

Plan of Correction

Program Name: Avera McKennan The Link	Date Due: 10/16/2021
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Client POC-1

Rule #: 67:61:17:05	<p>Rule Statement: Monitoring and documentation of client's condition. The program shall establish a written policy and procedure concerning the steps staff shall take when assessing and monitoring a client's physical condition and responding to medical complications throughout the detoxification process. Staff shall closely monitor the condition of each client during detoxification and document the following information in the client's case record:</p> <ol style="list-style-type: none"> 1. Blood pressure, pulse, and respiration at admission by staff trained to perform these tests, a minimum of two additional times in the first eight hours after admission, or at a greater frequency dependent on the degree of hypertension or hypotension, and at least once every eight hours thereafter; 2. Physical, mental, and emotional state, including presence of confusion, anxiety, depression, hallucinations, restlessness, sleep disturbances, tremors, ataxia, or excessive perspiration; and 3. Type and amount of fluid intake.
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Area of Noncompliance: All ten files reviewed were missing documentation of type and amount of fluid intake.


Corrective Action (policy/procedure, training, environmental changes, etc): 1) Staff were provided with education on documenting fluid intake not only during meal times. Intake report can be in the words of the patient. 2) QuickMAR documentation was updated to include documentation regarding fluid intake- see supporting evidence section.	<p>Anticipated Date Achieved/Implemented:</p> <p>Date 9/20/21</p>
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Supporting Evidence: 	<p>Position Responsible: Nurse Manager</p>
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How Maintained: Will be a part of charting within our QuickMAR	<p>Board Notified: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> n/a <input type="checkbox"/></p>
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Client Chart POC-2

Rule #: 67:61:07:12	<p>Rule Statement: Tuberculin screening requirements. A designated staff member shall conduct tuberculin screening for the absence or presence of symptoms with each client newly admitted to outpatient treatment, intensive outpatient treatment, day treatment, clinically-managed low intensity residential treatment, clinically managed detoxification, and intensive inpatient treatment within 24 hours of admission to determine if the client has had any of the following symptoms within the previous three months:</p>
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	<p>1. Productive cough for a two to three week duration; 2. Unexplained night sweats; 3. Unexplained fevers; or 4. Unexplained weight loss</p> <p>Any client determined to have one or more of the above symptoms within the last three months shall be immediately referred to a licensed 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 client confirmed or suspected to have infectious tuberculosis shall be excluded from services until the client is determined to no longer be infectious by the physician. Any client in which infectious tuberculosis is ruled out shall provide a written statement from the evaluating physician before being allowed entry for services.</p>
<p>Area of Noncompliance: Although there were tuberculin screenings completed for all ten reviewed files, The Link’s screening template did not include “unexplained night sweats”, and thus presence or lack of unexplained night sweats was not recorded in any of the files.</p>	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): 1. Staff were educated on the addition of this symptom. 2. Symptom was added to TB screening- see supporting evidence of screenshot</p>	<p>Anticipated Date Achieved/Implemented: Date 09/15/2021</p>
<p>Supporting Evidence:</p> <p>TB symptoms: Present within the last 3 months</p> <p><input type="checkbox"/> No symptoms <input type="checkbox"/> Productive cough for a two to three week duration <input type="checkbox"/> Unexplained fevers <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Unexplained night sweats </p> <p><i>Notify provider if positive for any of the above symptoms. Follow protocol for appropriate laboratory testing and safety</i></p>	<p>Position Responsible: Nurse Manager</p>
<p>How Maintained: Symptom was added- see above.</p>	<p>Board Notified: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> n/a <input type="checkbox"/></p>

Signature of Agency Director: 	Date: 
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Please email or send Plan of Correction to:

Department of Social Services
Office of Licensing and Accreditation
3900 West Technology Circle, Suite 1
Sioux Falls, SD 57106

Email Address: DSSLicAccred@state.sd.us

The Department of Social Services, Office of Licensing and Accreditation has reviewed and accepted the above plan.

Signature of Licensing Staff:

Date: