



## **Office of Licensing and Accreditation**

**Accreditation Survey Report  
for Community Mental Health Centers  
ARSD 67:62  
January 17-19, 2024**

Capital Area Counseling Services

2001 Eastgate Drive

Pierre, SD 57501

CYF, Outpatient Mental Health, CARE, IMPACT

<b>1. Governance</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
a. Non-profit organization (67:62:03:01)	<u>✓</u>	___	___
b. Annual, entity-wide financial audit (67:62:05:05)	<u>✓</u>	___	___
c. Business hours posted in a prominent place on-premises (67:62:04:02)	<u>✓</u>	___	___
d. Board of directors meets at least quarterly and keeps minutes of all meetings (67:62:03:03)	<u>✓</u>	___	___
e. Up-to-date policy and procedure manual (67:62:05:01)	<u>✓</u>	___	___
f. Up-to-date organizational chart (67:62:06:07)	<u>✓</u>	___	___
g. Sentinel event policy (67:62:02:19)	<u>✓</u>	___	___
h. Policy for notifying DSS of changes (67:62:02:18)	<u>✓</u>	___	___
i. Adopted by-laws (67:62:03:02)	<u>✓</u>	___	___
j. Serve the counties designated to them by the division (67:62:04:01)	<u>✓</u>	___	___
k. Policy for not denying clients equal access to services (67:62:03:04)	<u>✓</u>	___	___

Comments:

<b>2. Program Services</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
a. Schedule of fees based on client ability to pay (67:62:05:06)	<u>✓</u>	___	___
b. Policy prohibiting client abuse, neglect, and exploitation (67:62:07:03)	<u>✓</u>	___	___
c. Client rights policy (67:62:07:01; 67:62:07:02)	<u>✓</u>	___	___

- |   |          |     |     |
|---|----------|-----|-----|
| d. Client grievance policy (67:62:07:04)  | <u>✓</u> | ___ | ___ |
| e. Submits accurate statistical data (67:02:05:02)  | <u>✓</u> | ___ | ___ |
| f. Discharge policy (67:61:06:07)   | <u>✓</u> | ___ | ___ |
| g. Client orientation policy and procedure (67:62:05:07)  | <u>✓</u> | ___ | ___ |
| h. Services shall be available for those with complex Mental health issues and co-occurring disorders (67:02:04:02) | <u>✓</u> | ___ | ___ |

Comments:

<b>3. Personnel</b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
a. Orientation completed within 10 days of hire with all required components (64:62:06:04)	<u>✓</u>	___	___
b. Office of Inspector General Medicaid exclusion list check (67:62:06:10)	<u>✓</u>	___	___
c. Clinical director has at least master's degree in psychology, social work, counseling, or nursing, have a license in that field, and at least 2 years of supervised postgraduate clinical experience in a mental health setting (67:62:01:01; 67:62:06:02)	<u>✓</u>	___	___
d. Policy and procedure for supervising employees, volunteers, and interns (67:62:06:05)	<u>✓</u>	___	___
e. IMPACT services do not exceed a ratio of at least one primary therapist for every 12 clients (67:62:12:02)	___	___	<u>✓</u>
f. Staff hired after 12/31/10 who provide direct MH and support services have at least an associate's degree in the social sciences or human services field (67:62:06:03)	<u>✓</u>	___	___

- |  |            |                |                |
|--|------------|----------------|----------------|
| g. Complete employee records; policies to maintain those records (67:62:06:06) | ✓<br>_____ | _____<br>_____ | _____<br>_____ |
|--|------------|----------------|----------------|

Comments:

<b>4. <u>Case Record Management</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
---	-------------------	------------------	-------------------

- |  |            |                |                |
|--|------------|----------------|----------------|
| a. Procedures for closure and storage of case records (67:62:08:03)          | ✓<br>_____ | _____<br>_____ | _____<br>_____ |
| b. Policy for case records to be retained for at least 6 years (67:62:05:04) | ✓<br>_____ | _____<br>_____ | _____<br>_____ |
| c. Established ongoing compliance review process (67:62:05:03)               | ✓<br>_____ | _____<br>_____ | _____<br>_____ |

Comments:

<b>5. <u>Environmental/Sanitation/Safety/Fire Prevention</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
--	-------------------	------------------	-------------------

- |  |            |                |                |
|--|------------|----------------|----------------|
| a. Health, safety, sanitation, and disaster plan (67:62:09:01) | ✓<br>_____ | _____<br>_____ | _____<br>_____ |
|--|------------|----------------|----------------|

Comments:

<b>6. <u>Assessment (67:62:08:05)</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
---	-------------------	------------------	-------------------

- |  |            |                |                |
|--|------------|----------------|----------------|
| a. Strengths of the client and client’s family if appropriate; identification of resources within the family | ✓<br>_____ | _____<br>_____ | _____<br>_____ |
| b. Presenting problems or issues   | ✓<br>_____ | _____<br>_____ | _____<br>_____ |
| c. Identification of readiness for change in problem areas   | ✓<br>_____ | _____<br>_____ | _____<br>_____ |
| d. Current substance use and relevant treatment  | ✓<br>_____ | _____<br>_____ | _____<br>_____ |

history, including mental health history and treatment, gambling treatment, psychiatric hospital admissions, medications, relapse history, potential for relapse, physical illness, and hospitalization

- |  |          |          |       |
|--|----------|----------|-------|
| e. Relevant family history, including family relationship dynamics and family psychiatric and substance use history        | <u>✓</u> | _____    | _____ |
| f. Family and relationship issues along with social needs  | <u>✓</u> | _____    | _____ |
| g. Educational history and needs   | <u>✓</u> | _____    | _____ |
| h. Legal issues  | <u>✓</u> | _____    | _____ |
| i. Living environment or housing   | <u>✓</u> | _____    | _____ |
| j. Safety needs and risks with regard to physical acting out, health conditions, acute intoxication, or risk of withdrawal | <u>✓</u> | _____    | _____ |
| k. Past or current indications of trauma, domestic violence, or both if applicable   | <u>✓</u> | _____    | _____ |
| l. Vocational and financial history and needs  | <u>✓</u> | _____    | _____ |
| m. Behavioral observations or mental status  | <u>✓</u> | _____    | _____ |
| n. Formulation of a diagnosis  | <u>✓</u> | _____    | _____ |
| o. Eligibility determination   | <u>✓</u> | _____    | _____ |
| p. Clinician's signature, credentials, and date  | <u>✓</u> | _____    | _____ |
| q. Clinical supervisor's signature, credentials, and date  | <u>✓</u> | _____    | _____ |
| r. Completed within 30 days of intake  | _____    | <u>✓</u> | _____ |

Comments: Three of seven reviewed outpatient mental health assessments were not completed within 30 days of intake.

<b>7. <u>Treatment Plan (67:62:08:07)</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
a. Statement of specific client problems to be addressed during treatment, with supporting evidence	<u>✓</u>	_____	_____
b. Diagnostic statement and statement of short and long-term goals	<u>✓</u>	_____	_____
c. Measurable objective or methods leading to the completion of short-term goals including time frames for the anticipated dates of completion of each objective; include interventions that match the client's readiness to change	<u>✓</u>	_____	_____
d. Statement identifying staff member responsible for facilitating treatment methods	<u>✓</u>	_____	_____
e. Signed and dated by addiction counselor or addiction counselor trainee, and credentials	<u>✓</u>	_____	_____
f. Evidence of the client's meaningful involvement in formulating the plan	<u>✓</u>	_____	_____
g. Completed within 30 days of intake	_____	<u>✓</u>	_____

Comments: Three of seven applicable outpatient mental health treatment plans and two of eight applicable CYF treatment plans were not completed within 30 days of the first day of intake.

<b>8. <u>Progress Notes (67:61:07:08)</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
1. Progress note for each billable service	<u>✓</u>	_____	_____

- |  |          |       |       |
|--|----------|-------|-------|
| 2. Information identifying the client receiving services – name, unique ID number, service activity code, title describing the service, or both, date, time met, units of service, and length of session | <u>✓</u> | _____ | _____ |
| 3. Brief assessment of the client’s functioning  | <u>✓</u> | _____ | _____ |
| 4. Description of what occurred during the session, including action taken or plan to address unresolved issues  | <u>✓</u> | _____ | _____ |
| 5. Brief description of what client and provider plan to work on during the next session   | <u>✓</u> | _____ | _____ |
| 6. Signature and credentials of staff providing the services   | <u>✓</u> | _____ | _____ |

Comments:

<b>9. <u>Treatment Plan Review (67:62:08:08)</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
a. Treatment plan reviewed at a minimum of six month Intervals	_____	<u>✓</u>	_____
b. Review of progress made or significant changes to goals or objectives	<u>✓</u>	_____	_____
c. Justification for continued need for mental health Services	<u>✓</u>	_____	_____
d. Staff signature, credentials, and date of review	<u>✓</u>	_____	_____

Comments: Three of five applicable outpatient mental health files and two of eight applicable CARE files did not have treatment plan reviews completed every six months.

<b>10. <u>Supervisory Review (67:62:08:09)</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
a. Progress toward treatment plan goals/objectives	<u>✓</u>	_____	_____

- |  |          |     |     |
|--|----------|-----|-----|
| b. Significant changes to treatment goals/objectives           | <u>✓</u> | ___ | ___ |
| c. Justification for continued need for mental health services | <u>✓</u> | ___ | ___ |
| d. Staff signature, credentials and date of review             | <u>✓</u> | ___ | ___ |

Comments:

<b>11. Crisis Intervention (67:62:08:11)</b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
--	-------------------	------------------	-------------------

- |   |          |     |     |
|---|----------|-----|-----|
| a. Crisis intervention is completed if client has safety Issues or risks, frequent crisis situations, recurrent Hospitalizations, out of home placements, homelessness, Is a danger to self or others, or has involvement in the criminal justice system. | <u>✓</u> | ___ | ___ |
|---|----------|-----|-----|

Comments:

<b>12. <u>Transfer or Discharge Summary (67:61:07:10)</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>N/A</u></b>
---	-------------------	------------------	-------------------

- |   |          |     |     |
|---|----------|-----|-----|
| a. Completed by an addiction counselor or addiction counselor trainee within five working days after discharge, regardless of the reason for discharge              | <u>✓</u> | ___ | ___ |
| b. Summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan                         | <u>✓</u> | ___ | ___ |
| c. When a client prematurely discontinues services, reasonable attempts are made and documented by the agency to re-engage the client into services, if appropriate | <u>✓</u> | ___ | ___ |

Comments:



### 13. Signatures

X	Three Year Accreditation (100%-90%)
	Two Year Accreditation (89.9% - 70%)
	Probation (69.9% and below)
	One Year Provisional Accreditation (70% and above)

*Chris Kenyon*

Chris Kenyon, Program Specialist

February 6, 2024

Date

January 17-19, 2024

Date of Site Visit

*Muriel Nelson*

Muriel Nelson, Program Manager

February 6, 2024

Date