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	September 21, 2026	Status	In Process

Provider Name	Behavior Management Systems dba West River Mental Health - SUD Services
Provider Type	Accreditation
Accreditation #	847434422
Provider Address	350 Elk St, Rapid City, SD 57701
Provider Contact	Amy Hartman
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:

67:61:02:20

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

An accredited agency shall give the department thirty days' written notice of closure. The agency 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 arranging for the continuation of services to clients by another accredited agency before the closing.

Summary of Non-Compliance Finding:

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

Corrective Action:

The attached policy was drafted on 9/15/26 and will be presented to the Board of Directors for final approval on 10/27/26.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
	October 27, 2026	

POC Action #2

Administrative Rule:

67:61:04:07

The agency shall develop policy and procedures to ensure that a new client receives orientation to the program at or before the time of admission, or as soon thereafter as possible. The orientation must include:

(1) The agency's purpose and a description of the treatment process;
(2) All relevant agency policy;
(3) The hours during which services are available;
(4) The fees for services and the responsibility for payment of those fees;
(5) Information on 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 §§ 67:61:06:01 and 67:61:06:02.

Summary of Non-Compliance Finding:

West River Mental Health does not have a client orientation policy.

Corrective Action:

The attached policy was drafted on 9/15/26 and will be presented to the Board of Directors for final approval on 10/27/26.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
	October 27, 2026	

POC Action #3

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:
West River Mental Health does not have a policy for closure of clinical records.

Corrective Action:
The attached policy was drafted on 9/15/26 and will be presented to the Board of Directors for final approval on 10/27/26.

Supporting Evidence:

How Maintained:

Position Responsible:	Expected Completion Date:	Date Completed:
	October 27, 2026	

POC Action #4

Administrative Rule:
67:61:07:10
An addiction counselor or an addiction counselor trainee shall complete a transfer or a discharge summary for a client, within five working days after the client is transferred or discharged, regardless of the reason for the transfer or discharge. A transfer or a discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan must be maintained in the client's case record. A process must be in place to ensure that the transfer or discharge summary is completed in the management information system.

When a client prematurely discontinues services, reasonable attempts must be made and documented by the agency to re-engage the client, if appropriate.

Summary of Non-Compliance Finding:
West River mental health does not complete transfer summaries when clients transfer between levels of care, specifically transfers from 3.7 to 3.1.

Corrective Action:
Two documents were developed: A transfer summary has been developed for counselors to use to write a transfer summary to be placed in the file after it has been determined appropriate to transfer the client. Then a document for the clinical staff to follow and use as discussion points within the staff meeting.

Supporting Evidence:

Discussed the importance of the transfer summary and this process in the Clinical Staff meeting on 9/29/26. We also completed the new process by staffing a client and using the new document to discuss if they were ready to transfer from 3.7 to 3.1 according to ASAM criteria.

How Maintained:

The primary counselor will complete the document and place it in the client record. Routine file checks/record reviews by Clinical SUD Director.

Position Responsible:	Expected Completion Date:	Date Completed:
Primary counselors and Clinical Director.	January 01, 2027	

POC Action #5

Administrative Rule:

67:61:18:05

A medically-monitored, intensive inpatient treatment program for adults must provide daily, to each client, a combination of individual, group, or family counseling, which must total a minimum of twenty-one hours per week.

The program must provide a minimum of nine hours of additional services on specialized topics that address the specific needs of the client. The additional services must be identified on the client's treatment plan or continued stay review. These services must be provided by an individual trained in the specific topic presented.

A medically-monitored, intensive inpatient treatment program for adolescent clients must include at least fifteen hours per week of any combination of individual, group, or family counseling services.

Summary of Non-Compliance Finding:

66% of reviewed medically monitored intensive inpatient treatment files did not contain consistent documentation of at least 30 hours of treatment per week. There was no documentation indicating sessions in which clients were offered treatment but did not attend.

Corrective Action:

Client attended treatment hours have been reviewed by Clinical Director and Program Manager. These hours will be monitored and adhered to more closely. CSRs will include documentation about additional and specialized treatment groups that client is attending. We are correcting the EHR error that doesn't show non-attendance progress notes.

Supporting Evidence:

Will discuss in Clinical Supervision meeting on 10/13/26 the importance of high intensity (level 3.7) clients attending all offered treatment groups as well as Counselors will be asked to document client's attendance hours for additional services and specialized topics in in their treatment plans and CSRs.

How Maintained:

Clinical Director will check EHR files weekly for the first month of implementation of these corrections, then quarterly at record review time.

Position Responsible:	Expected Completion Date:	Date Completed:
Full Circle Counselors and Clinical Director of SUD services.	January 01, 2027	

POC Action #6

Administrative Rule:

67:61:18:02

A medically-monitored, inpatient treatment program must meet the following requirements:

(1) At the time of admission, each client's blood pressure, pulse, and respiration must be evaluated by staff trained to perform these tests and recorded in the client's case record;

(2) Within eight hours after admission, each client must receive a medical evaluation conducted by a registered nurse or a licensed practical nurse. The results of this medical evaluation must be provided to the program physician. The program physician shall assess whether the client needs an immediate and more extensive examination before determining the appropriateness of the admission. The program physician's approval must be documented in the client's case record.

The medical evaluation requires:

(a) A second reading of the client's blood pressure, pulse, and respiration;
(b) An assessment of the client's mental and emotional status;
(c) The identification of bruises, lacerations, cuts, wounds, and other medical conditions;
(d) Documentation of current medication use and medications being carried by the client; and
(e) Documentation regarding any history of diabetes; seizure disorders, including epilepsy; delirium tremens; and any history of having undergone convulsive therapies; and

(3) Within seventy-two hours after admission, the program must have completed the client's blood count and urinalysis tests and provided the client with a complete physical examination by, or under the supervision of, a licensed physician, who shall also evaluate the results of the tests conducted.

Summary of Non-Compliance Finding:

Approximately 83% of reviewed medically monitored intensive inpatient treatment files were missing complete physical examinations by, or under the supervision of, a medical provider with complete blood work and urinalysis.

Corrective Action:

Full Circle Nurse was not always receiving copies of physical examinations or labs from providers to be placed in client

files. Will be working with providers to obtain these for client records as needed. These will then be scanned into clients EHR file.

Supporting Evidence:

Discussed with Full Circle Nurse and she will assure that we do receive a copy of each client's physical exam and labs (blood work and urinalysis) from each providing medical agency. Next, she will make a copy and place it in the scanned box for support staff to place in the EHR.

How Maintained:

Full Circle Nurse communicates with medical providers and obtains records, copies, puts in to be scanned box, does record checks that physical exams and labs are in client files. Clinical Director also does routine record reviews to check that physical exams and labs are in each client file and have been completed within 72 hours of admission to program.

Position Responsible:	Expected Completion Date:	Date Completed:
Full Circle Nurse, Clinical Director of SUD Services - Angie Poile, Director of Operations (and Support Staff) Stacey Fields	January 01, 2027	

POC Action #7

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:

In at least two reviewed files, assessments from outside organizations recommended level 3.1, clinically-managed low-intensity residential treatment. However, an uncredentialed West River Mental Health staff member made an alternate recommendation of 3.7, Medically-Monitored Intensive Inpatient Treatment to the South Dakota Foundation for Medical Care. Recommendations for level of care can only be made by an LAC, CAC, or ACT, and a new integrated assessment or assessment addendum should be completed to make the new recommendation.

Corrective Action:

Moving forward, if a client is admitting at a recommended ASAM level 3.1, and the admissions/intake coordinator suspects the need for a higher level of care (3.7), they will immediately contact the SUD Director. Director will then re-

assess or assign an available counselor (LAC, CAC or ACT) to do an assessment addendum. An assessment addendum has been developed to assist in guiding the counselor and aiding the SD Foundation for Medical Care in justifying additional care.

Supporting Evidence:

An assessment addendum document has been created and will be used in this circumstance moving forward. Director has communicated with the intake/admissions coordinator to let her know about the process and the importance of this change.

How Maintained:

All clients who have a change in recommended level of care to their admission from level 3.1 to level 3.1 will have this addendum in their file. Director will do routine file reviews to confirm compliance.

Position Responsible:	Expected Completion Date:	Date Completed:
Admissions/Intake Coordinator, SUD counselors, SUD Clinical Director - Angie Poile	January 01, 2027	

POC Action #8

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 of what the client and clinician plan to work on during the next session was often not specific, not individualized, and not related to the session or what the client talked about during the session. Examples include, "continue treatment", "drink more water", and "be optimistic". The plan for the next session or in between sessions should be individualized and relate back to the topic of the current session or the topic of the next session.

Corrective Action:

The plan portion of group progress notes will be improved to be more specific to each client and the topic of the group. Counselors will ask clients to be more specific, and the action should connect to the session.

Supporting Evidence:

Discussed in clinical staff meeting with all counselors present this corrective action. Clinical SUD director provided some additional education and training about the plan portion of progress notes especially based feedback and direction from auditors. Also, sent a follow up email for additional reference and explanation.

How Maintained:

Clinical Director will specifically monitor the *plan* area in group progress notes weekly for the first month of implementation and then quarterly at record review time.

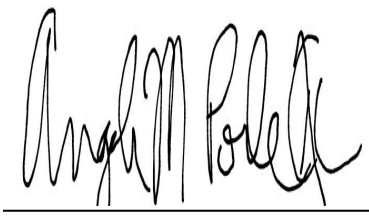
Position Responsible:	Expected Completion Date:	Date Completed:
Full Circle Counselors and Clinical SUD Director, Angie Poile.	January 01, 2027	

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.

Angela M Poile

Printed Name of Provider/Agency Contact



Signature of Provider/Agency Contact

October 07, 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



10/8/2026, 11:17:16 AM

Signature of DSS Staff:

October 08, 2026

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