South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LICENSING & ACCREDITATION
700 GOVERNORS DRIVE
PIERRE, SD 57501
Phone: 605.773.3165
Web: dss.sd.gov

Plan of Correction

Date Issued January 02, 2026 Status Closed

Provider Name	Southeastern Behavioral Healthcare
Provider Type	Accreditation
Accreditation #	1864451214
Provider Address	2000 S Summit Ave, Sioux Falls, SD 57104
Provider Contact	Hannah McManus
Board Notified	N/A

This is the Plan of Correction for your Community Mental Health Center Services. The following administrative rules have been found to be out of compliance. A corrective action plan is required to bring the provider into compliance. Continued non-compliance could lead to suspension or revocation of your accreditation.

POC Action #1

Administrative Rule:

67:62:08:05

A mental health staff member shall meet with the client and, if appropriate, the client's family if appropriate, to complete an integrated assessment, within thirty days of the first day the intake process begins. The integrated assessment must include both functional and diagnostic components. For a client under the age of eighteen, the mental health staff must obtain permission from the parent or guardian to meet with the child, and at least one parent or guardian must participate in the assessment. The assessment must contain:

(1) Strengths of the client and the client's family, if appropriate, as well as previous periods of success, the strengths that contributed to that success, and the 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 regarding problem areas, including motivation and supports for making such changes;

(4) Current substance use and relevant treatment history of any 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 family psychiatric and substance abuse 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 and risks with regard to physical acting out, health conditions, acute intoxication, or withdrawal;

(11) Past or current indications of trauma or domestic violence;

(12) Vocational and financial history and needs;

(13) Behavioral observations or mental status;

(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 mental health services based on a serious mental illness or serious emotional disturbance, and a level of care determination for substance use services, or both;

(16) Clinician's signature and credentials, and the date; and

(17) Clinical supervisor's signature and credentials, and the date, to verify review of the assessment and if there is agreement with:

(a) The initial diagnosis; or
(b) The formulation of the initial diagnosis, if the staff member conducting the integrated assessment does not have the education or training to make a diagnosis.

Summary of Non-Compliance Finding:

Approximately 63% of reviewed outpatient mental health files contained assessments that were not completed within 30 days of intake.

Corrective Action:

1. Southeastern will ensure that the appropriate Supervisor is assigned.
2. Intake staff will receive training to ensure that Signing Supervisors are entered for all new clients.
3. Staff will be trained on how to assign a supervisor if they notice one is missing or incorrect and who to contact to

correct the issue for all future paperwork.

4. Clinical Directors will review Supervisor sign queues to ensure documents are getting signed

Supporting Evidence:

- Sample client list with Signing Supervisor

- Email to Intake Staff with Instructions on adding Signing Supervisor
- Training materials for updating/assigning a supervisor in the document and who to contact to correct the supervisor on all documentation.
- Sample of supervisor sign queue

How Maintained:

IT staff will pull a client list monthly that includes the assigned Signing Supervisor. The client list will be reviewed to ensure that all clients are assigned a Signing Supervisor and make any changes necessary to reflect Signing Supervisor accurately.

Clinical Directors will review sign queues monthly and adjust sign loads as necessary.

Position Responsible:	Expected Completion Date:	Date Completed:
Megan Wexler-Clinical Director of Adult Services and Michael Digatono-Clinical Director of Children's Services	March 30, 2026	June 15, 2026

POC Action #2

Administrative Rule:

67:62:08:07

The initial treatment plan must be completed within thirty days of the first day the intake process begins and must include the mental health staff's signature and credentials, the date of the signature, and the clinical supervisor's signature and credentials, if the mental health staff member does not meet the criteria of a clinical supervisor, as defined in § 67:62:01:01. 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 client's clinical record.

The treatment plan must:

(1) Contain goals or objectives which are individualized, clear, specific, and measurable, so that both the client and the mental health staff can determine when progress has been made;
(2) Address multiple client needs, if applicable, that are relevant to the client's mental health treatment;
(3) Include interventions that match the client's readiness for change with respect to identified issues; and
(4) Be understandable by the client and the client's parent or guardian, if applicable.

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

Summary of Non-Compliance Finding:

Approximately 87% of reviewed outpatient mental health treatment plans were not completed within 30 days of intake.

Corrective Action:

1. Southeastern will ensure that the appropriate Supervisor is assigned.
2. Intake staff will receive training to ensure that Signing Supervisors are entered for all new clients.
3. Staff will be trained on how to assign a supervisor if they notice one is missing or incorrect and who to contact to correct the issue for all future paperwork.
4. Clinical Directors will review Supervisor sign queues to ensure documents are getting signed

Supporting Evidence:

- Sample client list with Signing Supervisor
- Email to Intake Staff with Instructions on adding Signing Supervisor
- Training materials for updating/assigning a supervisor in the document and who to contact to correct the supervisor on all documentation.
- Sample of supervisor sign queue

How Maintained:

IT staff will pull a client list monthly that includes the assigned Signing Supervisor. The client list will be reviewed to ensure that all clients are assigned a Signing Supervisor and make any changes necessary to reflect Signing Supervisor accurately.

Clinical Directors will review sign queues monthly and adjust sign loads as necessary.

Position Responsible:	**Expected Completion Date:**	**Date Completed:**
Megan Wexler-Clinical Director of Adult Services and Michael Digatono-Clinical Director of Children's Services	March 30, 2026	June 15, 2026

POC Action #3

Administrative Rule:

67:62:08:12

A mental health staff member must record progress notes in the client's case record that substantiate all services provided. A mental health staff member must document the 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 in the progress notes. A mental health staff member must also include attention to any co-occurring disorder as it relates to the client's mental disorder in the progress notes.

A progress note must be included in the client's clinical record for each billable service provided. Progress notes must include the following for the services to be billed:

(1) Information identifying the client receiving services, including the client's name and unique identification number;

(2) The date, location, time met, the units of service of the session, and the duration of the session;
(3) The service activity code or the title describing the service code;
(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 for the purpose of achieving treatment goals or objectives;
(6) A brief description of what the client and the provider plan to work on during the next session and work that may occur between sessions, if applicable; and
(7) The signature and credentials of the staff providing the service.

Summary of Non-Compliance Finding:

Approximately 33% of reviewed outpatient mental health progress notes did not contain descriptions of what the client and clinician plan to work on next time, were not specific to the client, or were not related to the description of what occurred during the session or interaction.

Corrective Action:

Clinical Directors will provide training to employees on progress note documentation. Samples will be given to staff and posted on the S drive for staff to refer back to.

Supporting Evidence:

1. Samples of Plan section of the progress note.

How Maintained:

Supervisors will receive a list of 10-15 progress notes each month (about 1 per staff) to review and ensure that staff are meeting this requirement. Supervisors will discuss any improvements needed in supervision meetings with staff each month.

Position Responsible:	Expected Completion Date:	Date Completed:
Megan Wexler-Clinical Director of Adult Services and Michael Digatono-Clinical Director of Children's Services	March 30, 2026	June 15, 2026

SIGNATURES

Your signature below certifies you have read and understand the non-compliance findings and agree to make corrections to be compliant with the identified administrative rules.

Southeastern Behavioral Health

Printed Name of Provider/Agency Contact



Signature of Provider/Agency Contact

January 16, 2026

Date

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

Chris Kenyon

Printed Name of DSS Staff



1/16/2026, 2:20:33 PM

Signature of DSS Staff:

January 16, 2026

Date

COMPLETION DETAILS

COMPLETION DATE: June 15, 2026

The Department of Social Services, Office of Licensing and Accreditation has reviewed the actions taken by the agency to resolve the above items and has accepted the above plan as completed.

Chris Kenyon

Printed Name of DSS Staff



6/17/2026, 9:53:15 AM

Signature of DSS Staff:

June 15, 2026

Date