South Dakota Department of Social Services

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

Date Issued	March 30, 2026	Status	In Process

Provider Name	Bowling Green Inn dba Keystone Treatment Center
Provider Type	Accreditation
Accreditation #	894569581
Provider Address	1010 E 2nd St, Canton, SD 57013
Provider Contact	Josh Merkley
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:

67:61:06:07

Each agency shall establish a written discharge policy. The policy must specify:

(1) Client behavior that constitutes a reason for discharge at staff request;

(2) The procedure for the staff to follow when discharging a client involved in the commission of a crime on the premises of the program or against its staff, consistent with the confidentiality of alcohol and drug abuse patient records, as set forth in 42 C.F.R. § 2.12(c)(5), in effect on October 1, 2018, and including who shall make the report to the appropriate law enforcement agency;

(3) The procedure for the staff to follow when a client leaves against medical or staff advice, including offering the client discharge planning and continuation of care for substance abuse and any other condition, and documentation of what was offered, consistent with the confidentiality of alcohol and drug abuse patient records, as set forth in 42 C.F.R. Part 2, in effect on January 18, 2017;

(4) A prohibition against automatic discharge for any instance of non-prescribed substance use, or for any instance of displaying symptoms of mental or physical illness; and

(5) The procedure for referrals in the case of clients with symptoms of mental illness or a medical condition and those requesting assistance to manage symptoms.

Summary of Non-Compliance Finding:

Keystone Treatment Center's discharge policy doesn't contain a prohibition against automatic discharge for non-prescribed substance use, or for any instance of displaying symptoms of mental or physical illness.

Corrective Action:

Review and update Keystone's discharge policy to include a prohibition against automatic discharge for non-prescribed substance use, or for any instance of displaying symptoms of mental or physical illness. This update shall be completed and approved no later than the end of the third quarter, September 30th, 2026.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
Director of Risk Management – Accreditation	September 30, 2026	

POC Action #2

Administrative Rule:

67:61:05:05

The agency shall provide orientation for all staff within ten working days after employment. The agency shall provide orientation for all contracted staff providing direct clinical services, interns, and volunteers, within ten working days after the start of their service with the agency. The orientation must be documented and cover:

(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, as set forth in 42 C.F.R. Part 2, in effect on January 18, 2017, and 45 C.F.R. Parts 160 and 164, in effect on September 26, 2016;

(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, contracted staff, interns, and volunteers, as applicable;

(7) The agency's policy and procedures manual, maintained in accordance with § 67:61:04:01; and

(8) The agency's procedures regarding the reporting of suspected child abuse or neglect, in accordance with SDCL 26-8A-3 and 26-8A-8.

Summary of Non-Compliance Finding:

Keystone Treatment Center's employee orientation does not include procedures regarding the reporting suspected child abuse or neglect.

Corrective Action:

Introduce procedures regarding the reporting of suspected child abuse or neglect to new employees during Keystones path purpose program. This update shall be completed and approved no later than the end of the third quarter, September 30th, 2026.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
Director-Clinical Services and Director-Nursing Recovery	September 30, 2026	

POC Action #3

Administrative Rule:

67:61:04:03

Each agency shall establish an ongoing compliance review process for the review of case records to assure the quality and appropriateness of services. Agency staff shall be informed of the review process, and the review process shall be made a part of the agency's policies and procedures manual. The agency shall have a procedure to address any issues discovered during the compliance review process.

Summary of Non-Compliance Finding:

Keystone Treatment Center does not have a written compliance review process for the review of case records to assure the quality and appropriateness of services.

Corrective Action:

Review Keystone's chart to charge policy and update as needed. Create a policy for reviewing open and closed records to assure the quality and appropriateness of services. The updates and new policy shall be completed and approved no later than the end of the third quarter, September 30th, 2026.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
Director of Risk Management – Accreditation	September 30, 2026	July 29, 2026

POC Action #4

Administrative Rule:

67:61:07:04

The agency shall establish a policy and procedures to ensure the closure and storage of clinical records upon the completion or termination of a treatment program. The policy and procedures must:

(1) Identify, by position or title, the staff members who are responsible for the closure of clinical records within the agency and the management information system;
(2) Provide for the closure of a client's clinical records if the client has not received services from an inpatient or residential program in three days or if the client has not received services from an outpatient program in thirty days; and
(3) Provide for the safe storage of case records for at least six years from the date of closure.

Summary of Non-Compliance Finding:

Keystone Treatment Center's policy and procedure for closure and storage of case records does not include a requirement to close inpatient clinical records after 3 days of not receiving services, or outpatient clinical records after 30 days of not receiving services.

Additionally, Keystone Treatment Center's case record storage policy states "In accordance with state and federal statutes". It should specifically say for at least six years from the date of closure.

Corrective Action:

Review Keystone's policy and procedure for closure and storage of case records and update as needed. Review Keystone's case record storage policy and update as needed. Create a policy for reviewing open and closed records to assure the quality and appropriateness of services. The updates shall be completed and approved no later than the end of the third quarter, September 30th, 2026.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
Director of Risk Management – Accreditation	September 30, 2026	July 29, 2026

POC Action #5

Administrative Rule:

67:61:07:06

An addiction counselor or addiction counselor trainee shall develop an individualized treatment plan, based upon the

integrated assessment for each client admitted to an outpatient treatment program, an intensive outpatient treatment program, a day treatment program, a clinically-managed, low-intensity residential treatment program, or a medically-monitored, intensive inpatient treatment program. Evidence of the client's meaningful involvement in formulating the plan must be documented in the client's clinical record. The treatment plan must be recorded in the client's clinical record and contain:

(1) A statement of specific client problems, including any co-occurring disorders, to be addressed during treatment, with supporting evidence;

(2) A diagnostic statement and a statement of short- and long-term treatment goals that relate to the problems identified;

(3) Measurable objectives or methods leading to the completion of short-term goals:

(a) Time frames for the anticipated dates of achievement or completion of each objective, or for reviewing progress towards objectives;
(b) A 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) Interventions, for identified issues, that match the client's readiness for change; and

(4) A statement identifying the staff member responsible for facilitating the methods or treatment procedures.

The individualized treatment plan must be developed within ten calendar days of the client's admission to an intensive outpatient treatment program; a day treatment program; a clinically-managed, low-intensity residential treatment program; or a medically-monitored, intensive inpatient treatment program.

The individualized treatment plan must be developed within thirty calendar days of the client's admission to a counseling services program.

All treatment plans must be reviewed, signed, and dated by the addiction counselor or addiction counselor trainee. The signature must be followed by the counselor's credentials.

Summary of Non-Compliance Finding:

Multiple clients had treatment plan goals that were identical to each other, not individualized, or only focused on attending treatment. Treatment attendance should be a method for achieving goals, not a goal in and of itself.

Corrective Action:

Treatment plan goals, standards, and expectations will be reviewed with the Keystone Outreach councilors. Due to turnover in the counseling department, more experienced counselors will be hired to fill the open positions. This will be accomplished before June 30th, 2026.

Supporting Evidence:

How Maintained:

Randomly audit charts monthly to determine if charting is complete, appropriate, and meets or exceeds the minimum required standards.

Position Responsible:	Expected Completion Date:	Date Completed:
Director-Clinical Services and Director of Risk Management – Accreditation	September 30, 2026	

POC Action #6

Administrative Rule:

67:61:07:08

The direct care provider must record at least one progress note in the client's clinical record each week when services are provided for any program, other than a prevention program.

Progress notes must be included in the client's clinical record and substantiate all services provided. Progress notes must document counseling sessions with the client, summarize significant events, reflect goals and problems relevant to the session, and reflect any progress in achieving those goals and addressing the problems. Progress notes must include attention to any co-occurring disorder, as it relates to the client's substance use disorder.

A progress note must be included in the client's clinical record for each billable service provided. In order for a service to be billed, the progress note must contain:

(1) Information identifying the client receiving the service, including the client's name and unique identification number;
(2) The date, location, time met, the units of service of the counseling 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 identified treatment goals or objectives;
(6) A brief description of what the client and the clinician 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:

The description on progress notes about what occurred during each session was usually vague and limited to what the curriculum for the session contained. Progress notes rarely contained individual or personalized information about the client. Progress notes were also missing a plan for what the client was going to work on during the next session or in between sessions.

Corrective Action:

Progress notes standards and expectations will be reviewed with the Keystone Outreach councilors. Due to turnover in

the counseling department, more experienced counselors will be hired to fill the open positions. This will be accomplished before June 30th, 2026.

Supporting Evidence:

How Maintained:

Randomly audit charts monthly to determine if charting is complete, appropriate, and meets or exceeds the minimum required standards.

Position Responsible:	Expected Completion Date:	Date Completed:
Director-Clinical Services and Director of Risk Management – Accreditation	September 30, 2026	

POC Action #7

Administrative Rule:

67:61:07:08

The direct care provider must record at least one progress note in the client's clinical record each week when services are provided for any program, other than a prevention program.

Progress notes must be included in the client's clinical record and substantiate all services provided. Progress notes must document counseling sessions with the client, summarize significant events, reflect goals and problems relevant to the session, and reflect any progress in achieving those goals and addressing the problems. Progress notes must include attention to any co-occurring disorder, as it relates to the client's substance use disorder.

A progress note must be included in the client's clinical record for each billable service provided. In order for a service to be billed, the progress note must contain:

(1) Information identifying the client receiving the service, including the client's name and unique identification number;
(2) The date, location, time met, the units of service of the counseling 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 identified treatment goals or objectives;
(6) A brief description of what the client and the clinician 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:

Progress notes for individual sessions with clients were rarely completed, and when they were, they often appeared vague or incomplete. For example, individual progress notes across multiple clients documented concerns the client shared, but did not document any response or plan from the counselor. Specifically, the clinical supervisor of Keystone Outreach met with a client individually multiple times without completing progress notes. Without notes, clinical staff

involved in this client's treatment were uninformed of what was being discussed in these sessions or the client's progress and plan after these sessions.

Corrective Action:

Progress notes standards and expectations will be reviewed with the Keystone Outreach councilors. Due to turnover in the counseling department, more experienced counselors will be hired to fill the open positions. This will be accomplished before June 30th, 2026.

Supporting Evidence:

How Maintained:

Randomly audit charts monthly to determine if charting is complete, appropriate, and meets or exceeds the minimum required standards.

Position Responsible:	Expected Completion Date:	Date Completed:
Director-Clinical Services and Director of Risk Management – Accreditation	September 30, 2026	

POC Action #8

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:

Keystone Treatment Center did not complete continued service reviews on any of the reviewed outpatient files. Continued service reviews should be completed every 30 days for outpatient treatment and every 14 days for Medically Monitored Intensive Inpatient Treatment and Intensive Outpatient Treatment.

Additionally, progress or lack thereof should not be based solely on a client's attendance and participation in group treatment.

Corrective Action:

Continued Services Reviews, referred to as a Weekly Transition Plan Summary will be performed each week or at a minimum, every other week. A weekly meeting will be held with all the Keystone Outreach counselors to review each patient's progress. A weekly progress note outlining the patience progress in treatment and the decision of the weekly team meeting will be entered in the patient's chart. This will be accomplished before June 30th, 2026.

Supporting Evidence:

How Maintained:

Randomly audit charts monthly to determine if charting is complete, appropriate, and meets or exceeds the minimum required standards.

Position Responsible:	Expected Completion Date:	Date Completed:
Director-Clinical Services and Director of Risk Management – Accreditation	September 30, 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.

John Stamp

Printed Name of Provider/Agency Contact



June 29, 2026

Signature of Provider/Agency Contact | Date

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

Printed Name of DSS Staff

Signature of DSS Staff: | Date

COMPLETION DETAILS

COMPLETION DATE:

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.

Printed Name of DSS Staff

Signature of DSS Staff: | Date