



Governor's Review
South Dakota Department of Social Services
Procedures and Practices for Licensed, Accredited, and
Certified Treatment Facilities for Children and Youth

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Executive Summary

The Department of Social Services (DSS) has recently come under scrutiny regarding the regulation of treatment facilities for children and youth. At the request of Governor Noem DSS conducted a full analysis on the process for licensing and inspecting private treatment facilities for children and youth. The analysis focused on: 1) the history and types of licensed and accredited treatment facilities for children and youth; 2) licensing, accreditation and certification process; 3) complaint process; 4) investigation process; 5) corrective action plans/plans of correction; 6) transparency and confidentiality of investigations; and 7) findings and recommendations.

History and Types of Licensed and Accredited Treatment Facilities for Children and Youth

Licensing statutes date back to 1939 and administrative rules were created in the 1970's and 1980's. Licensure and accreditation exist to ensure standards of care and safe environments for children. Family foster homes, child care programs, child placement agencies, shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers, independent living preparation programs, waived facilities, psychiatric residential treatment for substance use disorders, accreditation of outpatient substance use disorder treatment agencies, community mental health centers and prevention programs that serve youth fall under the purview of DSS.

Licensing, Accreditation and Certification Process

The Division of Child Protection Services (CPS) performs licensing responsibilities for family foster homes, child placement agencies, shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers, and independent living preparation programs. The Division of Behavioral Health (DBH) accredits substance use disorder treatment providers. Child Care Services (CCS) provides oversight to child care programs. Medicaid acts as the primary payer of treatment costs (not educational costs) for children placed in psychiatric residential treatment facilities. The Division of Economic Assistance (EA) is responsible for the Auxiliary Placement Program that pays educational expenses for youth in the legal custody of DSS, committed to the Department of Corrections (DOC) or youth in the legal custody of tribal court who are placed in group care centers for minors, residential treatment centers, intensive residential treatment centers, independent living preparation programs, community support providers, intermediate care facilities, or out of state group care centers and residential treatment centers. The Office of Provider Reimbursement and Audits establishes reimbursement methodology and rates for several of these entities. The Departments of Public Safety (DPS), Health (DOH), Human Services (DHS), DOC, and Department of Education (DOE) are also involved in this process.

Complaint Process

CPS has a Centralized Intake line for individuals to report concerns of alleged child abuse or neglect and staff are on-call 24/7 to receive emergency reports. DBH requires agencies to have written grievance policies. CCS has a hotline and online access for the public to report provider complaints.

Investigation Process

DSS is mandated to investigate reported incidents of child abuse and neglect involving a parent, guardian, or custodian. Reports are reviewed through a minimum of two-level oversight and may be screened out, referred to licensing, or assigned for investigation. Staff may investigate via an announced or unannounced, on-site monitoring visit.

Corrective Action Plans / Plans of Correction

CPS, DBH and CCS utilize a Corrective Action Plan (CAP) when non-compliance is found during a licensing study or complaint investigation. A CAP is a formal document that outlines the reason for non-compliance and actions necessary to achieve compliance. A CAP is monitored and closed when evidence of compliance is submitted. Monitoring can include announced or unannounced on-site visits. A licensee has the right to an administrative hearing if a negative action is taken against them.

Transparency and Confidentiality of Investigations

Transparency and confidentiality of investigations are important to DSS. Facility licensing studies must be available for public inspection and corrective action plans that are the result of non-compliance with licensing standards or an investigation are available upon request. CCS inspections and founded non-compliance results are accessible online. DBH is currently placing information online to include the Accreditation Certificate, on-site review report, plan of correction, and CAP and inspection reports for DBH or DOH.

Findings and Recommendations

After conducting a full analysis, DSS proposes the following recommendations: 1) increase number of licensing on-site visits; 2) enhance reporting process for serious injury and death including creation of a secure email box for reports to be sent to and dispositioned; 3) consideration of Auxiliary Placement from DSS to DOE; 4) revision of reporting protocols to CPS from licensees; 5) collaborate with providers to review licensure grievance procedures and draft a rule to support best practices; 6) explore legislation to create a grievance monitor; 7) add additional contracted investigators; 8) revise corrective action plan document and process; 9) transparency through creation of a central repository (one-stop shop) for DSS reports open to public inspection; 10) develop annual online report; and evaluate and identify opportunities for consolidation.

Conclusion

The State must clearly maintain its focus on ensuring children and youth placed in treatment facilities across the state are safe. There are areas needing attention and support to improve procedures and practices surrounding licensing, accreditation and certification of treatment facilities for children and youth in South Dakota. DSS is prepared to implement the above recommendations to ensure the welfare and safety of children and youth in South Dakota treatment facilities.

Overview

The Department of Social Services (DSS) has recently come under scrutiny regarding the regulation of treatment facilities for children and youth. DSS responded to several media and public information requests regarding the licensing and accreditation of these facilities by providing information allowable to be released under South Dakota law; however, South Dakota law prohibits the disclosure of confidential information.

In response to recent scrutiny, Governor Noem charged DSS with conducting a full analysis on the process for licensing and inspecting private treatment facilities for children and youth and to fully evaluate the Department's role in ensuring the wellbeing and safety of children placed there. She specifically asked for the implementation of more transparent reports on corrective action plans and to conduct independent contract investigations on reports of child abuse and neglect. The Governor also requested state agencies explore conducting more unannounced site visits to ensure proper care is consistently provided.

The analysis included a review of the role state agencies and divisions within them play surrounding accreditation and licensing of treatment facilities for children and youth in South Dakota, population served and referral process.

DSS, with input from multiple state agencies, has developed this report to help identify reforms in this critical area. The report provides descriptions and examples of facility types, outpatient treatment and prevention programs licensed and accredited by the South Dakota Department of Social Services and focuses on the following:

- ❖ History and types of licensed and accredited treatment facilities for children and youth;
- ❖ Licensing, accreditation and certification process;
- ❖ Complaint process;
- ❖ Investigation process;
- ❖ Corrective action plans / Plans of correction;
- ❖ Transparency and confidentiality of investigations; and
- ❖ Findings and recommendations.

DSS recommendations were developed in the following areas:

- ❖ Increase number of licensing on-site visits;
- ❖ Enhance reporting process for serious injury and death including creation of a secure email box for reports to be sent to and dispositioned;
- ❖ Consideration of Auxiliary Placement from DSS to the Department of Education (DOE);
- ❖ Revision of reporting protocols to CPS from licensees;
- ❖ Collaborate with providers to review licensure grievance procedures and draft a rule to support best practices;
- ❖ Explore legislation to create a grievance monitor;
- ❖ Add additional contracted investigators;
- ❖ Revise corrective action plan document and process;

- ❖ Transparency through creation of a central repository (one-stop shop) for DSS reports open to public inspection;
- ❖ Develop annual online report; and
- ❖ Evaluate and identify opportunities for consolidation.

History and Types of Licensed and Accredited Treatment Facilities for Children and Youth

The vision of DSS is “Strong Families – South Dakota’s Foundation and Our Future.”

South Dakota has a long history of striving to keep families strong, safe and together. The first licensing statutes were put into place in 1939 requiring licensure or registration for child care or placement by public or private agencies. The law designated that no entity, other than DSS, may establish or maintain a child welfare agency or receive children for care or for placement in a family home unless appropriately licensed or registered to do so by DSS. In the 1960’s, categories defining child welfare agency licenses were first added to the law and currently include intensive residential treatment centers, residential treatment centers, group care centers, group homes, foster homes, day care centers, child placement agencies, group family day care homes, before and after school day care programs and independent living preparation programs. Then, in the late 1970’s and early 1980’s administrative rules were created to add provisions and scope of services surrounding regulatory administration of these categories.

Under the direction of Governor Dennis Daugaard, behavioral health services in South Dakota transitioned from the Department of Human Services (DHS) to DSS effective April 14, 2011. The purpose of the behavioral health reorganization was to create a more integrated approach to behavioral health services in South Dakota. A workgroup was tasked with identifying systems-change initiatives important to realizing improvements to meet the needs of children, youth and adults who seek behavioral health care services.

Department of Social Services (DSS)

DSS performs licensing and/or accreditation of facilities that provide care and treatment for children and youth in South Dakota. Licensure and accreditation exist to ensure agencies maintain an acceptable standard of care and provide a safe environment for children. Within the Department, the Divisions of Child Protection Services (CPS), Behavioral Health (DBH) and Child Care Services (CCS) all perform some variation of these functions.

The Department also provides oversight of family foster homes, child care programs and child placement agencies. Additionally, the following licensed and/or accredited facilities fall under the purview of DSS and are utilized:

- ❖ Shelter care facilities
- ❖ Group care centers for minors
- ❖ Residential treatment centers
- ❖ Intensive residential treatment centers
- ❖ Independent living preparation programs
- ❖ Waivered facilities
- ❖ Psychiatric residential treatment for substance use disorders

In South Dakota, residential treatment centers and intensive residential treatment centers are also referred to as psychiatric residential treatment facilities (PRTFs). Throughout the report these facilities are identified as shown in statute and administrative rules.

The Department is also responsible for accreditation of outpatient substance use disorder treatment agencies, community mental health centers and prevention programs that serve youth.

Division of Child Protection Services (CPS)

CPS licensing responsibilities for non-facilities includes family foster homes and child placement agencies. The Division has agreements or contractual relationships with family foster homes and child placement agencies to provide care in a community setting for children and youth who are under the State's custody.

Family Foster Homes

Foster families are relatives or non-relatives who are trained and licensed, providing 24-hour care and supervision for children who have been abused and/or neglected. Foster parenting promotes the healing process by offering a safe and stable environment until a child can return home or establish an alternative lifelong relationship with a caring adult through guardianship, adoption, or another permanent situation.

DSS' Division of CPS contracts with Children's Home Society (CHS) to complete activities needed to license foster homes. These activities include inquiries on becoming a foster parent, training, and completing home studies. CHS makes recommendations on whether a family is suited to provide foster care, and DSS makes the final decision regarding licensure.

As of July 1, 2019, the Division of CPS is responsible for the licensure of 854 family foster homes.

The following example, as well as those contained throughout the remainder of the report, are taken from actual Department case files, with identifiable information redacted and the case generalized. Examples are provided to illustrate the complexity of the physical, emotional, and behavioral health needs of children and youth in out of home care. Below is an example of a child who was placed in a family foster home:

A one-year old born at 30 weeks gestation and addicted to drugs remained in the Neonatal Intensive Care Unit (NICU) until ready for discharge after two-months in the hospital. The child suffered from underdeveloped lungs as a result of being born prematurely and had a heightened risk of becoming fatally ill if not in a safe environment, free from cigarette smoke. Due to the parents' not having a safe and stable living environment and not being able to meet the child's medical needs, and no relatives to care for the child, the court granted DSS emergency custody with placement in a family foster home.

Child Placement Agencies (CPA)

Treatment foster care is a service available through child placement agencies that provides mental health supports and case management to a foster home licensed by the child placement agency. Children placed at this level of care have suffered significant emotional trauma or have behavioral needs requiring a higher level of foster care. This service is available to children until their 18th birthday.

Child placement agencies that provide treatment foster care receive referrals from DSS, Department of Corrections (DOC), and tribal child welfare programs via telephone calls followed by an application. When children are referred to a CPA, they are matched with a foster family equipped to meet the child's needs.

Adoption services are also provided by some of the child placement agencies. Services provided by CPAs include working with women who are considering an adoption plan for their babies and approving families for private adoptions.

Child placement agencies offering adoption services receive referrals from women wanting to make an adoptive plan for their baby and from families seeking to adopt a child.

There are 16 child placement agencies in South Dakota. Five (5) provide treatment foster care, seven (7) provide adoption services, and two (2) provide both treatment foster care and adoption services. Two (2) are licensed but are not actively providing services.

Below is an example of a youth supported through a child placement agency:

A sibling group of nine came into care due to neglect by the parents including meth use, physical and sexual abuse. One of the siblings, age 15, required treatment in a group care facility. The 15-year old was diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Unspecified Psychosis. The sibling would claim to not remember situations or deny doing anything wrong, would struggle when held accountable, become inappropriate and make threatening statements. After successfully completing treatment in a group care center for minors, the 15-year old was placed in a licensed treatment foster home through a child placement agency.

The Division of CPS also has licensing responsibilities for treatment facilities caring for children and youth including shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers, and independent living preparation programs.

Shelter Care Facilities

Shelter care facilities are group care centers providing short-term care for children often placed under emergency conditions. Care is provided for not more than 30 days unless an extension of no more than 30 days has been granted because a placement plan has been made but cannot be implemented within the 30-day time frame.

Due to the emergency nature of shelter care facilities, referrals are made via telephone calls to the facility from DSS, DOC, and tribal child welfare programs.

There are six (6) shelter care facilities located throughout the state including ARISE West, Rapid City; ARISE East, Sioux Falls; Children's Inn, Sioux Falls; Cheyenne River Sioux Tribe Emergency Shelter Home, Eagle Butte; Spotted Tail Children's Home, Mission; and Oglala Sioux Tribe Emergency Youth Center, Pine Ridge.

The staff to child ratio for shelter care is 1:8 during waking hours and 1:25 during sleeping hours.

Below are two examples of youth placed in a shelter care facility:

A 17-year old disrupted from a foster home. A statewide search for another foster family produced no placement options; therefore, the youth was placed at a shelter care facility awaiting acceptance into Job Corps.

A 16-year old was placed at a shelter care facility after running away from a foster home. There was not a foster family available to care for a youth with runaway behaviors. The youth remained at the shelter care facility until a group care placement was located.

Group Care Centers for Minors

Group care centers for minors provide group care, maintenance, supervision, and protection of children on a regular full-time basis as a substitute for regular parental care, in a non-family group setting. Children who are experiencing family problems and interpersonal conflicts, who are unable to remain in a family setting and require ongoing group and individual counseling or alternative services in a structured treatment program may be placed in a group care center for minors. Group care placements are warranted when a youth is displaying mild to moderate social behavioral, educational, and emotional problems. Examples of challenging behaviors are aggressive behaviors, assaulting others, harming themselves, and running away.

Group care centers for minors most often receive referrals from DSS, DOC, tribal child welfare programs, and parents via telephone calls followed by an application for admission.

There are six (6) group care centers for minors located throughout the state including New Beginnings Center, Aberdeen; McCrossan Boys Ranch, Sioux Falls; Wellfully Family Reconciliation Center, Rapid City; Sacred Heart Center, Eagle Butte; Sequel Falls Academy, Sioux Falls, and Sequel Transition Academy, Sioux Falls.

The staff to child ratio for group care centers for minors is 1:8 during waking hours and 1:25 during sleeping hours.

Below is an example of a youth placed in a group care center for minors:

A 15-year old and two younger siblings came into care through state court due to neglect by a relative caretaker. The mother's whereabouts were unknown throughout the case and dad was in jail. There was little supervision in the caretaker's home. The 15-year old was under the influence of substances at the time of removal and was placed in a group care center for minors where the youth is working on abstaining from substances and healthy interactions with authority figures and peers.

Residential Treatment Centers

Residential treatment centers provide care to children who have behavioral or emotional problems and require intensive professional assistance and therapy in a highly structured, self-contained environment. Medicaid pays for the cost of treatment.

Residential treatment centers receive referrals from DSS, DOC, tribal child welfare programs, school districts, and parents. Referral forms are sent to the State Review Team (SRT) facilitator. The SRT is comprised of representatives from the Departments of Social Services, Corrections, Human Services and Education. The SRT meets weekly to review and discuss each referral and provide a recommendation of approval or denial for placement. The SRT facilitator sends the recommendation to the Peer Review Organization (PRO) Certification Team for final determination of medical necessity for placement. The Division of Medical Services contracts with the PRO, South Dakota Foundation for Medical Care to serve as the Certification Team. The PRO physicians are Board Certified in Child/Adolescent Psychiatry and the PRO nurse is certified by the American Nurses Credentialing Center in Psychiatric and Mental Health Nursing, Addictions Nursing and Managed Care Nursing. The PRO Certification Team notifies the SRT facilitator of the determination, who then notifies the referring party and provider, if known, of the placement decision. If it is determined a child does not meet criteria, a denial letter which outlines their right to a fair hearing if they are not in agreement with PRO's decision, is sent to the referring party. Approval for placement is usually for a six-month period. Documentation for additional treatment stays must be provided to PRO for review and approval. No child is to be placed into a residential treatment center until Medicaid approval has been received from the PRO.

There are seven (7) residential treatment centers located throughout the state including Abbott House, Mitchell; Black Hills Children's Home, Rockerville; Sioux Falls Children's Home, Sioux Falls; Canyon Hills Center, Spearfish; Summit Oaks Center, Sioux Falls; Our Home, Parkston; and Our Home ASAP, Huron.

The staff to child ratio for residential treatment centers is 1:6 during waking hours and 1:12 during sleeping hours.

Below is an example of a child placed in a residential treatment center:

An 11-year old was removed from the home due to physical abuse and placed in foster care. The child reported being physically abused by the mother. It was

reported that the mother would whip the 11-year old with a charger cord when the mother thought the child did something wrong or was bad. The mother would also leave the child home alone. The child struggled with aggressive behaviors in the foster home including hitting, kicking, screaming and throwing things. Due to increased aggressive behaviors in the foster home it was determined a higher level of care was necessary. The child was placed at a residential treatment center where therapies were provided to address the behavioral and emotional needs of the child.

Intensive Residential Treatment (IRT) Centers

Intensive residential treatment (IRT) centers provide the most structure, therapy and care for children in a group or residential setting. A youth is eligible for placement in an IRT center if there is written documentation that the child did not respond to treatment in a residential treatment center, was denied placement in a residential treatment center, or left a residential treatment center before completing treatment. The child must also have a documented, chronic history of high level physical or sexual aggression.

Intensive residential treatment centers receive referrals from DSS, DOC, tribal child welfare programs, school districts and parents. Referral forms are sent to the SRT facilitator. The SRT is comprised of representatives from the Departments of Social Services, Corrections, Human Services and Education. The SRT meets weekly to review and discuss each referral and provide a recommendation of approval or denial for placement. The SRT facilitator sends the recommendation to the Peer Review Organization (PRO) Certification Team for final determination of medical necessity for placement. The Division of Medical Services contracts with the PRO, South Dakota Foundation for Medical Care to serve as the Certification Team. The PRO physicians are Board Certified in Child/Adolescent Psychiatry and the PRO nurse is certified by the American Nurses Credentialing Center in Psychiatric and Mental Health Nursing, Addictions Nursing and Managed Care Nursing. The PRO Certification Team notifies the SRT facilitator of the determination, who then notifies the referring party and provider, if known, of the placement decision. If it is determined a child does not meet criteria, a denial letter which outlines their right to a fair hearing if they are not in agreement with PROs decision, is sent to the referring party. Approval for placement is usually for a six-month period. Documentation for additional treatment stays must be provided to PRO for review and approval. No child is to be placed into an intensive residential treatment center until Medicaid approval has been received from the PRO.

There is only one (1) IRT in South Dakota, the Aurora Plains Academy in Plankinton.

The staff to child ratio is 1:3 during waking hours and 1:6 during sleeping hours.

Below is an example of a child placed in an intensive residential treatment center:

An 11-year old was removed from the home at the age of four due to witnessing the violent death of a relative in the home as well as suspected sexual abuse by a

relative and the parents' use of drugs and alcohol. Due to the traumatic events in this child's young life, the child has experienced multiple psychiatric placements. The child displays aggressive behaviors by physically attacking adults and other children, is defiant and attempts to run away. As a result, the 11-year old was transferred to an intensive residential treatment center to address behaviors resulting from the trauma.

Independent Living Preparation Programs

Independent Living Preparation programs are licensed and provide services to youth 16 to 21 years of age. Youth placed in this level of care receive services to teach self-sufficiency and responsible independent living. These agencies can be operated by child placement agencies, group care centers, or residential treatment centers.

There are four (4) of these programs in the state including McCrossan Boys Ranch, Sioux Falls; Volunteers of America Dakotas, Sioux Falls; Abbott House, Mitchell; and New Alternatives, Rapid City.

There is not a staff to child ratio for waking and sleeping hours; however, there are requirements for supervision.

Below is an example of a child or youth placed in an independent living preparation program:

A youth (currently age 19) came to the United States from a foreign country at age three. The three-year old had been abandoned by the father and left with a woman referred to as grandmother; although there was no biological relationship. Prior to 9th grade, the child had resided in Pennsylvania, Iowa, back to Pennsylvania, and then New York. The youth moved to South Dakota and completed 9th grade. A woman from a church brought the youth to the McCrossan Boys Ranch for a tour as she was looking for a place for him to stay. The boy's grandmother had left him to return to Pennsylvania. The boy was homeless and sleeping in abandoned houses, living in the streets. Since he was abandoned, custody was awarded to the Department of Social Services with placement at a group care center for minors before entering an independent living preparation program where he recently obtained his high school diploma, and to learn skills such as budgeting, preparing a resume, completing job applications and preparing for interviews to assist with the transition to adulthood. He is preparing to transition to Job Corps and would like to become a certified nursing assistant.

Waivered Facilities

[SDCL 26-6-9](#) allows waiver of licensure as a child welfare agency to agencies similarly regulated by another state agency. The agency requesting waiver of licensure must provide DSS with appropriate documentation to validate accreditation, certification or licensure by the state regulatory agency.

In order to continue the waiver, it is required that a request for waiver along with documentation of progress in the certification renewal process and/or a current certificate for a specific period be submitted to DSS' Division of CPS.

Below is an example of a situation when licensure was waived:

Southeastern Behavioral Health Care is a facility certified by the Department of Human Services (DHS), which allows the Department of Social Services (DSS) to use the DHS accreditation. Licensure of Southeastern Behavioral Health Care was waived based on documentation submitted from DHS' Division of Developmental Disabilities verifying that the agency was certified as a Certified Community Health Support Provider.

Division of Behavioral Health (DBH)

The Division of Behavioral Health accredits substance use disorder agencies for the following: substance use disorder psychiatric residential treatment, outpatient substance use disorder treatment, residential and inpatient substance use disorder treatment for adults, and substance use disorder prevention. In addition, the Division accredits community mental health centers for outpatient mental health services.

Substance Use Disorder Psychiatric Residential Treatment Facilities (PRTF)

The Substance Use Disorder PRTF's provide intensive inpatient treatment for youth with substance use disorders, who require a structured, supervised environment while participating in treatment, and whose substance use disorder treatment needs are unable to be met in a lower level of care in the community.

Length of stay is determined by clinical necessity and reviewed at least every 14 days to determine if the individual is making progress and working toward goals so that continued treatment at this level of care is appropriate, or if transfer to another level of care is needed. The average length of stay over the past five years has been 49 days.

Substance Use Disorder (SUD) PRTF services require prior authorization of funding from the Division of Behavioral Health (DBH) and Division of Medical Services (DMS). A referral is generated through an assessment process which provides a SUD diagnosis and recommendation for this level of care, which is submitted to the DBH for review. DBH staff submit to the Peer Review Organization (PRO) team to review for medical necessity. If it is determined that medical necessity is met for this level of care, the prior authorization of funding is completed. The referring agency works with the PRTF facility to coordinate admission.

There are four (4) substance use disorder psychiatric residential treatment facilities in the state including Wellfully dba Wellspring, Rapid City; Volunteers of America Dakotas, Sioux Falls; Our Home Rediscovery, Huron; and Bowling Green Inn dba Keystone Treatment Center, Canton.

Substance use disorder psychiatric residential treatment facilities follow staff to child ratios required by their national accreditation.

Below is an example of a youth placed at a substance use disorder psychiatric residential treatment facility:

A 17-year old was asked to complete an updated substance use assessment after on-going use of marijuana while in intensive outpatient treatment. During the updated assessment, the 17-year old reported continued use of alcohol and marijuana; admitted drinking a half bottle of vodka when drinking and smoking three joints daily; is often late for school or doesn't go at all; grades are slipping; doesn't enjoy things previously enjoyed (e.g., reading, drawing, and acting); and stated 95% of friends either drink or use drugs. The youth reported being an only child; father is supportive of sobriety; mother drinks and cannot be relied upon. The 17-year old has tools to stay sober and some days wants to stop using, and other days does not. Because the 17-year old continues to use and substance use has increased, the treatment recommendation is for inpatient treatment services where the youth will be able to receive intensive services in a residential setting as well as have family participate in family counseling.

Outpatient Substance Use Disorder Treatment Agencies

There are 40 accredited substance use disorder treatment agencies throughout the state including the four substance use disorder PRTFs. Of the 40 agencies, 35 are accredited for outpatient substance use disorder treatment and may provide outpatient treatment to adolescents.

The Division of Behavioral Health contracts with 30 of the 35 accredited outpatient treatment agencies located across the state.

Below is an example of a child or youth who may be receiving treatment at an outpatient substance use disorder treatment agency:

A 16-year old went to an outpatient substance use disorder treatment agency for a substance use assessment due to the mother reporting she is worried about the 16-year old's use. The 16-year old reported using alcohol and smoking marijuana; attended diversion classes for underage drinking; in the last few months consumption has increased; has used marijuana a few times during the last six months; friends have expressed concern about use of alcohol and want him on the basketball team; lost parents' trust, hangs out with a bad crowd. The youth reported not wanting the use of alcohol and marijuana to impact younger siblings; feels like may need some help but feels like has using under control. Based on reported use, supportive family and friend network as well as pro-social activities, the addiction counselor recommended outpatient treatment where the 16-year old will receive up to 6 hours of treatment services a week including individual, family and group counseling.

Community Mental Health Centers

Community Mental Health Centers provide emergency services 24 hours per day, seven days a week, assessment services, outpatient services, and specialized outpatient services for children or youth and adults.

The Division of Behavioral Health contracts with 11 Community Mental Health Centers (CMHC) that cover every county in the state.

Below is an example of a youth who received treatment from a community mental health center:

A 15-year old was referred by the school counselor to a community mental health center for services due to signs of depression, low self-esteem and thoughts of self-harm. The 15-year old had been skipping school or coming late to classes. The youth's parents divorced and the 15-year old is struggling with the relationship with both parents. The youth has difficulty sleeping and thoughts of cutting self. Mother reports the youth does not have any friends, has been withdrawn at home from siblings, and grades have recently dropped in school. The youth was diagnosed with depression and anxiety and will receive individual and family counseling at a community mental health center.

Prevention Programs

The Division of Behavioral Health accredits 22 prevention providers that provide substance use disorder prevention programming. A prevention program encompasses current research, theory, and practice-based strategies and activities implemented through structured prevention strategies. Agencies providing prevention programs delineate a work plan to outline the scope of services to be offered. One or more of the following services are offered by prevention program agencies: information dissemination services, education services, alternative services, problem identification and referral services, community-based services, and environmental services. The prevention agencies are accredited through [ARSD 67:61](#) in the same areas as SUD agencies but accreditation also has a focus on [ARSD 67:61:11](#).

The Division of Behavioral Health contracts with 20 of the 22 accredited prevention providers across the state.

Below is an example of a child or youth who received services through a prevention program:

A 15-year old was caught drinking alcohol at school and was referred to meet with the prevention specialist to complete a substance use screening. Based on the results of the screening, it was recommended the youth complete a 10-hour primary prevention program. The mother signed the 15-year old up for the program through the accredited prevention agency, which is an evidence-based prevention program designed to change drinking and drug use behaviors by changing beliefs, attitudes, risk perceptions, motivations and the knowledge of

how to reduce the risk of alcohol and drug related problems. The youth will attend four 2.5-hour sessions in a group setting to successfully complete the program.

Division of Child Care Services (CCS)

The Division of Child Care Services (CCS) regulates child care programs including registered family day care homes, group family day care homes, day care centers, and before and after school programs. The Division of Child Care Services is committed to improving the quality, availability and affordability of child care and before and after school programs in South Dakota. The Division helps parents, providers and others promote the importance of providing safe, healthy, and caring environments for children through the regulation and support of programs that provide care and supervision of children.

Registered Family Day Care Homes

South Dakota law defines a Family Day Care Home as providing care and supervision of children from more than one unrelated family, in a family home, on a regular basis for part of a day as a supplement to regular parental care, without transfer of legal custody or placement for adoption. A family day care home may not be registered for care and supervision of more than 12 children at any one-time including children under the age of six who are living in the home.

The Sioux Falls Health Department manages a required city registration process for family home providers within the city limits of Sioux Falls. Child Care Services has a Memorandum of Understanding (MOU) with the city to share certain information on providers who are city and state registered to reduce duplication of efforts.

A family day care provider may care for a maximum of 12 children, including the provider's own children who are under the age of six years. No more than four of the 12 children may be under the age of two years, and no more than two of these four children may be under the age of one unless there is a helper in the home. If a helper is present in the home, no more than eight of the twelve children may be under the age of two and no more than four of the eight may be under the age of one.

There are 447 providers who care for up to 12 children in their home that are voluntarily registered with the Division of Child Care Services. State law does not require registration. Providers who care for up to 12 children in their home but choose not to register with Child Care Services, are not eligible to receive public funding which includes child care assistance through the Department, and the Child and Adult Care Food Program funds provided by the Department of Education (DOE).

Below is an example of a child receiving care at a registered family day care home:

A child, typically between birth and 12 years of age, attends a family day care home to receive temporary care and supervision. This care is from an individual who is not related to the child.

Group Family Day Care Homes

South Dakota defines a Group Family Day Care Home as providing group care and supervision of children on a regular basis for part of a day as a supplement to regular parental care, with or without compensation, for 13 to 20 children, including children under the age of six living in the home and children from more than one unrelated family received for day care, in any facility, including a family home. Group family day care homes are required to obtain a license prior to providing care.

Licensed child care for group family day care homes staff to child ratio is as follows:

- ❖ For children up to three years of age, one staff person to every five children, or fraction thereof; (ages 0-3 = 1:5 ratio)
- ❖ For children three to six years of age, one staff person to every 10 children, or fraction thereof; and (ages 3-6 = 1:10 ratio)
- ❖ For children six years of age or older, one staff person to every 15 children, or fraction thereof; (ages 6 and up = 1:15 ratio)

The staff to child ratio of mixed-age groups must meet the requirements of the age grouping that comprises the majority of the children except when children under three years of age are present. When three or more children under the age of three years are present in the mixed-age group, the staff to child ratio for children under three years of age must be maintained.

There are currently 48 licensed group family programs.

Below is an example of a child receiving care at a group family day care home:

A child, typically between birth and 12 years of age, attends a group family day care for the purpose of temporary care and supervision while their parent is away.

Day Care Centers

South Dakota law defines a day care center as the providing of group care and supervision of children on a regular basis for part of a day as a supplement to regular parental care, with or without compensation, for 21 or more children, including children under the age of six living in the home and children from more than one unrelated family received for care in any facility, including a family home. Day care centers are required to obtain a license prior to providing care.

Licensed child care for day care center staff to child ratio is as follows:

- ❖ For children up to three years of age, one staff person to every five children, or fraction thereof; (ages 0-3 = 1:5 ratio)
- ❖ For children three to six years of age, one staff person to every 10 children, or fraction thereof; and (ages 3-6 = 1:10 ratio)
- ❖ For children six years of age or older, one staff person to every 15 children, or fraction thereof; (ages 6 and up = 1:15 ratio)

The staff to child ratio of mixed-age groups must meet the requirements of the age grouping that comprises the majority of the children except when children under three years of age are present. When three or more children under the age of three years are present in the mixed-age group, the staff to child ratio for children under three years of age must be maintained.

There are currently 220 licensed centers.

Below is an example of a child who receives care at a day care center:

A child, typically between birth and age 12 years of age, attends a day care center for the purpose of temporary care and supervision while their parent is away.

Before and After School Programs

South Dakota law defines a before and after school care program as the providing of care and supervision of children on a regular basis before and after regular school hours. Before and after school programs are required to obtain a license prior to the care of children enrolled in school.

The center must maintain a staff to child ratio of at least one staff person for every 15 children. The staff person may be included in the ratio if the staff member is at least 16 years of age and provides direct guidance and supervision of the children. The staff to child ratio must be maintained while children are on the playground.

There are currently 148 licensed programs.

Below is an example of a child who receives care at a before and after school program:

A child, at least age five and enrolled in school, attends a before and after school program for the purpose of temporary care while the parent is away.

Informal and In-Home Programs

Informal and in-home providers are not registered or licensed for the care provided to children from one family but are required to meet certain federal requirements when receiving child care assistance payments for care provided.

CCS just recently started regulating informal and in-home programs.

There are currently 24 regulated programs.

Below is an example of a child receiving care in an informal and in-home program.

A family chooses a friend or neighbor to care for their children, typically between birth and 12 years of age, while the parent is away.

Licensing, Accreditation and Certification Process

Beyond the licensing and accreditation functions through the Department of Social Services, multiple other state agencies also interact with these facilities either in providing additional licensing, accreditation, certification, or as a purchaser of services. The following is a description of the role DSS and other state government agencies play in ensuring the safety of children in our state.

Department of Social Services (DSS)

Division of Child Protection Services (CPS)

CPS licensing responsibilities include family foster homes, child placement agencies, shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers, and independent living preparation programs. Oversight authority by the Division of CPS comes from codified laws, state administrative rules, and federal rule. CPS regulates these programs through annual inspections to ensure compliance.

Basic licensing requirements of family foster homes include the following:

- ❖ Foster parents must be 21 years of age;
- ❖ Home safety checklist to ensure the home is be a safe place, without structural or health hazards;
- ❖ Family must have sufficient income to meet the essential needs of their family;
- ❖ Criminal background checks, central registry screenings and sex offender registry screenings;
- ❖ Health exam of adults and immunization records of children in the home;
- ❖ References from three individuals to share information about the ability of the perspective foster parents to provide care for children;
- ❖ Attendance and completion of a 30-hour foster parent education and training program; and
- ❖ Completion of a home study.

CPS has 18.5 family service specialists located in 15 DSS field offices responsible for the licensure of foster families. As of July 1, 2019, there are currently 854 foster family homes in South Dakota.

Licensing requirements for shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers and independent living preparation programs include the following:

- ❖ Licensing requirements
- ❖ Agency responsibilities
- ❖ Insurance
- ❖ Accounting systems
- ❖ Staff qualifications

- ❖ Staff to child ratio
- ❖ Personnel records (criminal background checks, central registry screenings and sex offender registry screenings)
- ❖ In-service training
- ❖ Reporting suspected child abuse or neglect, changes in circumstances, and serious occurrences
- ❖ Treatment
- ❖ Medications
- ❖ Emergency safety interventions (seclusion and restraints)
- ❖ Volunteers
- ❖ Physical facility (environmental health and safety standards such as food safety, cleanliness, children's health, medication administration, and Fire and life safety standards such as smoke detection, exiting, fire extinguishers, etc.)
- ❖ Emergency plans
- ❖ Nutrition

CPS has one licensing program specialist responsible for the licensing of 16 child placement agencies, six (6) shelter care facilities, six (6) group care centers for minors, seven (7) residential treatment centers, an intensive residential treatment center, and four (4) independent living preparation programs. Once licensed, [SDCL 26-6-13](#) requires a facility to submit an annual application for re-licensure which includes an on-site visit to assess compliance with state laws and administrative rules. Prior to the annual on-site licensing facility visit, documents such as changes in policy, proof of insurance listing of staff, staff schedules, annual financial audit, and proof of accreditation are submitted by the facility for review by the licensing program specialist. On-site visits are conducted by the licensing program specialist who is accompanied by the group and residential placement program specialist and at time other CPS staff. All staff involved with on-site licensing visits are trained in the compliance area they will assess and how to complete review tools. Compliance is assessed by interviewing residents and staff, reviewing personnel files, resident treatments plans, seclusion and restraint information, policies and procedures, and completing a walk-through of the facility. Prior to leaving the facility, an exit meeting is held with facility leadership to discuss areas of strength, recommendations for improvements and any areas of non-compliance with licensing rules that must be addressed through a formal corrective action plan which will be discussed later in the report. Following the on-site visit, the licensing program specialist completes a written licensing study and a certificate of licensure which is sent to the facility with a cover letter outlining what action(s), if any, the facility will need to take. The facility license is good for one year after which the relicensing process is repeated. The licensing study is available for public inspection based on [SDCL 26-6-11](#).

After doing a comparison of South Dakota, Minnesota and Iowa licensing standards, it was determined that South Dakota's licensing standards are comprehensive and comparable to Minnesota and Iowa facility licensing standards. One area to highlight is

the length of time between onsite licensing renewal visits. Minnesota requires a licensing on-site visit every two years, and Iowa requires an on-site licensing visit every three years including one unannounced visit each year. The length of time between visits is variable, depending on the degree of deficiencies found during the licensing on-site visit, reports of abuse and neglect, and other concerns that may require additional oversight.

CPS licensure and relicensing process, including the on-site visit protocol, is being reviewed by CPS to determine enhancements to the process. Currently shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers, and independent living preparation programs have one announced annual licensing visit. While CPS staff who have children placed at the facilities make visits to see children and youth monthly, DOC staff visit youth quarterly, and more if needed. The perspective of both CPS and DOC staff is on the safety and well-being of the child or youth, not on the systemic function of the facility. The knowledge and skills necessary to effectively evaluate a facility's functioning is a unique skill set. In order to increase on-site licensing visits from one per year (40 visits) to semi-annually (80 visits) or quarterly (160 visits) will require an analysis of division capacity for increased workload. **(See Finding 1 on page 44.)**

Division of Behavioral Health (DBH)

The Division of Behavioral Health (DBH) currently accredits 40 substance use disorder treatment providers throughout the state. The four psychiatric residential treatment facilities (PRTFs) providing residential treatment for youth with substance use disorders have deemed status accreditation as they are required to have accreditation through a national accreditation. Deemed status is stated in [SDCL 34-20A-2\(1\)](#).

The DBH contracts with 33 of the 40 accredited substance use disorder treatment agencies. The agencies that do not have a deemed status accreditation through a national accreditation (33 agencies) are reviewed every two to three years based on their compliance percentage during the previous on-site review. If an agency is in compliance with 90 percent or more of the requirements, the agency is granted a three-year accreditation certificate. If an agency is in 70 to 89 percent compliance of the requirements, the agency is granted a two-year accreditation certificate. If an agency is less than 70 percent compliant with the requirements, the agency is placed on probation. During the on-site survey, a substance use disorder treatment agency is reviewed for adherence to the Administrative Rules of South Dakota [ARSD 67:61](#) and contract attachments including the following areas:

- ❖ Governance
- ❖ General management requirements
- ❖ Personnel
- ❖ Client rights
- ❖ Clinical processes
- ❖ Medication control in residential programs

- ❖ Dietary services
- ❖ Environmental sanitation safety and fire prevention
- ❖ Eligibility criteria
- ❖ Intensity of services

The scores are derived from the on-site survey reviewing policies and procedures, personnel and case file records, and conducting interviews with clients, administration, and agency staff.

The DBH accredits 11 community mental health centers (CMHCs, or “centers”) that cover every county in the state. The centers are reviewed every two to three years based on their compliance percentage during an on-site review. If a center is in compliance with 90 percent or more of the requirements, the center is granted a three-year accreditation certificate. If a center is in 70 to 89 percent compliance of the requirements, the center is granted a two-year accreditation certificate. If an agency is less than 70 percent compliant with the requirements, the center is placed on probation. During the on-site survey, a center is reviewed for adherence to the Administrative Rules of South Dakota [ARSD 67:62](#) and contract attachments including the following areas:

- ❖ Governance
- ❖ Core service responsibilities
- ❖ General management requirements
- ❖ Personnel
- ❖ Client Rights
- ❖ Clinical Processes
- ❖ Environmental sanitation safety and fire prevention
- ❖ Eligibility Criteria
- ❖ Intensity of Services

The scores are derived from the on-site survey reviewing policies and procedures, personnel and case file records, and conducting interview with clients, administration, and center staff.

The DBH accredits 22 prevention programs. The prevention agencies are accredited through [ARSD 67:61](#) in the same areas as SUD agencies and specifically [ARSD 67:61:11](#).

DBH has four staff with accreditation responsibilities for 40 substance use disorder treatment programs, 11 community mental health centers, and 22 prevention programs.

Division of Child Care Services (CCS)

Child Care Services’ (CCS) authority to provide oversight to child care programs comes from codified laws, state administrative rules and federal rule. CCS regulates these programs through annual inspections to ensure compliance with the following requirements:

- ❖ Background checks

- ❖ Orientation training
- ❖ Ongoing annual training
- ❖ Staff qualifications
- ❖ Staff to child ratios
- ❖ Environmental health and safety standards such as food safety, cleanliness, children's health, medication administration, playground safety
- ❖ Emergency preparedness plans
- ❖ Nutrition
- ❖ Discipline
- ❖ Fire and life safety standards such as smoke detection, exiting, fire extinguishers

Ten CCS licensing specialists conduct all initial inspections for all types of programs listed above. These 10 licensing specialists complete the programming inspection for all licensed programs. Inspectors from the Department of Public Safety (DPS) conduct the fire and life safety inspection annually for all licensed programs. DPS and CCS share in the renewal inspections of registered family day care homes.

Complaint inspections related to licensing standards are investigated by CCS licensing specialists. CPS or law enforcement investigate allegations of child abuse or neglect in child care programs.

CCS contracts with five Early Childhood Enrichment (ECE) programs to provide training and technical assistance to child care providers statewide. This helps providers meet training requirements and supports providers and programs in ensuring they meet minimum licensing standards. In addition, the ECE's support programs in improving the quality of care above licensing requirements. Activities such as this are required by the federal Office of Child Care through the Child Care & Development Block Grant which provides funding to CCS.

CCS' 10 licensing specialists have responsibility for registration and licensing for 447 family day care homes, 48 group family day care homes, 220 day care centers, and 148 before and after school programs.

Other divisions within DSS also impact the services provided to children and youth placed in facilities.

Division of Medical Services (MS)

Since Medicaid acts as the primary payer of treatment costs (not educational costs) for children placed in psychiatric residential treatment facilities (PRTFs) there are federal regulations that the Division of Medical Services and PRTFs must comply with.

The Centers for Medicare and Medicaid Services (CMS) per the Code of Federal Regulation ([42 CFR §483.374](#)) require all State Medicaid Agencies to obtain a written attestation from each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21, that the facility is in compliance with CMS's standards governing the use of restraint and seclusion. This attestation must be signed by the facility

director. The completed attestation form is also shared with the South Dakota Department of Health (DOH), Office of Licensure and Certification (OLC), as the state survey agency.

The Division of Medical Services administers a contract with the Peer Review Organization (PRO), South Dakota Foundation for Medical Care to serve as the certification team for approval of psychiatric residential treatment facility (PRTF) placements. The PRO physicians are Board Certified in Child/Adolescent Psychiatry and the PRO nurse is certified by the American Nurses Credentialing Center in Psychiatric and Mental Health Nursing, Addictions Nursing and Managed Care Nursing. The PRO Certification Team receives PRTF referrals from the SRT facilitator and notifies the SRT facilitator of the determination. Approval for placement is usually for a six-month period with additional treatment time approved by PRO. No child is placed in a psychiatric residential treatment facility until Medicaid approval has been received from the PRO.

The Code of Federal Regulation ([42 CFR §483.374](#)) also requires psychiatric residential treatment facilities to report to the state Medicaid agency (Division of Medical Services) and the State-designated Protection and Advocacy system (Disability Rights South Dakota) a resident's death, a serious injury to a resident as defined in [§483.352](#) (burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else) and a resident's suicide attempt.

Review of the process for Psychiatric Residential Treatment Facilities (PRTFs) to report serious injuries or death as required by federal law [42 CFR §483.374](#) to the State Medicaid agency and the State-designated Protection and Advocacy system (Disability Rights South Dakota) was found to lack controls to ensure compliant reporting of incidents in a consistent format, as well as consistent disposition of reports received. **(See Finding 2 on page 44.)**

Division of Economic Assistance (EA)

The Auxiliary Placement Program pays educational expenses for youth in the legal custody of DSS, committed to the DOC or youth in the legal custody of tribal court who are placed in group care centers for minors, residential treatment centers, intensive residential treatment centers, independent living preparation programs, community support providers, intermediate care facilities, or out of state group care centers and residential treatment centers pursuant to [ARSD 67:22:01:02](#).

The tuition rate paid by the Auxiliary Placement Program is set annually by DSS. The full rate is paid for school days that include at least 5.5 hours of instructional time. One-half of the rate is paid for school days that include less than 5.5 hours of instructional time. If a child is residing in a residential treatment center that provides an educational program through a school district, the school district where the residential treatment center located is responsible for providing an educational program for the child. Monies received by the school district from the DOE in the form of general state aid to schools as calculated pursuant to [SDCL 13-13-73](#) and state aid for special education as calculated under [SDCL](#)

[13-37-36.3](#) reduce the Department's payment obligation under [SDCL 13-28-39](#) the extent the DOE payments are attributable to children in the Auxiliary Placement Program.

Tuition for a child who is not eligible for special education services or the Auxiliary Placement Program and is enrolled in a public school district or state operated school at the time of placement shall be paid by the DOE pursuant to [SDCL 13-28-11](#). Tuition for a child who is eligible for special education services and not eligible for the Auxiliary Placement Program shall be paid by the school district in which the child resided prior to placement in a residential treatment facility. It is up to that specific school district to agree to fund educational cost for an out of district placement of a child receiving special education services.

The Auxiliary Placement Program moved from DOE to DSS in 1995. At that time, all children and youth in group care centers for minors and residential treatment centers were in the custody of DSS CPS, so it was decided the Auxiliary Placement Program should be with DSS. Today, DSS, DOC, Bureau of Indian Affairs (BIA), tribal child welfare programs, school districts and parents seek placements of children and youth in group care centers for minors, residential treatment centers, and intensive residential treatment centers. Agreements between DSS and DOE and changes in state statutes have led to ongoing interactions between DSS and DOE regarding tuition payments when children are placed in these settings. DSS staff have been meeting with DOE staff to discuss ways to streamline the program and determine the best agency to house the program. (***See Finding 3 on page 45.***)

Office of Provider Reimbursement and Audits (PRA)

DSS is also the rate setting agency. The Office of Provider Reimbursement and Audits works with various programs within DSS to establish reimbursement methodology and reimbursement rates for several entities including hospitals, rural health clinics, medical providers, group care center for minors, residential treatment centers, intensive residential treatment centers, independent living preparation programs, inpatient and outpatient substance use disorder treatment providers, community mental health centers and prevention programs based on cost reports and other information submitted by the above entities.

Department of Public Safety (DPS)

Division of State Inspections

DPS inspectors conduct annual inspections in child care facilities as well as shelter care facilities, group care centers for minors, residential treatment centers, and intensive residential treatment centers to ensure compliance with Administrative Rules of South Dakota (ARSD) to include [ARSD 67:42.03](#), [61:15:05](#), [61:15:06](#), [67:42:07](#), [67:42:08](#), [67:42:10](#), [67:42:11](#), [67:42:14](#), [67:42:15](#), and [67:42:16](#) in two main areas:

- ❖ The Fire and Life Safety portion of the inspection ensures a program is maintaining areas such as unblocked exits, alarm system is operable, exit points are visible and accessible, electrical system is being used properly, sprinkler systems, etc.; and
- ❖ The Environmental Health portion of the inspection includes such areas as food handling, storage, and preparation techniques; housekeeping, garbage, rubbish, water and sewer, sanitization/cleanliness, handwashing, water sources and temperature; play areas are safe; etc.

DPS provides complete inspection reports to both CPS and CCS. DPS consults with CPS licensing program specialists regarding interpretation of rules and expectations of the Department as well as CCS staff. CCS staff provide annual ongoing training to DPS inspectors related to explanation and justification of child care regulations. Locally, new DPS inspectors shadow CCS licensing staff to learn philosophy and procedures utilized in inspection visits.

Any areas of non-compliance are noted on a compliance plan which includes a suggested date of completion. The DPS inspector shares areas of non-compliance and what needs to be done for correction with the provider before leaving the premises. The inspector sends the completed inspection form electronically to the licensing specialists for CCS and CPS for follow up to ensure compliance issues are corrected by the provider. If the provider fails to come into compliance, a formal corrective action plan under the oversight of CCS or CPS is implemented.

Department of Health (DOH)

Office of Health Care Facilities Licensure and Certification (OLC)

Among other areas, the Office of Health Care Facilities Licensure and Certification (OLC) staff are responsible for the Health and Life Safety inspections and licensure of health care facilities and Medicare and Medicaid certification of existing and new health care facilities and providers. The Centers for Medicare and Medicaid Services (CMS) maintains oversight for compliance with the Medicare health and safety standards.

OLC surveys investigate the health facility's compliance with rules and regulations relating to numerous areas including but not limited to: resident rights; quality of care; quality of life; freedom from abuse, neglect, and misappropriation; nursing services, quality assurance, etc. The surveyors utilize observation, interview, and record review to ensure compliance.

The Life Safety surveys investigate the health facility's compliance with rules and regulations involving fire safety, alternate power, safe building structures, safe egress, etc.

Surveyors (which include nurses, dietitians, pharmacists, laboratorians, x-ray technicians, and environmental sanitarians) review policies and procedures, staffing patterns and employee qualifications, orientation and in-service education, and standards of practice. They also review patient and personnel records, observe actual practice, and interview

patients and staff. OLC has offices in Pierre, Sioux Falls, Mitchell, Rapid City, and Spearfish.

OLC conducts investigations to verify that health care providers comply with the Conditions of Participation (CoPs) or requirements. This is referred to as the survey process. The survey (inspection) to determine compliance is done on behalf of CMS by the individual State Survey Agencies. The functions the States perform for CMS under the agreements in [Section 1864 of the Social Security Act](#) (the Act) are referred to collectively as the certification process. Federal certification surveys are conducted according to the CMS' timeline outlined within the CMS Mission Priority Document. Surveys are conducted using the appropriate State Operations Manual. CMS evaluates all State Survey Agencies each year by established performance measures including frequency, quality, and enforcement.

All surveys are documented on a *CMS-2567 Statement of Deficiency* form. If a deficient practice is cited, providers are required to submit a Plan of Correction (PoC) outlining how and when they will return to compliance. A revisit to ensure the provider follows the PoC is conducted by an on-site revisit or a phone visit.

Deficiencies are identified by the regulation or rule as well as Scope and Severity (S/S).

At the request of DSS, Child Care Services and Child Protection Services, DOH reviews the floor plans for new or renovated programs to ensure compliance with [ARSD 67:42:07](#), [67:42:08](#), [ARSD 67:42:10](#), [67:42:11](#), [67:42:14](#) and [67:42:15](#) and provides a copy of the completed plan review and recommendations to DSS. OLC consults with DSS on environmental non-compliance issues to ensure an adequate and timely plan is developed to bring the facility into compliance with regulations.

Division of Behavioral Health (DBH) annually contracts with DOH OLC to conduct surveys of community mental health centers and substance use disorder treatment (including inpatient chemical dependency treatment) facilities. A list of facilities requiring a survey is compiled and provided to the office by DSS. Surveys are conducted to determine compliance with Sanitations and Safety Standards ([ARSD 67:61:09:02](#); Safety and Sanitation plan; ([ARSD 67:61:10:01](#) and [ARSD 67:62:09:01](#)); and Life Safety Codes ([ARSD 67:61:10:02](#) and [ARSD 67:62:09:02](#)). When completing the annual on-site survey for inpatient chemical dependency treatment facilities, DOH also utilizes [ARSD 44:78](#) for compliance of physical and fire safety standards.

In addition, DOH OLC conducts federal certification and complaint surveys for the Centers for Medicare and Medicaid Services (CMS) to include seven residential treatment centers, one intensive residential treatment center, and four inpatient substance use disorder psychiatric residential treatment facilities. Criteria is based on [42 CFR 441.151 through 441.156](#). The Office determines compliance with federal standards and regulations, as set forth in 42 CFR 483, Subpart G. Frequency of certification surveys is determined by CMS, occurring approximately every 5 years. The Office survey focuses on several areas

primarily with restraint and seclusion. The surveys process involves observations, interviews, and the review of documentation and policies and procedures. A new federal requirement of the survey involves compliance with emergency preparedness. These facilities are licensed by the State Medicaid Agency (DSS). Each year a facility is not surveyed they are required to submit an attestation to the Division of Medical Services that they are in compliance with all federal regulations.

Department of Human Services (DHS)

Division of Developmental Disabilities (DDD)

The Division of Developmental Disabilities (DDD) under the SD Department of Human Services has funding, certification, and monitoring responsibilities for three non-profit community agencies serving children and youth with developmental disabilities. These agencies, which are certified by the DDD pursuant to [ARSD 46:11:02](#), are commonly referred to as community support providers (CSP) as defined by [SDCL 27B-1-17](#). These three agencies provide educational and residential services to nearly 100 children and youth with developmental disabilities. Providers remain certified in accordance with [ARSD 46:11:02:02](#) by undergoing review activities conducted by the DDD as described in [ARSD 46:11:02:09](#) and maintain good standing accreditation by the Council on Quality & Leadership. The three providers, described below, operate within the CHOICES Medicaid waiver program, which is administered by DHS, with oversight by DSS, Division of Medical Services and authorized by the Centers for Medicare and Medicaid Services. The three facilities are:

- ❖ Volunteers of America – West Oak
- ❖ Southeastern Directions for Life
- ❖ Black Hills Special Services Cooperative (BHSSC)

An on-site certification review of each provider is conducted every two years to ensure compliance with ARSD as well as CHOICES waiver requirements. DDD teams are assembled to include, minimally, the provider's assigned program specialist and a nurse. A sample review of personnel records is performed to ensure orientation training, on-going training, background checks, good standing with the Office of Inspector General (OIG), and drug screenings are completed. In addition to the biennial certification reviews, a representative sample of participant records are reviewed by DDD program specialists and nurses. These reviews assess all service plan and health & welfare elements for each participant on both their CSP and case management services. Leading up to the provider's certification renewal, each provider is required to develop and implement a DDD approved plan of enhancement to address systemic findings discovered during the monthly reviews and the on-site certification review. Providers are responsible through DDD's contract with The Council on Quality and Leadership to conduct Personal Outcome Measures Interviews (POMs) assessing outcomes and supports through individual interviews with participants supported. The scope and frequency of these POMs are driven by the CSP and their 4-year quality enhancement plan with the Council on Quality and Leadership (CQL).

Staffing ratios are determined on an individualized basis through team meetings held at least annually, led by case managers who are external to the CSP. If a participant has alone time in their home or the community without staff supervision this is agreed upon by the team and documented in the individual's annual service plan.

Department of Corrections (DOC)

Division of Juvenile Corrections

The Department of Corrections (DOC) provides a staff representative to participate in the State Review Team (SRT) as required by [ARSD 67:16:47:04.01](#). The DOC staff representative is responsible for completing the *State Review Team Level of Care Review Form* and submitting it to the SRT facilitator along with supporting documentation for all eligible youth in DOC custody.

The DOC determines the extent of security and treatment services provided to committed youth consistent with [SDCL 26-11A-8](#). As part of the agency's statutory responsibility, DOC contracts with facilities within and outside of the State of South Dakota. Through provider agreements DOC requires all contracted facilities to maintain and adhere to all current licensing standards and all related life-safety laws while providing services to youth referred by DOC.

DOC has specific policy and procedure related to out of home placement contact requirements. A juvenile corrections agent (JCA) is required to conduct an in-person quarterly review with all youth in placement settings. While this is a minimum expectation, JCA staff often exceed the minimum requirement as they may travel to the facility for the monthly reauthorization staffing. In accordance with [SDCL 26-8D-17](#) & [26-8D-18](#) and provider agreements, the DOC may place a child in a residential treatment center, intensive residential treatment center or group care center only in accordance with a performance-based reimbursement rate structure. The above statutes require the DOC to closely monitor the delivery of treatment services. The DOC is required to ensure contracted providers are meeting the treatment needs of DOC youth in the most efficient manner with the goal of conditional release to aftercare supervision and linkage to community-based services upon substantial completion of treatment plan goals. The DOC evaluates the need for continued out of home placement each month through the monthly reauthorization staffing process. This may be conducted in-person or via teleconference with the facility representative, JCA, youth and family.

Department of Education (DOE)

Division of Educational Services and Support

The Department of Education, Division of Educational Services and Support houses the Special Education Programs (SEP) office. SEP has the federal and state requirement to provide program monitoring and evaluation with its general supervisory responsibility under the Individuals with Disabilities Education Act, Part B, any agencies, institutions, and organizations responsible for carrying out special education programs in the state,

including any obligation imposed on those agencies, institutions and organizations pursuant to [ARSD 24:05:20:18](#).

The division also provides a member to participate in weekly state review team calls. One of the responsibilities of the department is to determine if a student is eligible for tuition payment based on [SDCL 13-28-11](#). Tuition for a child who is not eligible for special education services or the Auxiliary Placement Program and is enrolled in a public school district or state operated school at the time of placement shall be paid by DOE. Along with this responsibility is the actual payment of the tuition based upon [SDCL 13-13-87](#).

DOE, Office of Accreditation, provides state accreditation for school districts as required under [SDCL 13-1-12.1](#), [13-3-1.4](#), [13-3-47](#), and [13-13-18](#). The school district, where the residential treatment center is located, is responsible for providing an educational program for the child. As such, the facility is part of the school district's five-year accreditation timeline and must meet the relevant requirements of the school district where the facility is located.

Complaint Process

Department of Social Services (DSS)

Division of Child Protection Services (CPS)

CPS has a Centralized Intake line 1.877.244.0864 for individuals to report concerns of alleged child abuse or neglect Monday through Friday 8:00AM to 5:00PM. Outside of business hours, family services specialists are on-call to receive emergency reports. Reports can also be made in person or in writing. Reports may come from parents, relatives, neighbors, etc.

In addition to these reports, reports are also received from mandatory reporters. [SDCL 26-8A-3](#) defines mandatory reporters, who are the individuals required to report child abuse or neglect. The statute specifically names licensed or registered child welfare provider, which applies to all employees of a licensed facility. [SDCL 26-8A-8](#) directs reports to be made orally and immediately to the state's attorney, DSS, or to law enforcement officers.

In addition, [ARSD 67:42:01:12](#) requires the facility to report all incidents of suspected child abuse or neglect either to the department or to law enforcement officials and [ARSD 67:42:07:15](#) requires each staff member to immediately report any suspected incident of child abuse or neglect to the executive director or the director's designee. The executive director or the designee is to immediately report any suspected or alleged in-house incident of child abuse or neglect to the department and cooperate fully in the investigation of any incident.

As mandatory reporters, facility staff must provide detailed information about the incident for CPS to determine the intervention. Information not available at the time of the report must be provided to CPS as soon as possible. Mandatory reports from facilities of incidents include but are not limited to:

- ❖ Injuries resulting from a restraint or seclusion
- ❖ Self-inflicted injuries (e.g., suicide attempts or gestures)
- ❖ Injuries from physical contact between a child and staff
- ❖ Injuries from physical contact between children
- ❖ Sexual contact between children
- ❖ Sexual contact between staff and a child
- ❖ Lack of supervision
- ❖ Use of improper restraint or behavior management technique
- ❖ Use of excessive force

Management at a facility must assess the safety of the residents and take immediate personnel action as necessary. Staff provide therapeutic interventions immediately and following the incident to process potential trauma experienced by the child and to explain the reporting process.

Injuries that occur during recreational activities or are accidental in nature, do not require a report of child abuse or neglect to CPS; however, an incident report must be forwarded

to the placing agency and parent. Injuries that require off campus medical attention and are the result of self-harm, physical contact between children or a child and staff, must be reported to CPS. In addition, the Code of Federal Regulation ([42 CFR §483.374](#)) also requires psychiatric residential treatment facilities to report to the state Medicaid agency (Division of Medical Services) and the State-designated Protection and Advocacy system (Disability Rights South Dakota) a resident's death, a serious injury to a resident as defined in [42 CFR §483.352](#) (burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else) and a resident's suicide attempt.

Any suspected incidents of child abuse or neglect which occur outside of the facility (e.g., prior to being placed in the facility, on a home visit, etc.) also require a report to CPS Centralized Intake. Facilities must clearly document all incidents in the child's file.

[ARSD 67:42:01:12](#) states facilities are also required to report unusual incidents such as fire, death, client runaway, client/provider incompatibility, or serious injury to or serious illness of a client to the placing agency immediately after ensuring children in care are safe after the occurrence of the incident. This includes incidents requiring involvement of law enforcement with a child or youth.

Anytime there is a question of whether an incident should be reported to CPS Centralized Intake, facilities are advised to err on the side of caution and make a report.

CPS has a reporting protocol which provides guidance to facility providers when reporting alleged incidents of abuse and neglect, serious incidents or death, and runaway incidents, etc. To ensure the reporting protocol provided clear direction for facilities when making reports, CPS conducted an internal review of the facility reporting protocol and determined revisions were needed to enhance the reporting process. **(See Finding 4 on page 45.)**

The reporting protocol established by CPS for facilities was revised to provide clear direction to facilities when making reports. DSS met with South Dakota Association of Youth Care Providers on August 8, 2019 to review the revised facility protocol. DSS requested feedback by September 1, 2019 in order to finalize the protocol by September 15, 2019.

There is currently not a licensing rule requiring a standardized grievance procedure for children and youth placed in shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers and independent living preparation programs. However, most facilities have policies related to a grievance process for children and youth which include resident rights, a locked box for grievance forms to be placed in and the child or youth is allowed to speak to placing agency staff, their parent, or make a report to CPS. **(See Finding 5 on page 46.)**

Although facilities have policies and procedures to respond to grievances from children and youth, there is not an outside entity with the responsibility or authority to receive,

review and monitor grievances directly from children and youth. (*See Finding 6 on page 46.*)

Division of Behavioral Health (DBH)

DBH requires agencies to have a written grievance policy and procedure for hearing, considering and responding to client grievances per [ARSD 67:61:06:04](#) and [67:62:07:04](#). The agency must inform the client and client's parent or guardian in writing of the grievance procedure during the intake to services. The grievance procedure shall be posted in a place accessible to a client and a copy shall be available in locations the client can access it without making a request to agency staff. In addition, the grievance form must include the telephone number and address of the division.

Per [ARSD 67:61:02:21](#) and [67:62:02:19](#) each accredited agency shall make a report to DBH within 24 hours of any sentinel event and the report shall include a written description of the event, the client's name and date of birth and immediate actions taken by the agency.

If a complaint is received from a client there is an identified staff at DBH who take the initial call. Two staff are also identified by DBH as back-ups to take client calls if the primary staff is unavailable. Staff work with their supervisor to respond and address the complaint; if their supervisor is not available the staff will reach out to other leadership to assist. If a complaint is made against an agency that has deemed status accreditation, DBH would also work in conjunction with the national accrediting body.

Division of Child Care Services (CCS)

Child Care Services (CCS) has a hotline that parents or the public can use to report provider complaints. The toll-free hotline is announced on the Consumer Statement letter mailed to families and is available on the CCS website. When a call is received, CCS staff complete a complaint form to ensure necessary information is obtained. Messages left on the hotline are forwarded to the licensing specialist covering that area of the state as well as to the licensing supervisor. In addition, parents or the public can make a provider complaint report online via the CCS website and submit it to CCS for investigation. These are also forwarded to the licensing specialist covering that area of the state as well as to the licensing supervisor. The hotline number and the complaint form are both found on the CCS website at <http://dss.sd.gov/childcare/licensing/>. This process is the same for all categories of care.

Complaints are received via referral from another agency, by phone, in writing or through in-person contacts. All complaints received on regulated, informal, and in-home providers are sent to the licensing specialist and the licensing supervisor. In general, complaints that are not related to state laws, licensing regulations or endangerment of a child, are screened out. Complaints, related to child abuse and neglect, are referred to CPS and that Division takes the lead in these investigations, typically in collaboration with CCS when related to a child in care of a provider.

Department of Human Services (DHS)

Division of Developmental Disabilities (DDD)

Complaints or grievances should be raised by the complainant in accordance with each provider's grievance policy approved by the DDD. A copy of the policy in an accessible format is shared with participants and guardians annually and acknowledgement is signed. Typically, the grievance procedure begins with the supervisor of the area, then up the chain of command including administration, executive director, and board of directors. When a complaint or grievance cannot be remedied at the CSP level or if a complainant makes a referral to DDD, the program specialist or designee will take the referral through any method of contact. Most often phone calls and letters are the primary means of reporting complaints and grievances to DDD. The majority of the complaints and grievances to DDD are made by parents who are not the legal guardians of participants supported.

DDD has a complaint and grievance procedure as well as an investigatory process for complaints which warrant an on-site or remote comprehensive investigation into compliance with ARSD and waiver. Without a release information cannot be shared with callers who are not the participant themselves or a legally established guardian. Typically, findings are relayed via phone or mailed correspondence.

Investigation Process

Department of Social Services (DSS)

Division of Child Protection Services (CPS)

The Department of Social Services is mandated by [SDCL 26-8A-9](#) to investigate reported incidents of child abuse and neglect when those incidents involve a parent, guardian, or custodian. A custodian is further defined in [SDCL 26-7A-1](#) as any foster parent, employee of a public or private residential home or facility, other person legally responsible for a child's welfare in a residential setting, or person providing in-home or out-of-home care.

When a report is made to CPS Centralized Intake regarding a licensed facility, the report is reviewed through a minimum of two-level oversight. The first review is conducted by a lead family services specialist, who determines if sufficient information is contained in the report for CPS to make a decision about intervention. If additional information is needed, the lead family services specialist gathers additional information and provides a recommendation for next steps. The recommendation and report are reviewed by the protective services program specialist and the licensing program specialist to determine the appropriate response by CPS.

A report alleging child abuse or neglect from a facility may be screened out, referred to licensing, or assigned for investigation. A screened-out report does not meet the criteria for child/abuse neglect and requires no additional follow up by CPS.

Case Example: *A 17-year old youth was in the bathroom taking a shower and was taking longer than usual. Staff knocked on door and the youth answered. A few minutes later, staff knocked again, and the youth did not answer. Staff went into the bathroom and found the youth had cuts on her legs and arms. The youth had taken a razor out of a mechanical pencil sharpener and used it to cut herself. The youth was treated by nursing staff.*

Reports referred to licensing do not meet the criteria for child abuse and neglect but do require follow up by the licensing program specialist.

Case Example: *A staff member and a 15-year-old youth were engaging in horseplay. The staff member and the youth were snapping each other with towels and in doing so, both the staff member and the youth had welts and red marks on their legs.*

CPS has established criteria to determine if a report will be assigned for investigation.

Case Example: *A 17-year-old youth ran away from a residential treatment center at approximately 4:00AM. The staff member responsible for supervision had left the area and went into an adjacent room, which was out of sight of the residents. The staff member fell asleep. When the youth exited their room and noticed there was not a staff member on post, the youth ran away.*

Physical Abuse

Physical abuse occurs when the person(s) responsible for a child's care in a facility inflicts or allows to be inflicted upon a child any bodily harm, other than by accidental means. Examples of physical abuse may include excessive or inappropriate corporal punishment; excessive restraints or restraining devices; significant injuries to a child because of restraint (rug burns, lacerations, broken or fractured bones); inappropriate or excessive use of psychotropic and other drugs used as a method of keeping a child under control; an inappropriate or excessive use of isolation and/or seclusion for long periods of time.

Neglect

Neglect occurs when the actions or omissions of the person(s) responsible for a child's safety or well-being jeopardizes the safety or well-being of the child in such a way that the child sustains physical or emotional injury or damage while receiving care at a facility. This includes failure on the part of the person(s) responsible for his/her care to exercise prudent care.

Neglect due to lack of supervision must be considered when a staff member is under the influence of drugs/alcohol, falls asleep, or is generally inattentive and the child harms himself, or is harmed by other children or adults. In addition, neglect occurs when a staff member leaves a child alone without adult supervision appropriate for his/her age, mental or physical condition, or other special needs. Neglect may include failure to provide adequate food for proper nutrition; through failure to provide severely disabled children with adequate assistance in eating, or through withdrawal or restriction of food for disciplinary reasons; failure to meet the basic needs of a child; failure to provide proper supervision to the extent that children harm themselves or each other, runaway, or are involved in sexual behavior with each other; failure to provide medical care or proper treatment for a medically diagnosed condition or injury; failure to provide proper bedding and mattresses; failure to provide appropriate and sufficient seasonal clothing; failure to provide adequate living space and proper sanitation; or failure to provide proper education or intellectual stimulation.

Sexual Abuse

Sexual abuse occurs when the person(s) responsible for a child's care at a facility commits or allows to be committed an act of sexual maltreatment against a child. Sexual abuse takes place when the caregiver permits or participates in involuntary sexual activity with a child in care, including an individual who is unable through age or capacity to make a reasonable choice. This may include rape or attempted rape, fondling, voyeurism, exhibitionism, and the like. Such activity may be linked to neglect through inadequate supervision or the failure to provide sufficient clothing or privacy. Sexual abuse may include contacts or interactions between a child and an adult in which the child is being used for the sexual stimulation of the perpetrator or another person; and contacts or interactions of a sexual nature with a child by a person under the age of 18 when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over another child.

When a report is made regarding sexual behavior between two children, the following factors are considered such as the span of age between the two children and whether or not the older child was responsible for the younger child's care at the time of alleged incident; developmental capacity of a vulnerable child; specifics regarding the sexual behavior and whether it falls within the realm of healthy childhood sexual development; or any use of coercion or force involved in the incident.

Emotional Maltreatment

Emotional maltreatment in an out-of-home care setting must be considered when there is evidence that a child is experiencing diminished psychological or intellectual functioning as the result of a harmful pattern of behavior by the person responsible for the child's care. Emotional maltreatment of a child may include belittling or ridiculing of a child; ridiculing a child's family, background, culture or race; failure to appropriately respond to suicide threats; failure to provide appropriate mental health services; consistently treating members of a peer group unequally or unfairly; making one child in the group the scapegoat for the misbehavior of other children; and allowing a group of children to develop their own control system without appropriate adult intervention.

Facilities are directed not to conduct investigative interviews of the parties involved related to the reported incident, as this is the responsibility of CPS or law enforcement. If the alleged victim(s), or staff or residents who are witnesses want to discuss the incident, facility staff must listen to what they have to say, document the discussion and provide the documentation to CPS.

Depending on the severity of the allegations, facility management may place a staff member involved in the incident on administrative leave pending the outcome of the investigation.

When a report is assigned for an investigation, CPS attempts to assign the investigation to a contract investigator if available, under the oversight of CPS. CPS began using contract investigators in 2007 to remove the conflicting roles of CPS staff who placed children and youth in facilities and also completed facility investigations of child abuse and neglect. CPS also believes contract investigators are objective.

CPS utilizes three independent consultants who are contracted to complete investigations in facilities and family foster homes. These three individuals have extensive backgrounds in investigative work.

- ❖ Consultant One has interviewed over 2,000 children and conducted 1,500 child abuse investigations. This consultant previously worked in Child Protection and has eighteen years of law enforcement experience. This consultant started the first internet crimes against children in South Dakota and retired from the Sheriff's Office as a lieutenant of investigations.
- ❖ Consultant Two has twenty years of law enforcement and interview experience, dating back to 1995. This consultant was a patrol officer, community services officer, crimes against person detective, and a detective for traffic investigations.

- ❖ Consultant Three has specialized in confidential, private investigations and polygraph examinations since January 1991.

Due to scheduling conflicts, a contract investigator is not always available to investigate facility reports; therefore, CPS staff must handle the investigation out of necessity. Additional contract capacity for facility investigations should be evaluated.

During the investigation process, the contract investigator and/or CPS staff reviews the report and all documentation provided by the facility before going on-site to begin the investigation. The investigation will include an interview(s) with resident(s) alleged to be abused or neglected, interview residents and staff who witnessed the incident(s) or have knowledge about the incident, interview staff involved in the incident(s), review of facility's incident reports which document the incident, review of facility policies to determine if policies were followed, review of staff to child ratio during the incident and the surrounding time of the incident, review of any medical reports, review of pictures if there were injuries, review of video if available, review of law enforcement reports if involved, interviews with management, and review of staff's personnel file to determine any similar occurrences and/or to confirm staff have received proper training.

The investigative report is written by contract investigators and/or CPS staff and reviewed by the protective services program specialist and licensing program specialist. If additional information is needed, it is gathered and added to the report prior to determining a final outcome. When the report is final, a copy is provided to facility management and sent to the State's Attorney in the county where the facility is located for further review and to determine if criminal charges will be filed.

The investigation of allegations of abuse and neglect within the facility can have a finding of unsubstantiated or substantiated. An unsubstantiated finding means there is a determination the allegations are not supported or proven by the information gathered. A substantiated finding is one that is determined to have enough information and evidence to support and prove the truth of the allegations.

If there is a finding of substantiated abuse or neglect by a staff member within a facility, the staff member is notified of the finding and provided an opportunity to dispute the finding through an administrative hearing. If an administrative hearing judge upholds the substantiation, the staff member's name is then placed on the South Dakota Central Registry of Child Abuse/Neglect. Placement on this registry prohibits the staff member from being employed in any child welfare agency as defined in SDCL 26-6-14 (group care, psychiatric residential facilities, child placement agencies, daycare centers, or be a foster or adoptive family).

In addition, if during the investigation it is determined the facility has violated or is not in compliance with licensing standards, the facility will be placed on a corrective action plan. The corrective action plan may or may not be a result of the allegation findings or related to the incident that was investigated. For example, an allegation of neglect against a

specific staff member may be unsubstantiated; however, during the investigation it was determined the facility had been operating out of staff to child ratio, the facility would have a corrective action plan to remedy that situation.

CPS is responsible for the licensing of shelter care, group care for minors, residential treatment centers, intensive residential treatment centers and independent living preparation programs. CPS is also responsible for investigating reports of child abuse and neglect, determining the disposition of the report, and developing and monitoring of a corrective action plan if necessary. These responsibilities require CPS staff to wear multiple hats when working with facilities, which can result in conflicting responsibilities. **(See Finding 7 on page 46.)**

Division of Behavioral Health (DBH)

Staff work with the supervisor to determine further action needed following receipt of the complaint, typically within one business day. The follow up to the complaint can include contacting the client and/or the service provider in order to gather further information and seek a resolution to the complaint. If needed, staff will also go on-site to the agency for further investigation. If a client is at imminent risk, immediate action is taken.

Division of Child Care Services (CCS)

Any complaints related to regulated, informal or in-home providers, that allege non-compliance with regulations are investigated via an unannounced, on-site monitoring visit conducted by a Child Care Services licensing specialist. Child Care Services policy is to complete a complaint visit within one to two weeks of receipt of the complaint but completed within one to two days if the concern is of high risk to children in care. Based on the circumstances of the complaint and information gained in the visit, some complaints are "founded for non-compliance". If there is no information gathered to corroborate the allegations, then the outcome would be "unfounded for non-compliance".

Reports involving allegations of child abuse and neglect are investigated by CPS.

Department of Human Services (DHS)

Division of Developmental Disabilities (DDD)

Complaints and grievances are reviewed initially by the assigned program specialist. If the complaint or grievance warrants a referral to the DDD investigations team the program specialist makes this referral and by the end of the next business day at least three members of the DDD investigations team reviews the information and determine action steps based on the nature of the referral. Typical referrals to the DDD investigations team are sentinel events or red flag situations - adverse events that are unexpected and that lead directly to or places someone at risk of death or serious harm or that may have resulted in a serious injury.

The scope, method, and timeline of the investigation are determined by the team with DD Management input.

Corrective Action Plans / Plans of Correction

Department of Social Services (DSS)

Division of Child Protection Services (CPS)

Corrective action is the process of developing a specific plan for a facility to correct, in a timely manner, problems causing non-compliance with South Dakota Administrative Rules (ARSD). A Corrective Action Plan (CAP) is a formal document which outlines the specific ARSD the facility is not in compliance with, a clear description of the non-compliance issue, and actions necessary to achieve compliance. A CAP can be put in place following a yearly license renewal, resource complaint, or an investigation of abuse or neglect. The CAP is tailored to the area of non-compliance.

The facility must submit a plan to correct the finding within 30 days, which is reviewed and approved by the licensing program specialist. The CAP does not contain any identified information regarding staff or residents. A CAP is monitored by the licensing program specialist and closed when sufficient evidence of compliance is submitted. Monitoring can include additional announced and/or unannounced on-site visits. These visits may include a facility inspection, file reviews, and interviews with staff and residents. Continued non-compliance could lead to further action by CPS such as suspension or revocation of the agency's license to provide services. A CAP is available to the public upon request.

The Department of Social Services has the authority to deny, suspend or revoke a license based on non-compliance with licensing standards and/or safety of the child or youth being served in the family foster home or facility. The applicant or licensee has the right to due process through an administrative hearing if a negative licensing action is taken against them.

CPS did not have a standardized corrective action plan document to address non-compliance with licensing rules resulting from yearly license renewals, resource complaints, or investigations of abuse or neglect. The previous Corrective Action Plan (CAP) format was improved to clearly outline non-compliance with licensing rules and provide a format to release non-confidential information to the media or public when requested. **(See Finding 8 on page 47.)**

Division of Behavioral Health (DBH)

Per [ARSD 67:61:02:10](#) (3,5,6,7) if an agency has serious infraction of this article that affect the overall continuity of care or safety of clients; participates in, condones or permits illegal acts; is associated with fraud, deceit, or coercion; fails to comply with licensing and other standards required by federal or state laws, rules, or regulations; state and federal confidentiality laws; and this article, that may result in practices that are detrimental to the welfare of a client then an agency can be placed on accreditation probation.

Division of Child Care Services (CCS)

When non-compliance is found a corrective action is implemented to bring the provider into compliance. The licensing specialist makes unannounced follow-up visits to ensure the program has met and maintained compliance.

Department of Human Services (DHS)

Division of Developmental Disabilities (DDD)

Results of investigations commonly range from requiring the submission of a critical incident report, establishing a plan of enhancement, or probationary status as outlined in administrative rules. If a plan of enhancement or probation are established DDD will review progress monthly with quarterly on-site visits for probations, until all areas are considered remediated. If remediation does not occur within a year of the establishment of probationary status, certification may be revoked.

Department of Health (DOH)

Office of Licensure and Certification (OLC)

If a facility is found to not be in compliance with a regulation resulting in a systems breakdown or a resident/patient outcome, a deficiency may be written. A very prescriptive process is used to bring the facility back into compliance.

Generally speaking, the non-compliant facility must submit an acceptable Plan of Correction that states how they will correct each deficiency, they must then implement that Plan of Correction within a specific timeframe, and then often times a second survey/inspection is conducted to ensure that the facility has effectively implemented the Plan of Correction and has corrected all deficiencies.

Transparency and Confidentiality of Investigations

When CPS receives a report from a licensed facility regarding a child, specific statutes govern the ability to disclose information. [SDCL 26-8A-13](#) states in part:

All investigative case records and files relating to reports of child abuse or neglect are confidential, and no disclosure of any such records, files, or other information may be made except as authorized in [chapter 26-7A](#) or this chapter. Any person who knowingly violates the confidential nature of the records, files, or information is guilty of a Class 1 misdemeanor.

DSS may release records, files, or other information to certain parties upon receipt of a request showing that it is necessary for the parties to have such information in the performance of official functions relating to child abuse or neglect.

Runaway incidents, fires, serious injury or illness, or any other incidents regarding a child may or may not be a result of a custodian who fails to provide proper and necessary supervision, medical care, or other care necessary for the child's health, guidance, or well-being. This is the definition of an abused or neglected child under [SDCL 26-8A-2](#), and any reports to DSS regarding these issues are handled as a report of potential child abuse and neglect that must be assessed, screened, and possibly assigned for investigation. These reports fall under the scope of [SDCL 26-8A](#), and all information related to these reports is confidential under [SDCL 26-8A-13](#).

Additionally, when DSS conducts an investigation of a facility for licensing purposes, additional statutes govern the ability to disclose this information. Under [SDCL 1-27-1.5](#) the Legislature has exempted investigations undertaken by state agencies and any materials which are otherwise confidential from South Dakota's public records law. DSS does not release examination or investigation reports pursuant to public records requests, and often due to the nature of the investigation stemming from a report of suspected child abuse/neglect cannot release them due to the restrictions of [SDCL 26-8A-13](#).

DSS does release corrective action findings stemming from its investigations. However, any materials generated by DSS to determine whether regulatory action was necessary and any materials relating to the deliberative process concerning decisions are also confidential under [SDCL 1-27-1.7](#) and [SDCL 1-27-1.9](#). Additionally, information related to investigations of child abuse or neglect are redacted from these documents as this information is confidential under [SDCL 26-8A-13](#).

Department of Social Services (DSS)

Division of Child Protection Services (CPS)

[SDCL 26-8A-13](#) states "All investigative case records and files relating to reports of child abuse or neglect are confidential, and no disclosure of any such records, files, or other information may be made except as authorized in chapter 26-7A or this chapter." Certain

entities may receive the information as it is necessary for these entities to perform their function relating to child abuse or neglect. Those entities include attorney general, state's attorneys, law enforcement agencies, judges, etc.

Based on [SDCL 26-6-11](#) facility licensing studies must be available for public inspection. Facility licensing studies and any corrective action plans are available upon request; however, are not readily available for public inspection.

Division of Behavioral Health (DBH)

The Division of Behavioral Health is dedicated to transparency within state government. Currently, the DBH is working to place information on the DSS/DBH website including the Accreditation Certificate that indicates the start and end dates of an agency's accreditation and the services the agency is accredited to provide, the on-site review report with a summary of the on-site review, the plan of correction that outlines the issues of non-compliance which require correction and the timeframe in which the correction is expected, the Department of Health inspection report and includes the corrective action plans and a timeframe in which the correction is expected. Due to confidentiality there will be no client information on the website.

Division of Child Care Services (CCS)

Child Care Services inspections and founded non-compliance results for registration and licensure of family child care homes, group family child care homes, day care centers, and before and after school programs are accessible on the CCS website at https://dss.sd.gov/docs/childcare/inspection_results_instructions.pdf.

DSS Online Reports

CCS already has inspections and non-compliance results available online. DBH is nearing completion of online availability of accreditation reports. CPS licensing studies for shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers, independent living preparation programs and corrective action plans are not available for public inspection online, which leads to the public's perception that transparency is lacking. **(See Finding 9 on page 47.)**

CPS does not currently produce a yearly report with information about the number and type of reports of alleged child abuse and neglect involving facilities licensed by CPS, the number of those reports that required investigation, and the resolution of those investigations. **(See Finding 10 on page 48.)**

Department of Human Services (DHS)

Division of Developmental Disabilities (DDD)

The DDD does not offer a weblink to reviews or corrective action plans. Upon request of such records, HIPAA protected information would be redacted and issued to the requester.

Opportunities for Consolidation

There are multiple departments and divisions that share various responsibilities in the licensing, accreditation and certification of agencies caring for children and youth in South Dakota. Each has their own unique approach to their responsibilities, statutory mandates and administrative rules. This can contribute to a lack of clarity in roles and responsibilities not only for staff of state agencies, but may also cause confusion for licensed, accredited and certified agencies providing care for children and youth. For example, within DSS, there are three divisions responsible for licensing and accreditation for treatment programs and child care programs. **(See Finding 11 on page 48.)**

Findings and Recommendations

Finding 1: Increase number of licensing on-site visits.

CPS licensure and relicensing process, including the on-site visit protocol, is being reviewed by CPS to determine enhancements to the process. Currently shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers and independent living preparation programs have one announced annual licensing visit. While CPS staff who have children placed at the facilities make visits to see children and youth monthly, DOC staff visit youth quarterly, and more if needed. The perspective of both CPS and DOC staff is on the safety and well-being of the child or youth, not on the systemic function of the facility. The knowledge and skills necessary to effectively evaluate a facility's functioning is a unique skill set. In order to increase on-site licensing visits from one per year (40 visits) to semi-annually (80 visits) or quarterly (160 visits) will require an analysis of division capacity for increased workload. **(See page 20.)**

Recommendation

Semi-annual on-site licensing visits will provide additional oversight and opportunities for technical assistance to improve the quality of care of children and youth placed at facilities.

When facilities are under a corrective action plan, on-site licensing visits will be conducted quarterly.

Outside of the on-site licensing visits, other visits will be unannounced throughout the year.

Division resource capacity will need to be examined. Additional resources will likely be needed to increase from one on-site relicensing visit to semi-annual or quarterly, with at least half of the visits being unannounced.

Finding 2: Enhance reporting process for serious injury and death including creation of a secure email box for reports to be sent to and dispositioned.

Review of the process for Psychiatric Residential Treatment Facilities (PRTFs) to report serious injuries or death as required by federal law [42 CFR §483.374](#) to the State Medicaid agency and the State-designated Protection and Advocacy system (Disability Rights South Dakota) was found to lack controls to ensure compliant reporting of incidents in a consistent format, as well as consistent disposition of reports received. **(See page 23.)**

Recommendation

A standardized uniform reporting format is being developed to be utilized by all PRTF facilities.

Contained within the uniform report, are directions for PRTF facilities to report serious injuries or death of a resident to a secure email address. Medical Services has created a secure email box for these reports to be sent to prtfreports@state.sd.us. The report must also be sent to Disability Rights South Dakota at rod.raschke@drsdlaw.org. Within 24 hours of receipt of reports of serious injury or death, DSS will notify and share access to the reports with the Department of Health Office of Licensure and Certification.

Each uniform report will include an area to document disposition of each report (e.g., no further action required, CPS investigation, additional information requested from facility, etc.).

Division resource capacity will need to be examined to determine Department staff availability to monitor the secure email address and determine the disposition of each report.

Finding 3: Consideration of Auxiliary Placement from DSS to the Department of Education (DOE).

The Auxiliary Placement Program moved from DOE to the DSS in 1995. At that time, all children and youth in group care and residential treatment were in the custody of DSS CPS, so it was decided the Auxiliary Placement Program should be with DSS. Today, DSS, DOC, Bureau of Indian Affairs (BIA), tribal child welfare programs, school districts and parents seek placements of children and youth in group care centers for minors, residential treatment centers, and intensive residential treatment centers. Agreements between DSS and DOE and changes in state statutes have led to ongoing interactions between DSS and DOE regarding tuition payments when children are placed in these settings. DSS staff have been meeting with DOE staff to discuss ways to streamline the program and determine the best agency to house the program. **(See page 24.)**

Recommendation

The Department of Social Services (DSS) and the Department of Education (DOE) should continue to explore the transfer of Auxiliary Placement from DSS to DOE. DOE resource capacity will need to be examined if this change were to occur.

Finding 4: Revision of reporting protocols to CPS from licensees.

CPS has a reporting protocol which provides guidance to facility providers when reporting alleged incidents of abuse and neglect, serious incidents or death, and runaway incidents, etc. To ensure the reporting protocols provided clear direction for facilities when making reports, CPS conducted an internal review of the facility reporting protocol and determined revisions were needed to enhance the reporting process. **(See page 31.)**

Recommendation

The reporting protocol established by CPS for facilities was revised to provide clear direction to facilities when making reports. DSS met with South Dakota Association of Youth Care Providers on August 8, 2019 to review the revised facility protocol. DSS requested feedback by September 1, 2019 in order to finalize the protocol by September 15, 2019.

Finding 5: Collaborate with providers to review licensure grievance procedures and draft a rule to support best practices.

There is currently not a licensing rule requiring a standardized grievance procedure for children and youth placed in shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers and independent living preparation programs. However, most facilities have policies related to a grievance process for children and youth which include resident rights, a locked box for grievance forms to be placed in and the child or youth is allowed to speak to placing agency staff, their parent, or make a report to CPS. **(See page 31.)**

Recommendation

DSS should collaborate with providers to review grievance procedures and draft a licensing rule for shelter care facilities, group care centers for minors, residential treatment centers, intensive residential centers and independent living preparation programs that standardizes and supports best practice in this area.

Finding 6: Explore legislation to create a grievance monitor.

Although facilities have policies and procedures to respond to grievances from children and youth, there is not an outside entity with the responsibility or authority to receive, review and monitor grievances directly from children and youth. **(See pages 31-32.)**

Recommendation

Explore legislation to create a grievance monitor with the authority to directly respond to grievances received from children and youth placed in shelter care facilities, group care centers for minors, residential treatment centers, intensive residential centers and independent living preparation programs.

Finding 7: Add additional contracted investigators.

CPS is responsible for the licensing of shelter care, group care for minors, residential treatment centers, intensive residential treatment centers and independent living preparation programs. CPS is also responsible for investigating reports of child abuse and neglect, determining the disposition of the report, and developing and monitoring of a corrective action plan if necessary. These responsibilities require CPS staff to wear

multiple hats when working with facilities, which can result in conflicting responsibilities. **(See page 38.)**

Recommendation

CPS will recruit, contract with and train additional investigators to ensure a contract investigator is always available, so CPS staff do not have to investigate. Additional investigators will remove the conflicting responsibilities of CPS and provide an independent investigation which will allow for further objectivity.

Finding 8: Revise corrective action plan document and process.

CPS did not have a standardized corrective action plan document to address non-compliance with licensing rules resulting from yearly license renewals, resource complaints, or investigations of abuse or neglect. The previous Corrective Action Plan (CAP) format needed improvement to clearly outline non-compliance with licensing rules and provide a format to release non-confidential information to the media or public when requested. **(See page 39.)**

Recommendation

The Division of CPS revised the Corrective Action Plan in March of 2019 to outline the facility's non-compliance with licensing rules, non-identifying information regarding the incident resulting in non-compliance, and the timeframe for the facility to submit their Corrective Action Plan to become compliant. The Corrective Action Plan is now in a format easily available for public inspection.

Finding 9: Transparency through creation of a central repository (one-stop shop) for DSS reports open to public inspection.

CCS already has inspections and non-compliance results available online. DBH is nearing completion of online availability of accreditation reports. CPS licensing studies for shelter care facilities, group care centers for minors, residential treatment centers, intensive residential treatment centers, independent living preparation programs and corrective action plans are not available for public inspection online, which leads to the public's perception that transparency is lacking. **(See page 42.)**

Recommendation

CPS is exploring the creation of a central repository to list annual licensing studies and corrective action plans for public inspection on the division's website in the same manner as CCS and DBH.

Additionally, resource links to other state agencies that play a role in licensure, accreditation or certification of providers will be accessible on the Department of Social Services website. For example, a link to the Department of Health's Office of Licensure

and Certification, detailing their role in surveying facilities and providers for the Divisions of CPS, Behavioral Health and Child Care Services will be available on the DSS website.

Finding 10: Develop annual online report.

CPS does not currently produce a yearly report with information about the number and type of reports of alleged child abuse and neglect involving facilities licensed by CPS, the number of those reports that required investigation, and the resolution of those investigations. (*See page 42.*)

Recommendation

CPS should provide an annual online report for public inspection containing information about the number, type and disposition of those reports.

Finding 11: Evaluate and identify opportunities for consolidation.

There are multiple departments and divisions that share various responsibilities in the licensing, accreditation and certification of agencies caring for children and youth in South Dakota. Each has their own unique approach to their responsibilities, statutory mandates and administrative rules. This can contribute to a lack of clarity in roles and responsibilities not only for staff of state agencies, but may also cause confusion for licensed, accredited and certified agencies providing care for children and youth. For example, within DSS, there are three divisions responsible for licensing and accreditation for treatment programs and child care programs. (*See page 43.*)

Recommendation

Evaluate and identify opportunities for consolidation. Explore centralized and shared procedures and protocols utilized by all South Dakota state agencies that share responsibilities for licensure and accreditation.

Evaluate the creation of a Licensure and Accreditation Division within the Department of Social Services (DSS) to include DSS licensing/accreditation functions related to: family foster homes; child placement agencies; shelter care facilities; group care centers for minors; residential treatment centers; intensive residential treatment centers; independent living preparation programs; registration and licensure of family child care homes; group family child care homes; day care centers; before and after school programs; and accreditation of substance use disorder inpatient and outpatient treatment providers; community mental health centers; and prevention programs.