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	September 21, 2026	Status	In Process

Provider Name	Behavior Management Systems dba West River Mental Health
Provider Type	Accreditation
Accreditation #	1330107739
Provider Address	350 Elk St, Rapid City, SD 57701
Provider Contact	Stacey Fielder
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:

67:62:02:18

An accredited center shall notify the department before a change in the center director, a reduction in services provided by the center, or the impending closure of the center. Upon receiving a notification under this section, the department must make a determination on the center's continued accreditation.

An accredited center shall give the department thirty days' written notice of closure. The center shall provide the department with written documentation outlining the manner in which safe storage of financial records will be provided, for at least six years from the date of closure, and safe storage of client case records will be provided, for at least six years from the date of closure, as required by 42 C.F.R. § 2.19, in effect on October 1, 1999.

The department may assist in making arrangements for the provision of services to clients by another accredited center, prior to the closing.

Summary of Non-Compliance Finding:

West River Mental Health does not have a policy and procedure for changes requiring notification.

Corrective Action:
This policy has been drafted and will be presented to the board of directors on 10/27/26 for final approval.

Supporting Evidence:
See attached.

How Maintained:
Board Reviews

Position Responsible:	Expected Completion Date:	Date Completed:
CEO, Operations Director, and BOD	October 27, 2026	

POC Action #2

Administrative Rule:
67:62:05:07
Each center shall establish a policy and procedures to ensure that a new client is provided with orientation to the program, at or before the time of admission, or as soon thereafter as possible. The orientation must provide:

(1) A description of the center's purpose and the treatment process;
(2) A review of relevant center policies;
(3) The hours during which services are available;
(4) The fees for services and the responsibility for payment for those fees;
(5) Information regarding the right to confidentiality, in accordance with 42 U.S.C. § 290 dd-2, in effect on March 27, 2020; 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; and
(6) The rights of the client while receiving services, in accordance with §§ 67:62:07:01 and 67:62:07:02.

Summary of Non-Compliance Finding:
West River Mental Health does not have a policy and procedure for client orientation.

Corrective Action:
This policy has been drafted and will be presented to the board of directors on 10/27/26 for final approval.

Supporting Evidence:
See Attached

How Maintained:
Board Review

Position Responsible:	Expected Completion Date:	Date Completed:
CEO, Operations Director, and BOD	October 27, 2026	

POC Action #3

Administrative Rule:

67:62:08:03

The center shall establish a policy and procedures to ensure the closure and storage of case 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 case records within the agency and the management information system;
(2) Provide for the closure of case records belonging to clients who have had no contact, by phone or by person, with the agency for a time period no longer than six months; and
(3) Provide for the safe storage of case records for at least six years from the closure.

Summary of Non-Compliance Finding:

West River Mental Health does not have a closure and storage of records policy.

Corrective Action:

This policy has been drafted and will be presented to the board of directors on 10/27/26 for final approval. See attached.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
CEO, Operations Director, and BOD	October 27, 2026	

POC Action #4

Administrative Rule:

67:62:13:02

A center may provide services in a location preferred by a client, including settings outside the center.

A center may provide services within an integrated system of care. A center must provide services according to the individualized needs and strengths of the client and must be responsive to cultural differences and special needs of the client. The following individualized and mobile program of assertive community treatment (IMPACT) services must be provided according to the individualized needs of the client:

(1) Integrated assessment, evaluation, and screening;

(2) Crisis assessment and intervention services, with twenty-four hour per day and seven day per week availability;

(3) Case management;

(4) Psychiatric services, with the primary purpose of prescribing or reviewing a client's use of pharmaceuticals, including psychiatric assessments, treatment, and prescription of pharmacotherapy;

(5) Psychiatric nursing services, including components of physical assessment, medication assessment and monitoring, and medication administration;

(6) Symptom assessment and management, including medication monitoring and education;

(7) Individual therapy or counseling;

(8) Group therapy;

(9) Recovery support services;

(10) Direct assistance to ensure ongoing opportunities for the client to obtain the basic necessities of daily life and perform basic daily living activities;

(11) Psychosocial rehabilitative services provided on an individual or group basis, to assist the client with gaining or relearning self-care, interpersonal, and community living skills needed to live independently, sustain psychiatric stability, and progress towards recovery;

(12) Liaison services, to facilitate treatment planning and coordination of services between mental health and other entities;

(13) Encouragement for the active participation of family and a supportive social network; and

(14) Collateral contacts.

For IMPACT services, there must be at least one primary therapist for every twelve clients served. A center must provide clients with an annual average of sixteen contacts per month with IMPACT staff and more, if clinically appropriate.

Summary of Non-Compliance Finding:

West River Mental Health does not have a policy and procedure to ensure the therapist and client ratio does not exceed 1:12.

Corrective Action:

This policy has been drafted and will be presented to the board of directors on 10/27/26 for final approval.

Supporting Evidence:
See Attached

How Maintained:
Board Review

Position Responsible:	Expected Completion Date:	Date Completed:
CEO, Operations Director, and BOD	October 27, 2026	

POC Action #5

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:
100% of reviewed outpatient mental health assessments, 100% of reviewed children, youth and family assessments, and 80% of reviewed CARE assessments were missing readiness for change.

Corrective Action:
All mental health services teams have received training on the feedback regarding readiness for change documentation that is necessary in the assessments and have been given direction to begin adding this information into their documents moving forward. The quality development team has created a checklist for staff to utilize as a tool with this detail included in the strengths section of our assessment. We are also currently finalizing a new assessment document in our EHR and have added the strengths section and readiness for change. Our supervisors have been informed of this expectation and will plan to review this in all assessments moving forward when signing off on clinician's documents.

Supporting Evidence:
n/a

How Maintained:
Clinical Supervision

Position Responsible:	Expected Completion Date:	Date Completed:

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.

Stacey Fielder

Printed Name of Provider/Agency Contact



October 08, 2026

Signature of Provider/Agency Contact | 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



10/8/2026, 10:22:49 AM

October 08, 2026

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