South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LICENSING & ACCREDITATION
700 GOVERNORS DRIVE
PIERRE, SD 57501
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Plan of Correction

Date Issued March 02, 2026 Status Closed

Provider Name	Overcoat Counseling & Case Management
Provider Type	Accreditation
Accreditation #	1486282984
Provider Address	517 W 10th St, Sioux Falls, SD 57104, USA
Provider Contact	Brennan Thompson
Board Notified	N/A

This is the Plan of Correction for Substance Use Disorder Treatment Services. The following administrative rules have been found to be out of compliance. A plan of correction 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:

67:61:05:08

An agency shall maintain personnel policies and records for all staff, including provisions for equal employment opportunities. An agency shall maintain a personnel file for each staff member, including any contracted staff, intern, or volunteer. The file must contain:

(1) The application filed for employment, or any resume, transcripts, diploma, and evidence of continuing education;
(2) The position description, signed by the staff member, with a statement of duties and responsibilities, and the minimum qualifications and competencies necessary to fulfill these duties;
(3) Evidence of having completed appropriate pre-hire screening, in the case of a staff member who provides direct services to vulnerable populations;
(4) The staff member's orientation documentation, in accordance with § 67:61:05:05;
(5) Copies of the staff member's current credentials, as related to job duties; and
(6) Any staff health clearances, including tuberculin test results, if required, and any clearances from a physician after an infectious or contagious disease requires the staff member's absence from the program.

Summary of Non-Compliance Finding:

All reviewed personnel files contained resumes, but did not contain transcripts or degrees.

All employee files are required to have the application files for employment or a resume, transcript, and degree/diploma.

Corrective Action:

Ensure personnel files include transcripts or degrees, each current employee's file now includes a copy of their degree.

Supporting Evidence:

Personnel files are the evidence which are held and maintained in a filing cabinet in the main office.

How Maintained:

The degree will be a point of emphasis in future onboarding and added to the onboarding checklist.

Position Responsible:	Expected Completion Date:	Date Completed:
Owner - Brennan Thompson	June 01, 2026	April 23, 2026

POC Action #2

Administrative Rule:

67:61:05:12

Each agency shall routinely check the List of Excluded Individuals and Entities, maintained by the U.S. Department of Health and Human Services Office of Inspector General, to ensure that each new hire, as well as any current employee, is not on the list. No payment to the agency may be provided for services furnished by an excluded individual. Documentation that the check has been completed must be placed in the employee's personnel file.

Summary of Non-Compliance Finding:

All reviewed personnel files were missing checks of the Inspector General Medicaid Exclusion list upon hire.

Corrective Action:

Check the exclusion list at the time of hire and completed annually by 12/31

Supporting Evidence:

Please see the attached documentation

How Maintained:

All employees, including new hires, will be checked each time a new hire joins

Position Responsible:	Expected Completion Date:	Date Completed:
Owner - Brennan Thompson	June 01, 2026	April 23, 2026

POC Action #3

Administrative Rule:

67:61:07:05

An addiction counselor or addiction counselor trainee shall meet with the client and, if appropriate, the client's family, 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. The assessment must establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence, and must assess the client's treatment needs. The assessment must be recorded in the client's case record and 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 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 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, including level of care determination for substance use services, or serious mental illness or serious emotional disturbance for mental health services, or both;

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

(17) Clinical supervisor's signature, credentials, and 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 does not have the education or training to make a diagnosis.

Any information related to the integrated assessment must be verified through collateral contact, if possible, and recorded in the client's case record.

Summary of Non-Compliance Finding:
40% of reviewed assessments were not completed within 30 days of intake.

Corrective Action:
Assessments will be completed within 30 days of intake.

Supporting Evidence:
A review of new clients has shown all have completed assessments within 30 days of intake.

How Maintained:
Online EHR programming has been adjusted to include the portion of the assessment that was causing assessments to take longer than 30 days to be signed.

Position Responsible:	Expected Completion Date:	Date Completed:
Owner and ACTs	July 01, 2026	July 06, 2026

POC Action #4

Administrative Rule:
67:61:07:05
An addiction counselor or addiction counselor trainee shall meet with the client and, if appropriate, the client's family, 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. The assessment must establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence, and must assess the client's treatment needs. The assessment must be recorded in the client's case record and 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 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 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, including level of care determination for substance use services, or serious mental illness or serious emotional disturbance for mental health services, or both;

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

(17) Clinical supervisor's signature, credentials, and 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 does not have the education or training to make a diagnosis.

Any information related to the integrated assessment must be verified through collateral contact, if possible, and recorded in the client's case record.

Summary of Non-Compliance Finding:
80% of reviewed assessments were missing strengths of the client, as well as vocational and financial information.

Corrective Action:
All assessments will include strengths of the client and vocational and educational information instead of one or the other.

Supporting Evidence:
A review of new clients assessment showed a correction to the issue

How Maintained:
Onboarding, ongoing supervision, and routine trainings will include these points as points of emphasis

Position Responsible:	Expected Completion Date:	Date Completed:
Owner - Brennan Thompson	July 01, 2026	July 06, 2026

POC Action #5

Administrative Rule:
67:61:07:07
The program staff or direct care provider shall document, for each client, the progress and reasons for retaining the client at the present level of care and create an individualized plan of action to address the reasons for retaining the client at the present level of care. This document must be 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 must be assessed, as necessary, to permit the client to continue working 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. The client is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care must be assessed, as necessary, to permit the client to continue working toward his or her treatment goals; or

(3) A new problem or priority that is appropriately treated at the present level of care has been identified. The new problem or priority requires services, the frequency and intensity of which can only be delivered safely by continuing to stay at the current level of care. The client's level of care must be the least intensive level at which the client's new problem or priority can be addressed effectively.

The individualized plan of action to address the reasons for retaining the individual at the present level of care must be documented every:

(a) Two calendar days for clinically-managed, residential detoxification;

(b) Fourteen calendar days for early intervention services; intensive outpatient services; day treatment services; and medically-monitored, intensive inpatient treatment; and
(c) Thirty calendar days for outpatient treatment programs and clinically-managed, low-intensity residential treatment.

Summary of Non-Compliance Finding:

All continued service reviews were completed every 30 days but only stated that the client was appropriate to remain in their current level of care. None of them contained the progress of the client, the reasons for retaining the client at the present level of care, or the individualized plan of action to address that reason.

Corrective Action:

Continued stay reviews need significant overhaul to include progress and reason for retaining the client.

Supporting Evidence:

Please see the new version of the continued stay reviews template used by Overcoat staff

How Maintained:

When reviewing continued stay reviews before signature, ensure these points are included as a point of emphasis.

Position Responsible:	Expected Completion Date:	Date Completed:
Owner - Brennan Thompson	July 01, 2026	July 06, 2026

POC Action #6

Administrative Rule:

67:61:07:12

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, day treatment, clinically-managed, low-intensity residential treatment, clinically-managed detoxification, or intensive inpatient treatment, within twenty-four 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 duration of two-three weeks;
(2) Unexplained night sweats;
(3) Unexplained fevers; or
(4) Unexplained weight loss.

Any client determined to have had one or more of the listed symptoms within the last three months must be immediately referred to a licensed physician for a medical evaluation to determine the absence or presence of active tuberculosis. A physician, physician assistant, nurse practitioner, or clinical nurse specialist may request that a Mantoux skin test be conducted. Any client confirmed or suspected to have infectious tuberculosis may not be admitted for services until the client is determined to no longer be infectious by the physician. If infectious tuberculosis is ruled out, the evaluating physician must provide a written statement confirming the client does not have tuberculosis before the

client may be admitted for services.

Summary of Non-Compliance Finding:

All reviewed files were missing tuberculosis screening questionnaires. There must be a tuberculosis screening completed for every client upon admission.

Corrective Action:

All intakes will include a TB screening questionnaire. This has been included in the intake template to ensure it is completed everytime a new client is completing intake/assessment.

Supporting Evidence:

Please see attached documentation.

How Maintained:

When reviewing assessments before signature, this will be reviewed as a point of emphasis.

Position Responsible:	Expected Completion Date:	Date Completed:
Brennan Thompson	July 01, 2026	July 06, 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.

Brennan Thompson

Printed Name of Provider/Agency Contact



Signature of Provider/Agency Contact

April 01, 2026

Date

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

Muriel Nelson

Printed Name of DSS Staff



4/30/2026, 1:43:37 PM

Signature of DSS Staff:

April 30, 2026

Date

COMPLETION DETAILS

COMPLETION DATE: July 06, 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

Signature of DSS Staff:

July 06, 2026

Date