South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LICENSING & ACCREDITATION
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Plan of Correction

Date Issued June 05, 2026 Status Closed

Provider Name	Anchor'D Recovery Center
Provider Type	Accreditation
Accreditation #	1308480351
Provider Address	1809 N Wisconsin St, Mitchell, SD 57301, USA
Provider Contact	Jai Mimmack
Board Notified	Yes

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:

67:61:04:01

Each agency shall establish a manual that sets forth policy and procedures to ensure compliance with this article. Each agency shall review and update the manual.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center has an up to date policy and procedure manual, but they are not implementing the policies or procedures in the manual.

Corrective Action:

This finding is about putting the manual into practice, not the manual's content, so that is what the corrective action targets. ARC is doing three things. First, it is holding a mandatory all-staff in-service on the policy and procedure manual, and each staff member signs a dated acknowledgment that they reviewed and understood it. Second, it has built and put into use a compliance tracking application, restricted to agency staff, that turns every recurring clinical, personnel, and facility obligation into a dated task tagged to the specific administrative rule behind it and assigned to an owner. The application flags each task as upcoming, due, or overdue so nothing depends on memory, and it enforces the clinical-supervisor cosignature as a hard gate: a billing week cannot be marked submitted while any session still lacks the supervisor's cosignature. Every change is written to an append-only log showing who did what and when. The application holds only task status and pointers to where each record lives; the clinical records and client identifiers stay

in SimplePractice. Third, the Program Director runs a quarterly internal audit that checks whether the written policies are actually being followed and documents what was found. The other findings in this Plan are the specific places the manual was not being followed, and each is corrected in its own response and watched through the same tracker.

Supporting Evidence:

Signed, dated staff acknowledgments from the in-service, along with the agenda and sign-in sheet; screenshots of the compliance tracking application showing rule-tagged obligations with their owners, due dates, and overdue flags, plus the enforced cosignature gate; the quarterly internal audit form; and the manual review log.

How Maintained:

The Program Director runs the quarterly internal audit and keeps it in the administrative file. The tracking application runs continuously and is reviewed by the Program Director and Executive Director. The manual is reviewed and updated at least once a year, staff re-acknowledge it, and it is covered with every new hire at orientation.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS), with Executive Director (Jai Mimmack, ACS) oversight. Clinical Supervisor (Nikki Roth, LAC) for clinical policy.	August 22, 2026	October 14, 2026

POC Action #2

Administrative Rule:

67:61:03:03

The board of directors of each agency with a board shall meet at least quarterly. The agency must keep the minutes of all board meetings. The minutes must contain:

(1) The date of the meeting;
(2) The names of board members in attendance;
(3) The topics discussed;
(4) The actions taken;
(5) A summary of the agency director's report; and
(6) Any fiscal reports.

The agency shall make the minutes available for review by the department.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center has a list of board of director members, but does not have a policy about how often the board of directors meets or what topics must be covered during the meetings.

Corrective Action:

ARC will adopt a written board governance policy requiring the Board of Directors to meet at least quarterly, plus a standard minutes template that captures all six required elements: the meeting date, members present, topics discussed, actions taken, a summary of the agency director's report, and any fiscal reports. The Board will hold its next quarterly meeting and record the minutes on that template, and an annual meeting schedule will be set.

Supporting Evidence:

The adopted board governance policy stating the monthly first-Thursday meeting schedule and required content; the minutes template showing all six elements; and minutes from the most recent monthly board meeting on that template.

How Maintained:

The Board meets monthly on the first Thursday and records minutes on the template capturing all six required elements; minutes are kept and made available to the Department on request. The Executive Director makes sure each monthly meeting is held and its minutes are completed and filed.

Position Responsible:	Expected Completion Date:	Date Completed:
Executive Director (Jai Mimmack, ACS) and the Board of Directors.	August 06, 2026	October 14, 2026

POC Action #3

Administrative Rule:

67:61:04:02

Each agency shall submit to the department statistical data on each client receiving services in a manner agreed upon by the department and the agency. The agency shall provide statistical data on all services in accordance with the state management information system, and any other data required by the department and state and federal laws and regulations.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center has not entered any client information into the state STARS billing system or submitted any Medicaid claims into the system.

Corrective Action:

ARC has entered every active client into STARS with the admission completed. Medicaid claims are submitted through STARS and Cortex EDI on the weekly billing cycle. One position owns STARS entry at admission and weekly claim submission, and reconciles the entered clients against the active census at each weekly billing review.

Supporting Evidence:

STARS screenshots showing current clients entered with completed admissions; Cortex EDI submission confirmations and remittance advice; and the written weekly billing workflow naming the responsible position and the submission cutoff.

How Maintained:

The Program Director enters each new client into STARS at admission and submits claims on the weekly cycle (Tuesday 5:00 PM Central cutoff), checking entered clients against the active census at each weekly billing review.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS).	July 30, 2026	August 03, 2026

POC Action #4

Administrative Rule:

67:61:04:09

Each agency shall have policy and procedures to respond to potential medical emergencies that clients may encounter while residing at the agency. Each agency that provides treatment services shall provide adequate staffing, training, and hours of operation at the following levels:

(1) Early intervention, outpatient programs, and intensive outpatient treatment programs shall have counseling staff on duty at all times during scheduled hours of program operation or available by phone. The agency shall post the hours that the agency is open to the general public in a prominent place on the premises. The agency shall have an on-call system, available seven days a week, twenty-four hours a day, for client access to program services, in the event of an emergency;

(2) Day treatment programs without residential services shall have counseling staff on duty at all times during scheduled hours of program operation. The agency shall post the hours that the agency is open to the general public in a prominent place on the premises. The agency shall have an on-call system, available seven days a week, twenty-four hours a day, for client access to program services, in the event of an emergency;

(3) Day treatment with residential services and clinically-managed, low-intensity residential treatment programs shall operate seven days a week, twenty-four hours a day. The agency shall have, on duty at all times, a staff member who is trained to respond to fires and other natural disasters, as well as to administer emergency first aid and cardiopulmonary resuscitation. An addiction counselor or an addiction counselor trainee must be available to the clients at least eight hours a day, five days a week, and must be available on-call, twenty-four hours a day. The agency shall maintain written staff schedules, which must be available to the department at the time of the accreditation survey;

(4) Clinically-managed, residential detoxification programs shall operate seven days a week, twenty-four hours a day whenever clients are present. If no clients are present, a staff member must be on call to open the facility, if necessary. When the agency is open, a staff member who is trained, in accordance with § 67:61:17:06, to respond to fires and other natural disasters, as well as to administer emergency first aid and cardiopulmonary resuscitation, must be on duty. An addiction counselor or an addiction counselor trainee must be available to clients at least eight hours a day, five days a week, and available on-call, twenty-four hours a day. The agency shall maintain written staff schedules, which must be available to the department at the time of the accreditation survey; and

(5) Medically-monitored, intensive inpatient treatment programs shall operate seven days a week, twenty-four hours a day. The agency shall have, on duty at all times, a staff member who is trained to respond to fires and other natural disasters, as well as to administer emergency first aid and cardiopulmonary resuscitation. Training and annual training updates in each area must be documented in the staff members' personnel files. Nursing staff must be on-call twenty-

four hours a day, seven days a week. Counseling staff shall be on duty during normal daytime hours and must be on-call, twenty-four hours a day, seven days a week. The agency shall maintain written staff schedules, which must be available to the department at the time of the accreditation survey.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center has a policy requiring staff to complete CPR training, but there is not proof of CPR certification in any personnel files.

Corrective Action:

ARC will get current CPR, emergency first aid, and fire and disaster response certification for the staff who cover the 3.1 residential program, and file a copy of each in the personnel record with renewals tracked on a training log. Under 67:61:04:09(3), a staff member trained in these areas is on duty at all times, and an addiction counselor or trainee is available at least eight hours a day, five days a week, and on call around the clock. Written staff schedules are kept and available to the Department at survey.

Supporting Evidence:

Current CPR/first-aid/disaster-response certifications in the applicable personnel files; the training log showing status and renewal dates; and the written staff schedule.

How Maintained:

Current CPR/first-aid/disaster-response certifications in the applicable personnel files; the training log showing status and renewal dates; and the written staff schedule.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS) and Executive Director (Jai Mimmack, ACS).	October 31, 2026	October 14, 2026

POC Action #5

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:

Proof of client orientation was missing in over 50% of reviewed files.

Corrective Action:

Every client will get a standardized, documented orientation at or before admission covering all six required areas: the agency's purpose and treatment process; relevant agency policy; service hours; fees and payment responsibility; confidentiality rights under 42 U.S.C. 290dd-2, 42 C.F.R. Part 2, and 45 C.F.R. Parts 160 and 164; and client rights under 67:61:06:01 and 67:61:06:02. A signed, dated acknowledgment goes in each client record. For the clients currently in treatment whose files are missing this, orientation is being completed now.

Supporting Evidence:

The standardized orientation form covering the six areas; and signed, dated acknowledgments in current client records.

How Maintained:

Orientation is a required admission step; the tracker carries it per client and it is checked at the first weekly clinical review, with the signed form filed. The quarterly audit spot-checks it.

Position Responsible:	Expected Completion Date:	Date Completed:
ACS (Benny Medrano or Jai Mimmack); Clinical Supervisor (Nikki Roth, LAC) oversight.	October 31, 2026	October 14, 2026

POC Action #6

Administrative Rule:

67:61:06:01

An agency shall ensure that clients' rights are protected. The agency shall give each client a copy of the clients' rights and responsibilities, in writing, or in an accessible format, upon admission, and shall discuss the rights and responsibilities with the client or the client's advocate.

The clients' rights and responsibilities must be posted in a place accessible to clients. Copies must be available in locations where clients can access them, without making a request to agency staff. The agency shall make a copy of the clients' rights and responsibilities available to the department. The agency shall provide services to each client in a manner that is responsive to the client's need in the areas of age, gender, social support, cultural orientation, psychological characteristics, sexual orientation, physical situation, and spiritual beliefs.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center's policy and procedure manual contains all of the required client rights, but those client rights are not presented to clients during admission.

Corrective Action:

Each client receives a written copy of the clients' rights and responsibilities at admission, gone over with the client or the client's advocate, with a signed and dated acknowledgment filed. The rights are posted where clients can see them, with copies available without having to ask staff, and services are delivered in a way that responds to each client's age, gender, social support, cultural orientation, sexual orientation, physical situation, and spiritual beliefs. Current clients have signed acknowledgments on file.

Supporting Evidence:

Signed, dated rights acknowledgments in client records; a photo of the posted rights in client areas; and a copy of the rights and responsibilities document.

How Maintained:

Presenting and discussing rights is a required admission step, tracked per client and checked at the first weekly clinical review, with the signed form filed. Postings are checked during the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
ACS (Benny Medrano or Jai Mimmack); Clinical Supervisor (Nikki Roth, LAC) oversight.	June 30, 2026	August 03, 2026

POC Action #7

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:

Anchor'D Recovery Center has the required personnel orientation policies, but there is no documentation of orientation in any of the reviewed personnel files.

Corrective Action:

ARC will document staff orientation within ten working days of employment, and within ten working days of the start of service for contracted direct-service staff, interns, and volunteers, covering all eight required topics: (1) fire prevention and safety, including extinguisher locations and use, the evacuation plan, and the smoking policy; (2) confidentiality under 42 C.F.R. Part 2 and 45 C.F.R. Parts 160 and 164; (3) proper handling of client case records; (4) the agency's treatment philosophy and goals; (5) medical-emergency and natural-disaster procedures; (6) job descriptions and responsibilities; (7) the policy and procedures manual; and (8) reporting suspected child abuse or neglect under SDCL 26-8A-3 and 26-8A-8. A standardized checklist with a signed, dated record goes in each personnel file. Current staff whose files are missing this are being oriented and documented now.

Supporting Evidence:

The orientation checklist covering all eight topics; and signed, dated orientation records in personnel files.

How Maintained:

Orientation within ten working days is tracked on the onboarding checklist and verified by the Program Director, with the signed record filed. The quarterly audit checks it.

Position Responsible:	Expected Completion Date:	Date Completed:
Executive Director (Jai Mimmack, ACS), with Program Director (Benny Medrano, ACS).	August 15, 2026	October 14, 2026

POC Action #8

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:

Anchor'D Recovery Center has the required policy and procedure, but there is no documentation of checks of the Office of Inspector General Medicaid exclusion list in any of the reviewed personnel files.

In order to meet the "routinely" requirements, the Office of Licensing and Accreditation recommends checking the list for all employees, volunteers, and interns at least annually, as well as upon hire for all new employees. The search can be performed at this website:
https://exclusions.oig.hhs.gov/?_gl=1*1j0wp11*_ga*NzEzMzg5NDIwLjE3ODE3MzAzODQ.*_ga_W5DCJS81Y5*czE3ODE3MzAzODMkbzEkZzAkdDE3ODE3MzAzODMkajYwJGwwJGgw

Corrective Action:

ARC will run the HHS-OIG List of Excluded Individuals and Entities (LEIE) at exclusions.oig.hhs.gov for all current employees, contracted staff, interns, and volunteers, and file a dated printout in each personnel file. Going forward, the LEIE is checked at hire for every new person and monthly for all staff, contractors, interns, and volunteers, with dated printouts filed. ARC does not claim payment for services provided by an excluded individual.

Supporting Evidence:

Dated LEIE printouts for each current staff member, volunteer, and intern; the exclusion-check procedure specifying at-hire and monthly checks; and the tracking log.

How Maintained:

The Program Director runs the LEIE check at hire and monthly, files the dated result, and tracks it on the compliance calendar. Monthly checks meet the rule's “routinely” standard and line up with CMS Medicaid provider-screening guidance under 42 C.F.R. 455.436.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS) and Executive Director (Jai Mimmack, ACS).	August 01, 2026	August 03, 2026

POC Action #9

Administrative Rule:

67:61:05:01
Tuberculin screening requirements are as follows:

(1) Each new staff member, intern, and volunteer must receive both steps of the two-step tuberculin skin test or a tuberculosis blood assay test to establish a baseline, within fourteen days of employment. Any two documented tuberculin skin tests completed within a twelve month period before the date of employment may be considered a two-step test and one tuberculosis blood assay test completed within a twelve month period before employment may be

considered an adequate baseline test. Skin testing or tuberculosis blood assay tests are not required if a new staff member, intern, or volunteer provides documentation of the last skin testing completed within the prior twelve months. Skin testing or tuberculosis blood assay tests are not required if documentation is provided of a previous positive reaction to either test;

(2) A new staff member, intern, or volunteer, who provides documentation of a positive reaction to the tuberculin skin test or tuberculosis blood assay test must have a medical evaluation and chest X-ray to determine the presence or absence of the active disease;

(3) Each staff member, intern, and volunteer, with a positive reaction to the tuberculin skin test or tuberculosis blood assay test, must be evaluated annually by a physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse, and a record must be maintained of the presence or absence of symptoms of Myobacterium tuberculosis. If the evaluation results in a suspicion of active tuberculosis, the physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse, must refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and

(4) Any employee confirmed or suspected to have infectious tuberculosis must be restricted from employment until a physician, physician assistant, nurse practitioner, or clinical nurse specialist, determines that the employee is no longer infectious.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center has the required policy and procedure, but there was no proof of two step tuberculin testing in any of the reviewed personnel files.

Corrective Action:

ARC will obtain baseline tuberculin screening for all staff, interns, and volunteers within fourteen days of employment, using either a two-step skin test or an FDA-approved TB blood assay (IGRA), with results filed in personnel files. Per the rule, ARC will accept documentation of two qualifying skin tests in the prior twelve months, a single blood assay in the prior twelve months, a skin test in the prior twelve months, or a prior positive reaction. Positive reactors get a medical evaluation and chest X-ray and an annual evaluation, and anyone confirmed or suspected to be infectious is kept off work until a provider clears them.

Supporting Evidence:

TB screening results in each personnel file; the TB screening procedure showing the fourteen-day baseline window and how positive reactors are handled; and the staff TB tracking log.

How Maintained:

Baseline TB status is verified at hire and filed; positive reactors are evaluated annually, tracked on the compliance calendar. Confirmed at the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS) and Executive Director (Jai Mimmack, ACS).	August 15, 2026	October 14, 2026

POC Action #10

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:

Anchor'D Recovery Center does not have the required policy and procedure. They also do not have any of the required records in any of the reviewed personnel files.

Corrective Action:

ARC will adopt a written personnel policy that includes equal-employment-opportunity provisions, plus a standard personnel-file structure with all six required components: (1) the application or resume with transcripts, diploma, and continuing-education evidence; (2) a signed position description with duties, responsibilities, and minimum qualifications and competencies; (3) evidence of pre-hire screening for staff serving vulnerable populations; (4) orientation documentation per 67:61:05:05; (5) current credentials tied to job duties; and (6) health clearances including tuberculin results. Every current personnel file is being rebuilt to this standard using a file checklist.

Supporting Evidence:

The personnel policy with EEO provisions; the six-component file checklist; and rebuilt personnel files for current staff.

How Maintained:

Each file is built to the six-component standard at hire using the checklist. The Program Director checks completeness at hire and at the quarterly audit and tracks any missing item until it's resolved.

Position Responsible:	Expected Completion Date:	Date Completed:
Executive Director (Jai Mimmack, ACS), with Program Director (Benny Medrano, ACS).	October 31, 2026	October 14, 2026

POC Action #11

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:

Anchor'D Recovery Center's clinical record closure policy is incorrect. Their policy states that a discharge summary will be completed within 30 days of discharge for outpatient clients and within 3 days of discharge for residential clients. The policy and procedure should indicate when a client should be discharged when not receiving services.

Anchor'D Recovery Center also does not have a policy or procedure for arranging the safe storage of client records for at least six years after record closure.

Corrective Action:

ARC will rewrite its clinical-record closure and retention policy so it does three things. It names, by position, who closes clinical records in both the record and the management information system. It closes a client's record when the client has gone three days without services in a residential program or thirty days without services in an outpatient program (the prior policy had discharge-summary timeframes in this spot, which was the error). And it provides for safe storage of case records for at least six years from closure, spelling out the method and safeguards. Discharge-summary timing (five working days) is a separate requirement under 67:61:07:10 and is kept separate.

Supporting Evidence:

The revised closure and retention policy showing all three provisions; and a description or photo of the secure six-year storage.

How Maintained:

Records are closed on the corrected timelines by the named position and stored securely for at least six years. The Program Director checks closures and storage at the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS).	August 15, 2026	October 14, 2026

POC Action #12

Administrative Rule:

67:61:09:01

Each residential program shall develop and implement a written plan for meeting the basic nutritional needs, as well as any special dietetic needs, of each client. The program shall provide at least three meals a day. Any snacks provided by the program must be part of the overall dietary plan. Each meal must include foods from the basic food groups, according to the Dietary Guidelines for Americans, as released by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center does not have a written plan for meeting the basic nutritional needs of clients, as well as any special dietetic needs of each client.

Corrective Action:

ARC will put a written dietary plan in place that meets clients' basic nutritional needs and any special or therapeutic needs, provides at least three meals a day, folds any snacks into the overall plan, and includes foods from the basic food groups consistent with the USDA/HHS Dietary Guidelines for Americans. The plan includes a way to identify and accommodate individual special diets at admission.

Supporting Evidence:

The written dietary plan and menu cycle; and the process for identifying and documenting individual special diets at admission.

How Maintained:

Meals follow the written plan, individual dietary needs are identified at admission and accommodated, and the plan is reviewed at least once a year. Reviewed each quarter at the internal audit.

Position Responsible:	Expected Completion Date:	Date Completed:
Executive Director (Jai Mimmack, ACS) and Program Director (Benny Medrano, ACS).	October 31, 2026	October 14, 2026

POC Action #13

Administrative Rule:

67:61:08:02

Each residential program must meet the following requirements for the control, accountability, and safe storage of medications and controlled drugs:

(1) Any client on medications for a substance use disorder, mental health issue, or a medical condition shall surrender all medications and controlled drugs, upon admission to the agency, and be educated about how to take the client's prescribed medication, while in the program;

(2) Each client shall receive a formal orientation to the program's medication policy and procedures upon admission;

(3) All medications and controlled drugs must be kept in a locked medication storage area that is inaccessible to all persons at all times, except as provided in subdivision 67:61:08:02(5), and §§ 67:61:08:08 and 67:61:08:10;

(4) All controlled drugs must be kept in a separate locked box or drawer within the medication storage area;

(5) Poisons, disinfectants, and medications prescribed for external use must be stored separately from each other and from internal medications, with each in a separate locked area that is inaccessible to clients and visitors;

(6) Biologicals and medications, requiring refrigeration or other storage requirements as identified by the manufacturer's labeling, must be stored separately, including during refrigeration, freezing, and protection from the light, in an area that is inaccessible to clients and visitors. If these biologicals and medications are stored in a refrigerator containing items other than the biologicals and medications, the biologicals and medications must be kept in a separate, secured compartment;

(7) Each client's prescription medications must be stored in the medication's originally received container and may not be transferred to another container;

(8) Any container with a worn, illegible, or missing label must be destroyed along with the medication or drugs in the container, in accordance with § 67:61:08:05;

(9) Only a licensed pharmacist may label, relabel, or alter labels on medication containers;

(10) Any medication or drug prescribed for one client may not be administered to another client;

(11) If a client brings his or her own medications or controlled drugs into the program, the client's medications or controlled drugs may not be administered unless the client can be identified and written orders for the administration of the medications or controlled drugs is received from a licensed physician;

(12) Each program must have a procedure for contacting the client's identified pharmacies and physicians, as soon as possible after each client is admitted to the program;

(13) If medications or controlled drugs brought by a client into the program are not used, the medications or controlled drugs must be packaged, sealed, stored, and returned to the client, parent if the client is under the age of eighteen, guardian if applicable, or significant other, at the time of discharge, if the return of the medications or controlled drugs is approved by a program physician. The return of the medications or controlled drugs must be documented in the client's case record, with the name, strength, and quantity of the medication or controlled drug, and signed by the staff member identified to manage client medication; and

(14) The telephone number of the regional poison control center, the local hospital, the medical director, and the program administrator must be posted in all medication and controlled drug storage and preparation areas.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center has a policy for storing controlled drugs in a separate lock box or drawer in the medication storage area, but do not physically have the area available.

Corrective Action:

ARC keeps all controlled substances in a separate locked box inside the med-pantry, which serves as the locked medication storage area and stays inaccessible to unauthorized people. ARC will confirm and photograph the full setup the rule requires: the locked storage area, the separate controlled-drug lockbox inside it, separate locked storage for poisons, disinfectants, and external-use medications, and a separate secured compartment for any refrigerated medications. Clients surrender all medications at admission and are oriented to the medication policy, and prescriptions are kept in their original containers.

Supporting Evidence:

Photos of the locked med-pantry storage and the separate controlled-drug lockbox, plus the separate storage for poisons, disinfectants, and external-use meds and any refrigerated compartment; and the medication storage procedure describing the setup.

How Maintained:

Storage is kept up per policy. The Program Director checks the locked storage and separate controlled-drug lockbox at the quarterly audit and any time medication handling changes.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS). Jai Mimmack, Executive Director	August 06, 2026	October 14, 2026

POC Action #14

Administrative Rule:

67:61:08:02

Each residential program must meet the following requirements for the control, accountability, and safe storage of medications and controlled drugs:

(1) Any client on medications for a substance use disorder, mental health issue, or a medical condition shall surrender all medications and controlled drugs, upon admission to the agency, and be educated about how to take the client's prescribed medication, while in the program;

(2) Each client shall receive a formal orientation to the program's medication policy and procedures upon admission;

(3) All medications and controlled drugs must be kept in a locked medication storage area that is inaccessible to all persons at all times, except as provided in subdivision 67:61:08:02(5), and §§ 67:61:08:08 and 67:61:08:10;

(4) All controlled drugs must be kept in a separate locked box or drawer within the medication storage area;

(5) Poisons, disinfectants, and medications prescribed for external use must be stored separately from each other and from internal medications, with each in a separate locked area that is inaccessible to clients and visitors;

(6) Biologicals and medications, requiring refrigeration or other storage requirements as identified by the manufacturer's labeling, must be stored separately, including during refrigeration, freezing, and protection from the light, in an area that is inaccessible to clients and visitors. If these biologicals and medications are stored in a refrigerator containing items other than the biologicals and medications, the biologicals and medications must be kept in a separate, secured compartment;

(7) Each client's prescription medications must be stored in the medication's originally received container and may not be transferred to another container;

(8) Any container with a worn, illegible, or missing label must be destroyed along with the medication or drugs in the container, in accordance with § 67:61:08:05;

(9) Only a licensed pharmacist may label, relabel, or alter labels on medication containers;

(10) Any medication or drug prescribed for one client may not be administered to another client;

(11) If a client brings his or her own medications or controlled drugs into the program, the client's medications or controlled drugs may not be administered unless the client can be identified and written orders for the administration of the medications or controlled drugs is received from a licensed physician;

(12) Each program must have a procedure for contacting the client's identified pharmacies and physicians, as soon as possible after each client is admitted to the program;

(13) If medications or controlled drugs brought by a client into the program are not used, the medications or controlled drugs must be packaged, sealed, stored, and returned to the client, parent if the client is under the age of eighteen, guardian if applicable, or significant other, at the time of discharge, if the return of the medications or controlled drugs is approved by a program physician. The return of the medications or controlled drugs must be documented in the client's case record, with the name, strength, and quantity of the medication or controlled drug, and signed by the staff member identified to manage client medication; and

(14) The telephone number of the regional poison control center, the local hospital, the medical director, and the program administrator must be posted in all medication and controlled drug storage and preparation areas.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center does not have the telephone number of the regional poison control center, local hospital, or agency administrator posted in their drug storage or preparation area.

Corrective Action:

ARC has posted the telephone numbers of the regional poison control center, the local hospital, ARC's contracted medical provider under its MOU (serving as the agency's medical contact), and the agency administrator in every medication and controlled-drug storage and preparation area, per 67:61:08:02(14).

Supporting Evidence:

A photo of the posted emergency numbers in the medication storage and preparation area(s).

How Maintained:

The posted numbers are kept current in all storage and preparation areas. The Program Director checks them at the quarterly audit and updates them whenever the medical provider or a number changes.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS).	July 31, 2026	August 03, 2026

POC Action #15

Administrative Rule:

67:61:08:04

Each residential program shall maintain a separate log book to record the receipt and disposition of all Schedule II drugs. A residential program shall maintain a record of the receipt and administration of Schedule II, III, and IV drugs in a client's case record.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center does not have a separate log book to record the receipt and disposition of all schedule II drugs.

Corrective Action:

ARC keeps all controlled substances in a separate locked box in the med-pantry and will set up a separate bound logbook for the receipt and disposition of all Schedule II drugs, with receipt and administration of Schedule II, III, and IV drugs recorded in the client's case record. Entries are made at receipt and disposition.

Supporting Evidence:

The bound Schedule II receipt-and-disposition logbook in use; and a sample case-record entry showing receipt and administration of scheduled drugs.

How Maintained:

The logbook is kept up with entries at receipt and disposition. The Program Director reviews it for completeness at the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS).	August 08, 2026	October 14, 2026

POC Action #16

Administrative Rule:

67:61:08:10

A residential treatment program not employing a registered nurse, a licensed practical nurse, or unlicensed assistive personnel must make the controlled drug or medication available to a client for self-administration in accordance with the instructions of a licensed physician. The client shall self-administer the drug or medication, under the supervision of a designated employee who enters the name, strength, and quantity of the medication, and the time of self-administration, in the client's case record.

Clinically-managed, low-intensity residential treatment programs are exempt from the requirement of supervising the self-administration of over-the-counter drugs or medications. If the reasonable safety of all program clients is ensured, residential programs may allow clients to possess and self-administer, without supervision, those prescription medications that have been identified as allowable medications on a list developed specifically for the individual, in consultation with a licensed physician. The list of allowable medications must be reviewed at least annually, by a licensed physician. Any medication not identified on the list must be administered under supervision.

Each residential treatment program utilizing self-administration processes must establish a policy and procedures that outline these processes.

Summary of Non-Compliance Finding:

Anchor'D Recovery Center does not have a policy and procedure that requires doctors to develop a list for each client of allowable medications for self administration.

Corrective Action:

ARC will adopt a written self-administration policy. For clients cleared to keep and self-administer prescription medications without supervision, a licensed physician develops an individualized allowable-medication list and reviews it at least once a year; anything not on the list is given under the supervision of a designated employee, who records the name, strength, quantity, and time of self-administration in the case record. The policy reflects the 3.1 exemption from supervising over-the-counter self-administration. The physician role is filled through ARC's provider MOU.

Supporting Evidence:

The written self-administration policy; and a template individualized allowable-medication list, physician-developed and reviewed annually.

How Maintained:

The physician-developed allowable-medication list is kept per client and reviewed at least yearly; supervised self-administration is documented in the case record. Confirmed at the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS), with the licensed physician under ARC's provider MOU.	October 31, 2026	October 14, 2026

POC Action #17

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 clinically managed low intensity residential treatment files were missing integrated assessments.

Corrective Action:

An integrated assessment will be completed within thirty days of the first day intake begins, at every level of care, covering all seventeen required functional and diagnostic elements, including the diagnostic formulation, the eligibility and level-of-care determination, the clinician's signature, credentials, and date, and the clinical supervisor's signature, credentials, and date verifying review. Information is verified through collateral contact where possible and recorded in the case record. The clients currently in treatment who are missing an assessment are getting one now, and completion is tracked per client from here on.

Supporting Evidence:

The assessment template covering all seventeen elements, including the clinical supervisor cosignature; and completed, cosigned assessments for current clients.

How Maintained:

The tracker carries the 30-day deadline and the supervisor cosignature for each client, and both are checked at weekly clinical review. The cosignature is a Medicaid coverage condition, and the tracker will not let a billing week be submitted until every session that week is cosigned. Confirmed at the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
ACS (Benny Medrano or Jai Mimmack); Clinical Supervisor cosignature (Nikki Roth, LAC).	October 31, 2026	October 14, 2026

POC Action #18

Administrative Rule:

67:42:15:10

Within 14 days after admission to the facility, the child's treatment team must develop a written treatment plan for the child. Each team member must sign the plan. The plan must contain the following information:

(1) An assessment of the child's needs, strengths, weaknesses, and problems. The assessment must include a diagnostic evaluation of the medical, psychological, social, behavioral, and developmental needs of the child and reflect the need for intensive residential treatment;

(2) Treatment goals for the child and the child's family with an integrated program of therapies, activities, and experiences designed to meet the goals, and projected times for achieving the stated goals;

(3) The projected length of stay and the conditions under which the child will be discharged; and

(4) A discharge plan that meets the requirements of § 67:42:15:12.

Summary of Non-Compliance Finding:

75% of reviewed clinically managed low intensity residential treatment files did not have treatment plans completed with 10 days of admission. Additionally, the treatment plans were not dated by the addiction counselor trainee or clinical supervisor.

Corrective Action:

Respectful scope objection, with the underlying issue corrected by cross-reference. 67:42:15:10 sits in Article 67:42, which governs intensive residential treatment for children and sets a fourteen-day treatment-plan requirement for a child's treatment team. ARC is accredited as an adult substance use disorder agency under Article 67:61 and does not run a children's intensive residential program. The non-compliance summary describes 3.1 treatment plans not completed within ten days and not dated, which is the standard under 67:61:07:06, not 67:42:15:10. ARC respectfully asks that this citation be clarified or withdrawn, as it appears to have been entered in error. The timeliness and signature/date concerns behind it are fully corrected under ARC's response to 67:61:07:06, which is incorporated here by reference.

Supporting Evidence:

Cross-reference to ARC's corrective action and evidence for 67:61:07:06; and any correspondence with the Office of Licensing and Accreditation about this citation.

How Maintained:

As described under 67:61:07:06.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director (Benny Medrano, ACS) and Executive Director (Jai Mimmack, ACS); Clinical Supervisor (Nikki Roth, LAC).	October 31, 2026	October 14, 2026

POC Action #19

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:

50% of reviewed clinically managed low intensity residential treatment treatment plans did not contain short and long term goals, measurable objectives to achieve goals, or anticipated time frames for achievement of goals.

Corrective Action:

Each individualized treatment plan will be developed within ten calendar days of admission for the 2.1 and 3.1 programs, built from the integrated assessment, with the client's meaningful involvement documented and all required elements present: the specific client problems (including any co-occurring disorders) with supporting evidence; a diagnostic statement and short- and long-term goals tied to those problems; measurable objectives with time frames for achievement or review, indicators to track progress, referrals for services ARC does not provide directly, and interventions matched to the client's readiness for change; and the staff member responsible for each method. A treatment-plan template that requires the goals, measurable objectives, and time frames is being adopted to fix the content problem that was cited. Plans are reviewed, signed, and dated with credentials by the counselor and cosigned and dated by the clinical supervisor. Current clients' plans are being updated to add any missing elements and dates.

Supporting Evidence:

The treatment-plan template requiring short- and long-term goals, measurable objectives, and time frames; and completed, cosigned plans for current clients with the required content and dates.

How Maintained:

The tracker carries plan timeliness, content, dating, and the supervisor cosignature per client, and all four are checked at weekly clinical review; a billing week cannot be submitted until every session that week is cosigned. The quarterly audit reviews it.

Position Responsible:	Expected Completion Date:	Date Completed:
ACS (Benny Medrano or Jai Mimmack); Clinical Supervisor cosignature (Nikki Roth, LAC).	October 31, 2026	October 14, 2026

POC Action #20

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:

100% of reviewed clinically managed low intensity residential treatment files were missing continued service reviews.

Corrective Action:

ARC will use a standardized Continued Service Review as its own standalone document, never inside a progress note, completed every fourteen calendar days for the 2.1 program and every thirty calendar days for the 3.1 program. Each review documents the client's progress and the specific reasons for keeping the client at the current level of care, with an individualized plan of action that references the treatment-plan goals. Reviews for current clients are being brought current, and the interval is tracked per client going forward.

Supporting Evidence:

The standalone Continued Service Review template; and completed reviews for current clients meeting the interval and content.

How Maintained:

Due dates are carried per client in the tracker and checked at weekly clinical review, and the reviews stay as standalone documents in the record. Confirmed at the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
ACS (Benny Medrano or Jai Mimmack); Clinical Supervisor (Nikki Roth, LAC) oversight.	October 31, 2026	October 14, 2026

POC Action #21

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:

100% of reviewed clinically managed low intensity residential treatment discharge summaries were not completed within 5 working days of the client's discharge.

Corrective Action:

A transfer or discharge summary is completed within five working days of every transfer or discharge, whatever the reason, documenting the client's problems, course of treatment, and progress toward the treatment-plan goals and objectives, and completed in STARS. When a client leaves services early, ARC makes and documents reasonable attempts to re-engage them. Any outstanding summaries are being finished, and from here on all are done within five working days.

Supporting Evidence:

The transfer/discharge summary template; completed summaries showing the five-working-day turnaround; and the documented re-engagement process.

How Maintained:

The five-working-day deadline is tracked per client and checked, and STARS completion is confirmed on the weekly billing cycle. The quarterly audit reviews it.

Position Responsible:	Expected Completion Date:	Date Completed:
ACS (Benny Medrano or Jai Mimmack); Clinical Supervisor (Nikki Roth, LAC) oversight.	October 31, 2026	October 14, 2026

POC Action #22

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:

100% of reviewed client files were missing tuberculin screenings.

Corrective Action:

ARC will screen every newly admitted client for TB symptoms within twenty-four hours of admission, at every level of care, checking the four symptom areas from the previous three months: a productive cough lasting two to three weeks, unexplained night sweats, unexplained fevers, or unexplained weight loss. Any client with one or more symptoms is referred right away to a licensed physician, and any client confirmed or suspected to have infectious TB is not admitted for services until a physician clears them or provides written confirmation they do not have TB. A standardized 24-hour symptom screening form is completed and filed for each client, and current clients without one are being screened now.

Supporting Evidence:

The 24-hour TB symptom screening form; and completed screenings in current client records.

How Maintained:

The 24-hour screening is a required admission step, tracked per client and checked at the first weekly clinical review, with the form filed. The quarterly audit spot-checks it.

Position Responsible:	Expected Completion Date:	Date Completed:
Designated staff / ACS (Benny Medrano or Jai Mimmack); Clinical Supervisor (Nikki Roth, LAC) oversight.	October 31, 2026	October 14, 2026

POC Action #23

Administrative Rule:

67:61:16:04

A person admitted to a clinically-managed, low-intensity residential treatment program shall have received a medical examination conducted by or under the supervision of a licensed physician, within the three months before admission. The agency shall require that the results of the examination be provided to the program, before or at the time of admission.

If an examination has not been conducted or the results are not available, the program shall ensure that a medical examination occurs within five calendar days after admission. The results of all medical examinations must be placed in the case record.

The program staff shall consider the client's medical health in the development of the treatment plan.

Summary of Non-Compliance Finding:

100% of clinically managed low intensity residential treatment files were missing evidence of a medical exam upon admission.

Corrective Action:

Each client admitted to the 3.1 program will have a medical examination done by or under the supervision of a licensed physician within the three months before admission, with results provided before or at admission; if that has not happened or the results are not available, ARC makes sure the exam happens within five calendar days after admission. Exams are arranged through ARC's provider MOU. Results go in the case record and factor into the treatment plan. The current residential clients without a documented exam are having one arranged through the MOU provider, and exam status is checked at admission going forward.

Supporting Evidence:

The admission medical-exam process or checklist; and exam results in current residential client records, or documentation of the arranged five-day exam.

How Maintained:

Exam status is checked at admission and tracked per client, and results are filed and considered in the treatment plan. Reviewed at the quarterly audit.

Position Responsible:	Expected Completion Date:	Date Completed:
Program Director / Case Manager (Benny Medrano, ACS), with ARC's MOU medical provider; Clinical Supervisor (Nikki Roth, LAC) for treatment-plan integration.	October 31, 2026	October 14, 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.

Benny Medrano

Printed Name of Provider/Agency Contact



Signature of Provider/Agency Contact

July 30, 2026

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

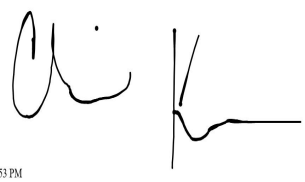
COMPLETION DETAILS

COMPLETION DATE: October 14, 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



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Signature of DSS Staff:

October 14, 2026

Date