## Plan of Correction

**Program Name:** Southeastern Behavioral Healthcare  
**Date Submitted:** 02/23/2021  
**Date Due:** 03/09/2021

<table>
<thead>
<tr>
<th>Administrative POC-1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rule #:</strong> 67:61:02:20 and 67:62:02:18</td>
</tr>
<tr>
<td><strong>Rule Statement:</strong> Changes requiring notification. The SUD agency/CMHC contacts the Division Director prior to any of the following changes: (1) change in agency director (2) reduction in services provided by the agency; and/or (3) the impending closure of the agency, to determine whether any changes in accreditation status are necessary.</td>
</tr>
</tbody>
</table>

**Area of Noncompliance:** Policy and procedure manual indicates notifying the division director of impending closure of the agency but needs to be updated to notify the division director of change in agency director or reduction in services as well.

**Corrective Action (policy/procedure, training, environmental changes, etc):** Southeastern Behavioral Healthcare’s policy and procedure manual will be changed to reflect that SEBH will notify the Division of Behavioral Health Director of change in agency director, impending closure of the agency for a determination on continued accreditation.

**Anticipated Date Achieved/Implemented:**

- **Date:** 01/21/2021

**Supporting Evidence:** Revised copies of policy 1.05 and policy 1.09 are attached.

**Staff Position Responsible:** Laura Boone

**How Maintained:** SEBH will review any administrative rule changes quarterly to make appropriate revisions.

<table>
<thead>
<tr>
<th>Administrative POC-2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rule Statement:</strong> Grievance procedures. Each agency shall have written grievance policies and procedures for hearing, considering, and responding to client grievances. The agency shall inform the client, the client’s parent, or guardian, in writing or in an accessible format, of the grievance procedures during the 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. 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 &amp; 67:62:07:05 and shall include the telephone number and address of the division.</td>
</tr>
</tbody>
</table>

**Area of Noncompliance:** Policy and procedure manual needs to be updated to reflect inclusion of the Division of Behavioral Health’s phone number and address on grievance policies.

Updated 2/24/2016
### Corrective Action (policy/procedure, training, environmental changes, etc.):
Southeastern Behavioral Healthcare’s policy and procedure manual will be updated with the Division of Behavioral Health’s phone number and address on grievance policies.

<table>
<thead>
<tr>
<th>Anticipated Date Achieved/Implemented:</th>
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<tbody>
<tr>
<td>Date 01/21/2021</td>
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<table>
<thead>
<tr>
<th>Supporting Evidence: Revised copy of Consumer Grievance Procedure policy 6.32 is attached.</th>
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<table>
<thead>
<tr>
<th>Staff Position Responsible: Laura Boone</th>
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<table>
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<tr>
<th>How Maintained: SEBH will review policies quarterly to make appropriate revisions.</th>
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<tr>
<th>Board Notified: Y X N n/a</th>
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### Administrative POC-3

<table>
<thead>
<tr>
<th>Rule #: 67:61:05:01</th>
<th>Rule Statement: Tuberculin screening requirements. Tuberculin screening requirements for employees are as follows:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• 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 complete 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.</td>
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<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• 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 Mycobacterium 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</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
</tbody>
</table>
**Area of Noncompliance:** None of the employee files reviewed showed a two-step tuberculin skin test or TB blood assay test was completed within 14 days of employment.

**Corrective Action (policy/procedure, training, environmental changes, etc.):** Southeastern Behavioral Healthcare will ensure that Tuberculin Skin Testing policy 4.74 will be followed. SEBH’s Tuberculin Skin Testing policy has been reviewed. Upon review, it was found that 2 employee files had received the one step TB test from SDSU upon hire, these employees have received the 2 step TB shot. Moving forward, TB 2 step shots will be administered by SEBH Nursing regardless of if they received a TB test from another organization or facility.

**Supporting Evidence:** Southeastern Behavioral Healthcare’s Tuberculin Skin Testing policy 4.74 is attached.

**How Maintained:** Southeastern Behavioral Healthcare will adhere to the Tuberculin Skin Testing procedure as outlined in policy 4.74. SEBH Nursing will administer all TB 2 Step shots to employees that work at Cayman Court or in our SUD programs.

**Anticipated Date Achieved/Implemented:**
- **Date** Immediately

**Staff Position Responsible:**
- Melonie Steffen, SEBH Director of Nursing

**Board Notified:**
- Y X N [ ] n/a [ ]

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**Client Chart POC-1**

<table>
<thead>
<tr>
<th>Rule #: 67:62:08:05</th>
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<tr>
<td><strong>Rule Statement:</strong> Integrated assessment. A mental health staff member 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. For children under 18 year of age, the mental health staff shall obtain permission from the parent or guardian to meet with the child, and at least one parent or guardian shall participate in the assessment. The assessment includes the following components:</td>
</tr>
</tbody>
</table>

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.  
2. Presenting problems or issues that indicate a need for mental health services.  
3. Identification of readiness for change for problem areas, including motivation and supports for making such changes.  
4. Current substance use and relevant treatment history, including attention to previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization.  
5. Relevant family history, including family relationship dynamics and...
6. Family and relationship issues along with social needs.
7. Educational history and needs.
8. Legal issues.
9. Living environment or housing.
10. Safety needs and risks with regards to physical acting out, health conditions, acute intoxication, or risk of withdrawal.
11. Past or current indications of trauma or domestic violence or both if applicable.
12. Vocational and financial history and needs.
13. Behavioral observations or mental status, for example, a description of whether affect and mood are congruent or whether any hallucinations or delusions are present.
14. Formulation of a diagnosis, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder or gambling issues or a combination of these based on integrated screening.
15. Eligibility determination for SMI or SED for mental health services or level of care determination for substance use services, or both if applicable.
16. Clinician’s signature, credentials, and date; and
17. Clinical supervisor’s signature, credentials, and date verifying review of the assessment and agreement with the initial diagnosis or the formulation of the initial diagnosis in cases where the staff does not have the education or training to make a diagnosis.

**Area of Noncompliance:** 15 of 18 reviewed assessments in CYF, CARE and Mental Health outpatient services did not have assessments completed within 30 days of intake.

**Corrective Action (policy/procedure, training, environmental changes, etc.):**
Southeastern Behavioral Healthcare will ensure that Integrated assessments in CYF, CARE and Mental Health outpatient services are completed within 30 days of intake.

**Anticipated Date Achieved/Implemented:**
Date 03/05/2021

**Supporting Evidence:** Integrated assessments in CYF, CARE and Mental Health outpatient services will be flagged in the agency's electronic health record (EHR) for reminders to clinicians and case managers. Additionally, a paper copy of the integrated assessments needing to be completed will be provided to clinicians and case managers 1 month prior to the due date monthly. Policy 5.20 is attached.

**Staff Position Responsible:**
Nicole Robideau and Melissa Tauer, Clinical Directors

**How Maintained:** Clinical supervisors will complete monthly spot checks of staff’s assessments to ensure they are appropriately competed and signed within 30 days of intake and to enhance our quarterly QA process. All staff will receive updated paperwork training starting in March of 2021.

**Board Notified:**
Y X N [ ] n/a [ ]

Page 4 of 7
| Rule #: 67:62:08:07 | Rule Statement: Treatment plan. The initial treatment plan shall be completed within 30 days of intake and shall include the mental health staff's signature, credentials, and date of signature, and the clinical supervisor's signature and credentials if the mental health staff does not meet the criteria of a clinical supervisor as defined in subdivision 67:62:01:01(8). Evidence of the client's or the client's parent or guardian's participation and meaningful involvement in formulating the plan shall be documented in the file. This may include their signature on the plan or other methods of documentation. The treatment plan shall:

1. Contain either goals or objectives, or both, that are individualized, clear, specific, and measurable in the sense that both the client and the mental health staff can tell when progress has been made.
2. Include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the client's mental health treatment.
3. Include interventions that match the client's readiness for change for identified issues; and
4. Be understandable by the client and the client's family if applicable.

A copy of the treatment plan shall be provided to the client, and to the client's parent or guardian if applicable. |

| Area of Noncompliance: 12 of 18 reviewed treatment plans in CYF, CARE and Mental Health outpatient services did not have treatment plans completed within 30 days of intake. |

| Corrective Action (policy/procedure, training, environmental changes, etc.): Southeastern Behavioral Healthcare will ensure that treatment plans in CYF, CARE and Mental Health outpatient services are completed within 30 days of intake. | Anticipated Date Achieved/Implemented: Date 03/05/2021 |

| Supporting Evidence: Treatment plans in CYF, CARE and Mental Health outpatient services will be flagged in the agency's electronic health record (EHR) for reminders to clinicians and case managers. Additionally, a paper copy of the treatment plans needing to be completed will be provided to clinicians and case managers 1 month prior to the due date monthly. Policy 5.20 is attached. | Staff Position Responsible: Nicole Robideau and Melissa Tauer, Clinical Directors |
**How Maintained:** Clinical supervisors will complete monthly spot checks of staff’s treatment plans to ensure they are appropriately competed and signed within 30 days of intake and to enhance our quarterly QA process. All staff will receive updated paperwork training starting in March of 2021.

<table>
<thead>
<tr>
<th>Rule #: 67:62:08:08</th>
<th>Rule Statement: Treatment plan review – Six-month review. Treatment plans shall be reviewed in at least six-month intervals and updated if needed. Treatment plan reviews shall include a written review of any progress made toward treatment goals or objectives, significant changes to the treatment goals or objectives, and a justification for the continued need for mental health services. Treatment plan reviews may be documented in the progress notes or other clinical documentation; however, any changes in the client’s treatment plan goals or objectives shall be documented in the treatment plan. Treatment plan reviews shall include the mental health staff’s signature, credentials, and date.</th>
</tr>
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</table>

**Area of Noncompliance:** 3 out of 5 files reviewed for Mental Health outpatient services did not have treatment plan reviews completed every six months.

**Corrective Action (policy/procedure, training, environmental changes, etc.):** Southeastern Behavioral Healthcare will ensure that treatment plans in CYF, CARE and Mental Health outpatient services are completed every six months.

**Supporting Evidence:** Treatment plans in CYF, CARE and Mental Health outpatient services will be flagged in the agency’s electronic health record (EHR) for reminders to clinicians and case managers. Additionally, a paper copy of the treatment plans needing to be completed will be provided to clinicians and case managers 1 month prior to the due date monthly. Policy 5.20 is attached.

**How Maintained:** Clinical supervisors will complete monthly spot checks of staff’s treatment plans to ensure they are appropriately competed and signed every six months and to enhance our quarterly QA process. All staff will receive updated paperwork training starting in March of 2021.

**Board Notified:**

Y X N □  n/a □

<table>
<thead>
<tr>
<th>Rule #: 67:62:08:09</th>
<th>Rule Statement: Supervisory reviews. Staff meeting clinical supervisory criteria as defined in subdivision 67:62:01:01(8), shall conduct one treatment plan</th>
</tr>
</thead>
</table>

**Anticipated Date Achieved/Implemented:**

Date 03/05/2021

**Staff Position Responsible:**

Nicole Robideau and Melissa Tauer, Clinical Directors

**Board Notified:**

Y X N □  n/a □
review at least annually. This review shall include documentation of:

1. Progress made toward treatment goals or objectives.
2. Significant changes to the treatment goals or objectives.
3. Justification for the continued need for mental health services; and
4. Assessment of the need for additional services or changes in services, if applicable.

This review qualifies as a six month review pursuant to § 67:62:08:08. The annual supervisory review shall include the clinical supervisor's signature, credentials, and date.

<table>
<thead>
<tr>
<th>Area of Noncompliance:</th>
<th>4 out of 8 files reviewed for CARE services did not have supervisory reviews completed at least annually.</th>
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<tbody>
<tr>
<td></td>
<td>2 out of 3 files reviewed for Mental Health outpatient services did not have supervisory reviews completed at least annually.</td>
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<tr>
<th>Corrective Action (policy/procedure, training, environmental changes, etc.):</th>
<th>Southeastern Behavioral Healthcare will ensure that supervisory reviews in CARE and Mental Health outpatient services are completed annually.</th>
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<tbody>
<tr>
<td>Anticipated Date Achieved/Implemented:</td>
<td>Date 03/05/2021</td>
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</table>

<table>
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<tr>
<th>Supporting Evidence:</th>
<th>Supervisory reviews in CARE and Mental Health outpatient services will be flagged in the agency’s electronic health record (EHR) for reminders to clinicians and case managers. Additionally, a paper copy of the supervisory reviews needing to be completed will be provided to clinicians and case managers 1 month prior to the due date monthly. Policy 5.20 is attached.</th>
</tr>
</thead>
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<tr>
<td>Staff Position Responsible:</td>
<td>Nicole Robideau and Melissa Tauer, Clinical Directors</td>
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<tr>
<th>How Maintained:</th>
<th>Clinical supervisors will complete monthly spot checks of staff's supervisory reviews to ensure they are appropriately competed and signed annually and to enhance our quarterly QA process. All staff will receive updated paperwork training starting in March of 2021.</th>
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</thead>
<tbody>
<tr>
<td>Board Notified:</td>
<td>Y X N [square] n/a [square]</td>
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</tbody>
</table>

Program Director Signature: [Signature]

Date: 02/23/2021

Send Plan of Correction to:

Office of Licensing and Accreditation
Department of Social Services
3900 W Technology Circle, Suite 1
Sioux Falls, SD 57106
DSSBHAccred@state.sd.us
PURPOSE:
To ensure uninterrupted operation of SBH should there be an expected or unexpected absence of the CEO.

POLICY
In the event the CEO of SBH is no longer able to serve in the position (i.e. leaves the position permanently), the Board President or their designee shall notify the South Dakota Department of Behavioral Health Division Director before the change in leadership. The Executive Committee shall appoint an Interim CEO. The Interim CEO shall ensure that SBH continues to operate without disruption and that all organizational commitments previously made are adequately executed, including but not limited to loans approved, reports due, contracts, licenses, certifications, memberships, obligations to lenders to SBH.

Within a reasonable period of time as deemed by the Board, the Executive Committee shall appoint a Search Committee to recruit a replacement CEO. The committee shall be comprised of at least one member of the Executive Committee and two Board members.

For a temporary change in leadership (i.e. illness, leave of absence) of the current CEO, the CEO shall designate a person to act in his/her stead.

Please refer to policy 1.09 regarding reduction of services or agency closing.
SUBJECT: Accreditation

EFFECTIVE DATE: 01-28-2021
APPROVAL DATE: 01-28-2021

PURPOSE:

To state general policies which will guide the agency in seeking accreditation and approval for its services.

GUIDELINES:

It is the Board’s policy:

1) To seek and maintain formal accreditation from recognized accreditation or approval programs for appropriate services.

2) To seek and, where possible, to obtain licensing from recognized programs or bodies for appropriate services.

3) To seek and maintain approval from the recognized body for applicable education programs that are sponsored by SBH.

In the event of the agency permanent closure or reduction of services, SBH will provide a written notice to the State of South Dakota Department of Behavioral Health Division Director 30 days prior to the closing. SBH will provide written documentation ensuring safe storage of financial/clinical records according to 42 C.F.R § 2.19.

Please refer to Policy 1.05 regarding change in Agency Director.
Southeastern Behavioral HealthCare

POLICY STATEMENT

SUBJECT: Tuberculin Skin Testing

EFFECTIVE DATE: 04-27-2017
APPROVAL DATE: 04-27-2017

PURPOSE:

To establish a policy requiring Tuberculin Skin Testing

POLICY:

Employees shall receive a Tuberculin Skin Test upon employment with the Agency.

1. Any new employee at Cayman program and the Education and Integration Programs, must receive the two-step method of Mantoux testing. Skin testing is not necessary if the new employee can document a previous positive reaction to skin testing. If a new employee can document results of a negative Mantoux test conducted within the previous 12 months, a single Mantoux test may be administered and be considered the second step of the two-step method. Any new employee who has a positive reaction to the skin test shall seek a medical evaluation and a chest x-ray to determine the presence or absence of the active disease.

Any new employee in the Chemical Dependency program shall receive a two-step method of Mantoux skin test to establish a baseline within 14 days of employment. Any two documented Mantoux skin tests completed within a 12 month period from the date of hire shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive result. A new employee provides documentation of a positive reaction to the tuberculin skin test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease.

If an employee has a positive reaction to the skin test during re-testing, the employee shall seek medical evaluation and a chest X-ray to determine the presence or absence of the active disease through their private physician. A positive reaction will be reported to the South Dakota Department of Health/Communicable Disease Division.

Any employee identified to have a positive reaction to the Mantoux skin test shall be evaluated annually by a designed staff person and a record maintained of the absence or presence of the following symptoms:

1. Productive cough for a two to three week duration;
2. Unexplained night sweats;
3. Unexplained fevers; or
4. Unexplained weight loss.
Any employee identified to have one or more of these symptoms shall immediately consult a physician for a medical evaluation and chest X-ray to determine if the employee has active tuberculosis. 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.

Any employee exposed to an infectious case of tuberculosis shall be screened within 24 Hours by a Mantoux skin test, or chest X-ray if indicated, as recommended and Directed by the South Dakota Department of Health, TB Control Program.

In the event an employee is pregnant, it is recommended they consult with their physician and may decline TB Testing till a later date.

SBH provides TB Testing at no cost to the employee through our Nursing Department. If they choose to get a TB test done at their own physician this will be at their own expense.
Southeastern Behavioral HealthCare

POLICY STATEMENT

SUBJECT: Consumer Grievance Procedure

EFFECTIVE DATE: 01-21-2021
APPROVAL DATE: 01-21-2021

PRIOR REVISION DATE: 04-27-2017
ORIGINATION DATE: 11-19-1984

Section No. 632
Page No. 1 of 3

PURPOSE:

To establish guidelines for processing grievances, complaints and/or dissatisfactions expressed by consumers while in consumer status. This section establishes a formal mechanism which facilitates expression, consideration, and follow-up of consumer concerns and grievances regarding the services provided.

OPERATIONAL GUIDELINE

Definition:

A grievance shall be defined as a claim based upon an event, situation or decision which is felt to be unjust or is felt to adversely affect the conditions or circumstances of a consumer’s treatment.

Rights and Conditions:

A consumer filing a grievance or his/her parent/guardian/advocate shall have the right to follow all the steps of the grievance procedure with complete freedom from reprisal and intimidation. This does not confer the right upon anyone to make slanderous or libelous statements or to violate Board policies.

The consumer shall be allowed at any step beyond the first step of the grievance procedure to be accompanied or represented by an individual of his choice which may be legal counsel. Such representation must be at the grievant expense. The Board may, as necessary, provide legal representation for itself, for the Executive Director, or for an Agency employee.

Time limits provided at each level shall be considered as maximum and every effort should be made by all parties concerned to expedite the process. If, at any step in this procedure, the supervisor or the Executive Director fails to provide a response within the established time limits, the grievant may immediately appeal to the next step, unless an extension of the limit has been accepted previously, in writing by both parties. Failure by the grievant to process a grievance with the established time frames shall constitute termination of the grievance. Nothing in the Grievance Procedure is intended to circumscribe or modify the existing authority and responsibility of the Agency/employee.

If a grievance is submitted by a group the same procedures apply.

Procedure:

Grievances shall be processed in the following manner:
Southeastern Behavioral HealthCare

POLICY STATEMENT

SUBJECT: Consumer Grievance Procedure

EFFECTIVE DATE: 01-21-2021
APPROVAL DATE: 01-21-2021

The aggrieved consumer/parent/guardian (grievant) will discuss the grievance with the employee providing services within a reasonable time period not to exceed ninety (90) days. The employee must reply verbally to the grievant within five (5) working days of the date of this discussion. The employee shall make a written record of this response and provide the consumer and Executive Director, through intermediate supervisors, with a copy.

Step 2: If the grievance is not resolved verbally in Step 1, the consumer may submit it in writing, within five (5) working days of the employee’s verbal reply, to the Department Director. The Department Director must meet and discuss the grievance with the consumer and the employee, and they must reply in writing to the consumer within five (5) working days of receipt of the written grievance. If the employee is the Department Director, steps 1 and 2 are consolidated into one step.

Step 3: If the grievance is not resolved in Step 2, the grievant may appeal the decision by forwarding the written grievance to the Executive Director within five (5) working days of the Department Director’s response. The Executive Director must reply to the grievant in writing within five (5) working days of the receipt of the appeal.

Step 4: If the grievance is not resolved, the grievant may request a hearing before the Executive Committee of the Board of Directors within five (5) working days following receipt of the Executive Director’s response. The request must be in writing and must be submitted through the Executive Director to the Board President. The Board President shall decide in what manner the Board will respond to the grievant, and shall provide the Executive Committee’s response regarding final resolution of the grievance.

The consumer/parent/guardian may at anytime during the grievance process or following final decision by SBH obtain legal counsel or the aid of South Dakota Advocacy Services.

Appeal of ineligibility or termination:

A consumer, a consumer’s parent if the consumer is under 18 years of age, or a consumer’s guardian may appeal the center’s decision regarding ineligibility or termination of services to the Division. An appeal shall be made in writing to the Division of Mental Health: SD DSS DBH, 700 Governors Drive, Pierre, SD 57510, phone 605-773-3123 within 30 days of receipt of the notice regarding ineligibility or termination. The Division shall provide a determination within 30 days.
of receipt of request for appeal. A consumer, a consumer’s parent if the consumer is under 18 years of age, or a consumer’s guardian dissatisfied with the division’s determination regarding ineligibility or termination of services may request a fair hearing by notifying the Department of Human Services in writing within 30 days of receipt of the Division’s decision. When termination is being appealed, the consumer shall continue receiving services from the center until a decision is reached after a hearing pursuant to SDCL chapter 1-26. (See ARSD 67:62:07:05, 67:61:06:05)

Consumer Notification:

The grievance procedure shall be posted in SBH facilities that are accessible to the public. A copy of the grievance procedure shall be distributed to all persons receiving Community Support Services (CSS) or Severely Emotionally Disturbed Services (SED) and/or their legal guardian upon entering services (See ARSD 67:62:07:04, 67:61:06:04).
PURPOSE:
To establish a mechanism for completeness of clinical records.

GUIDELINES:
Clinical Record shall include:

A. Client identification data to include:
   - Client’s name;
   - Client’s identification number;
   - Date of birth;
   - Primary race;
   - Ethnicity;
   - Gender;
   - Service start date;
   - Street Address and telephone number;
   - Referral Source;
   - Outcome measures and
   - Data for the state MIS

B. Integrated assessment. A mental health staff member shall meet with the client and the
   client’s family, if appropriate, to complete an integrated initial assessment, within 30 days of
   intake. The integrated initial assessment shall include both functional and diagnostic
   components. For children under 18 years of age, the mental health staff must obtain
   permission from the parent or guardian, if any, to meet with the child, and at least one
   parent or guardian must participate in the initial assessment. The initial assessment shall
   include the following components: ARSD 67:62:08:05, 67:61:07:05
   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;
   2) Presenting problems or issues that indicate a need for mental health services;
   3) Identification of readiness for change for problem areas, including motivation and
      supports for making such changes;
   4) Relevant treatment history, including attention to previous mental health and
      substance abuse treatment and periods of success, psychiatric hospital
      admissions, psychotropic and other medications, physical illness, and
      hospitalization;
   5) Relevant family history, including family relationship dynamics and family
      psychiatric history;
   6) Family and relationship issues along with social needs;
   7) Educational history and needs;
   8) Legal issues;
   9) Living environment or housing;
10) Safety needs with regards to physical acting out or health conditions;
11) Past or current indications of trauma or domestic violence or both;
12) Vocational and financial history and needs;
13) Behavioral observations or mental status;
14) Formulation of a diagnosis per DSM-V, including documentation of co-occurring medical, developmental disability, or substance abuse issues or a combination of these based on integrated screenings;
15) Eligibility determination, including documentation regarding sufficient information to determine SMI or SED, if applicable;
16) Mental health staff’s signature, credentials, and date; and
17) Clinical supervisor’s signatures, credentials, and date verifying review of the assessment and agreement with the initial diagnosis or the formulation of the initial diagnosis in cases where the mental health staff does not have the education and training to make a diagnosis.

C. On-going assessment. An on-going assessment and identification of changes in the client’s needs and strengths must occur throughout treatment and must be documented in progress notes or other clinical documentation. ARSD 67:62:08:06, 67:61:07:05

D. Client Rights and Responsibilities

E. SMI eligibility for CSS (paper or computer form)

F. Means tests for all

G. Appropriate Releases of Information

H. Intake Screening for CSS

The intake form shall contain documentation of client identification data which includes client name, identification number, birth date, living arrangement, family income, race, sex, service start date, therapist/case manager identification, source of referral, the name and telephone number of client’s physician if possible, and client diagnosis.

I. Treatment Plan. The initial treatment plan must be completed within 30 days of intake and shall include the mental health staff’s signature, credentials, and date of signature, and the clinical supervisor’s signature and credentials if the mental health staff does not meet the criteria of a clinical supervisor as defined in subdivision ARSD 67:62:01:01(8), 67:61:01:01(9). Evidence of the client’s or the client’s parent or guardian’s participation and meaningful involvement in formulating the plan must be documented in the file. This may include their signature on the plan or other methods of documentation. The treatment plan shall:

1. Contain either goals or objectives, or both, that are clear, specific, and measurable in the sense that both the client and the mental health staff can tell when progress has been made;
2. Include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the client’s mental health treatment;
3. Include interventions that match the client’s readiness for change for identified issues; and
4. Be understandable by the client and the client’s family if applicable. A copy of the treatment plan shall be provided to the client, and to the client’s parent or guardian, if applicable. ARSD 67:62:08:07, 67:61:07:05

J. Treatment plan review – Six month review. Treatment plans shall be reviewed at six month intervals and updated if needed. Treatment plan reviews shall include a written review of any progress made toward treatment goals or objectives, significant changes to the treatment goals or objectives, and a justification for the continued need for mental health services. Treatment plan reviews may be documented in the progress notes or other clinical documentation; however, any changes in the client’s treatment plan goals or objectives must be documented in the treatment plan. Treatment plan reviews shall include the mental health staff’s signature, credentials, and date. ARSD 67:62:08:08, 67:61:07:06

K. Purple Referral Card for non SED/SMI Medicaid Cases

L. Progress Notes
Progress notes shall be included in the client’s file and must substantiate all services provided. A progress note must be included in the file for each billable service provided. Individual progress notes do not need to reflect all goals and problems from the treatment plan; however, progress notes must reflect goals and problems that were relevant during the session and any progress in achieving those goals and addressing the problems. Progress notes must also include attention to any co-occurring disorder as they relate to the client’s mental illness. Progress notes must include the following for the services to be billed. ARSD 67:62:08:12, 67:61:07:08

1. Information identifying the client receiving services, including name and unique identification number;
2. The date, location and time met of the service provided;
3. The service activity code or title describing the service code or both;
4. The units of service provided and the duration of the session if this is not identifiable by the units of service;
5. A brief assessment of the client’s functioning;
6. 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;
7. A brief description of what the client and provider plan to work on during the next session, including work that may be occurring between sessions, if applicable; and
8. The signature and credentials of the staff providing the service.

Progress notes together with the treatment plan shall reflect the initial and ongoing treatment needs and the psychiatric, physical, and psychosocial status of the client.

M. Annual Supervisory Review – Staff meeting clinical supervisory criteria as defined in subdivision ARSD: 67:62:08:09 shall conduct one treatment plan review at least annually. This review shall include documentation of:

1. Progress made toward treatment goals or objectives:
2. Significant changes to the treatment goals or objectives;
3. Justification for the continued need for mental health services; and
4. Assessment of the need for additional services or changes in services, if applicable.

This review qualified as a six month review pursuant to ARSD 67:62:08:08. The annual supervisory review shall include the clinical supervisor's signature, credentials, and date. (ARSD 67:62:01:01(8)).

N. Transition Planning - Transition planning shall be provided to clients moving to different levels of services, leaving services, or for youth nearing adulthood. Goals related to transition planning must be included in the clinical documentation either as part of the treatment plan or as a separate transition plan. ARSD 67:62:08:11

O. Termination Note/Discharge Summary for CSS, SED and Out-patient clients
Upon termination or discontinuation of agency services, a summary shall be prepared by the employee responsible for treatment within five working days and filed in the clinical record. The summary shall indicate services provided and any progress toward treatment goals or objectives, reason for discharge, and referral disposition. 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. ARSD 67:62:08:14, 67:61:07:09

For SED children, an Outcome Determination form shall be submitted to the Division of Mental Health within ten (10) working days. For Community Support Services a Notice of Discharge to SMI clients needs to be filed with the Division of Mental Health for approval, see 9.84 for further information on Community Support Services terminations.

In addition to the above, the clinical record may include but not limited to:

- Crisis Intervention plans – Crisis intervention planning must be provided to any client who has safety issues or risks or has frequent crisis situations or recurrent hospitalizations. Crisis intervention planning must be offered to any client who may need such planning to prevent hospitalization, out of home placement, homelessness, danger to self or others, or involvement with the criminal justice system. Crisis intervention plans shall be developed in partnership with the client, if possible, the client’s parent if the client is under 18 years of age, or the client’s guardian, if any, and include interventions specific to the client, and address issues relative to co-occurring disorders.

- Group therapy progress notes. One progress note can be used for each group therapy session if the note includes specific information for each client participating in the group. Group progress notes shall include:
  a) Information identifying the client receiving services, including name and unique identification number;
  b) The date and location of the service provided;
c) The service activity code or title describing the service code or both;
d) The units of service provided and the duration of the session if this is not
identifiable by the units of service;
e) Individualized description of the client's level of participation;
f) Documentation of progress toward achieving individualized treatment plan
goals; and
g) The signature and credentials of the staff providing the service.

- Psychological evaluations,
- testing reports,
- referral information, and
- outside information.

For specialized services including CARE services and SED Children's services additional
documentation may be required. See appropriate department sections (6.0 and 9.0)

All notes need to be completed by the end of the week; any exceptions must be approved by
the supervisor. If notes are not completed the employee will be subject to disciplinary action
per policy 4.58.