South Dakota Department of Social Services

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

Program Name: Brookings Behavioral Health & Wellness

Plan of Correction Items for Substance Use Disorder Services

The following administrative rules were found to be out of compliance. In a State accreditation review, Administrative Rule requires a plan by the agency to bring these items into compliance in order for accreditation to be renewed. Failure to provide a plan could result in suspension or revocation of accreditation.

Administrative POC-1	
Rule #: 67:61:05:01	**Rule Statement: Tuberculin Screening Requirements.** Tuberculin screening requirements for employees are as follows: 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 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 positive 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 *Myobacterium tuberculosis.* If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer to 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: All reviewed SUD employee files contained the first step of the TB skin test, but were missing the second step of the test.	
Corrective Action (policy/procedure, training, environmental changes, etc): Administrative policy and procedure regarding two step TB testing on employees shall be updated to clarify the requirements of a two step test vs. one step. Training shall be completed for all employees on this policy.	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023

Supporting Evidence: Updated Administrative Policy and Procedure -	**Position Responsible:** Associate Director reporting to Executive Director
How Maintained: Updated policy and procedure shall be maintained in the agency policy and procedure manual. Additionally, evidence of the completed two step TB testing shall be maintained in the employee files and documented on the new employee checklist.	**Board Notified:** Y x☐ N ☐ n/a ☐

Administrative POC-2	
Rule #: 67:61:05:05	**Rule Statement: Orientation of Personnel.** The agency shall provide orientation for all staff, including contracted staff providing direct clinical services, interns, and volunteers within ten working days after employment. The orientation must be documented and must include at least the following items. 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 CFR Part 2 (June 9, 1987), and the security and privacy of HIPAA, 45 CFR 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 policies and procedure manual maintained in accordance with ARSD 67:61:04:01; and 8. The agency's procedures regarding the reporting of cases of suspected child abuse or neglect in accordance with SDCL 26-8A-3 and 26-8A-8.
Area of Noncompliance: All reviewed personnel files had the required components completed in orientation, but none of the files had the orientation items completed within 10 working days.	
Corrective Action (policy/procedure, training, environmental changes, etc): This agency has an existing policy and procedure related to orientation and training requirements. This policy has been reviewed with relevant staff and adherence to this policy will be reviewed on an individual basis by the Executive Director for compliance.	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023

Supporting Evidence: Administrative Policy -	Position Responsible: Associate Director reporting to Executive Director
How Maintained: Orientation checklist to be completed and signed by staff and Associate Director reviewed by Executive Director.	**Board Notified:** Y x☐ N☐ n/a☐

Administrative POC-3	
Rule #: 67:61:05:12	**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: None of the reviewed personnel files had evidence of checks of the Inspector General's Medicaid Exclusion List. To meet the "routinely" requirement, the Office of Licensing and Accreditation recommends completing the checks at least annually.	
Corrective Action (policy/procedure, training, environmental changes, etc): The Agencies New Hire Checklist and associated policy shall be updated to include routine checks of the Inspector General's Medicaid Exclusion List upon hire and annually there after.	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023
Supporting Evidence: Administrative Policy	**Position Responsible:** Associate Director
How Maintained: Documentation of the check on exclusion list shall be printed and placed in the employee files.	**Board Notified:** Y x☐ N☐ n/a☐

Administrative POC-4	
Rule #: 67:61:11:07	**Rule Statement: Record of Activities.** An agency conducting prevention services shall maintain a record of all prevention activities provided in accordance with the described program content. Each record shall include: 1. A list of presenters and participants involved using non-identifiable information. 2. Demographic characteristics of participants, including: i) Age; ii) Race/ethnicity; iii) Gender; iv) Type of prevention populations, such as universal, selective, or indicated; and v) Any other information as requested by the division;

	3. Record of all program activities; and 4. A copy of the programmatic materials.

Area of Noncompliance: Brookings Behavioral Health and Wellness did not provide prevention services during 2022, and do not have lists of presenters and participants nor demographic characteristics on file for services provided in 2021.

Brookings Behavioral Health and Wellness needs to submit their strategic plan for prevention services and any additional information or documentation that will help explain their upcoming 2023 prevention work.

Corrective Action (policy/procedure, training, environmental changes, etc): See attached 2023 prevention strategic plan	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023
Supporting Evidence: Prevention strategic plan for 2023	**Position Responsible:** SUD Program Manager reporting to the Clinical Director
How Maintained: Requirements under this rule and adherence to the prevention strategic plan shall be reviewed quarterly.	**Board Notified:** Y x☐ N ☐ n/a ☐

Administrative POC-5	
Rule #: 67:61:11:08	**Rule Statement: Quality Assurance and Evaluation.** An agency shall conduct a quality assurance review of its prevention programming to monitor, protect, and enhance the quality and appropriateness of its programming and to identify qualitative problems and recommend plans for correcting each problem. The agency shall conduct the following: 1. Annual satisfaction surveys of all individuals or stakeholders who requested and participated in prevention services; 2. Participant evaluations after each prevention presentation the agency provides; and 3. Pre and post tests for all evidence based curricula presented to individuals. A summary of these reports shall be made available to the board of directors or agency staff annually, and to the division and community members upon request.

Area of Noncompliance: Brookings Behavioral Health and Wellness did not provide prevention services during 2022, and do not have satisfaction surveys, participant evaluations, or pre and post tests on file for services provided in 2021.

Brookings Behavioral Health and Wellness needs to submit examples of the satisfaction surveys, participant evaluations, and pre and post tests they plan to use in 2023.

Corrective Action (policy/procedure, training, environmental changes, etc): Please see attached Prevention Strategic Plan and copies of the required surveys as well as pre and post tests.	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023

Supporting Evidence: Satisfaction surveys, participant evaluations, and pre and post tests.	Position Responsible: SUD Program Director reporting to the Clinical Director.
How Maintained: Documentation shall be reported in the matrix system as well as maintained in agency records.	Board Notified: Y x☐ N☐ n/a☐

Clinical POC-1	
Rule #: 67:61:07:05 (1)	**Rule Statement: Integrated Assessment.** An addiction counselor or counselor trainee shall meet with the client and the client's family if appropriate, to complete an integrated assessment, within 30 days of intake. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the clients' alcohol and drug abuse or dependence and shall assess the client's treatment needs. The assessment shall be recorded in the client's case record and includes the following components: 1. Strengths of the client and the client's family if appropriate, as well as previous periods of success and the strengths that contributed to that success. Identification of potential resources within the family, if applicable;
Area of Noncompliance: Three out of seven reviewed outpatient SUD integrated assessment did not contain strengths of the client.	

Corrective Action (policy/procedure, training, environmental changes, etc): Agency policy and procedures regarding clinical documentation shall be reviewed and updated to ensure compliance with administrative rule. Training of all clinical staff shall be completed.	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023
Supporting Evidence: Updated policy and procedure	**Position Responsible:** SUD Program Manager reporting to the Clinical Director
How Maintained: Quarterly quality assurance reviews shall be completed on clinical charts to ensure compliance with administrative rule and this policy.	**Board Notified:** Y x☐ N☐ n/a☐

Clinical POC-2	
Rule #: 67:61:07:07	**Rule Statement: Continued Service Criteria.** The program shall document for each client the progress and reasons for retaining the client at the present level of care; and an individualized plan of action to address the reasons for retaining the individual in the present level of care. This document is maintained in the client case record. The individualized plan of action to address the reasons for retaining the individual in the present level of care shall be documented every 14 calendar days for intensive outpatient services and every 30 calendar days for outpatient services.

Area of Noncompliance: All eight reviewed outpatient treatment files had continued service criteria documented at least every 30 days, however six out of eight did not contain individual plans of action to address the reasons for the client being retained at the current level of care.	
Corrective Action (policy/procedure, training, environmental changes, etc): Agency policy and procedures regarding clinical documentation shall be reviewed and updated to ensure compliance with administrative rule. Training of all clinical staff shall be completed.	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023
Supporting Evidence: Updated policy and procedure	**Position Responsible:** SUD Program Manager reporting to the Clinical Director
How Maintained: Quarterly quality assurance reviews shall be completed on clinical charts to ensure compliance with administrative rule and this policy.	**Board Notified:** Y x☐ N ☐ n/a ☐

Clinical POC-3	
Rule #: 67:61:07:10	**Rule Statement: Discharge Summary.** An addiction counselor or counselor trainee shall complete a transfer or discharge summary for any client within five working days after the client is discharged regardless of the reason for discharge. A transfer or discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan is maintained in the client case record. A process shall be in place to ensure that the transfer or discharge is completed in the MIS. When a client prematurely discontinues services, reasonable attempts shall be made and documented by the agency to re-engage the client into services if appropriate.
Area of Noncompliance: All four reviewed files in which clients prematurely discharged were missing documentation of reasonable attempts to re-engage.	
Corrective Action (policy/procedure, training, environmental changes, etc): Policy and procedure regarding documentation for SUD services will be reviewed for compliance with administrative rule and all staff will be trained on this requirement.	**Anticipated Date Achieved/Implemented:** **Date** 01/01/2023
Supporting Evidence: Clinical Policy and Procedure -	**Position Responsible:** SUD Program Manager reporting to Clinical Director
How Maintained: Documentation of reasonable attempts to re-engage clients which prematurely discontinued services shall be kept in the medical record of each client. These attempts shall be made and documented by both administrative and clinical staff through phone and letter correspondence . This shall be reviewed further by quarterly quality reviews.	**Board Notified:** Y x☐ N ☐ n/a ☐

Signature of Agency Director: Mary E. Fishback	Date: 01/09/2023

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: 1/25/23