

Plan of Correction

Program Name: Human Service Agency	Date Submitted: 07/17/2017	Date Due: 08/17/2017
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Administrative POC-1

Rule #: 67:61:04:01 & 67:62:05:01	Rule Statement: Policies and procedures manual. Each agency shall have a policy and procedure manual to establish compliance with this article and procedures for reviewing and updating the manual.
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Area of Noncompliance: The agency's policies and procedures that reference ARSD still reference the old Rules of 46:05 and 46:20. There are several areas within your policies and procedures manual listed below that need to be updated to reflect the new Rules of 67:61 and 67:62 that went into effect in Dec 2016.

Corrective Action (policy/procedure, training, environmental changes, etc): <ul style="list-style-type: none"> Each clinician was given a bound updated copy of the ARSD for mental health and Addictions. Each new hire will also receive a copy. (POC-1) Grievance policy was re-written, along with consumer rights and responsibilities.(POC-1a) Sentinel policy was written and implemented as well as shared with staff.(POC-1b) Signs have been posted within each facility associated with HSA promoting the priority populations we serve. (POC-1c) Policies outlining closure and storage of case records have been updated. (POC-1d) 	Anticipated Date Achieved/Implemented: Date Completed
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Supporting Evidence: Enclosed please find new copies of all policies and administrative rules binders.	Person Responsible: Kari Johnston
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How Maintained: Changes made are permanent.	Board Notified: Y <input type="checkbox"/> N X n/a <input type="checkbox"/>
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Administrative POC-1a

Rule #: 67:61:06:04 & 67:62:07:04	Rule Statement: Grievance procedures. Each agency/center shall have written grievance policies and procedures for hearing, considering, and responding to client grievances. <p style="margin-left: 40px;">The agency shall inform the client, the client's parent or guardian, in writing or in an accessible format, of the grievance procedures during intake services. The grievance procedure shall be posted in a place accessible to a client and a copy shall be available in locations where a client can access the grievance procedure without making a request to agency staff. The grievance procedure shall be available to a former client upon request.</p> <p style="margin-left: 40px;">The procedure shall include the ability to appeal the agency's decision regarding ineligibility or termination of services to the division as provided in § 67:61:06:05 and/or § 67:62:07:05 shall include the telephone number and address of the division.</p>
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Administrative POC-1b

Rule #: 67:61:02:21 & 67:62:02:19	Rule Statement: Sentinel event notification. Each accredited agency shall make a report to the division within 24 hours of any sentinel event including; death not primarily related to the natural course of the client's illness or underlying condition, permanent harm, or severe temporary harm, and intervention required to sustain life. <p style="margin-left: 40px;">The agency shall submit a follow-up report to the division within 72 hours of any sentinel event and the report shall include:</p> <ol style="list-style-type: none"> 1) A written description of the event; 2) The client's name and date of birth; and 3) Immediate actions taken by the agency.
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	<p>Each agency shall develop root cause analysis policies and procedures to utilize in response to sentinel events.</p> <p>Each agency shall also report to the division as soon as possible: any fire with structural damage or where injury or death occurs, any partial or complete evacuation of the facility resulting from natural disaster, or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours.</p>
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Administrative POC-1c

<p>SUD Contract Attachment 1</p>	<p>Statement: <u>Populations to be Served</u> It is the intent of the Division of Behavioral Health to fund services in South Dakota for residents living in South Dakota. It is the Division's expectation that state funds be targeted to those citizens of South Dakota in need of substance use disorder and gambling treatment services.</p> <p>A. Priority Populations Target populations to be served under the contract, in order of priority for State and Federal funds paid to the agency, and in accordance with 45 CFR 96.124 and 45 CFR 96.131, are as follows:</p> <ol style="list-style-type: none"> 1) Pregnant Women <ol style="list-style-type: none"> a) Agencies must ensure that each pregnant woman in the state who seeks or is referred for and would benefit from treatment is given preference in admissions to treatment facilities receiving block grant funds. b) The agency shall publicize by public service announcement or street outreach programs the availability to such women of these treatment services designed for pregnant women and women with dependent children. c) Services for pregnant women/women with dependent children must comply with the provisions set forth in 45 CFR Sec. 96.124. d) Pregnant Women who are also Intravenous Drug Users are the highest priority for services. 2) Intravenous Drug Users <ol style="list-style-type: none"> a) The agency shall develop and implement a program of outreach services to identify individuals in need of treatment for their intravenous drug use and to encourage the individual to undergo treatment for such use. b) The agency shall maintain a record of outreach services provided to intravenous drug users. c) Services for intravenous drug users must comply with the provisions set forth in 45 CFR 96.124 and 45 CFR 96.131. d) The agency shall develop and implement a policy to ensure that they will not distribute sterile needles or distribute bleach for the purpose of cleaning needles and shall develop and implement a policy to ensure they will not carry out any testing for the acquired immune deficiency syndrome without appropriate pre- and post-test counseling. 3) Adolescents
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Administrative POC-1d

<p>Rule #: 67:61:07:04 & 67:62:08:03</p>	<p>Rule Statement: Closure and storage of case records. The agency shall have written policies and procedures to ensure the closure and storage of case records at the completion or termination of a treatment program including:</p> <ol style="list-style-type: none"> 1) The identification of staff positions or titles responsible for the closure of case records within the agency and the MIS; 2) Procedures for the closure of inactive client records, that are clients who have not received services from an inpatient or residential program in three days or clients who have not received services from an outpatient program in 30 days; or mental health clients who have had no contact by phone or by person with the agency for a time period of no longer than six months; and 3) Procedures for the safe storage of client case records for at least six years from closure.
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Administrative POC-2

<p>Rule #: 67:61:05:05 & 67:62:06:04</p>	<p>Rule Statement: Orientation of personnel. The agency/center shall provide orientation for all staff, including contracted staff providing direct clinical services, interns, and volunteers within ten working</p>
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	<p>days after employment. The orientation must be documented and must include at least the following items:</p> <ol style="list-style-type: none"> 1) Fire prevention and safety, including the location of all fire extinguishers in the facility, instruction in the operation and use of each type of fire extinguisher, and an explanation of the fire evacuation plan and agency's smoking policy; 2) The confidentiality of all information about clients, including a review of the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2 (June 9, 1987), and the security and privacy of HIPAA, 45 C.F.R. Parts 160 and 164 (April 17, 2003); 3) The proper maintenance and handling of client case records; 4) The agency's philosophical approach to treatment and the agency's goals; 5) The procedures to follow in the event of a medical emergency or a natural disaster; 6) The specific job descriptions and responsibilities of employees; 7) The agency's/center's policies and procedure manual maintained in accordance with § 67:61:04:01 or §67:62:05:01 ; and 8) The agency's procedures regarding the reporting of cases of suspected child abuse or neglect in accordance with SDCL <u>26-8A-3</u> and <u>26-8A-8</u>.
<p>Area of Noncompliance: Personnel records reviewed do not clearly document that new employee orientation is completed within 10 working days of hire.</p>	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): New Hire Orientation checklist has been created and will be implemented online. Alerts will be sent to supervisor(s) reminding them of need to complete all areas within specified ten days of hire. See attached (<i>POC-2</i>)</p>	<p>Anticipated Date Achieved/Implemented: Date 9/01/2017</p>
<p>Supporting Evidence: Attached please find copy of new hire orientation.</p>	<p>Person Responsible: Kari Johnston & Michelle Spies</p>
<p>How Maintained: Changes made are permanent. Adherence to new hire timeline monitored by supervisor, COO and HR assistant.</p>	<p>Board Notified: Y <input type="checkbox"/> N X n/a <input type="checkbox"/></p>

Administrative POC-3	
<p>Rule #: 67:61:05:01</p>	<p>Rule Statement: Tuberculin screening requirements. Tuberculin screening requirements for employees are as follows:</p> <ol style="list-style-type: none"> 1) Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test; 2) A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; 3) Each staff member, intern and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of <i>Myobacterium</i> tuberculosis. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and 4) Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.

Area of Noncompliance: The personnel records of SUD program staff did not have TB tests documented as required. The agency will also need to update their policies and procedures to reflect the changes with ARSD that went into effect in December 2016.	
Corrective Action (policy/procedure, training, environmental changes, etc): All SUD staff did have up to date TB tests documented during accreditation visit but perhaps were difficult to view online. These can be made available at any time for reviewers. TB policy has been updated. (POC-2)	Anticipated Date Achieved/Implemented: Date Completed
Supporting Evidence: See attached policy.	Person Responsible: Kari Johnston & Cynthia Binde
How Maintained: Change is made in policy.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Administrative POC-4

Rule #: 67:61:05:12 & 67:62:06:10	Rule Statement: Office of Inspector General Medicaid exclusion list. Each agency shall routinely check the Office of Inspector General's List of Excluded Individuals and Entities to ensure that each new hire as well as any current employee is not on the excluded list. No payment may be provided for services furnished by an excluded individual. Documentation that this has been completed shall be placed in the employee's personnel file.
Area of Noncompliance: The personnel files reviewed did contain that the OIG Medicaid Exclusion list was checked once upon new hire for employees, but did not have routine checks of current employees. Policies and procedures should be developed to ensure this is completed as required.	
Corrective Action (policy/procedure, training, environmental changes, etc): Policy to reflect checking of OIG website has been written and implemented. New hires will have this checked before start date and is reflected on orientation checklist.	Anticipated Date Achieved/Implemented: Date Completed
Supporting Evidence: See attached policy and new hire orientation checklist.	Person Responsible: Kari Johnston & Michelle Spies
How Maintained: Change is complete. Annual updating will take place during employee performance reviews by CEO.	Board Notified: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-1

Rule #: 67:61:17:02	Rule Statement: Information required to be obtained at time of admission. The agency admitting the client shall obtain the information required by § 67:61:17:07(1), and record the following observations and information in the client's case record: <ul style="list-style-type: none"> 1) Blood pressure, pulse, and respiration; 2) Presence of bruises, lacerations, cuts, or wounds; 3) Medications the client is currently taking, particularly sedative use; 4) Medications carried by the client or found on the client's person; 5) Any history of diabetes, seizure disorders including epilepsy, delirium tremens, and any client history of convulsive therapies, e.g., electroconvulsive or insulin shock treatments, and any history of exposure to tuberculosis and any current signs or symptoms of the disease; 6) Any history of medical, psychological, or psychiatric treatment; and 7) Any symptoms of mental illness currently present.
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Area of Noncompliance: In review of the clinically-managed residential detoxification charts (Level 3.2), charts were missing the information required at time of admission.	
Corrective Action (policy/procedure, training, environmental changes, etc): This is routinely completed on all detox clients. This was true of files reviewed, however, reviewer view did not reflect this. Future reviews will have better viewer access	Anticipated Date Achieved/Implemented: Date Completed
Supporting Evidence: We can send these files again for review if requested.	Person Responsible: Deb Hamer & Amber Hughes & Michelle Spies
How Maintained: IT staff will be more involved in reviewer process.	Board Notified: Y <input type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-2

Rule #: 67:61:17:07	Rule Statement: Services provided. The program may provide its clients with a variety of treatment services, but it must provide the following services: 1) Initial assessment and planning within 48 hours of admission. The initial assessment shall be recorded in the client's case record and includes: a) The client's current problems and needs; b) The client's emotional and physical state including screening for the presence of cognitive disability, mental illness, medical disorders, collateral information, and prescribed medications; c) The client's drug and alcohol use including the types of substances used, including prescribed or over the counter medications, age of first use, the amount used, the frequency of use, the date of last use, the duration of use, and the criteria met for a diagnosis of use disorder for each substance; and d) A statement of the intended course of action
Area of Noncompliance: There was no documentation in three of the four files reviewed that this was completed within the 48 hours of admission.	
Corrective Action (policy/procedure, training, environmental changes, etc): Files provided for review did have this completed within 48 hours, however, view could not accommodate reviewers.	Anticipated Date Achieved/Implemented: Date Completed
Supporting Evidence: Files can be made available if requested.	Person Responsible: Deb Hamer & Michelle Spies
How Maintained: Continued QA to be assured it continues to be done within 48 hours.	Board Notified: Y <input type="checkbox"/> N X <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-3

Rule #: 67:61:07:08	Rule Statement: Progress notes. All programs, except prevention programs, shall record and maintain a minimum of one progress note weekly. Progress notes are included in the client's file and substantiate all services provided. Individual progress notes shall document counseling sessions with the client, summarize significant events occurring, and reflect goals and problems relevant during the session and any progress in achieving those goals and addressing the problems. Progress notes shall include attention to any co-occurring disorder as they relate to the client's substance use disorder. A progress note is included in the file for each billable service provided. Progress notes shall include the following for the services to be billed: 1) Information identifying the client receiving services, including name and unique identification number;
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	<ol style="list-style-type: none"> 2) The date, location, time met, units of service of the counseling session, and the duration of the session; 3) The service activity code or title describing the service code or both; 4) A brief assessment of the client's functioning; 5) A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues to achieve identified treatment goals or objectives; 6) A brief description of what the client and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and 7) The signature and credentials of the staff providing the service.
Area of Noncompliance: Within the clinically-managed residential detoxification treatment service files (Level 3.2D); there was no documentation of the above requirements.	
Corrective Action (policy/procedure, training, environmental changes, etc): Serenity Hills staff will record weekly therapy provided by CD trainee or certified therapist in medical record as a progress note. In the past this was done in observation notes. Med staff will continue to provide education/interventions and record this in observation notes.	Anticipated Date Achieved/Implemented: Date Change made
Supporting Evidence: Files can be made available if requested.	Person Responsible: Deb Hamer & Amber Hughes
How Maintained: Continue QA of files.	Board Notified: Y <input type="checkbox"/> N X <input checked="" type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-4

Rule #: 67:61:17:08	Rule Statement: Intensity of services. The program shall provide daily to each client a minimum of 90 minutes of any combination of the services listed in subdivisions § 67:61:17:07(2)(a)(b)(c)(d). 67:61:17:07: Services provided. The program may provide its clients with a variety of treatment services, but it must provide the following services: (2) Individual, group, and family counseling may include the following: a) Provide information about alcohol and drug abuse programs whose capabilities most nearly match the client's needs based on completion of the initial assessment; b) Encourage the client to use alcohol and drug abuse programs for long range rehabilitation; c) Education regarding alcohol and drug abuse and dependence, including the biomedical effects of drug and alcohol use and abuse and the importance of medical care and treatment in recovery; and d) Education regarding tuberculosis and the human immunodeficiency virus, how each is transmitted and how to safeguard against transmission;
Area of Noncompliance: While review of the client's charts in Level 3.2D, there was little to no indication that an addiction counselor or counselor trainee provided the programming. Documentation that a video was given to a client to watch does not meet the requirement for 90 minutes of daily treatment via face-to-face individual, group or family counseling as defined in ARSD 67:61:01:01.	
Corrective Action (policy/procedure, training, environmental changes, etc): Adding more CD clinician time to SH staff schedule has been implemented to account for the daily requirement of detox clientele. Continued efforts at providing 90 minutes of intervention/education/therapy daily will be made and logged as progress notes.	Anticipated Date Achieved/Implemented: Date Completed
Supporting Evidence: Files can be reviewed at any time to monitor compliance,	Person Responsible: Deb Hamer & Kari Johnston
How Maintained: Supervision by Deb Hamer, coordinator and Kari Johnston, COO through chart review and staff meetings.	Board Notified: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> n/a <input type="checkbox"/>

Program Director Signature: 

Kari O'Hara, LPC QMHP

Date: 

9/16/17

Send Plan of Correction to:

Accreditation Program
Department of Social Services
Division of Behavioral Health
811 E. 10th Street, Dept. 9
Sioux Falls, SD 57103
DSSBHAccred@state.sd.us

BH Mental Health/1.00 GENERAL

1.00 GENERAL

1.05 Client Grievance

PURPOSE:

The primary purpose of the grievance procedure is to ensure any complaint or grievance expressed by a client, legal guardian, or advocate is responded to in an objective, timely, and effective manner. The Human Service Agency (HSA) is committed to ensuring each individual client is informed of his/her rights as soon as possible upon intake and/or admission. HSA is also committed to an objective and formal process of responding to client grievances and to ensuring the person(s) presenting the complaint or grievance will be free from reprisal, restraint, retaliation, or discrimination.

POC-1a

PROCEDURE:

1. All clients will be informed at the time of admission as to their rights and the procedure to follow if those rights have been violated. The grievance procedure is described on the form entitled "Consumer Rights and Responsibilities" which the client as well as a staff member signs during the intake process. The completed form is filed in the client's case record. This procedure also includes termination from services or client's ineligibility for services.
2. If a client, legal guardian, or advocate has concerns about the services provided them or they believe their rights are being violated, they are urged to:
 - a. Discuss the problem or concern with the staff person and/or the supervisor having the most direct involvement with the issue and attempt to reach an agreeable solution.

if not resolved....

- b. Submit client concerns on a written HSA grievance form to the department coordinator. Upon receipt of the filed grievance, the following steps will be taken:
 1. The coordinator will review the complaint, gather the necessary information, assess the situation and determine what further action, if any, is warranted, working with all parties toward resolution.
 2. The coordinator will contact the client to discuss resolution and steps that will be taken to resolve the grievance.
 3. The written grievance form, along with written resolution, will be scanned into the client file.

if not resolved.....

c. The grievance form will be forwarded to the Chief Operating Officer of Behavioral Health who will meet with the client/ family and staff member to seek resolution to the issue.

if not resolved.....

d. The client is advised to contact the Department of Social Services; Division of Behavioral Health at (605) 773-3123 or via letter:

Department of Social Services
Division of Behavioral Health
700 Governors Drive
Pierre, SD 57501

Effective Date: 07/27/2017

Date Updated/Reviewed: By who:

HUMAN SERVICE AGENCY
Behavioral Health
CONSUMER RIGHTS AND RESPONSIBILITIES

As a consumer of services provided by the Human Service Agency, you have the RIGHT:

- ✓ The right to refuse extraordinary treatment;
- ✓ The right to be free of any exploitation or abuse, including, for example, any financial or sexual relationship with any agency personnel or any member of the governing board;
- ✓ The right to seek and have access to legal counsel;
- ✓ The right to participate in decision making, related to treatment, to the greatest extent possible.
- ✓ The right to confidentiality of records, correspondence, and information relating to assessment, diagnosis and treatment pursuant to SDCL 27A-12-26, SDCL 34-23-2 and SDCL 34-20A-91

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations, 42 C.F.R. part 2. See below:

HSA may not tell a person outside the program that a patient receives services here, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in medical emergency or to qualified personnel for research, or program evaluation.

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

As a consumer of services provided by the Human Service Agency you have the RESPONSIBILITY:

- ✓ To be open with your counselor;
- ✓ To participate in your treatment and to cooperate fully with your counselor;
- ✓ To attend your appointments promptly and to notify staff when you will not be attending scheduled appointments;
- ✓ To treat staff with respect and courtesy;
- ✓ To pay the day of service unless other arrangements have been made; and
- ✓ To ensure that children who accompany you to the center are properly supervised.

The signature below verifies that you fully understand the above consumer rights and responsibilities and have also received the Human Service Agency Notice of Privacy Practices. If you have any questions about your rights and responsibilities, please contact your counselor. If you believe your rights have been violated in your contacts with the Human Service Agency, please contact your therapist, or complete a grievance form and follow the posted grievance procedure.. You may also contact the Department of Social Services; Division of Behavioral Health 700 Governor's Drive; Kneip Building, Pierre, SD 57201 or call at (605) 773-3123.

My signature also means that I GIVE CONSENT to the Human Service Agency to provide clinical services to me. This includes the use of standard medical, psychiatric, psychological, and chemical dependency procedures deemed necessary in my evaluation or treatment or the treatment of my child or other person to whom I am legal guardian.

Signature of Consumer _____ Date _____

Name of Consumer (please print) _____

Parent/Legal Guardian _____ Date _____

BH Mental Health/1.00 GENERAL

1.00 GENERAL

1.10 Sentinel Event Notification Policy

In the unlikely and unfortunate event of the death of a client NOT primarily related to natural causes or illness, the Human Service Agency Chief Operating Officer will make a report to the Division of Behavioral Health, within 24 hours via phone call or email stating the facts of the event.

This report will be made by the Chief Operating Officer of Behavioral Health. In absence of the COO, the departmental coordinator will make the report. The reporting party should also inform the CEO and board president. Incidents requiring a sentinel report include:

- 1). Death that is untimely and unexpected.
- 2). Injury that causes permanent harm; damage
- 3). Interventions used to sustain life

The Chief Operating Officer of Behavioral Health, or designee, will conduct an immediate investigation gathering information regarding the circumstances surrounding the incident and staff/collateral interventions used. A careful review of the record will also be performed, interviews will be conducted with relevant staff, other clients, and family if relevant, as well as law enforcement and the coroner. The COO will provide this written summary report within 72 hours to the CEO as well as the Department of Social Services Division of Behavioral Health. This report will include:

- a. A written description of the event;
- b. The client's name and date of birth; and
- c. Immediate actions taken by the agency.

POC-1b

The CEO and COO will review the investigative report reviewing the following:

- d. Staff's response to sentinel event prior to and during the situation.
- e. Possible training and/or procedures to be adapted if event was preventable.
- f. Any corrective action deemed necessary.

The COO is also responsible for reporting to the Division the following:

- 1). Fire with structural damage or where injury/ death occurs
- 2). Any partial or complete evacuation of the facility resulting from natural disaster
- 3). Loss of utilities and other critical equipment necessary for operation of the facility for more than 24 hours.

Date Updated/Reviewed: By who:



The Human Service Agency provides services for anyone seeking assessment, treatment & aftercare for any substance abuse/dependency. We do not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin, disability, marital status, sexual orientation, or military status. We do prioritize services for pregnant women or women with dependent children. We also prioritize treatment for individuals using intravenous drugs as the lethality of such use is severe and life threatening. If you fall into one of these priority groups, please make the schedulers & therapists aware of your needs.

POC-1E

BH Addictions/5.00 CASE RECORD

5.00 CASE RECORD

5.12 Discharge Status

PURPOSE:

To provide formal designations for the status of each client's discharge from alcohol and drug programs. These designations are arrived at per staff consensus. Established criteria for these designations are outlined below. These criteria ensure greater objectivity in establishing discharge status for clients. They also ensure that the staff are consistent among themselves in designating discharge status and in the criteria they use for the status designated. These formal designations also provide referents with concise and consistently used language for referencing the nature and rationale of discharge.

1. The primary counselor is responsible for coordinating the establishment of routine and tentative discharge status designations for each client at the time aftercare recommendations are formulated in the clinical staffing preceding the scheduled discharge date. This discharge status is established according to the consensus of the clinical team.
2. All clients will be terminated upon treatment completion OR if they have not been active for a designated period of time outlined below:
Clients in mental health programs will be terminated in the EHR if they have not received services in six months.
Clients in addictions outpatient programs will be terminated in the EHR if they have not received services in 30 days.
Clients in the halfway house will be terminated in the EHR if they have not received services in three days and do not have justification/approval to be gone longer than that for medical reasons.
Clinicians will make multiple efforts to re-engage clients before terminating any clients in the EHR.
3. The primary counselor for each client in a mental health program will complete any outcome survey documentation, discharge summary, note goals on treatment plan and close on the client cover page.
4. The primary counselor for each client participation in any drug and alcohol program is responsible for documenting the discharge status, ASAM Discharge Criteria met, and the rationale in the clients record. Specifically, it is documented in the:
 - a) final progress note in the clients medical record; or
 - b) in the discharge summary.
5. The formal discharge status designations are as follows:

PAC-1d

ASA-Against Staff Advice
PWSA-Premature with Staff Advice
WSA-With Staff Advice
Med-Due to medical reasons.
ASR-At Staff Request

Effective Date: 08/16/2017
Date Updated/Reviewed: By who:

BH/Destruction of Clinical Records

DESTRUCTION OF CLINICAL RECORDS

Destruction of Clinical Records

Destruction of Electronic Clinical Records

Entire electronic clinical records of services shall remain intact for a minimum of seven (7) years following discharge from services.

Discharged client electronic records will be stored within the Archive View within the Behavioral Health electronic record software. A discharged client record will be transferred to the Archive View on the 15th day of the following month it was discharged in.

The electronic record of services provided to children or adolescents shall remain intact at least until the client is 24 years of age. If the electronic record shows services provided to a family, the client record shall remain intact until the youngest member of the family is at least 24 years of age.

During the eighth year of inactivity or after the minor child has reached the age of 24 and a client record has been closed for clinical services;

- a. The Cover Sheet will be retained permanently for Unique ID purposes.
- b. Remaining record shall be destroyed according to the electronic media destruction policy.

No record will be destroyed without prior authorization from the CEO or Vice President of Behavioral Health.

If/when a clinical staff determines that an electronic clinical record shall be retained for permanent retention based on the below criteria, the electronic record will be marked for "Permanent Retention". That record will then be transferred to the Archive view and the Permanent Retention view.

If/when a clinical staff determines that an electronic clinical record shall be retained for permanent retention based on below criteria, an electronic email notification will be generated and sent to the staff maintaining the master listing of permanent records upon discharge of the client record.

The staff maintaining the master listing of permanent records will update the master listing upon receiving email notification.

Records for Permanent Retention

Clinical staff may identify that the record of services provided certain clients be tagged for permanent retention in storage. Examples of records that may be considered for permanent retention include, but are not limited to, the records of clients who have;

- Stalked staff;
- Demonstrated or threatened violence toward staff;
- Committed or threatened arson;
- Murdered someone, or;
- Is an adult registered Sexual Offender
- NA

The decision to permanently retain a clinical record should be at the discretion of the clinical staff providing services, a Division COO or CEO.

All clinical charts that have been labeled as “Permanent Retention” charts will be included in a permanent storage area in BH only accessible to the CEO, Division COO and the Coordinators. The permanent storage area will include the chart unless otherwise stated.

1. Whenever a patient is terminated, the therapist will be asked if any of the following apply to the client. Choose NA if these do not apply.

The screenshot shows a dialog box with the title "Add to Permanent File - Reasons". The main text asks, "Does this client meet any of the below criteria? Choose one or more options:". Below this text is a list of six criteria, each with an unchecked checkbox: "Stalked Staff", "Demonstrated or threatened violence toward staff", "Committed or threatened arson", "Murdered someone", "Is a registered Sexual Offender", and "NA". An "OK" button is located in the top right corner of the dialog box.

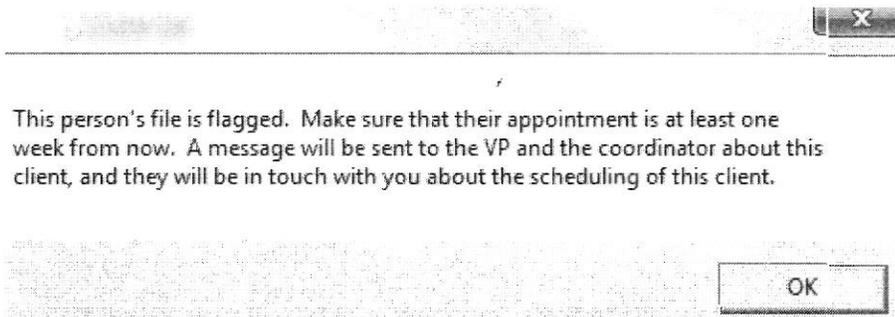
2. If the answer is anything but NA, the person will be added to the permanent storage list and an email will be sent to the manager of BH notifying them of the addition.

3. The permanent storage list is in the view 00. Permanent Storage in BH for clients just terminated or currently open and in the archives for terminated clients that are archived. This list is viewable only to the manager of BH, the COO, and the coordinators.

00. Permanent Storage

4. When a person is referred to HSA, if the person was previously open at HSA the system will check if the person is listed in the permanent storage. This check will be completed when the scheduler uses the "Previous Client?" button on the referral.

5. If the person is listed in permanent storage, the scheduler will receive the following notice.



6. Also an email about the person will be sent to the BH-COO and to either the AS or MH coordinator regarding the client.

Date Updated/Reviewed: By who:

Training schedule to be completed within TEN working days of hire

Prior to starting:

	<u>Person Responsible</u>
○ Check OIG Exclusionary Site	Supervisor
○ Receive Job Offer letter & Job Description	Supervisor
○ Copies of licenses/Degrees <ul style="list-style-type: none">• Account Specialist• HR file• MIS Coordinator	Supervisor
○ IT informed of new hire	Supervisor
○ Office Assigned and cleaned	Supervisor
○ Proof of negative TB test from medical provider for Addictions new hire staff	Supervisor

New Beginnings:

○ Orientation Paperwork	HR?Payroll Asst.
○ Fire prevention including location & operation of fire extinguishers	Supervisor
○ Confidentiality procedures & CFR 42	Supervisor
○ Keys Given/Door Code/Parking	Supervisor
○ Contract Attachments & Administrative Rule book given and reviewed	Supervisor
○ Review Agency philosophy & goals	Supervisor
○ View mandated reporting video from NEPRC	Supervisor

POC - 2

- View Haz Mat in Essential Learning IT emails instructions to employee
- View HIPAA on Essential Learning IT emails instructions to employee
- View Blood borne Pathogen in Essential Learning IT emails instructions to employee
- View Fire Safety on Essential Learning IT emails instructions to employee
- Voice Mail Box Set Up/Cell phone assignment Supervisor
- Tour of agency & off site buildings Supervisor
- Given Community Resource Directory Supervisor
- Given Community Referral Listing Supervisor

Database Orientation:

- Vouchers Supervisor
- Vehicle Checkout Supervisor
- Purchase Requisitions Supervisor
- Absence Requests Supervisor
- Maintenance Requests Supervisor
- Office Supply Requests Supervisor
- Computer Requests Supervisor
- KITS Supervisor
- Time Cards Supervisor
- Phone listing Supervisor

- NEPRC Library Supervisor
- HSA Intranet Supervisor

Manuals Reviewed:

- Sentinel Policy Supervisor
- Disaster Recovery Policy Supervisor
- Personnel Policy Supervisor
- Help Desk Supervisor

Computer Introduction:

- Email Supervisor
- Calendar Supervisor
 - Progress notes
- Behavioral Health & client record Supervisor
 - Co-occurring Assessment
 - Treatment Plan
 - Outcome surveys
 - Crisis plans
 - Treatment plan reviews
 - Letters
 - Discharge Summary
 - Releases
 - Record of Correspondence
- Safe Room database Supervisor
- Crisis Call Log Supervisor

03. HIRING AND ORIENTATION

05. Tuberculosis (TB) Testing of Employees

It is the policy of the Human Service Agency to administer a TB Risk Assessment to all new addiction and prevention employees.

- 1). Each new Addictions/Prevention staff member, intern and volunteer shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not required if documentation is provided of a previous position reaction to either test.
- 2). A new additions staff member, intern or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation.
- 3). Each staff additions staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a license physician, physician assistant , nurse practitioner, clinical nurse specialist or a nurse and record maintained of the response or absence of symptoms of Myobacterium tuberculosis. If this evaluation results in suspicion of active tuberculosis the licensed physician shall refer the staff member, intern or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis and
- 4). Any employee confirmed or suspected to have inflection tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.
- 5). All new Addictions/Prevention staff will be required to go to the clinic of their choice for the TB test if they are in need of one on their first day of employment at the expense of HSA.
- 6). Annually the Addictions/Prevention staff will complete the Tuberculosis screening which will be kept in the employee file.

The Chief Operating Officer of Behavioral Health will complete an agency-wide TB risk assessment found on the DOH website.



TB Risk Assessment.docx

POC-3

Effective Date: 03/14/2014
Date Updated/Reviewed: By who:

Tuberculosis Screening:

Tuberculin screening requirements: A tuberculin screening for the absence or presence of symptoms shall be conducted for each new employee within 24 hours of the onset of services by a designated staff person to determine if the employee has had any of the following symptoms within the previous three months.

In the last 3 months have you had productive cough that has lasted 2 to 3 weeks in duration?
Yes No

In the last 3 months have you had any unexplained night sweats? **Yes No**

In the last 3 months have you had any unexplained fevers? **Yes No**

In the last 3 months have you had any unexplained weight loss? **Yes No**

Any employee determined to have one or more of the above symptoms within the last three months will be immediately referred to a physician for a medical evaluation to determine the absence or presence of active disease. A Mantoux skin test may or may not be done during this evaluation based on the opinion of the evaluating physician. Any employee confirmed or suspected to have infectious tuberculosis will be excluded from services until they are determined to no longer be infectious by the physician. Any employee in which infectious tuberculosis is ruled out will provide a written statement from the evaluating physician before being allowed entry for services.

Source:

General Authority: SDCL 34-20A-27(1)(4)(6).

Law Implemented: SDCL 34-20A-27(1)(4)(6).

Reference: *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005*, December, 2005. "Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, Recommendations and Reports," December 30.

Employees's signature: _____

Date: _____

HR/03. Hiring and Orientation

03. HIRING AND ORIENTATION

03. Background Checks/OIG/Social Security Checks

Positions Included:

11F HUMAN RESOURCES REPRESENTATIVE

CRIMINAL BACKGROUND CHECK:

It is the intent of the Human Service Agency to conduct criminal background checks on all employees hired after January 6, 2002, (per DD Policy Memorandum 02-15) to ensure employees hired do not have a history of behavior that would put people receiving supports and/or Human Service Agency operations at risk.

1. All employee's hired will have a background check as part of the employment process unless hired before 1/6/02 and being grand fathered in. The employee will need to sign a release of information form allowing HSA to do a background check. In some cases, the employment may begin before the results are received. In some cases, the employment is contingent upon the results.
2. The Human Resources Assistant sends a Record Search Request Form to PreCheck Background Check providing name and birth date of the new employee along with a copy of the application form.
3. Upon receipt of the information from PreCheck Background Check, the Human Resources Assistant will route any questionable information to the CEO or appropriate Chief Operating Officer. Human Resources maintains information for further review if needed.
4. The Human Service Agency may withdraw the offer of hire for the following reasons:
 - a. Conviction of felony crime.
 - b. Conviction of a crime against a person causing bodily harm including abuse, neglect, assault, etc.
 - c. Letters of Hire may also be withdrawn for other convictions. Circumstances to consider include: number of convictions, length of time since the conviction, severity of the crime and moral turpitude.
5. If the Chief Operating Officer determines that the new employee is rejected due to the information received from PreCheck Background Check, the Chief Operating Officer or designee will contact the employee and either withdraw the offer of employment or inform the prospective employee that an offer will not be made. If we chose not to hire them, send out FCRA letter (located in the Supervisor Manual) with copy of background check.

OIG MEDICARE FRAUD CHECK:

1. After new hire orientation, HR will check name against OIG Database to check for medicare/medicaid fraud at <http://exclusions.oig.hhs.gov/>.
2. After entering the name and clicking enter, one of two items will come up as results.
 - A. If the results come up no record found, File, Save to W Drive with name and date.
 - B. If a name comes back, you must follow instructions and enter in SS # to check to see if the SS # matches, if it does not, it will state so and file save this to the W Drive. If it does, contact Michelle Spies.

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SOCIAL SECURITY DATABASE CHECK:

1. Must be signed up and have access cleared to run this database.
2. Once you are approved you will be given a User ID and password. Go to <http://www.socialsecurity.gov/bsowelcome.htm>
3. Click Log In and Enter User Name and Password.
3. After logging in, request on-line verification and accept the information.
4. Enter in Tax ID Number and information asked for on employee. Once sheet comes back verified,

File, copy and save to W Drive.

Date Updated/Reviewed: By who:

**SERENITY
HILLS**



**Serenity Hills
Detox Admission Form**

CID#: 23310955

Name: Last First

Address: djflsdj
 City, State, Zip: Watertown, sd
 Date: 08/16/2017 Time:
 Age: 32
 Phone: (605) 200-0000 Sex: Male
 Female

Mother's First Name:

Emergency Contact:	jon		
Emergency Contact Relationship:		Emergency Contact Phone: (area code, number)	(000) 000-0000
Referent:	0	Emergency Contact Cell Phone: (area code, number)	(000) 000-0000

Personal Doctor: Location of Doctor.:

Presenting Problem/Reason for Admission:

Strengths:

Admission Vitals

BP: Pulse: Resp. Height:
 Temp. Weight:
 Breath Allergies:
 Alcohol: O2:
 Physical
 Appearance:

Assessment

Cuts/Lacerations: Yes No
 Bruises: Yes No
 Wounds: Yes No
 Pearl: Yes No
 Pain Present: Yes No
 Smoker: Yes No
 Have you had recent medical or psychiatric Yes No

- (a) The client is experiencing signs and symptoms of withdrawal or there is evidence (based on chemical use history, previous withdrawal history, physical condition, etc.) that withdrawal is imminent: Yes No

The client is intoxicated: Yes No

The client is assessed as not being at risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service: Yes No

- (b) The client is assessed as not requiring medication, but requires this level of service to complete detoxification and enter into continued treatment or self-recovery because of inadequate home supervision or support structure, as evidenced by (1), (2), or (3):

(1) The client recovery environment is not supportive of detoxification and entry into treatment, and the client does not have sufficient coping skills to safely deal with the problems in the recovery environment: Yes No

(2) The client has a recent history of detoxification at less intensive levels of service that is marked by inability to complete detoxification or to enter into continuing addiction treatment, and the client continues to have insufficient skills to complete detoxification: Yes No

(3) The client recently has demonstrated an inability to complete detoxification at a less intensive level of service, as by continued use of other-than-prescribed drugs or other mind-altering substances: Yes No

Comments:

Staff Signature:

Date:

08/16/2017

2017

Additions

Administrative

Rules



Given to all CD staff
& will be Given to
New Hires

2017

Mental Health Administrative Rules



Given to all
MH clinical staff
& will be Given to
new hires

www.we-online.com