFP) may continue to be available during the appeal process to the extent specified in 42.C.F.R. 442.40. In the event that the appeal hearing is not made available prior to the effective date of the termination, you would be entitled to request an informal reconsideration as described at 42 C.F.R. 431.153(e)(ii) and 431.154.

This termination would only effect your facility's ability to participate in the Medicaid Program. As long as you maintain your appropriate licensing status through DHEC, your facility may continue to operate to the extent allowed by State law. You would also be able to seek re-certification as a Medicaid provider through the normal process.

Mims 0257

If you have questions regarding this matter you may contact Ms. Cindy Pedersen at (803) 898-2590.

Sincerely,

Nicole Mitchell-Threatt
Interim Department Head
Division of Community & Facility Services

NMT/cp/cra

cc: Darlynn Thomas
Karen Price
Ron Dozier
Pam Askins

Mims 0258

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: FD6FJV
Facility ID: 42G0770000

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 42G077
2. VENDOR OR MEDICAID NO.

3. NAME AND ADDRESS OF FACILITY
(L3) BRUTON SMITH COMM. RES..
(L4) 139 BRUTON SMITH ROAD
(L5) LEXINGTON, SC (L6) 29072

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Termination of ICF Beds

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)
6. DATE OF SURVEY 01-27-05 (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 JCAHO
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 11 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP
02 SNF/NF/Dual 06 LAB 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 IMR 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)

11. LTC PERIOD OF CERTIFICATION
From (a): 04/01/2005
To (b): 03/31/2006

12. Total Facility Beds 8 (L18)

13. Total Certified Beds 8 (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
				8
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
LSC SURVEY DATE: 01-27-05.
HEALTH SURVEY DATE: 12-10-04.

The ACC of 05-31-05 is set.

SURVEYOR SIGNATURE
Richard Cummings for
Gene Baughman, PCT
Date: 03/25/2005 (L19)

18. STATE SURVEY AGENCY APPROVAL
Arthur L. Starnes, Director, Division of Certification
Date: 03/25/2005 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__ 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE 4-1-05 (L41)

24. LTC AGREEMENT ENDING DATE 3-31-06 (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00000 (L31)

30. REMARKS No docs attached cp

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE 3-29-05 (L33)

Cindy Redenour
DETERMINATION APPROVAL

Mims 0259

Dear Mum
Thank you for
Christmas
DOS
Love

Mims 0260



ANNUAL ACCOUNTABILITY REPORT

Fiscal Year 2004-05

Exhibit 3

Mims 0261

Accountability Report Transmittal Form

Agency Name – S.C. Department of Disabilities and Special Needs

Date of Submission – September 15, 2005

Agency Director – Dr. Stanley J. Butkus

Agency Contact Person – Mr. Tom Waring

Agency Contact's Telephone Number – 803-898-9792

Mims 0262

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Mims 0263

South Carolina Department of Disabilities and Special Needs
2004-2005 Accountability Report

Mission and Values: The South Carolina Department of Disabilities and Special Needs (DDSN), as stated in Section 44-20-240 of the South Carolina Code of Laws, has authority over all the state's services and programs for South Carolinians with severe lifelong disabilities, including mental retardation and related disabilities, autism, traumatic brain injury, and spinal cord injury and similar disabilities. Primary responsibilities include planning, development and provision of a full range of services for children and adults, ensuring that all services and supports provided meet or exceed acceptable standards, and improve the quality of services and efficiency of operations. The department advocates for people with severe lifelong disabilities both as a group and as individuals, coordinates services with other agencies and promotes and implements prevention activities to reduce the occurrence of both primary and secondary disabilities.

DDSN provides 24-hour residential care for individuals with the most complex and severe disabilities at five regional facilities across the state. Community residential services and in-home support services are provided through contracts with local disabilities and special needs boards and other community providers. The department works closely with consumers and families, service providers, advocacy organizations, the executive and legislative branches of government, county officials, state and federal agencies, the business community and the general public. These partnerships are integral to strategic planning, ensuring health and safety, and measuring outcomes and customer satisfaction.

VISION - WHERE WE ARE GOING!

To provide the very best services to assist persons with disabilities
and their families in South Carolina.

MISSION - WHAT WE DO!

Assist people with disabilities and their families
through choice in meeting needs, pursuing possibilities and achieving life goals;
and minimize the occurrence and reduce the severity of disabilities through prevention.

VALUES - OUR GUIDING BELIEFS!

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

PRINCIPLES - FEATURES OF SERVICES AND SUPPORTS

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

Adopted 11/20/03

Mims 0264

Major Achievements FY 2004-2005

Management of Services Based on Anticipated DOR Revenues and Additional State Budget Reductions: The FY 2004-2005 Appropriations Act replaced $9 million of permanent state funding to DDSN with one-time funding that lawmakers anticipated the Department of Revenue Increased Enforcement collections would bring in during the year. These funds were providing services to 7,300 individuals across the state and represented six and one half percent (6.5%) of the agency's State base funding. These funds were primarily budgeted for Individual and Family Support Services including respite care, personal care aids, therapies, day programs, etc. While there was confidence that the Department of Revenue initiative to collect taxes would be successful, there was no guarantee and services were in jeopardy. Therefore, the agency had to be prepared at the beginning of the fiscal year to manage service reductions should the one-time funding not be collected. This would have increased the already growing numbers of individuals on waiting lists for services.

In addition, over the past four fiscal years, the Department has managed permanent reductions in State Funds of over $26 million. This totals more than $85 million when the Medicaid revenue attached to these State dollars is considered. The Department implemented organizational changes and administrative reductions that allowed it to manage this level of budget reductions with minimal reductions in service to the individuals and families currently served by the agency. Actions started in FY 2001 continued, such as freezing non-direct care positions, severely restricting critical placements of individuals and reducing administration. (See Graph 7.2-7 and Graph 7.4-3) In addition, DDSN implemented an updated Service Management and Permanent Budget Reduction plan beginning in FY 2003 to absorb the additional State fund reductions and the resulting Medicaid fund reductions. The plan minimized administrative costs and maximized dollars to maintain current service levels to all persons receiving services while preparing to respond to new critical care life and death situations that arose during the year.

The agency downsized, restructured and eliminated positions in administration, mid-level management and field personnel. Regional functions were streamlined, other responsibilities and functions previously regionalized were centralized. Savings were realized from 193 employees terminating employment through the Voluntary Separation Program (VSP) or a Reduction in Force (RIF), 286 positions being deleted and 268 fulltime equivalent (FTE) positions remaining unfilled. DDSN's payroll has decreased by $5.4 million.

Direct care positions were not reduced. Service quality was not reduced. The agency cannot jeopardize the health and safety of individuals it serves or go below federal Medicaid standards. The combination of actions taken and changes made were done with the challenges of improving performance and increasing efficiency while responding to the increased need for services, the increased number of people served and an increased scope of services.

The Department worked closely with the Governor's Office and the Legislature, particularly with the leadership to inform them of the agency's initiatives to maintain services and what the impact of additional reductions would be. The result was the Governor's Executive Budget recommendation and the deliberate decision of the Legislature to restore this base funding and to reduce DDSN's budget less than most other agencies to minimize negative impact on services.

Meeting Service Needs: DDSN currently serves 26,500 persons with mental retardation and related disabilities, autism, head injury and spinal cord injury. Approximately 82% of these individuals live at home with their families, which compares to only 61% nationally. The remaining 18% of individuals have complex needs that cannot be met at home and require services provided in community residential settings or in one of five state-operated regional centers. (See Graph 7.1-2 and Graph 7.2-4)

Most service levels were maintained during FY 2005 to all persons receiving them. In addition, increased levels of services were provided for 121 individuals whose jeopardized health and

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safety made their situation critical. Home and community-based waiver services were provided to approximately 5,200 individuals. Other in-home supports were provided for 986 persons to enable them to remain in their own home or their family's home. Providing these new services and increasing services to some individuals was accomplished with reduced state dollars. Meeting service needs was managed through natural attrition, prioritizing the needs of individuals, improving the use of Medicaid reimbursements, and reducing administration further. (See Graph 7.3-1; Graph 7.2-7 and Graph 7.4-3)

However, the number of eligible persons waiting for services continues to grow. (See Graph 7.1-5 and Graph 7.1-6) Each month DDSN receives 300 requests from new people requesting eligibility and services. More babies are born each year with severe birth defects and more adults survive accidents that leave them with severe brain or spinal cord injuries. Advances in science and modern medicine save lives, but also add a growing group of children and adults who need services for the rest of their lives. Over 80% of DDSN's consumers are served only by DDSN. (See Graph 7.2-3) Turnover is very limited in the service system as severe disabilities are lifelong.

Implementation of Person-Centered Services: The department through its statewide organized service delivery system fully implemented the Person-Centered (not program-centered) approach to services. In FY 2005, 1,100 new individual plans were facilitated that incorporate the individual's needs, preferences on how to meet those needs, and the person's strengths, talent and abilities. Choice of service provider is an essential element to the person-centered approach. DDSN implemented a policy change in 1998 and began working with the State Budget and Control Board's Office of Materials Management to develop an ongoing national solicitation to create a Qualified Provider List. The result is 15 providers, which is a 25% increase, and includes the expansion of 2 providers during the 2005 fiscal year. The redesigned accountability mechanism is operational. Assessment of consumer/family satisfaction through surveys and face-to-face interviews continue and is integrated into ways of planning efforts to bolster the person-centered approach.

Implementation of South Carolina's Response to the Olmstead Decision: DDSN continues to be very active in South Carolina's Olmstead process. Dr. Stan Butkus, State Director, was appointed to serve on S.C.'s full Olmstead Committee and to serve as co-chairman on the Disabilities and Special Needs Work Group. The Olmstead U.S. Supreme Court decision established that individuals living in institutions should be able to move to community options if they desire; that individuals should not be unnecessarily institutionalized, or put at risk of unnecessary institutionalization and that placements move at a reasonable pace.

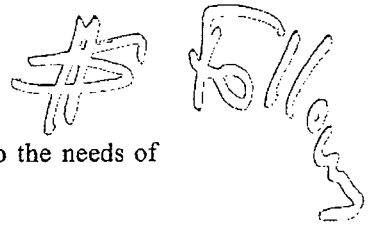
DDSN's "money-follows-the-person" policy provides the financial flexibility for persons choosing to move to community settings from institutions. Sixty-eight consumers have relocated since the Olmstead plan was implemented. The agency's critical case review process is the primary method to prevent and limit unnecessary institutional placement. This process develops individual solutions to provide the care required ranging from increased individual in-home supports to community residential services as appropriate.

Improved Quality and Accountability: DDSN receives/utilizes more than $275 million in federal Medicaid funding to provide services. Compliance with Medicaid standards is essential and the agency prepared for and implemented two significant Centers for Medicare and Medicaid Services (CMS) changes. The first was Intermediate Care Facilities for people with Mental Retardation (ICF/MR) "look behind" reviews which entail re-inspection of facilities after the regulatory authority (DHEC) completes its survey review. The second was an entirely new review protocol for home and community-based Medicaid Waiver services. The Waiver review was completed in March 2004. Federal officials noted the progress made and were impressed with the agency's efforts to strengthen opportunities for consumer choice, the system for tracking critical incidents, and DDSN's initiative to outsource a major portion of quality assurance. In July 2002, DDSN began an independent quality assurance initiative through a bid contract to a

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nationally recognized vendor. This method is more objective, efficient and provides better data to further improve services and processes. It gives the department more ways to compare South Carolina with national data and to trend and evaluate provider progress over time. The shift of resources from internal, self-administered quality assurance to external, independent quality assurance returns a more efficient and better product with an expanded scope. In addition, DDSN was awarded a federal Real Choice Grant from the Centers for Medicare and Medicaid Services (CMS) to determine how well DDSN's external quality review model operationalizes the key features of CMS' Quality Framework. This will enable DDSN to measure the validity of South Carolina's model while enabling the federal government to test the practicality of their framework concept. DDSN is using a private vendor to conduct this evaluation.

This year, DDSN advanced its quality management system by designing, developing and implementing an organized approach to measuring organizational performance. A key feature of this approach is collecting a wide array of information from our consumers and their families regarding their experiences with the service system, its responsiveness in addressing their needs and areas of priority for people served. This information is then integrated into local and statewide quality enhancement efforts. Another important feature of this approach is the use of data to understand the strengths of an organization as well as areas requiring attention. The process is built on a technical assistance and learning approach to quality enhancement which promotes agency self-assessment and the development of the knowledge and skills essential to continuous internal quality improvement.



Key Strategic Goals

1. Improve the quality and range of supports and services that are responsive to the needs of individuals and families.

    a. Address critical needs of new persons in crisis situations.
    b. Provide services to persons on waiting lists.
    c. Serve new persons who become eligible.
    d. Allow consumers to choose the services they need from providers they prefer using individually-defined resource limits.
    e. Continue to move individuals from regional centers who choose community alternatives consistent with the Olmstead Decision and using a budget neutral method.
    f. Continue to maximize Medicaid by shifting service dollars to local operations. (See Graph 7.3-4)
    g. Continue to partner with other agencies to avoid duplication and share resources as appropriate. (See Graph 7.2-3)

2. Increase accountability to all citizens of South Carolina.

    a. Continue implementation of a performance measurement system linked to customer satisfaction and achievement of consumer's outcomes.
    b. Enhance quality assurance and quality improvement initiatives and maintain compliance with federal standards.
    c. Minimize the occurrence and reduce the severity of disabilities through primary and secondary prevention initiatives.

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Opportunities and Barriers

Opportunities

1. Increase use of Medicaid funding to develop flexible in-home supports for increased individual/family independence and prevention of more costly out-of-home residential placements. (See Graph 7.3-1)

2. Strengthen technology capacities to support self-determination initiatives and create efficiencies.

3. Enhance service provider productivity and efficiency.

4. Utilize improved statewide Quality Assurance Program to determine performance in the areas of health and safety of each person, dignity and respect, personal choice, participation in the community and attainment of goals.

Barriers

1. Each month DDSN receives 300 requests from new people for eligibility and services. Turnover is very limited in the service system as severe disabilities are lifelong and many people are waiting for the essential services they need to be more independent. DDSN has 1,863 people waiting for residential services and a waiting list of 969 people for day and employment programs. (See Graph 7.1-5, and Graph 7.1-6) In addition, almost 1,600 people with severe disabilities live at home with parents who are 65 years old or older; of these, 759 live with a parent 72 or older. Almost 300 of these caregivers are over 80 years old. (See Graph 7.2-8) As parents age, their ability to provide care and supervision becomes more difficult, eventually impossible. When parents become ill, develop chronic diseases, need nursing home care themselves or pass away, the state must respond by providing 24-hour care for those left in vulnerable life or death situations.

2. Waiting lists continue to grow. More individuals will be added to the waiting lists with no real hope of being served. Multiple years of budget reductions have only worsened the situation. Consumer expectations for substantial growth and development of community-based services as a result of the U.S. Supreme Court's Olmstead decision are countered by the state's ability to appropriate new revenue to fund new services. This exact situation in South Carolina has led to lawsuits in 25 other states for community services for individuals with developmental disabilities. The Olmstead decision requires that waiting lists move at a reasonable pace. South Carolina is vulnerable as it has been unable to address the waiting list for four years.

3. The recruitment and retention of nurses continues to be extremely difficult in specific locations around the state. The unavailability of nurses caused by a nation-wide shortage of nurses is further complicated by competition from nursing homes, doctor's offices, school districts, and other providers. Some of these providers offer sign-on bonuses; all offer competitive salaries making it more difficult for DDSN to attract nurses especially on the second and third shifts.

Use of Accountability Report to Improve Organizational Performance

The annual accountability report reflects the agency's primary mission, its major initiatives to carry out that mission and its performance on the implementation of its responsibilities. It is an excellent report card that is useful as both an informational and educational tool available to everyone from the taxpayer to the state's policy makers. It offers the agency the opportunity to ensure that its strategic goals and allocation of resources are aligned appropriately and to compare effectiveness over time. It demonstrates the systematic comparison of DDSN's practices, outcomes and efficiencies to national benchmarks.

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Section II – Business Overview

Employment and Operation Information

DDSN has approximately 2,400 full time permanent employees who work in central administration, five regional centers, and two district offices, located throughout South Carolina. DDSN uses approximately 214 temporary employees periodically during the year to cover existing vacancies and some long-term absences due to illnesses, but not to supplement its work force on a permanent basis. Additionally, DDSN contracts with a statewide provider network to administer services to DDSN eligible individuals. There are 7,224 permanent full time contract provider employees in the statewide provider network. These numbers reflect a decrease of almost 500 positions in the department and provider workforce over the last year.

Since 1992, DDSN-operated regional centers have continued to reduce the number of individuals served. At the same time, local community providers have increased their residential capacity by over 70%. This allows most individuals to remain in their local community, close to family, even when residential services are needed. (See Graph 7.1-3 and Graph 7.2-5)

Real estate?

Base Budget Expenditures and Appropriations

	03-04Actual Expenditures		04-05Actual Expenditures		05-06 Appropriations Act	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Services	$64,565,450	$44,608,015	$64,946,793	$46,120,701	$66,836,253	$46,107,835
Other Operating	$270,880,316	$78,111,258	$284,097,527	$69,545,948	$319,415,774	$80,007,997
Special Items	$200,175	$200,175	$300,175	$174,175	$300,175	$174,175
Permanent Improvements	$6,309,522	$0	$4,025,621	$0	$0	$0
Case Services	$7,703,310	$261,302	$8,839,574	$700,538	$9,824,547	$1,055,979
Distribution to Subdivisions	$119,222	$0	$64,425	$0	$150,000	$0
Fringe Benefits	$23,830,651	$16,231,395	$23,388,503	$16,584,138	$25,431,090	$17,098,093
Non-recurring	$0	$0				
Total	**$373,608,646**	**$139,412,145**	**$385,662,618**	**$133,125,500**	**$421,957,839**	**$144,444,079**

Other Expenditures

Sources of Funds	03-04 Actual Expenditures	04-05 Actual Expenditures
Supplemental Bills	$0	$0
Capital Reserve Funds	$6,237,475	$4,060,875
Bonds	$16,670	$1,485

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Key Customers and Key Suppliers

DDSN's key customers are the individuals with disabilities and their families who receive services or who are eligible and waiting for services. DDSN serves about 26,500 persons with mental retardation and related disabilities, autism, head injury or spinal cord injury. These disabling conditions are severe, life-long and chronic. Approximately 82% of these individuals served live at home with their families. This compares with only 61% nationally. The remaining 18% of individuals have needs that cannot be met at home and require services provided in community residential settings or in one of the state operated regional centers. (See Graph 7.2-1 and Graph 7.5-2, and Graph 7.1-2 and Graph 7.2-4)

Turnover is very limited in the service system as severe disabilities are life-long and many individuals are waiting for the services they need to be independent. DDSN has a waiting list of over 900 people for day and employment programs and over 1,800 for priority residential services. In addition, almost 1,600 people with severe disabilities live at home with parents who are 65 years old or older; 759 of whom live with caregivers aged 72 or older. (See Graph 7.1-5, Graph 7.1-6 and Graph 7.2-8)

Equally important are the local provider organizations that DDSN contracts with to provide services. The fluid working relationship between DDSN and the executive directors of these local service agencies, their board members and staff is very important to ensuring the continuous availability of high quality services. Disability advocates and their organizations are integral in promoting consumer-focused services and providing valuable feedback on effectiveness, issues and concerns. The Governor, his staff, members of the General Assembly and their staff are all very important partners in the system of services as they guide policy, appropriate funds and connect individual constituents to available services.

Description of Major Products and Services

DDSN and its statewide network of local providers began implementing a new service-delivery approach statewide in July 1998. This approach, called Person-Centered Services, gives South Carolinians with disabilities and their families more choice and control of the services and supports they receive from DDSN. Person-centered services provide new tools and processes for achieving the results individuals and families want. This new approach gives consumers and their families the power to use the resources allocated to them in ways that make sense in their lives. They set goals and develop a plan that identifies the services and supports they need, and who will provide these services. Consumers and others evaluate the plan and the services and supports delivered, in terms of actual results produced in the person's life and how satisfied he or she is with the supports provided.

DDSN strives to serve all persons who are eligible for services and to ensure that services meet the highest standards. The department structures services so that the greatest number of people possible can be served and, at the same time, insure that out-of-home care is available for those individuals with truly critical needs. Services are grouped in four major categories:

In-Home Individual and Family Support Services: Preventing unnecessary and costly out-of-home placements for individuals with severe lifelong disabilities is the main objective of the in-home individual and family support program. These in-home services provide the supports necessary to enable the consumer to continue living at home. On average, in-home supports cost less than one-half of the least expensive out-of-home placement options. It is generally accepted by professionals and consumers alike that remaining in one's own home is preferable to out-of-home placement. It is rare that a better, more desirable service costs less, but that is the case with in-home family support. In-home supports include day services, supported employment, early intervention, respite, stipends, rehabilitation support services and behavior support services.

DDSN provides employment services to train and supervise individuals in the skills and knowledge required for different levels of employment. Some individuals receive individualized supportive employment at their own worksite, while others are provided group employment in enclaves at various business and factory work sites.

As the number of individuals who become competitively employed increases, public support through Social Security (SSI) and Medicaid decreases. An employment service for a disabled family member often means the difference between the state only helping the family versus the state having to provide 24 hour residential care. Efforts that DDSN makes in training and supervising consumers in employment opportunities greatly decrease the funds needed to care for consumers. As of June 30, 2005, there were 969 eligible individuals waiting for this service. (See Graph 7.1-6)

Community Residential Services: When in-home individual and family supports prove ineffective in meeting the needs of the individual, community residential services are offered. Small, family-like community residential services provide 24 hour care, yet cost less than the cost of state operated regional center placements. Families and individuals alike prefer these types of services, located closer to the individuals' home communities. As of June 30, 2005, there were 1,829 eligible individuals waiting for this service. (See Graph 7.1-5)

Regional Centers: Regional centers serve persons with the most complex needs. The centers are the most expensive residential alternative due to the level of care and supervision needed. The number of persons served in regional facilities continues to decline as local community supports are expanded to meet more of the needs of the individuals served closer to their families' homes. As individuals move from state operated to local programs, the service funds are moved with them. As of June 30, 2005, there were approximately 34 individuals waiting for this service.

Prevention Services: It is estimated that government will save more than $1 million over the life span of an individual if that individual, whether child or adult, remains healthy rather than incurring a severe disability. DDSN has initiated many prevention programs through contractual and other agreements with the Center for Disease Control in Atlanta, the Greenwood Genetic Center, the University of South Carolina School of Medicine, Medical University of SC, Department of Family and Preventive Medicine, DHEC and Department of Health and Human Services.

Organizational Structure

The South Carolina Department of Disabilities and Special Needs (DDSN) is the state agency that plans, develops, coordinates and funds services for South Carolinians with severe life-long disabilities including:

- Mental retardation and related disabilities
- Autism
- Traumatic brain injury and spinal cord injury and similar disabilities

DDSN is governed by a seven-member commission appointed by the Governor with the advice and consent of the Senate. A commission member is appointed from each of the state's six Congressional districts, and one member is appointed from the state-at-large. The commission is the agency's governing body and provides general policy direction and guidance. The State Director is the agency's chief executive and has jurisdiction over the central administrative office located in Columbia, SC, five regional centers and all services provided through contracts with local agencies.

DDSN provides 24-hour residential care for individuals with more complex, severe disabilities in Regional Centers, located in Columbia, Florence, Clinton, Summerville, and Hartsville. DDSN

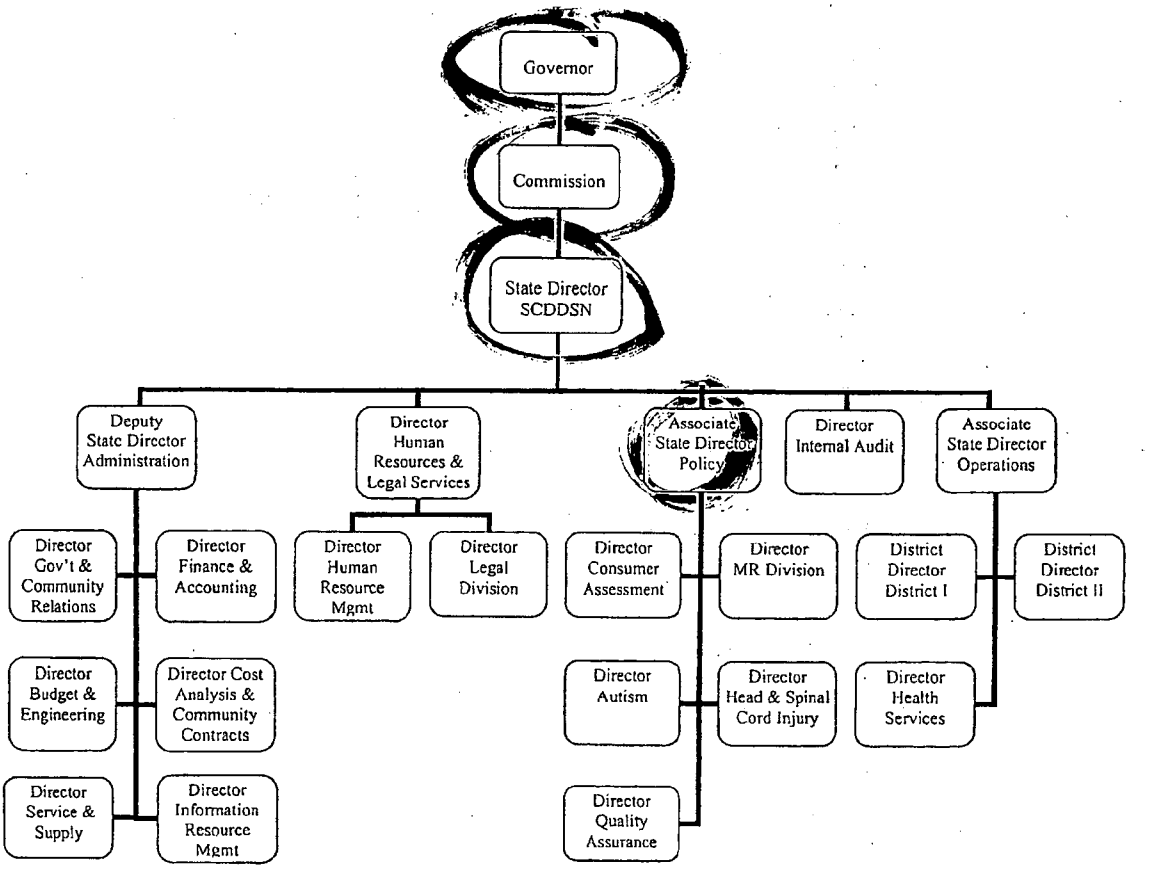
directly oversees the operations of these facilities, each of which is managed by a facility administrator.

DDSN provides services to the majority of eligible individuals in their home communities, through contracts with local service-provider agencies. Most of these agencies are called Disabilities and Special Needs (DSN) Boards, serve every county in South Carolina and are the local, single point of entry into the State's organized disability service delivery system.

Local Disabilities and Special Needs (DSN) Boards are created by state statute and county ordinance. While they are not local state agencies with state employees, they are public entities, governmental bodies in nature and combine the best aspects of public and private organizations. DSN boards provide a consistent level of services statewide; yet encourage local initiative, volunteerism and pride in service delivery. Local flavor and community preferences are present, yet services are provided at a consistent level of quality statewide.

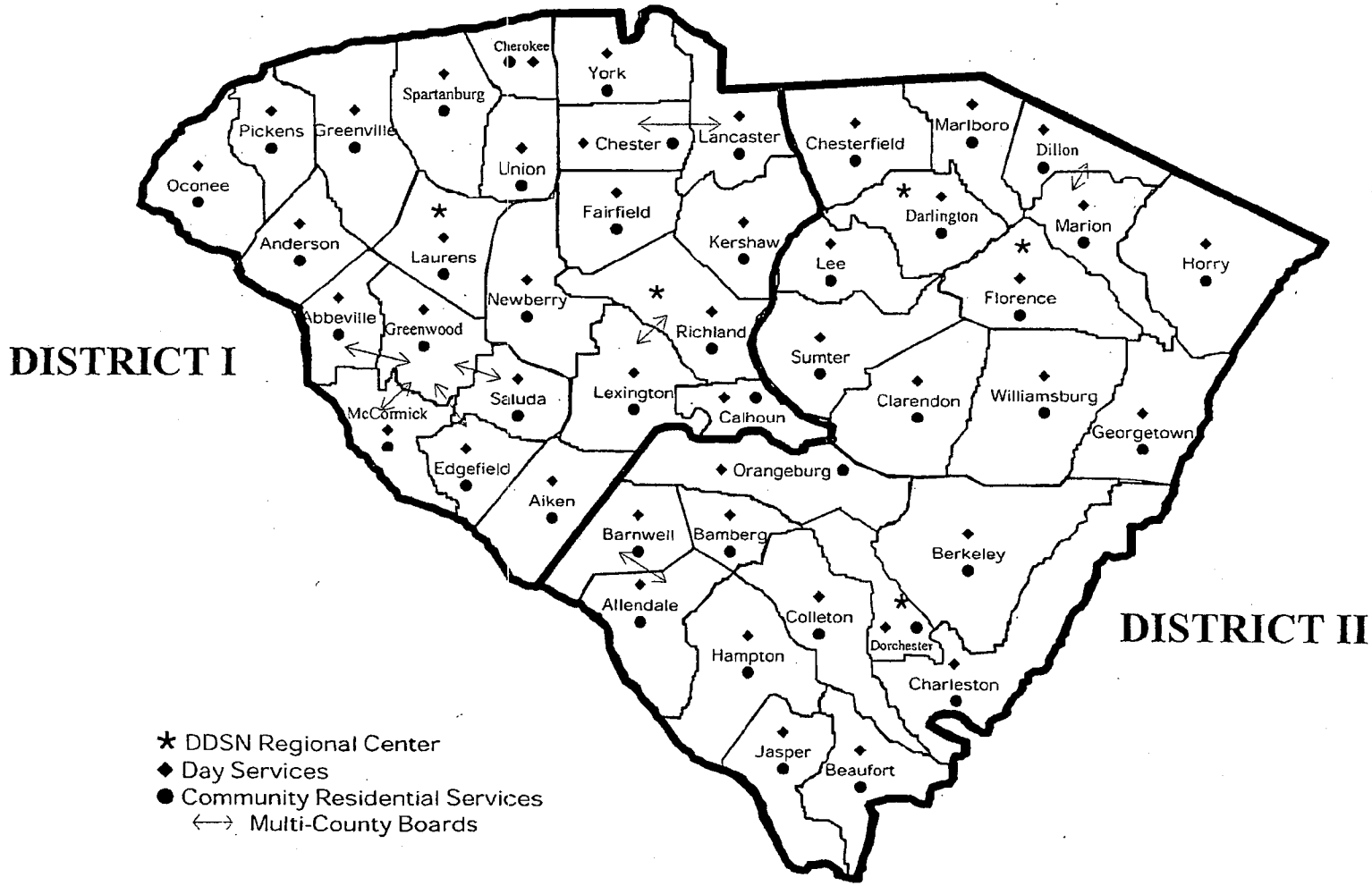
Consumers and family members play a critical role in the service delivery system and in evaluating the effectiveness of that system. Each DSN Board and regional residential center is required to have a documented process for consumers and families to participate as advocates for service recipients and to review and monitor services that are rendered. Consumers and family members participate in customer satisfaction surveys and face-to-face interviews to measure quality and responsiveness of services. This information is utilized in policy development and planning of service delivery.

SC Department of Disabilities & Special Needs
Organizational Chart



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SC Department of Disabilities and Special Needs
DDSN Service Delivery



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Category 1: Leadership

1.1-.2 Senior leadership direction; Focus on customers: Dr. Stan Butkus is the State Director of the S.C. Department of Disabilities & Special Needs. Under his leadership, beginning in 1998 the Department has been on the cutting edge of developing and implementing a statewide service model that relies on consumer choice and consumer satisfaction based on a person-centered needs assessment and personal outcomes review system. A variety of techniques helped shift the organized statewide service delivery system to a person-centered system from a program-centered system. Information on the new concept of service delivery was mailed statewide to all consumers, many potential consumers and a vast network of provider groups and advocacy organizations. Consumers and family members were invited to attend regional informational meetings to learn about person-centered services and give input. The state director established on going work groups to develop new processes and tools. All stakeholders were represented as well as cross-functional staff representation.

Senior leaders actively promote open communication throughout the organization. Cross-functional committees are utilized to develop agency plans and strategies. These committees consist of staff with programmatic skills as well as staff that are skilled in fiscal matters. This cross-functional staffing provides for a thorough review of all issues involved in establishing or changing agency wide policies. The State Director also established an Information Workgroup to bolster the agency's efforts in consumer and family education. Membership includes leaders of advocacy organizations, consumers, parents, provider organizations, executive directors and representatives from provider and DDSN program areas.

The agency head/executive team maintains open lines of communications with many different stakeholder groups to be aware of concerns and areas of needed improvement. The State Director and his executive staff meet regularly with consumers, various grassroots parent/advocacy groups - each with their own special interest, the leadership of provider organizations, and leaders from other state agencies. Discussions occur in both small and large groups, often in geographical "clusters". Personal involvement with each of the aforementioned groups allows for continuous and open exchange to identify and address necessary issues. The Department relies heavily on its consumers, service providers, parents and advocates for providing feedback on how well the services provided are meeting the needs of each consumer. The State Director is available to parents, individuals with disabilities, advocates, Board members, providers, elected officials-all the stakeholders. The State Director listens to their needs and wants, concerns, and feelings about how the agency is responding and performing.

The agency's executive leadership team is made up of individuals who have many years of experience in their respective fields of expertise. Top managers in the areas of fiscal and administration work together as do the managers of the various disability divisions and community services to set goals and accomplish objectives that improve the lives of DDSN's consumers. Policy and day-to-day operation managers coordinate regularly. Short term and long term goals are set to provide direction for the agency. Technical training, one-on-one communication, and workgroups are used to disseminate the goals and directions to agency staff. The Department utilizes staff development opportunities to stress team-building concepts and to train employees and service provider employees on mediation techniques. Each member of the executive team takes a "hands on" approach to leadership. The Department intentionally has minimal layers of middle management so senior leaders are aware of needs as they arise and are able to quickly develop solutions. Executive staff members remain involved until goals are met and issues are resolved. Direction and performance expectations are communicated in a variety of ways. The state director and his executive staff work together as a team to communicate to

agency staff at all levels areas of need/improvement, new direction of emphasis and performance expectations. Willing to make the tough decisions, the State Director led his staff through the necessary process of taking unpopular but prudent actions to manage anticipated state budget cuts. Administrative reductions continued while protecting the essential functions of direct care and nursing. Over the past several years the agency has successfully implemented three RIF's and three Voluntary Separation Programs, an initiative that has now become a model for State Government. (See Graph 7.4-2)

Cross-functional committees and stakeholder workgroups are utilized. Consumer groups/advocacy organizations and provider leadership are kept informed through regular meetings. Special conferences or trainings are sponsored to focus on specific areas of emphasis.

1.3 **Maintaining fiscal, legal, and regulatory accountability:** DDSN uses a contracting mechanism to ensure fiscal, legal and regulatory accountability. For all program areas, providers agree to follow policy and standards established by DDSN, other state agencies, and the federal government, where appropriate. In some cases this oversight extends to actual licensing of programs. For other programs licensed by other state agencies, DDSN provides day-to-day oversight. Providers have external audits; DDSN reviews these and other financial records and initiates audits as appropriate, in both fiscal and program areas. Quality assurance practices monitor and ensure quality of services and strict compliance with standards. If DDSN determines that a provider cannot maintain the requirements under contract, it can seek another provider or take over operations itself.

1.4 **Key performance measures:** Assessment of functions is ongoing to ensure resources are directed to priority areas. This assessment along with a required review of non-direct care position vacancies guides how DDSN organizes, targets funds and evaluates performance. DDSN's reorganization streamlined processes, centralized certain functions and improved utilization of administrative staff. (See Graph 7.2-7 and Graph 7.4-3) Critical placements, residential waiting lists, day service waiting lists, waiver service waiting lists, service vacancies, expenditures, utilization of Medicaid funds, critical incidents and the agency's staff-to-consumer ratio are key performance measures that are reviewed regularly. (See Graph 7.3-2, Graph 7.1-5, Graph 7.1-6, and Graph 7.4-1 and Graph 7.5-5) Leadership actively promotes the health, safety and well being of the consumers DDSN serves, as well as the dignity and respect for these individuals and their families.

1.5 **Performance review/feedback:** All levels of the organization contribute to decision making processes and setting performance goals. Employees are empowered with the knowledge that their input and role in the whole process is necessary to fulfill the agency's mission. Agency leaders consistently encourage open communication with employees and have an "open door" style, hold open staff meetings, and provide access to the agency's extranet.

Executive team members lead internal agency committees which make decisions and provide oversight. These committees cover areas of service development, organizational and system responsiveness and funding. Committees meet regularly to identify and address areas of need, potential barriers and opportunities. Employee feedback and participation are relied upon to determine the effectiveness of leadership throughout the organization.

1.6 **Impact on the public**: The State Director and his executive staff meet directly with the Governor's office and members of the General Assembly and their staff to discuss the potential impact of the Department's programs, services, facilities and operations and the associated risks of each. These meetings and shared perspectives guide our focus and improve responsiveness to consumers of services and taxpaying citizens alike. The State Director maintains a good reputation and is known to work with legislators to prevent problems, provide information and

find solutions. Legislators find the State Director accessible and approach him directly to discuss an issue or seek his assistance.
The office of community education monitors and responds to public inquiries and keeps the media and general public informed about the agency's mission, needs of consumers and direct impact of change in public policies. Examples of this are HIPAA, the Atkins Supreme Court decision, state budget reductions and waiting lists. The organization addresses the current and potential impact including the associated risks by meeting its strategic goals and objectives.

1.7 **Priorities for improvement:** Key priorities are communicated in a variety of ways. The planning process used to carry out the agency's mission is a continuous process. It is primarily concerned with developing organizational objectives, forecasting the environment in which objectives are to be accomplished and determining the approach in which they are to be accomplished. To be successful, planning requires an analysis of data from the past, decisions in the present, and an evaluation of the future.

Agency leadership is active in professional organizations at the state, regional and national levels. Up-to-date knowledge of state-of-the-art practices, trends and approaches used by other states is shared throughout all levels of the organization and is used to enhance and improve South Carolina's system. Information is incorporated into training opportunities for front line staff and managers alike.

The state director and his executive staff meet directly with the Governor's Office staff, members of the General Assembly and their staffs to keep them informed. The agency's executive leadership works together as a team to communicate and disseminate the objectives and directions to agency staff. DDSN has assisted disability and special needs boards in developing strategic quality enhancement plans using the organizational performance review system. This approach is being used statewide to train local boards on how to develop strategic organization goals in order to improve their performance.

1.8 **Strengthening the community:** DDSN is actively involved in community outreach. Agency leaders encourage staff participation in community events and set the example by their own community involvement. Senior leadership as well as other DDSN staff is actively involved in civic organizations, professional organizations, and community and statewide charities. Staff members at all levels participate in and promote various community efforts including the United Way, Community Health Charities of South Carolina, foster care program, Red Cross blood drive, Special Olympics, Families Helping Families, Palmetto Place Children's Emergency Shelter, Palmetto Health Children's Hospital, the Mayor's Committee on Employment for People with Disabilities, Health South's Spinal Cord Injury Peer Support Group, Spinal Cord Injury Association of South Carolina and Limitless Sports, an organization dedicated to provide recreational and athletic events for people with physical disabilities. A high level of importance is placed on community involvement for all DDSN employees through planned on-site activities and off-site participation during business hours. Individual community and professional involvement is encouraged and recognized.

Category 2: Strategic Planning

The planning process used to carry out the agency's mission is a continuous process. It is primarily concerned with developing organizational objectives, forecasting the environment in which objectives are to be accomplished and determining the approach in which they are to be accomplished. To be successful, planning requires an analysis of data from the past, decisions in the present, and an evaluation of the future.

2.1 **Strategic planning process:** The department's strategic planning sets the overall direction for the development of programs through a multi-year period for persons with autism, mental retardation and related disabilities, brain injuries, and spinal cord injuries in South Carolina. Planning is guided by direction from the Governor and the General Assembly, and by our customer's needs and preferences and how they want to be served. It also reflects the Department's responsiveness to national trends, to advocates who promote state-of-the-art services and to citizens who require sound stewardship of their tax dollars. This provides a framework to guide agency policy and actions in terms of how to organize, fund and evaluate outcomes of services.

Input from DDSN's Regional Centers and the local Disabilities and Special Needs, (DSN) Boards is integral to the process. Monthly meetings are held with key regional center staff to remain abreast of activities and needs at each center. These meetings provide input into various resource needs such as staffing, operating budget, permanent improvement needs and quality of consumer care. The local DSN Boards provide input to DDSN through several functional committees. These committees are made up of leadership from the DSN Boards, as well as key DDSN staff. The committees provide input and direction on numerous items ranging from contractual compliance to quality of services. Each Center and Board conducts a facility assessment which outlines renovations, construction, or change in use of specific buildings in order to provide adequate and appropriate facilities to meet individual needs in a high quality setting. To determine services needed over a multi-year period, a review is done of current programs and services, the number of individuals served, underserved and unserved, and the new resources needed to meet the need.

The strategic planning process includes a multi-year analysis of operating budget needs and permanent improvement needs. These multi-year analyses encompass historical trends, regional center evaluations, key regional staff input, local community provider and consumer input. Once the analysis is refined the Department prepares its annual budget request for the Governor and General Assembly that includes both recurring and non-recurring items. Capital needs are stated in the Comprehensive Permanent Improvement Plan (CPIP), which is submitted to the Joint Bond Review Committee and the Budget and Control Board.

Cross-functional committees which include stakeholders are utilized in the development of agency-wide plans and strategies. When changes are being proposed which impact the way services are provided or funded, taskforces are utilized to ensure that all levels of the organization are represented. A broad range of individuals serve on these taskforces in order to obtain a full understanding of the issues involved.

As directed over many years by Governors' administrations and the General Assembly, DDSN has pursued an aggressive effort to have as many of the agency's services as possible covered by the federal government through Medicaid. DDSN has aggressively used Medicaid waivers to develop a flexible system of in-home supports and to expand their availability. South Carolina was the first state to be approved for a head and spinal cord injury Medicaid waiver. This has meant a reduced cost to the State to provide services to persons with lifelong disabilities. DDSN continues to maximize Medicaid revenue even as state appropriated funds have decreased due to budget reductions over the past several fiscal years. (See Graph 7.3-1)

DDSN works with consumers and their families to provide residential services in the most appropriate place and in the least restrictive environment. This philosophy of consumer choice also allows DDSN to provide residential services in a very cost efficient manner. (See Graph 7.3-2)

2.2 **Key strategic objectives:** (See Strategic Planning Chart)

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2.3 **Key Action Plans and Initiatives** (See Strategic Planning Chart)

2.4 **Developing and tracking action plans:** Customer satisfaction is a priority in DDSN's approach to planning and service delivery. All service providers throughout the state perform customer satisfaction assessments. The principle of continuous quality improvement guides DDSN in determining whether services and service providers are meeting consumer expectations. The policies, processes and procedures used by service providers are reviewed. Services are observed while being provided. Some consumers and family members receive a survey by mail to learn how satisfied they are with the services received. Other consumers and family members participate in face-to-face interviews. The primary measure of quality is how the person with the disability and the family view the responsiveness of the services. This information is used along with regularly reviewed key performance measures to develop work plans.

DDSN undertakes specific measures to assure consumer health and safety, and to increase the quality of services and supports offered by its system of service providers: (a) traditional activities; (b) consumer–oriented activities; (c) quality assurance activities including – licensing, contractual compliance, personal outcomes measures, consumer satisfaction measures, policies, and internal audits.

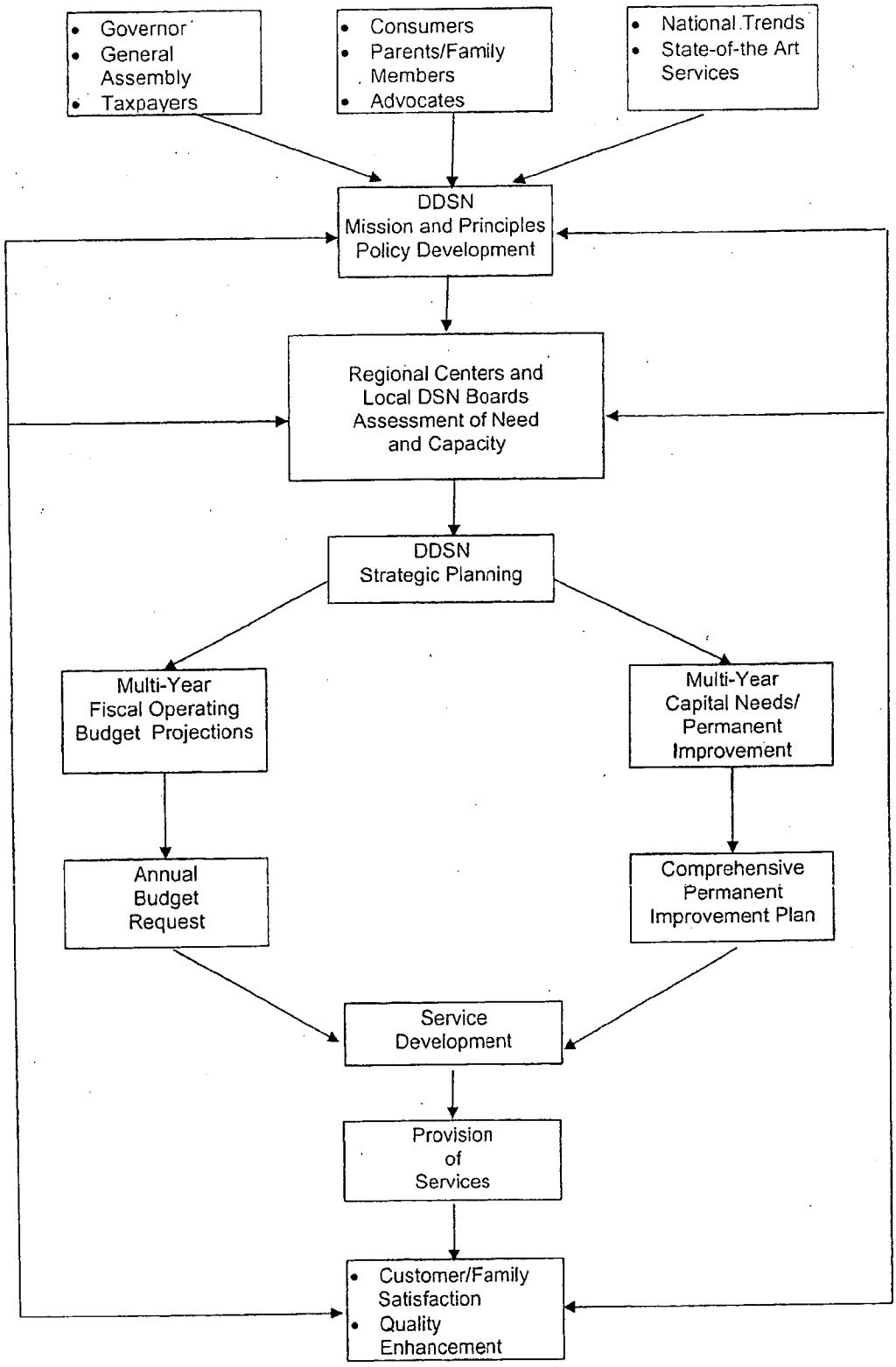
DDSN utilizes a customer driven approach. Needs, both met and unmet, are identified. System changes are planned to increase consumer and family satisfaction and increase service provider productivity and efficiency. Increases in efficiencies are redeployed to address unmet service needs. This approach increases accountability to the citizens of South Carolina.

2.5 **Communication and deployment:** Strategic objectives, action plans and performance measures are communicated in a variety of ways. The state director and his executive staff meet directly with the Governor's Office, members of the General Assembly and their staffs to keep them informed. The agency's executive leadership works together as a team to communicate and disseminate the objectives and directives to agency staff. Cross-functional committees and stakeholder workgroups are utilized. Consumer groups/advocacy organizations and provider leadership are kept informed through regular meetings.

2.6 **DDSN Strategic Plan:** http://www.state.sc.us/ddsn/mission/mission.htm

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S.C. Department of Disabilities and Special Needs
Planning Process



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Category 3: Customer Focus

3.1 **Key customers and stakeholders:** The key customers of DDSN are people with lifelong disabilities of mental retardation, related disabilities, autism, traumatic head injuries, spinal cord injuries, and similar disabilities. Other stakeholders include South Carolina citizens, community service provider organizations, the Governor's office, members of the General Assembly, families of the customers DDSN serves, advocates and advocacy organizations.

3.2 **Keeping current with changing customer/business needs:** The Department is governed by a seven member commission as set forth in 44-20-220, whose duties include educating the public and state and local officials as to the need for funding, development and coordination for services. The Code of Laws also clearly outlines those citizens of the state for whom DDSN is responsible for serving. DDSN has a single point of entry into its service delivery system through its network of local disabilities and special needs boards. The board assesses the needs of potential customers and either forwards an eligibility packet to DDSN's centralized eligibility team or refers the inquirer to an agency or provider that can address their needs. DDSN tailors a practical service plan for persons found to meet the DDSN eligibility criteria, the plan being a strategic method used to determine what are the requirements and needs of our primary customers. The plans are developed with the customer and the people most important to them. The focus is on the person and not what the system is able to provide. Consumers and their families are given a choice of qualified service provider, based on the amount of funding approved for them. Most individuals served by DDSN do not receive services from other state agencies. (See Graph 7.2-3)

Since 1992, DDSN-operated regional centers have continued to reduce the number of individuals served by 53%. At the same time, local community providers have increased their residential capacity by over 70%. This has allowed most individuals to remain in their local community, even when residential services are needed. (See Graph 7.1-3 and Graph 7.2-5)

The individualized planning process enables the department to identify and address both individual and uniform needs. DDSN's consumer data system allows the agency to keep current with the changing needs/demands of its customers. Agency leadership is active in professional organizations at the state, regional and national levels. Up-to-date knowledge of state-of-the-art practices, trends and approaches used by other states is shared throughout all levels of the organization and is used to enhance and improve South Carolina's system. Information is incorporated in training opportunities for front line staff and managers alike.

3.3 **Using feedback information from customers/stakeholders:** The numerous methods used to collect information result in three primary and responsive efforts, Discovery, Remediation and Systems Improvement. Discovery methods are tools for assessing performance of a process, program policy or provider. Remediation action is taken when the feedback informs the agency that immediate intervention or action is needed. Systems Improvement is the result of feedback that indicates patterns and trends that require systems revision, such as creating and implementing a revised policy initiative.

The most significant effort that has resulted from the information gathering process is the continued need to provide choice and control for the consumers. The agency continues to create systems that are based on choice and control, utilizing feedback from the consumers as the primary guiding influence. An example of this effort is the RFP sent out nationally for qualified providers. The department recognized that consumers wanted more choice in service providers and therefore initiated a process by which to recruit providers whose focus is on customer safety, choice, and quality.

DDSN's secondary customer group consists of the community service provider organizations. The agency contracts with these entities to deliver services directly to individuals with

disabilities and their families in their home communities. While the department requires the providers to meet specific standards and adhere to agency policy, DDSN works cooperatively to encourage contract compliance and quality. Provider representatives have on-going participation in the department's development of quality assurance/risk management processes and significant policy changes. They participated in planning and phasing in the capitated funding approach, which equalized payment for services for person with similar needs and the creation of a case management system that provides the highest level of services for the people with the highest level of need, minimizing unnecessary involvement with customers with minimal level of needs.

In the process of gathering information from the consumers and stakeholders, DDSN has revised processes and reallocated resources to address feedback. Two Regional Coordinators of Consumer and Family Affairs positions and a trending system have been created to ensure that systemic effects are known and addressed. Redistributions of workloads occurred in the policy area so that trending is utilized directly by policy writers. Efforts have been bolstered in Waiver, Service Coordination, Day Services, and Early Intervention to enhance the provision of Technical Assistance to those providing services, customers, and families.

3.4 **Measuring customer/stakeholder satisfaction:** DDSN contracts with two independent national quality assurance/quality improvement companies to conduct four different customer satisfaction surveys. (See Graph 7.1-1)

1. The first is a structured personal interview. Customers are observed in their daily environments and then interviewed using a reliable and valid interviewing tool and staff. If customers are unable to communicate, then a family member or other knowledgeable person is used as an informant. Approximately 5% of our customers are represented in this survey.

2. The second is a family satisfaction survey. There are three separate valid and reliable surveys that address: (1) a family with a disabled child in the home, (2) a family with a disabled adult in the home, and (3) a family with a disabled adult living in a DDSN residential program. These 3 surveys combined represent 16% of those currently receiving services.

3. The next satisfaction survey focuses on the customers' satisfaction with their annual planning meeting. This gives the Department essential information regarding how well the consumer's plan of service was developed and if there are any individual or systemic issues to be addressed.

4. Another DDSN effort to assess consumer satisfaction uses a personal outcome measurement system dedicated to ensuring that people with disabilities live within and contribute to their communities. Personal outcomes focus attention on what people supported by the system want from the services and supports they receive, guiding the system to provide what is desired and needed versus using a "cookie cutter" approach to service delivery.

5. Another measure of consumer satisfaction is conducted by community service provider organizations. Each service provider is required through DDSN contract to conduct its own consumer satisfaction survey annually and to use the data to improve organizational performance.

The surveys and personal interviews are designed to assist organizations/providers and the Department in using the information gathered to gain a better understanding of the priorities for customers and to integrate this information into local quality enhancement planning and efforts. For example, only 3.65% of the developmental disabilities population in South Carolina is placed in nursing facilities as compared with the National average of 6.58%. This effort continues to be reinforced since the consumer demand for nursing home services is extremely low and national efforts communicate that nursing home placement is inappropriate for younger people with developmental disabilities. (See Graph 7.2-6 and Graph 7.5-4)

Each of these systems provides feedback to the agency. Feedback is used to address potential policy needs, conduct regional conferences to offering technical assistance and training to individual providers and best utilization of resources.

3.5 **Building positive relationships with customers and stakeholders:** Many activities are ongoing to keep DDSN consumers, families and advocates informed. DDSN also has a full-time Director of Consumer and Family Empowerment whose primary responsibility includes developing positive relationships with consumers and their families. Publications including the Practical Guide to Services, Choosing a Caregiver and others in addition to our Person-Centered Services – A Guide to Consumers and Families, and the agency's website are kept updated and widely disseminated. DDSN has an Office of Community Education, which develops and produces materials to educate and assist consumers, family members and professionals.

The Department contracts with grassroots advocacy organizations to train, educate, and empower individuals with disabilities and their families. The Center for Disability Resources, USC, organizes and provides training meetings around the state on the concepts and practical application of South Carolina's person-centered service approach. They also work with local self-advocacy groups to ensure they understand their rights and roles in the service delivery system. Family Connections of S.C. works for families with children who have special needs. The Brain Injury Alliance of South Carolina educates through local support groups and the S.C. Spinal Cord Injury Association assists individuals through peer to peer counseling. The S.C. Autism Society works through its network of support groups to offer information, training and technical assistance.

DDSN participates regularly with the S.C. Partnership of Disability Organizations, a coalition of numerous statewide advocacy groups to provide updated information and listen and respond to concerns about services and budget matters. Regular meetings are held with regional center parents once per quarter on Saturdays to update them on current/anticipated issues of interest to them and address concerns they raise.

An "Information Workgroup" has convened for the focused purpose of providing accessible information to our primary customers. Information for communication ranges from who is eligible for services, how one goes about the intake/assessment process, to who are the providers of services, etc. The workgroup consists of leaders from the various advocacy groups, executive directors and staff of provider agencies, consumers of services, family members and departmental staff members who act as a representative for their particular constituency, contributing to an inclusive perspective. The Director of Government and Community Relations chairs the workgroup.

To help meet the specialized needs of people with disabilities, regular meetings are held with key members of the Governor's staff and key legislative leaders and their staffs on funding and policy issues. This significant amount of involvement keeps the Governor and Legislators current on our customer's needs and our progress to meet those needs so that they have complete information regarding current status and future goals and related constraints.

Category 4: Information and Analysis

4.1 **Determination of measures:** DDSN's performance measurement system is multi-faceted and comprehensive. The first order of business is to protect, assure, and improve the health, safety, and welfare of our primary customers. The second priority is to provide services that can help consumers' achieve their unique needs, desires and goals. The service delivery approach used is innovative and state-of-the art and is often referred to as "person-centered." The effectiveness of this approach is measured in many different ways. To meet the highest standards of health and safety at all times, consumer services in terms of quality, efficiency, effectiveness, outcome, and very importantly, consumer and their families' satisfaction are continually evaluated.

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PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection & Advocacy System for South Carolina

October 27, 2005

Dear Elected Officials and Citizens of South Carolina:

South Carolina cannot wait to improve the protection of its most vulnerable citizens: persons with disabilities who reside in facilities across the state. The enclosed report, *Unequal Justice for South Carolinians with Disabilities: Abuse and Neglect Investigations*, clearly shows the need for an independent system within criminal justice to investigate ongoing abuse, neglect, and exploitation.

For many years, investigations of abuse, neglect, and exploitation have been entrusted to state agencies, particularly the Department of Disabilities and Special Needs, and organizations with whom they contract. These entities are failing to protect the individuals with disabilities whom they are charged to serve. As you will learn from the report, we cannot continue to excuse the current system by saying that incidents of abuse, neglect, and exploitation are infrequent or trivial or that incidents are being adequately investigated. This is clearly not the case.

This report includes one homicide, two deaths from choking[1], physical injuries with excruciating pain, and other shocking examples of abuse and neglect. The injured individuals include people who are non-verbal and unable to tell their own stories. This report sets out some of the stories from a sample population. Based on the cases we have reviewed, we believe that procedures for preventing and investigating the abuse and neglect of individuals with disabilities are totally inadequate. The State's "out of sight, out of mind" inadequate response must end now.

A major problem identified by this report is that agencies investigate themselves, with little external oversight. Law enforcement is rarely contacted. Agencies use their own standards rather than following the state's comprehensive Omnibus Adult Protection Act, which was designed to protect vulnerable adults. Investigators in provider agencies and local law enforcement lack expertise in the abuse and neglect of people with disabilities. While the process for investigating abuse and neglect of vulnerable adults is often described as a system, in fact there is no system at all.

Protection and Advocacy for People with Disabilities, Inc. (P&A) calls on the Governor, Lieutenant Governor, and members of the General Assembly to move this issue to the top of the agenda for action this year. P&A also asks the media to assure that this disgrace is in the public

[1] The choking death mentioned in the September 13, 2005 Wall Street Journal is not included in this report.

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eye until addressed. Investigation of abuse and neglect can no longer be left to be handled by the service providers themselves.

Since we completed the review, a member of the press contacted me about an August 2005 death of a middle-aged person residing in a group home. The staff on duty documented that during the shift ending at 11:30 p.m. the resident was making "girgling" (sic) sounds in his chest. Rather than contacting medical personnel, the resident was simply placed on fifteen minute checks. On the following shift, another staff person found the resident unresponsive and contacted administrators before contacting medical personnel. It appears that there was an additional delay of approximately an hour before 911 was called. When paramedics arrived they determined that the resident was dead; a coroner's report is pending.

Some of South Carolina's most vulnerable citizens are needlessly suffering, even dying. They will continue to do so until South Carolina has the will, backed by the funds, to protect persons with disabilities by demanding an effective, independent investigation system to address these often criminal activities. Those least able to speak for themselves deserve no less.



P&A knows that elected officials, family members, the media, and other concerned citizens care about the very vulnerable people who reside in group homes, residential facilities, and long-term care institutions. The data in this report offers the necessary information to begin making desperately needed changes. We are ready to assist in this process and await the opportunity to explore the next steps with all interested parties.

Thank you for your immediate attention to this unequal justice for South Carolinians with disabilities.

Very truly yours,

Gloria M. Prevost

Gloria M. Prevost
Executive Director

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PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection and Advocacy System for South Carolina

Unequal Justice

For

South Carolinians with Disabilities:

Abuse and Neglect Investigations

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Prepared by:
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October 2005

Mims 0286

EXECUTIVE SUMMARY

Physical Abuse. Sexual Abuse. Neglect. Misuse of medications. Few incidents are reported. Fewer are properly investigated. Rarely are offenders held accountable. Those who should protect people with disabilities often fail to do so. The State's response is a fragmented collection of agencies lacking the expertise to properly investigate allegations of abuse, neglect, and exploitation of vulnerable adults. It is a collective failure that needs to become a system.

Recent media reports have disclosed extensive problems with the entities that investigate possible abuse, neglect and exploitation of vulnerable adults. The focus of these reports has been on vulnerable adults who receive services from the South Carolina Department of Disabilities and Special Needs (DDSN) or contract providers.[1] At the request of Protection and Advocacy for People with Disabilities, Inc. (P&A) a study was conducted of the entities responsible for investigating and prosecuting abuse, neglect and exploitation. P&A requested and obtained 50 cases of alleged abuse and neglect which represented a variety of programs and environments and which had taken place over a period of approximately two years. Of the cases reviewed, 18 were selected for inclusion in this report because they illustrate the issues that arose from fragmentation.

[1] The South Carolina Department of Disabilities and Special Needs (DDSN) is the state agency with the primary responsibility for serving individuals with developmental and related disabilities, including autism. S.C. Code Ann. §§ 44-20-10 et seq. DDSN provides these services through five regional centers (Whitten, Coastal, Midlands, Saleeby, and Pee Dee), through contracts with county Boards of Disabilities and Special Needs, S.C. Code Ann. §§ 44-20-375 et seq., and contracts with large private providers (Charles Lea Center, Emerald Center, and Babcock Center). Most individuals receiving residential services from DDSN are served by a county board or contract provider. DDSN exercises little control over the delivery of services by boards or contract providers. The DDSN system is highly fragmented; availability and quality of services vary widely across the state.

This report provides an in-depth review of the entities that respond, or fail to respond, to allegations of abuse, neglect and exploitation. Focus was placed upon compliance with South Carolina's Omnibus Adult Protection Act (S.C. Code Ann. §§ 43-35-5 et seq. (OAPA)), internal policies and procedures of DDSN, and the quality of the investigative responses. This report also addresses issues raised by several cases in which allegations of abuse and neglect were not reported or investigated by the appropriate body. Several allegations of abuse and neglect of P&A clients who were not directly served by DDSN were also included in the cases screened. In every instance, the investigative reports were reviewed with attention paid to the fundamentals of a quality investigation.

- Did it determine what happened?
- How did it happen?
- And, if appropriate, who did it?

The ultimate goal must be to protect the victim and, if appropriate, hold the offender accountable. The review of cases determined that in a vast majority, abuse and neglect occurred. In other cases staff may have violated polices, procedures or quality of care standards that did not reach the level of abuse and neglect.

Key issues and possible remedies were identified upon completion of the review of the cases. Overall, it was apparent that the current fragmented approach does not serve vulnerable adults well and may even place them at risk of further abuse and neglect. The response by the numerous state agencies that have some responsibility to protect vulnerable adults, investigate allegations, or provide oversight of the investigative process is cumbersome and uncoordinated. The major agency involved with these issues, DDSN, has created policies and procedures that are inadequate in some places and not followed in others. Other agencies responsible for

conducting investigations or reviewing those done by DDSN or contract providers have not exercised their responsibility effectively. In summary, immediate attention by policymakers as well as those directly responsible for the protection of vulnerable adults in South Carolina is required. The conduct of investigations by those who are responsible for the care of the victims is an inherent conflict of interest and must be changed.

The specific findings and recommendations are as follows:

FINDINGS

1. Reporting often is delayed, or in some cases non-existent. Delays in reporting present serious problems with evidence preservation and victim protection.
2. Investigations are viewed from an administrative perspective and are conducted by administrators. They seem to focus on whether or not policies and procedures were followed with little effort made to refer to law enforcement. It did not appear that sufficient effort is being made by the Long Term Care Ombudsman to review reports and make a referral for a criminal investigation when the facts support that action or to require additional effort by DDSN to address substandard investigative reports.
3. Inconsistent definitional foundations impede investigation. OAPA contains the definitions that determine the elements of abuse and neglect. DDSN has developed a set of definitions to be used in investigations that do not adhere to the ones set forth in OAPA. These discrepancies lead to confusion and often lead to conclusions not consistent with the governing statute.
4. Investigations conducted by contract agencies were seriously flawed. In one case reviewed, there was a failure to properly investigate a case of sexual abuse as well as a failure to protect the victim from further harm.

5. DDSN's documentation procedures are confusing in that DDSN does not appear to mandate their use by facilities and the forms lack sufficient information for the conduct of a criminal investigation.
6. Cases reported to law enforcement do not always receive the necessary investigative effort.
7. Cases referred to the local solicitor for review were, in almost every case, not prosecuted.
8. No single oversight process ensures that cases are screened for possible criminal behavior and that the investigative process meets a minimum standard.

RECOMMENDATIONS

1. Establishment of a state-level investigative entity within the criminal justice system, i.e. SLED, and outside of any agency providing services to vulnerable adults, with responsibility for all reports of abuse involving vulnerable adults in facilities.
2. No longer permit agencies and their contractors to investigate allegations of abuse and neglect within their facilities.
3. Establish separate policies and procedures for administrative/quality control investigations after determining that no criminal abuse or neglect took place.
4. Develop and present adequate training to criminal justice professionals charged with the responsibility of investigating and prosecuting abuse and neglect.
5. Review all agency (DDSN, contractor, and Long Term Care Ombudsman) policies and procedures to insure that they conform to all the provisions of OAPA, including definitions.

It is imperative that corrective action be taken as the current system does little to provide the appropriate protection to some of our most vulnerable citizens.

INTRODUCTION

In response to ongoing concerns about the quality of investigations of allegations of abuse, neglect and exploitation, Protection and Advocacy for People with Disabilities, Inc. (P&A) initiated a study of the investigative process. P&A is the federally and state mandated protection and advocacy system for South Carolina. It was established in 1977 by state law, S.C. Code Ann. 43-33-310 et seq., to protect the rights of people with disabilities. Each year P&A serves thousands of South Carolinians with disabilities who have been abused, neglected or denied access to services. P&A has broad authority under state and federal law to advocate for the rights of individuals with disabilities in this state and to investigate allegations of abuse and neglect when such incidents are reported to them or when they determine that there is probable cause that abuse and neglect occurred.

This report examines the South Carolina investigatory process using cases provided by P&A, reviews the Directives of the South Carolina Department of Disabilities and Special Needs (DDSN), and evaluates the involvement of other investigative entities such as the Long Term Care Ombudsman. The cases were reviewed for compliance with the statutes, quality of the investigation, and outcomes. Every attempt has been made not to single out a particular agency, location or program. While the focus of this report is primarily on those adults served by DDSN and represented by P&A in the following environments, it is important to note that similar problems exist with the investigation of abuse and neglect of children with disabilities and adults with mental illness.

- Intermediate Care Facilities for the Mentally Retarded (ICF/MR) provide 24-hour care, supervision, counseling, recreation and other activities to individuals with mental retardation. These facilities are located on large campuses or are home-like

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and located in residential neighborhoods. Each facility has four to sixteen residents. These facilities are licensed by the Department of Health and Environmental Control (DHEC).

- Community Training Homes (CTH I and II) are located in residential communities and offer a homelike environment under the supervision of qualified and trained caregivers who provide personalized care, supervision and individualized training to no more than four persons. CTH I homes are operated by trained private citizens. CTH II homes are owned or rented and operated by a provider organization. These homes are licensed by DDSN.
- Community Residential Care Facilities (CRCF) are homes that offer room and board and a degree of personal care to individuals on a continuous basis. These homes are licensed by DHEC.

The investigation of possible abuse, neglect, and exploitation of vulnerable adults is a complex task. There are issues with reporting, determining what constitutes abuse, and conducting a quality investigation. Failure to properly identify, report, and investigate possible cases of abuse, neglect and exploitation can result in further harm to our most vulnerable population.

The South Carolina framework for conducting effective investigations, protecting the victim from further harm and ultimately holding an offender accountable is found in the Omnibus Adult Protection Act (OAPA).[2] Using the OAPA framework, this report addresses the legal environment for conducting investigations, policies and procedures utilized by DDSN, and case data to make recommendations for improving the system. This report is not intended to

[2] The Omnibus Adult Protection Act, S.C. Code Ann. §§ 43-35-5 et seq. The Act was passed in 1993 with the goal of improving prevention, reporting, and investigation of abuse, neglect, and exploitation of vulnerable adults.

furnish specific solutions to any particular agency, nor is it intended to criticize any particular agency or facility. Many quality investigations were included in the review. These examples provide a standard by which improvements can be made. It is also not the intent of this report to address quality management issues affecting client care. The intent is to present those recommendations that will address systemic problems documented in this report. Many of the findings and recommendations contained in this report are applicable to any system of facilities providing care and services to any vulnerable individuals, including adults with mental illness and children with disabilities and adults with mental illness.. Addressing the issue of abuse, neglect and exploitation in an effective manner will lead to quality of care outcomes that enhance the lives of vulnerable adults in our state.

THE PROBLEM IN PERSPECTIVE

In a report prepared by Protection and Advocacy, Inc. of California,[3] it is estimated that people with disabilities are at least four times more likely to be victimized than people without disabilities. Individuals with intellectual impairments are at the highest risk. Of greatest concern are the studies that show people with disabilities are more likely to experience severe abuse of longer duration and to suffer multiple episodes perpetrated by multiple suspects. Most of these incidents go unreported. It is estimated that 80-85% of incidents of criminal abuse and neglect in facilities never reach the proper authorities. Studies also show an extremely low rate of prosecution and conviction.

According to the report, many factors contribute to this problem. Studies suggest that victims have:

- Cognitive deficits which may make it difficult for them to recognize unlawful activity or know their rights to safety and protection;
- Dependence on others for activities of daily living and personal care;
- Presence of communication or physical impairments which limit their ability to verbally or physically defend against a perpetrator and disclose abuse;
- Lack of training in sex education;
- Lack of experience and socialization which encourages compliance rather than self-advocacy;

[3] Protection and Advocacy, Inc.; Tarjan Center for Developmental Disabilities at UCLA; University Affiliated Program; and the State Council on Developmental Disabilities. (2003). *Abuse and Neglect of Adults with Developmental Disabilities: A Public Health Priority for the State of California.* Protection and Advocacy, Inc., California (7019.01). http://www.pai-ca.org/pubs/701901.pdf.

- Fear of retribution from the perpetrator if they do report or fear that they will have to move from their home as a solution to the abuse.

It is important to note that most often these individuals are abused by the very persons who provide care and often by those whom they know and trust. The California report also discusses the problem of late reporting to law enforcement and law enforcement not receiving any reports. These incidents are initially reported to administrators and either are never referred to law enforcement or referred too late to preserve critical evidence. However, even early reporting to law enforcement could be ineffective because law enforcement personnel and prosecutors receive little or no training in working with victims with disabilities and do not have the necessary expertise to properly investigate.

The following quote addresses the key problems associated with the entire system of investigating incidents of abuse involving people with developmental disabilities:

> "It is notable that very few situations involving potential victims from the general population permit potential criminal conduct to be investigated initially by administrative agencies, as is the case with victims with developmental disabilities. This represents a separate and unequal system of justice for crime victims with developmental disabilities." (Protection and Advocacy, Inc., et al., p. 19)

The fact that these incidents are most often viewed as issues of policy and procedure and not viewed as violations of the criminal statutes is a significant impediment to holding offenders accountable. It is also an inherent conflict of interest for those who are responsible for the care of the victims to be responsible for the conduct of the investigation. It is an organizational structure rife with potential issues of organizational conflict.

THE INVESTIGATIVE ENVIRONMENT

The investigative environment in South Carolina is fragmented with varying legal mandates and agencies responsible for their implementation. The agencies that have some form of jurisdiction over allegations of abuse and neglect of vulnerable adults served by DDSN or other state agencies are:

- Local law enforcement (there are over 260 law enforcement agencies in South Carolina)
- State Law Enforcement Division (SLED)
- Department of Health and Environmental Control (DHEC)
- Department of Social Services (DSS)
- Long Term Care Ombudsman (Lieutenant Governor's Office on Aging, LTCO)
- Department of Health and Human Services (DHHS)
- Attorney General's Office, Medicaid Fraud Control Unit (MFCU)
- Department of Mental Health Public Safety (DMHPS)
- Department of Disability and Special Needs and contract agencies (DDSN)
- Centers for Medicare and Medicaid Services (United States Department of Health and Human Services, CMS)
- Department of Labor, Licensing, and Regulation (LLR)
- Various state licensing boards

These agencies may exercise regulatory authority, focus on criminal investigations, or a combination of the two. A number of agencies must adhere to both state statutes and regulations and federal statutes and regulations with respect to their authority. Any single investigation may have one or more of the agencies involved with little or no coordination and no central

management system to insure the best possible results for the victim are achieved. Additionally, there is no common data collection system that allows for shared access and assists in oversight of the quality of the process. Reporting requirements can be difficult, subject to interpretation and sometimes easily avoided. Adding to this complicated process is the existence of Memoranda of Agreement (MOA) that further delegate responsibility.[4] For instance, the MOA between the LTCO program and DDSN allows DDSN and its contractors to conduct their own internal investigations with the results reviewed by the LTCO. In practice, this is a conflict of interest that results in a system of cursory reviews of investigations with little follow-up or few challenges to the results. A copy of the MOA can be found in Appendix D.

Certain investigative standards apply to every potential incident of abuse, neglect, or exploitation. All investigations depend on gathering information in three critical areas: physical evidence, witnesses, and confessions. To be successfully prosecuted, a case must have two of the three. The initial focus must be on what happened and how it happened, ultimately leading to who did it, if appropriate. The information gathered must establish a legal basis for determining whether or not a particular incident can be characterized as abuse, neglect or exploitation. This legal basis turns on specific definitions of prohibited conduct. In other words, does the information establish all the elements of the crime? While not all cases will be criminal, not all criminal cases will be prosecuted. This standard of establishing the elements of the crime is absolute.

In South Carolina, the OAPA provides specific definitions (see Appendix A). The OAPA definitions were deliberately designed to include all the legal elements for prohibited behavior. The intent of this statute is to provide a common set of definitions for all those who

[4] These memoranda are permitted by the OAPA, section 43-35-15(A). Policies and procedures that interfere with the OAPA reporting requirements are not authorized, section 43-35-25(E). DSS was removed from the MOA in 2005.

have a role in the adult protection system and avoid varying definitions of abuse, neglect, and exploitation depending upon which agency or function drafted the definition.

Every investigation should be structured to address the elements in the OAPA in reaching a determination as to whether or not abuse, neglect or exploitation took place. It is absolutely critical that investigative entities speak the same language. To develop additional definitions that depart from the OAPA for use in investigations can only lead to confusion and gaps in the process of holding an offender accountable. Moreover, an investigator who is not very familiar with the OAPA elements will encounter difficulty in identifying abuse and neglect and gathering facts that support these elements. It is also important to gather and record facts and present the results of an investigation pursuant to a standardized system. Finally, the selection and training of investigators is the foundation of a responsive system.

During the case reviews, it became apparent that DDSN has developed definitions of abuse, neglect and exploitation that differ from those contained in OAPA. DDSN's definitions contain some of the language used in the statute, but also include definitions of abuse not addressed in the statute. Many of the definitions used by DDSN appear to be "quality of care" issues, which should not be used in the initial investigation. These discrepancies pose serious problems for an investigator whose initial goal is to determine what constitutes abuse and if it meets the initial requirement for a criminal investigation. While quality of care issues are important, they should be addressed separately and only after a determination that a specific incident was not the result of criminal activity.

Appendix A provides a comparison of the statutory definitions contained in OAPA and those outlined in DDSN Directive 534-02, Procedures for Reporting, Investigating, and

Preventing Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency (revised March 2004). Some specific examples are:

- Exploitation-the definition used by DDSN does not parallel the language in the definitions section of OAPA;
- Neglect-the DDSN definition does not contain many of the elements found in OAPA;
- Physical Abuse-the DDSN definition provides additional acts not addressed in OAPA;
- Psychological Abuse-DDSN uses additional terms such as "Emotional," and "Mental" that are not included in OAPA;
- DDSN creates additional categories of abuse not found in OAPA such as "Verbal Abuse", "Sexual Abuse", "Threatened Abuse", and "Abuse".

Another legal issue raised by the case reviews was addressed in the United States Supreme Court in *Garrity v. New Jersey*, 385 U.S. 493 (1967). Under *Garrity*, information obtained during the course of an interview where the employee can be disciplined or terminated cannot be used in a subsequent criminal prosecution. Some of the interview forms used by DDSN indicate that disciplinary action can be taken against an employee under some form of "confidentiality" agreement. DDSN Directive 534-02 also states that employees are required to cooperate with an investigation and that failure to do so could result in disciplinary action, including termination and referral for prosecution. Such action by DDSN could create a *Garrity* situation rendering any statements against interest inadmissible in a criminal case. This risk raised by *Garrity* is especially great since non-law enforcement investigators are not required by *Miranda v Arizona*, 384 U.S. 436 (1966), to advise an individual of the right to remain silent and

to request an attorney, unless they are acting as an agent of law enforcement. Several of the cases reviewed clearly raise *Garrity* issues with statements taken by internal investigators that may not be available in a criminal prosecution. One included a clear confession by the perpetrator to an act of physical abuse. This individual was terminated but no referral was made to law enforcement.

Specific examples of these issues will be presented in this report with recommendations to improve the investigative response. However, those tasked with investigative responsibilities first must recognize the importance of these issues. The lack of a commonly accepted legal framework for determining abuse and neglect can have serious implications on outcomes. The critical issue may be the inherent conflict of interest in permitting agencies to conduct their own internal investigations. It is apparent that organizational pressures may put investigators in an untenable position and lead to conclusions that are not in the best interest of the victim.

POLICIES AND PROCEDURES

This report addresses the investigative process in three specific areas: reporting, investigating and follow-up. DDSN has a detailed directive for reporting and investigating abuse, neglect, and exploitation, directive 534-02-DD (March 31, 2004) *Procedures for Reporting, Investigating, and Preventing Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency.* Because DDSN or its designated provider agencies conduct the initial response to a reported incident, this report focuses on investigations conducted by DDSN or its contractor. However, additional documentation from follow-up investigations conducted by SLED, the Ombudsman or the Attorney General's Office (MFCU) were also included because DDSN and its contractors decide whether to report to another investigative entity based upon their initial investigation. Applicable excerpts from DDSN 534-02 are contained in Appendix E.

The DDSN policy does not conform to the requirement of the OAPA that all incidents that may be criminal in nature be reported to the appropriate criminal justice agency (local law enforcement, SLED or the Attorney General's Office). For example, the section of the directive that addresses reporting "serious physical injury" ignores the fact that any assault, whether there are visible injuries or not, is a criminal act. It is also difficult to understand why the number of victims plays a role in determining criminal behavior when the number of victims is not critical to defining criminal events.

Under the OAPA, a determination to report to law enforcement should be made by applying the elements of the definitions contained in the statute to the facts available to establish the reasonable suspicion that a criminal act took place. This determination is case specific and based upon the facts presented to an investigator. Failure to report in a timely manner very often

results in the loss of critical evidence. Several of the cases reviewed for this report should have been reported to law enforcement as the record strongly supported the fact that a criminal act took place. In other cases, late reporting to law enforcement compromised the ability to build a prosecutable case.

The section that addresses resident versus resident incidents is another issue requiring attention. OAPA excludes altercations or acts of abuse between vulnerable adults from its definition of physical abuse. The exclusion was intended to avoid the difficulty of determining criminal intent among a population group with limited cognitive abilities and to focus on abuse by providers. It does not prohibit criminal charges under other provisions of the South Carolina Code (Title 16), if appropriate.

These DDSN policies contain provisions that negatively impact the conduct of investigations. First, the section addressing the prosecution of substantiated cases states a requirement that has no basis in criminal law: "the seriousness... and nature of the injuries." (See Appendix E). It is only necessary to establish probable cause that a criminal act took place and that a suspect can be identified. Other limiting language only affords the agency an "out" for not referring cases to the appropriate investigative entity.

The second problem is the ability of specific facilities or contract providers to develop their own policies, creating a potential situation of conflict with existing DDSN policies and contributing to a lack of consistent procedures used in investigating allegations. The importance of consistent policies and procedures throughout the system cannot be overstated. Consistent policies ensure that all investigations conform to a single set of standards which can be reviewed for compliance with the goals of protecting the victim and holding the offender accountable.

Third, the section that allows DDSN's internal investigations, including DDSN contract provider investigations, to be accepted as the "official" investigation for the LTCO raises serious issues which will be addressed in the recommendations section.

It is important to note that the majority of cases reviewed for this project had little or no oversight exercised by other agencies unless they were specifically referred for investigation. We found no evidence found of any coordinated effort by DDSN, the LTCO or the AG to oversee the investigative process to determine if the cases are being reported to the appropriate entity, followed up on, and offenders held accountable. While OAPA does not contain any requirement for the Attorney General's Office to conduct investigations unless they are referred to them, some of the cases reviewed were referred to the AG and resulted in criminal prosecution. In fact, most of these cases could have been referred to local law enforcement or SLED with the same possible results. No entity has developed clear guidance as to which law enforcement agency should exercise jurisdiction or how law enforcement efforts should be coordinated.

CASE MATERIAL

Fifty cases were reviewed involving 54 victims. Some cases had more than one victim or the victim was named in more than one case. The investigations reviewed took place between 2003 and 2005. There were no specific guidelines for selection, except that the cases should not target one specific location or contract agency. The cases were from a variety of different locations and time periods and fairly represent a cross-section of possible abuse and neglect situations. The majority were allegations of physical abuse, followed by neglect. Many cases had more than one type of abuse or neglect. Personally identifiable information has been redacted to protect individuals' privacy.

It was difficult to determine the final outcome of many of the cases or establish which other investigative agencies may have been involved. While the number of cases reviewed does not provide a valid statistical sample, the selected cases do allow an evaluation of the investigative process at both DDSN facilities and one contract provider. Some of these cases were investigated in a very thorough manner and met the investigative standard for determining whether a criminal event took place. Others were incomplete or inadequate. The cases presented in this report illustrate the issues addressed in the report.

Appendix B lists each case by type of abuse, whom the abuse was reported to, and the results of the investigation. Personally identifiable information was redacted to protect the individuals' privacy. The breakdown by type of cases reviewed is summarized in the following chart:

TYPE OF ABUSE	TOTAL NUMBER OF CASES
Physical Abuse	28
Sexual Abuse	5
Psychological Abuse	2
Neglect	10
Exploitation	1
Unexplained Injury	1
Homicide	1
Death	9

Below is a brief summary of some of the cases reviewed. In each case P&A asked the facility where the abuse or neglect occurred to provide its investigative file. These files were extremely inconsistent in their content and format, making comparisons of investigations and results very difficult.

PHYSICAL ABUSE CASES:

CASE 001

Allegations: It was alleged that five victims were each physically abused in different ways by four staff members. These acts, which took place over a two week period, involved putting a victim in a cold shower, assault with a belt, slapping and choking, and assault with a

chair. After these incidents were reported by another staff member, an internal investigation was initiated along with a report to the LTCO and Attorney General's Office. One of the perpetrators attempted to obstruct the investigation by making a phone call to the investigator claiming that he was the staff member that made the initial complaint and stated he "made this up". The actual complainant was sitting in the investigator's office at the time this call was received. The employees were terminated. The report furnished by DDSN indicates that the Attorney General's Office conducted a follow-up investigation and may have charged one of the individuals. The record also reflects that DSS may have conducted an investigation as well. The record is incomplete because there is no documentation of any criminal charges filed, interviews with possible victims, or the reasons why possible victims were not interviewed.

Issues: This case should have been conducted as a criminal investigation from the beginning. It contains essential facts that would lead a reasonable person to believe that several assaults had taken place and that the suspect(s) could be identified and should have been immediately reported to law enforcement. The fact that the case was also referred to DSS demonstrates the fragmented way in which incidents are investigated.



CASE 002

Allegation: An anonymous letter was received by an administrator alleging that a staff member gave six victims suppositories (rectal) taken from a nurse's station. The internal investigation determined that the suspect inserted these suppositories as a form of retaliation against another staff member. The suspect apparently wanted the other staff member to have to clean the individuals and their beds and rooms after they were unable to control their bowels. A witness to this incident observed the suspect insert the suppositories and heard her state that this was an act of retaliation. The Ombudsman was notified of this incident.

Issues: Sufficient information presented in the initial stages to involve law enforcement. There is no record that the Ombudsman ever received a report of this incident although the internal investigation states that they were notified. The suspect was terminated but no criminal charges were filed. This case was strong enough to have been followed up by law enforcement as the record indicates that sufficient probable cause was established to charge this suspect with assault.

CASE 006

Allegation: A series of reports of abuse were initiated with respect to this victim over a period of approximately one year. One report described an incident of physical abuse where a staff member struck the victim and it was witnessed and reported by another staff member. The internal investigation substantiated this incident. A second report described an incident where both staff and a family member observed bruises in the chest area. The internal investigation stated that the Director of Nursing thought the bruising looked like the victim had been struck by "a belt or wire looped object".

Issues: The first report where there was a witness does not indicate whether or not this report was referred to any other agency such as law enforcement or the Long-Term Care Ombudsman. There was sufficient credible information to have this case referred to law enforcement or the Attorney General. The incident where the Director of Nursing rendered an opinion as to the way in which the bruise was caused should have been referred for a criminal investigation. There is no indication that the Vulnerable Adult Abuse Protocol was used, which was developed by the Adult Protection Coordinating Council (S.C. Code Ann. §§ 43-35-310 et seq.) and the medical community to document medical information and would have provided

more detailed medical data. A copy of the Vulnerable Adult Abuse Protocol can be found in Appendix C.

CASE 012

Allegation: A hospital employee reported that a staff member, who had escorted the victim to the hospital, abused the victim by pushing him down on the bed and grabbing his throat. The hospital employee reported the incident to the hospital charge nurse who then contacted the facility. An internal investigation was conducted and the suspect provided a statement that she did not abuse the victim. She did admit that she was "having problems" and was receiving mental health counseling and taking a psychotropic medication. Although the employee was offered a job that did not require her to have contact with consumers at the facility there was no documentation of the ultimate outcome.

Issues: The record does not indicate that this case was referred to any law enforcement agency. The internal investigation clearly indicates that this was a criminal case of assault which should have been immediately referred to law enforcement.

CASE 014

Allegation: It was reported that the victim had been physically abused by staff on a number of occasions, sustaining 36 injuries of unknown origin. An internal investigation was initiated and the local police department was contacted. As a result of the investigation, seven staff members were terminated for abuse and the police department subsequently charged seven individuals. No results of the criminal prosecution were indicated.

Issues: The police department record indicates that they did not charge the same seven individuals that the facility terminated, which indicates a discrepancy in investigative results between the internal investigation and law enforcement investigation. Although the overall

internal investigation was conducted in an acceptable manner, it may have been better to have law enforcement involvement at an earlier stage rather than at the conclusion to eliminate the discrepancy.

CASE 021

Allegation: A staff member observed bruises on the victim in the area of the right thigh, buttocks, rectum, scrotum and penis. From the nature of the injuries, it appeared that the victim had been kicked. It was obvious the injuries were not accidental in nature given the severity and location, which was verified by a physician. An internal investigation was conducted by staff who were unable to determine a possible suspect or suspects. As a result of the internal investigation, the case was referred to SLED, who began their investigation approximately three days after the internal investigation. SLED's investigation was also unable to determine the possible suspect or suspects and the case was closed.

Issues: The delay in involving law enforcement may have contributed to the difficulty in determining a possible perpetrator. The photographs that were included in the report did not meet basic evidentiary standards such as scaling and identification shots. Three of the employees who had the opportunity to observe the bruises 2-3 days prior to their discovery failed to report them and gave conflicting statements to the internal investigator and the SLED agents. These inconsistent statements do not appear to have been challenged by investigators. There is a strong possibility that a suspect or suspects could have been developed with earlier SLED involvement.

CASE 022

Allegation: On a trip with several residents of the facility, a staff member provoked an altercation between two residents that resulted in an assault on the victim, who was in a wheelchair. The internal investigation disclosed that the staff member verbally abused the victim

and used another resident to assault the victim stating, "I might not can get you but I can't stop the other girls from doing so". The victim received "minor scratches" on her arm and minor injuries to her legs as a result of the altercation. The case was reported to the Ombudsman and the record reflects that "the appropriate personnel action was taken".

Issues: This case is clearly physical and psychological abuse under OAPA that should have resulted in a criminal investigation by the appropriate law enforcement agency. There is no record of any evidence collection such as photographs or a medical report about the possible injuries.

CASE 035

Allegation: The victim reported to his sister that he had been assaulted by a staff member. A subsequent medical examination determined that he had bruises and abrasions on both shins, bruises on both thighs, a large bruise on one hip, bruises on his buttocks, bruises under his arms and bruises on both arms. An X-ray revealed that he also had two broken ribs on his right side. An internal investigation was initiated and the victim was interviewed. He was able to identify a possible suspect. A witness also identified the same suspect. The case was referred to SLED and the Ombudsman was notified. SLED interviews of both residents and staff provided conflicting statements. Many residents supported the allegation that the suspect assaulted the victim. The staff statements stated that they did not see anything happen to the victim. An interview with the suspect produced a denial, although he did admit that he had problems with the victim in the past. The case was referred to the Solicitor and he declined to prosecute.

Issues: The case clearly illustrates the problem with these incidents. The victim and a number of residents give statements implicating the suspect, however, many of them are

conflicting. When the suspect denies the abuse it becomes his or her word against a number of witnesses with cognitive disabilities. The SLED report is very thorough and there is sufficient evidence to support an abuse case. This case indicates a broader issue of prosecutorial reluctance to pursue these cases and may be based upon their perception of victim/witness ability to present credible testimony.

CASE 038

Allegation: Staff noticed bruises under the arm of the victim and reported them to the supervisor. The victim stated that somebody at the day program grabbed him. The record does not reflect that an investigation was initiated. P&A then made a request for further investigation. Records show that additional bruises were discovered on his torso along with a scratch on his abdomen. Subsequent body checks showed a continuing pattern of bruising on the victim.

Issues: There is no indication that any internal investigation or reporting was done for this victim. Although there is a letter from the County Disabilities and Special Needs Board that the allegation of abuse is unsubstantiated, the non-existent reporting and required follow-up make it impossible to substantiate that determination.

CASE 048

Allegation: A letter to the South Carolina Department of Health and Environmental Control by the daughter of the victim details an allegation of misuse of major pain medication by the facility. This resulted in an emergency admission to the hospital with a final diagnosis of a drug overdose of the type of drug taken and dehydration. No report was made to any agency by the facility. DHEC ultimately cited the facility for overmedication and dehydration and the facility submitted a plan of correction.

Issue: This case should have been referred to the Ombudsman for an initial investigation and then possibly law enforcement for additional investigation. This may be a case of physical abuse or neglect under OAPA for the misuse of the medication or neglect for the dehydration.

CASE 050

Allegation: The victim stated a staff member took a hammer to his door and knocked off the lock. The staff member then struck the victim with the hammer. The victim filed a report with the County Sheriff's Department. A staff member from P&A personally observed the damage to the victim's door as well as injuries to the victim. The middle finger of the right hand was swollen and the first joint appeared injured. This individual also observed damage to the victim's CD player. The P&A representative then questioned staff. They stated they were not aware of the injuries and had not sought medical treatment. There was no report made by the facility with respect to this incident. It has been subsequently referred to the Ombudsman by P&A and is currently being investigated.

Issues: It is clear that some type of incident took place between a staff member and the victim that should have resulted in a report and investigation.

SEXUAL ABUSE CASES:

CASE 046

Allegation: Two witnesses (staff members) reported seeing the suspect touch the victim "inappropriately" at different times. This touching was in the vaginal area and each witness observed it at a different time, indicating at least two events. An internal investigation was initiated. A medical exam was conducted with negative results. The suspect stated that he was performing a required medical procedure, a digital rectal exam for possible impaction. The witnesses both said he was not wearing gloves at the time they witnessed the incidents. In one case the suspect stated he was administering oral medication. The case was referred to SLED, whose investigation led to the suspect's indictment. The case was then closed by the Solicitor after being informed by the suspect's attorney that he had passed a private polygraph.

Issues: This case was properly investigated by both the facility and SLED and the two witnesses were very credible. However, after being informed of the polygraph results, the Solicitor declined to prosecute even though polygraph test results are not admissible as evidence in court. The dismissal of this case, which had excellent preparation, may indicate a lack of support for these cases within the criminal justice system.

CASE 004

Allegations: A number of incidents were reported over a period of several months regarding possible physical abuse of the subject. Many involved assaults by another resident. During the course of the investigation, it was alleged that the victim had been sexually abused by another resident with a history of sexual aggression. This abuse had been reported to the appropriate staff and recommendations were made to protect the victim. Facility management did not follow the recommendations resulting in possible further sexually abuse of the victim.

The record contains one report of physical abuse filed with local law enforcement but no indication of any follow-up.

Issues: The allegation of physical abuse was reported to local law enforcement with no indicated action on their part. The records do not indicate that the sexual abuse by another resident was reported to any other agency, nor did management make any attempt to protect the victim from further harm even when staff members made attempts to get them to do so. While OAPA would not support any action against the alleged perpetrator of the sexual abuse, he could have been charged under Title 16. The record does indicate that possible criminal action could have been taken against management for neglect because they did nothing to prevent further abuse of the victim after being clearly notified (in writing) of the problem by staff.

CASE 008

Allegation: An allegation was made by the victim that a staff member "reached under the covers and touched his private areas" while watching a sexually explicit video. An internal investigation was conducted and the case was referred to SLED for a criminal investigation. The victim was able to provide a statement. Based upon the internal investigation, the employee was terminated. The SLED report was provided to the Solicitor who felt there was not enough to proceed with a criminal case.

Issues: The internal investigation and the one conducted by SLED were thorough but did not provide any witnesses to this event, making this a difficult case to prosecute. The video was found in the possession of the victim but no other physical evidence was discovered that would substantiate the victim's statement. The report provided no information as to where the victim obtained the video.

DEATH CASES:

CASE 024

Allegation: A Report of Death was completed on the resident. The report and the death certificate both indicate that the death was from natural causes (respiratory arrest, aspiration of vomitus and cerebral edema).

Issues: The Report of Death was handwritten. The notes indicate some issues with the resident's eating. No autopsy was performed. The report lacks sufficient detail to determine if there was a problem with the victim's food not being finely chopped as required. While this case is probably not abuse, it may have been neglect. This demonstrates the lack of sufficient information that makes it impossible to determine if further investigation is needed.

CASE 025

Allegation: The Report of Death completed by the facility is detailed and indicates that the resident had complicated and serious medical issues and his death was a result of these conditions. The death was reported to the Coroner and an autopsy was done with the results attached to the Report. The findings of the pathologist were consistent with a natural death.

Issues: This case provided complete and thorough documentation including an autopsy. This report does not provide any findings that would lead to any allegation of abuse. When contrasted with the documentation in Case 024, it demonstrates a system that requires consistent and standardized reporting in death cases so that abuse or neglect can be ruled out.

CASE SUMMARY

The majority of cases reviewed contained evidence consisting only of victim and witness statements. Little effort was made to further investigate inconsistent statements, collect physical evidence or interview the victim. This lack of further investigation is clearly indicative of proceeding from a purely administrative view to establish that policies and procedures were followed. In many cases, the termination of an employee was the only outcome; with little thought given to holding the offender criminally responsible. Case 004 clearly documents that the facility was aware of possible sexual abuse yet the facility failed to report it to law enforcement, initiate an investigation or respond to the recommendations of staff. These lapses could have resulted in further harm to the victim. Case 006 had extensive documentation of physical abuse that was not referred to law enforcement but instead to DSS. It appears that DSS failed to report it to law enforcement or conduct a thorough investigation. Case 012 had sufficient evidence to support a possible prosecution, but the case was not referred.

Overall, it appears that individuals working in the system to deliver services to individuals with developmental disabilities do not have a clear understanding of the need to refer cases to agencies that can conduct a proper criminal investigation when there is sufficient evidence to support that course of action. The lack of oversight by the Ombudsman contributes to this problem. It did not appear that the Ombudsman was conducting a thorough screening of reports and contacting law enforcement when necessary. Not holding offenders criminally accountable sends a clear message to employees that the most that can happen to them is termination. In the cases that were reviewed, even termination was not always a response.

Two cases included the results of a SLED investigation. Neither case was referred for prosecution. In Case 021, major problems were identified with the way the case was

investigated by both the facility and SLED. Ample initial evidence shouted that the victim had been physically abused. Photographs, as well as medical opinion, left no doubt that the victim had been assaulted in the genital and anal area and that it was intentional. The initial investigation conducted by the facility made reference to "age dating" the bruises, which should not be done as there is no medical support for this technique in practice or research. The interviews conducted by the facility failed to further investigate the inconsistent statements by staff regarding the period prior to the initial discovery of the injuries. The case was then referred to SLED which conducted interviews of staff that may have had contact with the victim in the period before the injuries were discovered, particularly those who worked the prior two days. In at least three specific statements taken from staff, there were inconsistencies between what was told to facility personnel and then subsequently related to the SLED Agents. A more aggressive approach to the interview process might have provided the focus necessary to develop a suspect. All three of these individuals were in a position to have seen the injuries during the preceding 24-48 hours, yet the fact that the injuries were not reported or mentioned in their statements indicates a lackadaisical attitude on the part of the investigators to develop additional information. It appears that in the internal investigation, investigators only determined whether or not staff complied with policy and procedure. It is difficult to tell from the record why the SLED agents did not follow up on the facts about the injuries.

In summary, while DDSN policies are adequate for some purposes, they have serious flaws that interfere with the goal of protecting victims from further abuse and of holding offenders accountable. Most of the investigations reviewed seem to be focused on quality control issues. In some cases, they were specifically concerned with determining whether or not facility policies or procedures were violated and how to deal with the employee(s) that were involved in

an administrative way. Most of the files reviewed were inadequate, incomplete and did not meet OAPA's requirements for reporting to law enforcement.

The case review determined that the following issues are not adequately addressed in current investigative policies, procedures and practices.

- **Policies and Procedures**-The policies and procedures reviewed for this report clearly appear to be focused on administrative issues. They also modify and, in some cases, ignore the requirements of OAPA.
- **Documentation**-There is no consistent format used for documenting the results of an investigation. DDSN provides guidelines and suggested formats but does not mandate their usage. Therefore facilities, local boards, and contract providers use modified policies and corresponding forms which are similar to those of DDSN proper. Most of the forms used in the furnished reports were inadequate because they did not clearly indicate what physical evidence may have been gathered, such as a chain of custody form; lack of medical data, such as the Vulnerable Adult Abuse Protocol; and the necessary identification data required if the case is to be referred to law enforcement.
- **Terminology**-Definitions used by DDSN do not conform to the definitions found in OAPA.
- **Reporting**-While required reporting seems to occur most often to the Ombudsman, there is little or no reporting to law enforcement. The Ombudsman does not appear to have reviewed reports referred to them for further action. In several cases, there were clear indications that law enforcement should have been notified but were not.
- **Administrative versus Criminal Investigations**-Many of the reports that were reviewed seemed to be focused on whether procedures were followed. If the procedures were not

followed, the response was to train staff. Most of the internal investigators are administrators and come to these incidents using that perspective. Conducting a criminal investigation often requires a different mind set. If the purpose of the investigation is to see if individuals complied with policies and procedures, then the focus will be on administrative issues instead of on whether or not a criminal act took place. As previously mentioned, there is an inherent conflict of interest issue with the current situation because internal investigators can easily lose objectivity and can be intimidating to the individual who has been abused during the course of the investigation.

- **Training**-DDSN appears to have established, in policy, an adequate training program for their internal investigators. However, it is difficult to evaluate the level of expertise or effectiveness of the program because it was impossible to determine if the investigator had the training, when they had the training, the number of cases an investigator handles, or the turnover rate. If a case is referred to law enforcement, it will probably be investigated by an individual with little or no training or expertise in dealing with vulnerable adults. The only training a law enforcement officer receives in this area is a brief two hour orientation during recruit training. No documented additional training for investigators or prosecutors has been offered that would provide the enhanced skills necessary in this area. While the South Carolina Adult Protection Coordinating Council has made efforts to provide training in this area, it can be safely said that few prosecutors have attended. Ultimately, if offenders are to ever be held accountable, training must take place on a continuous basis.
- **Oversight**-Those charged with oversight of the current system, such as the LTCO and HHS, are not exercising this authority on a consistent basis.

FINDINGS

The current South Carolina entities for reporting and investigating allegations of abuse and neglect against vulnerable adults do little to protect victims, determine those responsible for their abuse and neglect and, when appropriate, prosecute them. The procedures seem to be designed to ensure that agencies are not adversely impacted by the victimization of their clients. There are several reasons for these failures to protect or hold offenders accountable:

1. Reporting often is delayed, or in some cases non-existent. Delays in reporting present serious problems with evidence preservation and victim protection.
2. Investigations are viewed from an administrative perspective and are conducted by administrators. They seem to focus on whether or not policies and procedures were followed with little effort made to refer to law enforcement. It did not appear that sufficient effort is being made by the Long Term Care Ombudsman to review reports and make a referral for a criminal investigation when the facts support that action to require additional effort by DDSN to address substandard investigative reports.
3. Inconsistent definitional foundations impede investigation. OAPA contains the definitions that determine the elements of abuse and neglect. DDSN has developed a set of definitions to be used in investigations that do not adhere to the ones set forth in OAPA. These discrepancies lead to confusion and often lead to conclusions not consistent with the governing statute.
4. Investigations conducted by contract agencies were seriously flawed. In one case reviewed, there was a failure to properly investigate a case of sexual abuse as well as to protect the victim from further harm.

5. DDSN's documentation procedures are confusing in that DDSN does not appear to mandate their use by facilities and the forms lack sufficient information for the conduct of a criminal investigation.
6. Cases reported to law enforcement do not always receive the necessary investigative effort.
7. Cases referred to the local solicitor for review were, in almost every case, not prosecuted.
8. No single oversight process ensures that cases are screened for possible criminal behavior and that the investigative process meets a minimum standard.

In summary, vulnerable adults, including those with disabilities, who are victims of abuse, neglect, and exploitation do not receive adequate investigative and prosecutorial responses from those charged with their protection. Most of the initial investigations reviewed were conducted by an administrator. The administrator would decide to refer possible cases of abuse and neglect to law enforcement after conducting an initial investigation. This procedure resulted in delayed reports that can only have a negative effect on evidence gathering, building a criminal case, and subsequent possible prosecution. It is also important to understand that the initial investigative response is framed by the facts presented and the need to match those facts with the elements of abuse and neglect contained in the governing OAPA statute. If the investigator uses definitions inconsistent with this statute, or those created by the agency, then the investigator lacks the analytical framework to make critical decisions regarding possible criminal behavior.

The most critical issue identified by this report is the extreme fragmentation of roles. The current process is one where numerous state and local bodies have some form of jurisdiction

but no overall supervision or coordination is in place. There is no true system. Individuals receiving services through DDSN are subject to internally developed policies which can be modified at the local level, leading to inconsistency in reporting and documentation of incidents. Throughout the state serious incidents of abuse and neglect are inadequately investigated and rarely prosecuted. Further, the lack of data makes it impossible to determine the frequency of incidents or whether they are adequately investigated and referred to law enforcement.

Virtually no oversight or coordination among entities exists. While some efforts have been made by the Attorney General's Office, although they have no mandate to do so, and the Ombudsman to meet these needs, both are understaffed and do not have the resources to do the job required. The criminal justice system (law enforcement and prosecutors) does little to improve this situation. Law enforcement personnel receive minimal or no training in the issues of abuse and neglect of vulnerable adults. There seems to be no public pressure to change this situation. Until vulnerable adults are viewed as individuals in need of an aggressive system of protection, little will improve. Vulnerable adults who have been victims of abuse and neglect are subjected to cruel and unusual punishment by the current process. Not only are they abused, neglected, and exploited, they also suffer the act again when the process fails to properly investigate and prosecute on their behalf. Until critical changes are made they will continue to be victimized and the offenders rarely held accountable.

RECOMMENDATIONS

1. Establishment of a state-level investigative entity within the criminal justice system, i.e. SLED, and outside of any agency providing services to vulnerable adults, with responsibility for all reports of abuse, neglect, or exploitation involving vulnerable adults in facilities.

South Carolina must recognize that little will improve until a specific entity is charged with the investigative responsibility for these cases, regardless of where the incident occurs. This entity should provide initial screening, investigative follow up when required and oversight of all allegations of abuse and neglect. It should have personnel assigned who have law enforcement authority and expertise to conduct these complex investigations, as well as training in the special issues associated with this population group. Personnel should have access to individuals with medical or social work backgrounds in this special population. There must be a single point of entry for these allegations with the ability to coordinate an effective response and track data. While not superseding the mandates of the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office, the entity would focus on cases that often fall outside the jurisdiction of the MFCU. Creation of such an entity may also require a review of the duties of the Long Term Care Ombudsman. Neither the Attorney General nor the Ombudsman has the mandate nor the resources to implement a system for the investigation of abuse and neglect of vulnerable adults, including people with disabilities. Law enforcement personnel and solicitors receive grossly inadequate training regarding abuse and neglect of vulnerable adults. Only a single entity with clear responsibility and specialized staff can offer accountability to some of South Carolina's most vulnerable citizens.

2. No longer permit agencies and their contractors to investigate allegations of abuse and neglect within their facilities.

Agencies and contractors should not have responsibility for conducting internal investigations. The pressure to conform to organizational expectations is too great to insure an objective investigation.

3. Develop and present adequate training to criminal justice professionals charged with the responsibility of investigating and prosecuting abuse and neglect.

It was obvious that even when cases were referred to law enforcement and prosecutors there was no guarantee that a proper investigation would be the result. These are complicated investigations which require specialized training not currently available in this state. Successful models of specialized prosecution in the areas of child abuse, sexual assault and domestic violence demonstrate the efficacy of trained professionals.

4. Establish separate policies and procedures for administrative/quality control investigations after determining that no criminal abuse or neglect took place.

Once it is determined that an allegation is not criminal in nature, then a quality control system to conduct this type of investigation needs its own set of policies and procedures. This change would reduce any confusion as to the purpose of the investigation.

5. **Review all agency policies and procedures to insure that they conform to all the provisions of OAPA, including definitions.**

DDSN needs to conduct a thorough review of their policies and procedures to address the issue of conformity to OAPA. The current arrangement leads to confusion about the purpose of an investigation and does not provide the focus necessary to determine if an event is criminal. Not only must DDSN ensure their policies reflect OAPA, DMH and DSS must also ensure their policies reflect OAPA.

APPENDIX A:

COMPARISON BETWEEN THE OMNIBUS ADULT PROTECTION ACT DEFINITIONS AND DDSN DIRECTIVE 534-02-DD DEFINITIONS

Mims 0326

Omnibus Adult Protection Act	DDSN Policy 534-02 (March 2004)
Abuse means physical abuse or psychological abuse. **Physical abuse** means intentionally inflicting or allowing to be inflicted physical injury on a vulnerable adult by an act or failure to act. Physical abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery as defined in § 16-3-651, use of medication outside the standards of reasonable medical practice for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment except that a therapeutic procedure prescribed by a licensed physician or other qualified professional or that is part of a written plan of care by a licensed physician or other qualified professional is not considered physical abuse. Physical abuse does not include altercations or acts of assault between vulnerable adults.	**Abuse, Neglect, and Exploitation** Abuse is defined as any intentional physical or mental injury or harm or the threat of such injury to a consumer by any employee or volunteer of DDSN or its contract provider agencies. Abuse as defined below is prohibited. **Physical abuse** is defined as an intentional assault upon a consumer whether or not the assault causes injury. This includes but is not limited to: (a) Slapping, hitting, kicking, shaking, biting, choking, pinching, pulling hair, throwing objects, spanking, corporal punishment; or (b) Provoking, directing, encouraging, condoning, or allowing people receiving services to discipline or abuse one another; or, (c) Using medications (outside the standard of prescribed medical practice) for the purpose of controlling behavior.

Omnibus Adult Protection Act	DDSN Policy 534-02 (March 2004)
Psychological abuse means deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress. **Investigative entity** means the Long Term Care Ombudsman Program or the Adult Protective Services Program.	**Emotional, Mental or Psychological Abuse** (a) Intentionally subjecting a consumer to inhumane or unconscionable conditions or acts that cause fear or other forms of emotional distress; or (b) Subjecting a consumer to degrading, harassing, or dehumanizing conditions; or (c) Unreasonable confinement or restraint that is not a part of the consumer's approved behavior support plan. **Verbal abuse** is defined as referring, gesturing, or speaking to a consumer in threatening, degrading, or discriminatory terms which have an adverse effect on the person receiving services.

Omnibus Adult Protection Act	DDSN Policy 534-02 (March 2004)
(There are no more definitions of abuse.)	**Threatened abuse** is defined as an intentional offer of physical or mental abuse that causes emotional distress to the consumer or creates a well-founded fear of imminent peril coupled with the ability to execute the threat. This also includes threatened use of any of the abusive acts defined in this policy. **Sexual abuse** is defined as an employee or volunteer becoming sexually involved with a consumer or encouraging the consumer to become sexually involved with another person. **It is also considered abuse if an employee furnishes non-prescribed drugs or other illegal or harmful substances to a consumer.** **Abuse by complicity** is defined as aiding, abetting, conspiring with or covering up an act of abuse. Anyone who commits complicity is considered to be as guilty of abuse as the person who commits the abuse.

Mims 0329

Omnibus Adult Protection Act	DDSN Policy 534-02 (March 2004)
Exploitation means: (1) causing or requiring a vulnerable adult to engage in activity or labor which is improper, illegal, or against the reasonable and rational wishes of the vulnerable adult. Exploitation does not include requiring a vulnerable adult to participate in an activity or labor which is a part of a written plan of care or which is prescribed or authorized by a licensed physician attending the patient; or (2) an improper, illegal, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a vulnerable adult by a person for the profit or advantage of that person or another person.	**Exploitation** is defined as the improper use or manipulation of a consumer or his/her resources for profit or advantage by an employee or volunteer. This includes but is not limited to exploitation for money, gifts, or other personal gains.

Omnibus Adult Protection Act	DDSN Policy 534-02 (March 2004)
Neglect means the failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Neglect may be repeated conduct or a single incident that has produced or can be proven to result in serious physical or psychological harm or substantial risk of death. Noncompliance with regulatory standards alone does not constitute neglect. Neglect includes the inability of a vulnerable adult, in the absence of a caretaker, to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death.	Neglect is defined as the failure to provide for basic needs, such as food, clothing, shelter, health care, safety, or adequate supervision, and the failure results in risk to the life safety of the consumer.

APPENDIX B:

CASE INFORMATION

Case No.	Type	Reported To:	Results
001	Physical	AG	Employees terminated
002	Physical	LTCO	Employee terminated
003	Neglect	None	None
004	Sexual/Physical	Law Enforcement/AG	Unknown
005	Sexual	Law Enforcement	Unknown
006	Physical	None	Founded/NFI
007	Neglect	LTCO	Founded/disciplinary
008	Sexual	SLED	No prosecution
009	Neglect	Unknown	No action taken
010	Physical	LTCO	Unfounded
011	Unexplained injury	None	No action required
012	Physical	Unknown	Employee terminated
013	Death/Neglect	AG	Pending
014	Physical	LTCO	7 staff terminated,/ 1 disciplinary/no results on LE
015	Physical	LTCO	Unfounded
016	Physical/Psych.	LTCO	Unfounded (related to 015)
017	Physical/Psych	LTCO	Unfounded (related to 15)
018	Death	AG	Pending
019	Physical	none	Employee terminated
020	Physical	none	Unfounded
021	Physical	SLED	No prosecution
022	Physical/Staff neglect	None	Unknown
023	Exploitation	None	Unfounded
024	Death	None	Natural
025	Death	Coroner	Natural
026	Death	Coroner	Natural
027	Death	Unknown	Natural
028	Neglect	LTCO	Employees terminated
029	Physical	None	Unfounded/staff filed compl v. resident
030	Physical	LTCO	Employee suspended
031	Sexual	DMH PS	No prosecution
032	Neglect	LTCO	Employee terminated

033	Physical	LTCO	Unfounded
034	Physical	LTCO	Unfounded (10,33,34 same subject)
035	Physical	SLED	Employee terminated/No prosecution
036	Death	None	Natural
037	Death	None	Natural
038	Physical	Contract Inv	Unfounded
039	Physical	LTCO	Employees received training in procedures
040	Physical	None	Unfounded
041	Physical	None	Employee Terminated
042	Physical	None	Unfounded
043	Physical/Staff Neglect	None	Employee Disciplined
044	Neglect	None	Unfounded
045	Physical	LTCO	Unfounded (040-045, same subject)
046	Sexual	SLED	Employee charged, No prosecution
047	Death	Law Enforcement	Traffic fatality
048	Physical/Neglect	DHEC	DHEC cited facility
049	Homicide	Law Enforcement	Suspect charged w/Murder
050	Physical	None	Pending investigation

DEMOGRAPHIC INFORMATION:

FOR VULNERABLE ADULTS
AGE 18 OR OVER

Date of Visit: / /	Time:
Source of Intake Information:	
Relation: [ ] Adult Protective Services [ ] Law Enforcement [ ] Caregiver	[ ] Medical Provider [ ] Long Term Care Ombudsman [ ] Other:
Maltreatment Assessment: Emergency Protective Custody - [ ] Yes [ ] No	Date:
Site:	
Provider Name Group:	

DEMOGRAPHIC INFORMATION
Photocopy of Agency Demographic Information May Be Substituted

Patient Name:		Sex:[ ] Female [ ] Male
DOB:	Age:	SSN:
Race: [ ] White [ ] Black [ ] American Indian [ ] Oriental [ ] Bi-Racial [ ] Other		Migrant: [ ] Yes [ ] No
Residence: [ ] Lives Independently [ ] Residential Home [ ] Family Residence Under Care of:		
Mailing Address:		
Street Address:		
Phone:		County of residence:
Emergency Contact Name:		Contact Phone:
Legal Custodian/Relation:		
Accompanying Guardian/Relation:		
Payment Source:		Policy #:

INVOLVED AGENCIES

Law Enforcement: County:		[ ] Police Dept: [ ] Sheriff's Dept.
Officer:	Badge #:	Phone:
Report Date:	Phone:	Ext.
Address:		
Other Agency(ies):		
Signature of Recorder:	Print Name:	Date:

WHITE - HOSPITAL PINK - LAW ENFORCEMENT GREEN - VICTIM COMPENSATION

Mims 0335

PATIENT INFORMATION

Accompanying Adult(s)/Relationship(s):

Patient's Communication Ability: [ ] Normal [ ] Impaired [ ] Non-Communicative

Personal Physician's Name:
City/Address: Phone:

Current Medications:

Medical History

Allergies: [ ] N/A [ ] No [ ] Yes - Drug(s):

Medical Problems:

Major Hospitalizations:

Surgeries:

Trauma/Injuries: [ ] Head Injuries [ ] Fractures [ ] Burns

Gynecological History (If Applicable)

[ ] LMP: Contraception: [ ] OCs [ ] Injectable [ ] Tubal Ligation [ ] Other -

Menopausal [ ] Yes [ ] No [ ] Unknown Hormonal Replacement [ ] Yes [ ] No [ ] Unknown

Sexually Active Voluntarily [ ] No [ ] Unknown [ ] Yes - Last Voluntary Intercourse:

Substance Use

Alcohol [ ] No [ ] Unknown [ ] Yes - Amount:

Tobacco [ ] No [ ] Unknown [ ] Yes - Amount:

Drugs [ ] No [ ] Unknown [ ] Yes - Amount:

Family History

[ ] Bleeding Disorders [ ] Bone disease [ ] Neurological Disease [ ] Substance Abuse [ ] Violence [ ] Mental health

Comments:

Examiner's Signature Date

WHITE - HOSPITAL PINK - LAW ENFORCEMENT GREEN - VICTIM COMPENSATION

Mims 0336

53

PHYSICAL EXAMINATION RECORD

Examiner: Date:

Person(s) Present: [ ] No [ ] Yes - Give Name(s):

Other Person(s) Present - Give Names:

Behaviors Observed During Exam: [ ] Appropriate [ ] Mental Status Exam [ ] Other - Describe Below:

Physical Exam: Height: % Weight: % H.C.: %

	WNL	ABN	N/A	EXPLAIN
General Appearance				
CN II - XII				
Motor Strength/Tone				
Deep Tendon Reflexes				
Ears/TMs				
Eyes/Fundi				
Nose				
Mouth/Oropharynx				
Teeth: upper				
Teeth: lower				
Neck				
Breasts				
Chest				
Back				
Lungs				
CV				
Abdomen				
Hair/Scalp				
Skeletal				
Balance/Gait				
Sensory Exam				

Comments:

Examiner's Signature: Date:

WHITE - HOSPITAL PINK - LAW ENFORCEMENT GREEN - VICTIM COMPENSATION

PHYSICAL EXAMINATION RECORD, CONT

Skin findings (Describe color, configuration, measurements, and any remarks by the adult as to the etiology for each lesion. See body diagrams.)
Photos Taken: [ ] No [ ] Yes - Number Taken: Forensic Dentistry Consult: [ ] Yes [ ] No Lesions Consistent with Bite Marks: [ ] Yes [ ] No
_____ _____
_____ _____

Male Genital Exam	WNL	ABN	Describe
Inguinal Adenopathy			
Medial Thighs			
Perineum			
Penis			
Urethral Meatus			
Circumcised	[ ] Yes	[ ] No	
Scrotum			
Testes			
Female Genital Exam	**WNL**	**ABN**	**Describe**
Inguinal Adenopathy			
Medial Thighs			
Perineum			
External Genitalia			
Vagina			
Cervix			
Uterus			
Male/Female Exam			
Buttocks			
Anus			
Anal Tone			
Stool Incontinence			
Rectal Exam:			Stool Occult Blood Test [ ] Positive [ ] Negative
Examiner's Signature:			Date:

WHITE - HOSPITAL PINK - LAW ENFORCEMENT GREEN - VICTIM COMPENSATION

LAB SUMMARY

Laboratory Specimens (Check specimens collected)
Date:

GC/Chlamydia Culture	[ ] Throat [ ] Vaginal [ ] Urethral [ ] Rectal	
Wet Prep	[ ] No	[ ] Yes -
bHCG	[ ] No	[ ] Yes -
Urinalysis	[ ] No	[ ] Yes -
Culture [ ] Throat [ ] Vaginal [ ] Urethral [ ] Rectal [ ] Urine [ ] Wound [ ] Blood [ ] Other -		
RPR/VDRL	[ ] No	[ ] Yes -
HIV	[ ] No	[ ] Yes -
CBC	[ ] No	[ ] Yes -
Coags	[ ] No	[ ] Yes -
Chemistry Panel	[ ] No	[ ] Yes -
Other:		
Treatment:		

PHYSICIAN SUMMARY

Recommendation for Follow-Up

Medical:
Mental Health:
Other:
Examiner's Signature:

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Mims 0339

SEXUAL ABUSE/ASSAULT INFORMATION

(Optional Supplement to Interview)

Stamp Plate or Name of Patient

Patient Interviewed in the Presence of:

	Described by Patient			
	Y	N	U	Comments
Vaginal Contact				
Penis				
Finger				
Foreign Object (Describe)				
Anal Contact				
Penis				
Finger				
Foreign Object (Describe)				
Oral Copulation of Genitals				
of Victim by Assailant				
of Assailant by Victim				
Oral Copulation by Anus				
of Victim by Assailant				
of Assailant by Victim				
Masturbation				
of Victim by Assailant				
of Assailant by Victim				
Did Ejaculation Occur? If yes, write adult's description.				
Describe location(s) on body:				
Where did ejaculate go?				
Describe assailant's genitals:				
Condom used				
Foam, jelly, or lubricant used (circle)				
Fondling, licking, kissing or biting (circle)				
Describe the location on the body:				
Examiner's Signature				Date

WHITE - HOSPITAL PINK - LAW ENFORCEMENT GREEN - VICTIM COMPENSATION

APPENDIX D:

MEMORANDUM OF AGREEMENT

MEMORANDUM OF AGREEMENT

The State Long Term Care Ombudsman Program of the Lt. Governor's Office on Aging, (hereinafter referred to as the "SLTCOP"), and the South Carolina Department of Disabilities and Special Needs (hereinafter referred to as "SCDDSN"), hereby agree to the terms of this MEMORANDUM OF AGREEMENT as revised on March 1, 2005.

I. **PURPOSE:** It is the public policy of the State of South Carolina as reflected in the Omnibus Adult Protection Act (OAPA) to protect vulnerable adults from abuse, neglect and exploitation. The purpose of this Memorandum of Agreement is to establish relationships to implement the intent and provisions of this Act.

II. **SPECIFIC OBJECTIVES:** The major objectives of this Memorandum of Agreement are:

A. To provide a system for receiving and investigating reports of alleged abuse, neglect and exploitation occurring to vulnerable adults receiving services in facilities or programs and services operated or contracted for operation by SCDDSN .

B. To assist SLTCOP in the furtherance of its responsibility to receive reports of and investigate allegations of abuse, neglect, or exploitation in facilities or programs and services operated or contracted for operation by SCDDSN and to provide a system for oversight by SLTCOP by (1) independently reviewing investigations conducted by SCDDSN and its contractors; (2) conducting independent and/or joint investigations when SCDDSN or the SLTCOP deem appropriate; and (3) referring serious cases to law enforcement.

C. To identify those programs and services operated or contracted for operation by SCDDSN that should report alleged abuse, neglect, or exploitation to SLTCOP.

D. To establish cooperative relationships for the purpose of training and technical assistance.

III. **RESPONSIBILITIES:**

A. SCDDSN will comply with OAPA by establishing an effective system for reporting allegations of abuse, neglect and exploitation of vulnerable adults and by informing all Departmental and contractor employees of their legal responsibility to report under the Act.

B. All reports of alleged abuse, neglect and exploitation will be made to the SLTCOP for incidents occurring in facilities operated by SCDDSN or its contractors in accordance with Attachment 1.

C. Under OAPA, certain persons employed by SCDDSN or its contractors are personally responsible for making a report of alleged abuse, neglect and exploitation to

SLTCOP. By virtue of this MOA, OAPA allows employees of SCDDSN and DSN Boards or organizations serving in that role to make the required report to a supervisor, officer of the day, or other authority who will then make the required report on behalf of the employee. Contractor employees, however, must personally report the alleged abuse, neglect and exploitation to the SLTCOP as appropriate. All reports of alleged abuse, neglect and exploitation must be made to the SLTCOP within the statutory time frame of 24 hours or within the next business day. Reports may be made in writing or orally by telephone or otherwise.

D. Any individual employee of SCDDSN or its contractors having reason to believe that abuse, neglect or exploitation has occurred or having actual knowledge of the incident may make a personal and direct report to the SLTCOP. However, as a condition of employment, employees must also timely notify their employer, SCDDSN or its contractors, of the alleged abuse, neglect or exploitation.

E. Under the authority of the OAPA, the SLTCOP authorizes SCDDSN and its contractors to receive reports and conduct internal investigations of all cases of alleged abuse, neglect and exploitation of vulnerable adults occurring in facilities or programs and services operated or contracted for operation by SCDDSN when the suspected perpetrator is an employee of SCDDSN or its contractors or when the suspected perpetrator is unknown.

F. Reporting procedure shall be conducted in accordance with policies and procedures reviewed and approved by SLTCOP.

G. SCDDSN or its contractors will notify law enforcement immediately when there is a serious allegation of abuse or neglect of a resident occurring in a facility, program, or service operated or contracted for operation by SCDDSN. Serious may be defined as "needing immediate medical attention or hospitalization". The SLTCOP shall also be notified of the referral to law enforcement.

H. SCDDSN or its contractors will establish procedures to notify the appropriate occupational licensing or certification authority whenever the alleged perpetrator of abuse, neglect, or exploitation is a licensed health care professional.

I. SCDDSN or contractor representative will inform the individual or family of their right to contact SLTCOP if they have concerns regarding the outcome of the investigation. The oversight responsibilities of the SLTCOP will be explained. The SLTCOP according to the authority given them under the OAPA, may conduct an investigation of any reports made by or requested by an individual, family member or relative.

J. The SLTCOP retains the authority to investigate any allegation of abuse, neglect or exploitation occurring in a facility, program, or service. Likewise, SCDDSN may request an independent or joint investigation. Any personnel action resulting from an investigation covered by the Memorandum shall be at the sole discretion of the

or federal law, or otherwise be found to be unenforceable, such portion shall be stricken from this Memorandum without affecting any other provision.

U. Individuals receiving services from SCDDSN or its contractors are entitled to all services and assistance from SLTCOP as any other citizen of the State, including services when needed to protect a vulnerable adult from abuse, neglect, and exploitation.

IV. **CONDUCTING THE INVESTIGATION:** Upon completion of its internal investigation, SCDDSN and its contractors will forward a copy of the complete investigation to the SLTCOP as appropriate within ten (10) working days from completion of the internal investigation. The internal investigation will be completed in accordance with the requirements of SCDDSN policy 534-02-PD. The investigation report will contain any factual reference or determination made as a part of the investigation, including, but not limited to, a copy of any personnel action taken as a result of the investigation; all statements taken as a part of the investigation, signed by the person providing the statement; and all investigative material of documentation that assisted in the determination of abuse, neglect or exploitation.

V. **COOPERATION:** The parties to this Memorandum will coordinate and in good faith seek to resolve conflicts through joint meetings of appropriate agency designees.

VI. **REVIEW:** SCDDSN and SLTCOP shall annually review this Memorandum of Agreement.

VII. **TERMINATION/MODIFICATION:** This Memorandum of Agreement may be terminated by any of the parties upon 60 days written notification and may be modified as necessary through mutual written agreement. It will continue in effect until it is revised.

VIII. **IMPLEMENTATION:** This Memorandum of Agreement is effective upon signature and each party will take appropriate action within their respective systems to ensure the effective implementation of the terms of this agreement.

This Memorandum of Agreement is entered into this_____day of _____, 2005.

Lt. Governor's Office on Aging

By:_____

Cornelia D. Gibbons
Director

Department of Disabilities and Special Needs

By: _____

Stanley J. Butkus, Ph. D.
Director

ATTACHMENT 1

The parties to this Memorandum of Agreement agree to the following:

The State Long Term Care Ombudsman Program will receive reports of suspected abuse occurring in facilities operated or contracted for operation by the South Carolina Department of Disabilities and Special Needs. This includes SCDDSN Regional Centers and facilities operated directly by the County Disabilities and Special Needs Board or a contract provider agency such as Babcock Center or Charles Lea Center. For the purpose of this Memorandum of Agreement, a facility is defined as any program or service listed as follows:

1. SCDDSN Regional Centers
2. ICF/MR Community Residences
3. Community Residential Care Facilities
4. Community Training Homes - Level II

The South Carolina Department of Social Services - Adult Protective Services will continue to receive reports of abuse, neglect or exploitation occurring in all other settings.

individual's employer.

K. Upon review of the investigative reports, the SLTCOP may request further information to be provided or may elect to conduct an independent investigation. SCDDSN will cooperate in any further investigation conducted or arranged by SLTCOP.

L. SLTCOP will notify the SCDDSN State Director or his designee of any abuse, neglect or exploitation cases which were not reported through procedures prescribed in their Memorandum of Agreement.

M. SLTCOP will notify the SCDDSN and the appropriate contractor director whenever an alleged abuse, neglect or exploitation investigation has been conducted in a facility, program, or service operated or contracted for operation by SCDDSN. The findings of the investigation shall be forwarded to the SCDDSN State Director and the appropriate contractor director.

N. In carrying out investigative responsibilities, SLTCOP may request and receive written statements, documents, and other items pertinent to the investigation to the extent permitted by law, and shall have access to witnesses, facilities, program sites, etc., as may be necessary to complete their investigation.

O. Unless prohibited by law, SLTCOP and SCDDSN may share information related to an investigation conducted as a result of a report made under this Memorandum of Agreement. The investigation and the information contained therein are confidential and may not be disclosed to other parties. However, this does not preclude disclosure to appropriate law enforcement and regulatory licensing authority in the furtherance of their investigation or to other parties upon court order.

P. In accordance with the OAPA, SCDDSN and its contractors shall prominently display notices in its facilities to its employees stating the requirements of the OAPA concerning the reporting of abuse, neglect and exploitation.

Q. SLTCOP will assist in providing training and technical assistance for SCDDSN and contractor personnel to encourage timely and accurate reporting of actual or suspected abuse, neglect and exploitation of vulnerable adults receiving services from SCDDSN or its contractors.

R. Each party to this Memorandum will designate a person to serve as an agency contact point.

S. SCDDSN and SLTCOP agree to exercise a good faith effort of cooperation in compliance with state law and the OAPA.

T. Nothing in this agreement in any way prohibits the carrying out of OAPA or other statutes. If any portion of the Memorandum shall be determined to violate any state

APPENDIX E:

EXCERPTS OF DDSN DIRECTIVE 534-02-DD: PROCEDURES FOR REPORTING, INVESTIGATING, AND PREVENTING ABUSE, NEGLECT, OR EXPLOITATION OF PEOPLE RECEIVING SERVICES FROM DDSN OR A CONTRACT PROVIDER AGENCY (MARCH 2004)

These are selected excerpts from DDSN Directive 534-02 and are addressed in the report.

Reporting Requirements

Employees and volunteers of DDSN or a contract provider agency are mandated to report when they have reason to believe that a vulnerable adult may have been abused, neglected, or exploited. Through a Memorandum of Agreement among DDSN, the State Long Term Care Ombudsman (DHHS), and Adult Protective Services of the South Carolina Department of Social Services (DSS), procedures have been approved for DDSN and its contract provider agencies to receive reports of suspected abuse, neglect, or exploitation and shall forward the report to the appropriate state investigative agency on behalf of the reporter. The employee may also make a direct report to the State Long Term Care Ombudsman or DSS. Reports shall be made to:

a. Long Term Care Ombudsman (Lieutenant Governor's Office)

When an employee or volunteer of DDSN or a contract provider agency has reason to believe that a vulnerable adult has been abused, neglected, or exploited in a DDSN Regional Center, ICF/MR community residence, community residential care facility, or a Community Training Home II, a report shall be made to the Regional Long Term Care Ombudsman.

b. DSS - Adult Protective Services

Abuse, neglect, or exploitation occurring to a vulnerable adult in all other settings shall be reported to the Department of Social Services in the county where the alleged incident occurred.

c. Law Enforcement

Reports may also be made to law enforcement but this does not relieve the reporter from their responsibility to report to the Long Term Care Ombudsman or the

County DSS.

Acts of Assault Between People Receiving Services

Reporting requirements pursuant to the state laws do not apply to altercations or acts of assault between people (consumers) protected by these laws except as noted below. However, corrective/preventive action should be taken to protect and intervene whenever people receiving services may be harming themselves or others. All injuries should be thoroughly reviewed and appropriate action taken including the filing of a Critical Incident Report where indicated. (See DDSN policy 100-09-DD).

Failure to provide proper supervision to prevent people receiving services from assaulting each other could be a form of neglect if the employee fails to intervene or provide proper supervision when they clearly have a duty to do so. Each situation should be reviewed and if it is determined that the employee failed to provide appropriate supervision which resulted in risk to the life safety of the person receiving services, the incident should be reported as suspected neglect and investigated by established procedures as outlined in this policy and in compliance with state law.

If it is determined that an employee provoked, directed, encouraged, or allowed a person receiving services to discipline or abuse another person, it is considered abuse and should be reported and investigated.

Referral to Law Enforcement

Local and state law enforcement agencies may investigate an allegation of abuse, neglect, or exploitation. A referral to law enforcement does not relieve DDSN or contract provider agencies from also reporting the allegation to the State Long Term Care Ombudsman, DSS, or

State Ombudsman. The state investigative agency should be informed whenever a referral has been made to law enforcement.

A referral should be made to law enforcement in the following cases:

(a) All sexual assaults between consumers and staff, volunteers, or other persons responsible for their care.

(b) There is serious physical injury (such as fractures, burns, serious lacerations, death, etc.) and there is reason to believe the injury was caused by possible abuse or neglect, or when a physician documents that the injury was due to abuse or neglect.

(c) There are multiple victims.

(d) Abuse or neglect was inflicted on a child (age 17 and under) by a person who is not a parent or a childcare worker.

(e) Serious abuse, neglect, or exploitation occurred and there is a cover up or failure to report when clearly an obligation existed to report.

(f) Intimidation of the victim or witness, or impediment to an investigation.

(g) Time sensitive evidence.

(h) When the victim or victim's family requests a referral to law enforcement.

Referral to SLED

DDSN operated services and supports and Regional Centers may refer a case to the State Law Enforcement Division (SLED). SLED has jurisdiction to conduct investigations in state agencies and to assist local law enforcement agencies, upon request.

Executive Director/ Facility Administrator

If the allegation of abuse, neglect, or exploitation falls into the suggested criteria for law enforcement investigation, a referral will be made immediately.

Internal Investigations

All allegations of abuse, neglect, or exploitation occurring in services and supports operated by DDSN, Regional Centers and contract provider agencies will be thoroughly investigated and an internal investigation conducted according to procedures outlined in the most current DDSN Abuse Investigation Manual. In addition to the finding of substantiation or non-substantiation, the internal investigation will be used as a management tool to identify corrective and preventive actions that may lead to abuse prevention. The Executive Director/Facility Administrator is responsible for ensuring that an internal investigation is conducted according to procedures contained in this policy. An investigative protocol has been established for conducting a thorough investigation based on facts.

State investigative agencies, as well as law enforcement, may conduct their own investigation in order to substantiate or not substantiate abuse, but an internal investigation is still required by the provider agency to identify personnel and management actions that may be required. DDSN and contract provider agencies will cooperate with all external investigations. External investigations, particularly law enforcement, take precedence over an internal investigation. Before pursuing an internal investigation, the investigator should coordinate with the external investigator to ensure that the external investigation will not be jeopardized if the internal investigation proceeds. In some situations the external investigator may want to do joint interviews or investigations.

Authority for Conducting Internal Investigations

Through a Memorandum of Agreement with the State Long Term Care Ombudsman and Adult Protective Services of the South Carolina Department of Social Services, DDSN and its County Boards of Disabilities and Special Needs and designated non-profit agencies whose

contractual relationship with DDSN is similar to that of a County DSN Board are authorized to conduct internal investigations of suspected abuse, neglect, or exploitation occurring to vulnerable adults in its services and supports. The State Long Term Care Ombudsman and DSS Adult Protective Services will review the investigation and may use it as the official investigation. The State Long Term Care Ombudsman and DSS Adult Protective Services, however, retain the right to conduct an independent or joint investigation, request additional information, or refer serious cases to law enforcement.

Prosecution of Substantiated Cases

When law enforcement conducts an investigation, their findings will be reviewed by the solicitor to determine if there is sufficient evidence to bring criminal charges. Prosecution is at the discretion of the solicitor.

In other cases, where abuse, neglect, or exploitation is substantiated, the Executive Director or DDSN may make a referral to the local solicitor, taking into consideration the seriousness of the incident, the nature of the injury, and possible violations of criminal statutes. Whether or not a case will be prosecuted will ultimately rest with the solicitor.

Internal Investigative Report to State Investigative Agency

Pursuant to the Memorandum of Agreement, the State Long Term Care Ombudsman's Office, DSS Adult Protective Services, and the State Ombudsman's Office, will accept the internal investigation of DDSN, the DSN Board, or designated non-profit agencies whose contractual relationship is similar to that of the DSN Boards as the official investigation, subject to the state investigative agency's oversight review.

Sexual Assaults between People Receiving Services

All sexual assaults between consumers will be reported and investigated according to DDSN policy 533-02-DD "Sexual Assaults, Prevention and Follow-up" and DDSN policy 100-09-DD "Reporting of Critical Incidents". Referrals will be made to law enforcement as indicated. The Executive Director/ Facility Administrator will also review the sexual assault incident to determine appropriate corrective/preventive action.

APPENDIX F:

"GREATER PROTECTION NEEDED FOR VULNERABLE ADULTS"

THE STATE NEWSPAPER

JULY 12, 2005

Greater protection needed for vulnerable adults

A RECENT REPORT OF abuse at a state-run residential care facility in Columbia, coming on the heels of similar reports at the state-subsidized Babcock Center facilities, raises serious questions about whether the state has appropriate safeguards in place to protect vulnerable adults. The latest report involves allegations that employees at the Midlands Center kicked, pushed down and beat a 26-year-old mentally retarded woman and attempted to hit her with a wall sconce. The attorney general's office is investigating, and three employees have been fired, but officials at the residential home weren't even aware of the assault until police showed up, called by the woman's mother. That means there probably wouldn't have been an investigation, and the people alleged to have assaulted the woman would still be caring for her and other people with mental retardation, autism and other developmental disabilities, if the woman's sisters had not happened by for a visit the day after the assault. As bad as it is that such an assault could occur, it's even worse that it could happen and no one in the facility would report it, or even raise questions about the woman's injuries. That suggests a serious problem in the culture of such institutions, which could be putting other people in the care of the state Department of Disabilities and Special Needs at risk. Changing such a culture starts with passing laws that make not reporting abuse or neglect a crime comparable in seriousness to the abuse itself. That type of "incentive" to report crimes is particularly important in situations in which the victims are unable to speak up for themselves.

Lawmakers should put that change near the top of their "to do" list when they return to work in January. Lawmakers also need to make sure that the people who investigate allegations of abuse are independent of the agency where the abuse occurred. That doesn't automatically happen in South Carolina, where the state's long-term care ombudsman has contracted out to the

Department of Disabilities and Special Needs and to the Department of Mental Health the duty of investigating problems within their own agencies. An independent investigator is more likely to make sure possible criminal activity is referred to law enforcement, and to make sure appropriate steps are taken when problems don't rise to that level. As Columbia attorney Patricia Harrison told The State's Roddie Burris, it's not uncommon for abuse to go unnoticed and, even when it is noticed, for abusers to be quietly fired without facing criminal prosecution. Ms. Harrison and other advocates for the mentally disabled are calling for the state to establish a central registry of people who have abused or neglected vulnerable adults, so that abusive employees would not be able to move from facility to facility. Such a registry could serve the dual purpose of offering some level of protection to the mentally ill and the elderly in nursing homes, who likewise are vulnerable to abuse and neglect. It is simply inconceivable that the state doesn't already operate such a registry, and that institutions that provide care for those who cannot report their abuses — be they public or private — are not required to vet their employees. We maintain a registry to keep up with people who have abused or neglected children. Adults with developmental disabilities, mental illnesses and age-related vulnerabilities deserve, and need, every bit as much protection from abuse.

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APPENDIX G:

AUTHOR BIOS

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Randolph W. Thomas, MA, Consultant

RANDOLPH W. THOMAS is a retired police officer having served for over 26 years in the law enforcement profession. His experience encompasses patrol, investigations, planning and research and over 14 years as a law enforcement trainer. He develops and presents training material relating to the investigation of child and elder abuse and juvenile crime. Mr. Thomas was the Project Director for South Carolina's law enforcement domestic violence training program. He was a member of the South Carolina Adult Protection Coordinating Council andhas served on a number of committees in the area of Elder Abuse. He is currently the President-Elect, National Committee for the Prevention of Elder Abuse and serves in an advisory capacity to the United States Department of Justice in the area of elder abuse. He has been an adjunct professor at the University of South Carolina, Department of Criminology and Criminal Justice in the area of juvenile delinquency, crime prevention and child abuse. Mr. Thomas currently presents training to law enforcement and social service personnel in the area of elder abuse investigations throughout the United States. He provides consulting services to law enforcement and others in the investigation of elder abuse cases. Mr. Thomas is a retired Colonel (United States Army) with over 37 years experience (active and reserve) as an intelligence officer. He received his undergraduate degree in Political Science from Chaminade University (Honolulu, 1971) and his Master's degree in Political Science from the University of South Florida (Tampa, 1974).

Nikki E. Fair, MSW, MHR Candidate

NIKKI E. FAIR has been employed with Protection and Advocacy for People with Disabilities, Inc. since August 2001. Her experience encompasses conducting institutional inspections and advocating for persons with disabilities who have been abused, neglected, or excessively restrained. Prior to her joining the organization, she worked with children with special health care needs teaching independent living skills. Ms. Fair received her undergraduate degree in Biology from Francis Marion University (Florence, 1996) and her Master's degree in Social Work from the University of South Carolina (Columbia, 2001). She is currently a candidate for her Master's degree in Human Resources from the University of South Carolina (Columbia, 2007).