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

Plan of Correction

Program Name: Wellfully IOP	**Date Due:**

Clinical POC-1	
Rule #: 67:61:07:06	**Rule Statement: Treatment Plan.** An addiction counselor or counselor trainee shall develop an individualized treatment plan based upon the integrated assessment for each client admitted to an outpatient treatment program, intensive outpatient treatment program, day treatment program, clinically-managed low-intensity residential treatment program, or medically-monitored intensive inpatient treatment program. Evidence of the client's meaningful involvement in formulating the plan shall be documented in the file. The treatment plan shall be recorded in the client's case record and includes: 1. A statement of specific client problems, such as co-occurring disorders, to be addressed during treatment with supporting evidence; 2. A diagnostic statement and a statement of short term and long term treatment goals that relate to the problems identified; 3. Measurable objectives or methods leading to the completion of short term goals including: a. Time frames for the anticipated dates of achievement or completion of each objective or reviewing progress towards objectives; b. Specification and description of the indicators to be used to assess progress; c. Referrals for needed services that are not provided directly by the agency; and d. Include interventions that match the client's readiness for change for identified issues; 4. A statement identifying the staff member responsible for facilitating the methods or treatment procedures. The individualized treatment plan shall be developed within ten calendar days of the client's admission for an intensive outpatient treatment program, day treatment program, clinically-managed low-intensity residential treatment program, or medically monitored intensive inpatient treatment program. The individualized treatment plan shall be developed within 30 calendar days of the client's admission for a counseling services program. All treatment plans shall be reviewed, signed and dated by the addiction counselor or counselor trainee. The signature must be followed by the counselor's credentials.
None of the outpatient treatment plans reviewed were completed by an addiction counselor or counselor trainee. Instead, they were in the format of questionnaires given to the clients to complete. Additionally, the treatment plan document did not include item 3 of the above requirements. They were also not signed and dated by the counselor.	

The treatment plan should be based on information received during the assessment, as well as conversations with the client.	
Corrective Action (policy/procedure, training, environmental changes, etc): Please see the attached revision of our treatment plan. There is a pen and paper version that can be uploaded into the system and a template that is in the Simple Practice our EMR. We have added a section for the client to put down what they feel is their issue of concern. They will also be able to list the items they would like to work on during treatment. From the treatment needs assessment or discharge plan together with the client input the treatment plan will be created. The treatment plan for the IOP group will be started at the pre class one on one session. Refinement and modification of the plan will take place as progress or additional issues are presented. The treatment plan design takes into consideration short term and long term issues, shows the need that the goals need to be SMART goals, it has space to include the intervention to be used and who was responsible to provide the services.	**Anticipated Date Achieved/Implemented:** **Date** 5/1/2023
Supporting Evidence: We have attached a template of our new treatment plan.	**Position Responsible:** Burke Eilers Felicia Swallow
How Maintained: The treatment plans will include the client signature, the clinician and either the CEO or clinical director's signature. Thus, all plans are reviewed by an additional staff member.	**Board Notified:** Y ☐ 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. It is appropriate to retain the client at the present level of care if: 1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals; or 3. New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the client is receiving treatment is therefore, the least intensive level at which the client's new problems can be addressed effectively. 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.

Area of Noncompliance: *Continued service criteria were not being completed for any client in the intensive outpatient treatment program.*

Corrective Action (policy/procedure, training, environmental changes, etc): We have created a continue stay review form to be completed. We will create a excel sheet log to be a check and balance to ensure that we are meeting the14 day review periods, as well as other time sensitive issues.	**Anticipated Date Achieved/Implemented:** **Date** 5/1/2023
Supporting Evidence: we have attached the continued stay review form and with the database log we can make sure items have been addressed.	**Position Responsible:** Felicia Swallow Candace Wright Kellen Claymore
How Maintained: the clinical director will review the data log on a monthly basis .	**Board Notified:** Y ☐ N ☐ n/a ☐

Clinical POC-3	
Rule #: **67:61:07:12**	**Rule Statement: Tuberculin screening requirements.** A designated staff member shall conduct a tuberculin screening for the absence or presence of symptoms with each client newly admitted to outpatient treatment, intensive outpatient, 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. 1. Productive cough for a two to three week duration; 2. Unexplained night sweats; 3. Unexplained fevers; or 4. Unexplained weight loss. 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.

Area of Noncompliance: *Three out of six reviewed client files did not have evidence of a tuberculin screening.*

Corrective Action (policy/procedure, training, environmental changes, etc): The TB screening is conducted by testing on our addiction unit and for the IOP class it is now placed in our intake paperwork. Attached is a copy of the form used.	**Anticipated Date Achieved/Implemented:** **Date** 5/1/2023
Supporting Evidence: we have attached a copy of our TB screening.	**Position Responsible:** Marcia Taylor Felicia Swallow

	Kellen Claymore
How Maintained: When the director of the residential program or the IOP instructor up loads the treatment plan into our EMR part of the check list will include verification of the TB screening.	**Board Notified:** Y ☐ N ☐ n/a ☐

Signature of Agency Director: W. Burke Eilers	Date: 4/28/2023

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: 5/1/23