



Office of Licensing and Accreditation

Accreditation Survey Report for Substance Use Disorder Treatment Providers ARSD 67:61 January 17-19, 2024

Capital Area Counseling

2001 Eastgate Drive

Pierre, SD 57501

Outpatient SUD (0.5, 1.0, 2.1)

1. Governance	Yes	No	N/A
a. Governmental agency, federally recognized tribe, business corporation, non-profit corporation or limited liability company (0.5 and 1.0 only) (67:61:03:01)	<u>✓</u>	_____	_____
b. Policy for not denying clients equal access to services (67:61:03:04)	<u>✓</u>	_____	_____
c. Annual, entity-wide, independent financial audit completed (67:61:04:05)	<u>✓</u>	_____	_____
d. Business hours posted in prominent place on premises (67:61:04:09)	<u>✓</u>	_____	_____
e. Board of directors meets at least quarterly and keeps minutes of all meetings (67:61:03:03)	<u>✓</u>	_____	_____
f. Up-to-date policy and procedure manual (67:61:04:01)	<u>✓</u>	_____	_____
g. Up-to-date organizational chart (67:61:05:09)	<u>✓</u>	_____	_____
h. Sentinel event policy (67:61:02:21)	<u>✓</u>	_____	_____
i. Policy for notifying DSS of changes (67:61:02:20)	<u>✓</u>	_____	_____

Comments:

2. Program Services	Yes	No	N/A
a. Schedule of fees based on client ability to pay (67:61:04:06)	<u>✓</u>	_____	_____
b. Policy prohibiting client abuse, neglect, and exploitation (67:61:06:03)	<u>✓</u>	_____	_____
c. Client rights policy (67:61:06:01; 67:61:06:02)	<u>✓</u>	_____	_____
d. Client grievance policy (67:61:06:04)	<u>✓</u>	_____	_____

e. Submits accurate statistical data (67:61:04:02)	<u>✓</u>	___	___
f. Discharge policy (67:61:06:07)	<u>✓</u>	___	___
g. Client orientation policy and procedure (67:61:04:07)	<u>✓</u>	___	___
h. Policy for responding to medical emergencies (67:61:04:09)	<u>✓</u>	___	___
i. Electronic or written directory with name address, and phone number of support services (67:61:04:10)	<u>✓</u>	___	___
j. In level 3.1, 3.2D, and 3.7 facilities, staff is on duty at all times who is trained to respond to fires and natural disasters (67:61:04:09)	___	___	<u>✓</u>

Comments:

3. Personnel	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Orientation completed within 10 days of hire with all required components (64:61:05:05)	<u>✓</u>	___	___
b. Office of Inspector General Medicaid exclusion list check (67:61:05:12)	<u>✓</u>	___	___
c. In 3.2D facility, all counseling and supervisory staff are trained in emergency first aid, CPR and responding to natural disasters; Documentation in file (67:61:17:06)	___	___	<u>✓</u>
d. Policy and procedure for supervising employees, volunteers, and interns (67:61:05:06)	<u>✓</u>	___	___
e. Two-step TB test or blood assay test within 2 weeks of hire or 12 months before hire (67:61:05:01)	<u>✓</u>	___	___

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|---|---------------------|
| f. Employee TB policies and procedures
(67:61:05:01) | <u>✓</u> ___ ___ |
| g. Complete employee records; policies
to maintain those records (67:61:05:08) | <u>✓</u> ___ ___ |

Comments:

4. <u>Case Record Management</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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|---|---------------------|
| a. Procedures for closing inactive client records
for inpatient programs within 3 days and
outpatient programs for 30 days [67:61:07:04(1-2)] | <u>✓</u> ___ ___ |
| b. Policy for case records to be retained for at least
6 years [67:61:07:04(3)] | <u>✓</u> ___ ___ |
| c. Established ongoing compliance review process
(67:61:04:03) | <u>✓</u> ___ ___ |

Comments:

5. <u>Environmental/Sanitation/Safety/Fire Prevention</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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|---|---------------------|
| a. Health, safety, sanitation, and disaster plan
(67:61:10:01) | <u>✓</u> ___ ___ |
|---|---------------------|

Comments:

6. <u>Assessment (67:61:07:05)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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|--|---------------------|
| a. Strengths of the client and client's family if
appropriate; identification of resources within
the family | <u>✓</u> ___ ___ |
| b. Presenting problems or issues | <u>✓</u> ___ ___ |
| c. Identification of readiness for change in
problem areas | <u>✓</u> ___ ___ |

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|---|----------|-------|-------|
| d. Current substance use and relevant treatment history, including mental health history and treatment, gambling treatment, psychiatric hospital admissions, medications, relapse history, potential for relapse, physical illness, and hospitalization | <u>✓</u> | _____ | _____ |
| 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:

7. <u>Treatment Plan (67:61:07:06)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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:			
i. Ten calendar days (2.1, 2.5, 3.1, 3.7)	<u>✓</u>	_____	_____
ii. Thirty calendar days (1.0)	<u>✓</u>	_____	_____

Comments:

8. <u>Progress Notes (67:61:07:08)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Minimum of one progress note weekly which substantiates all services provided and summarizes significant events occurring throughout the treatment process	<u>✓</u>	_____	_____

b. 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>	_____	_____
c. Brief assessment of the client’s functioning	<u>✓</u>	_____	_____
d. Description of what occurred during the session, including action taken or plan to address unresolved issues	<u>✓</u>	_____	_____
e. Brief description of what client and provider plan to work on during the next session	_____	<u>✓</u>	_____
f. Signature and credentials of staff providing the services	<u>✓</u>	_____	_____

Comments: Eight of ten reviewed files did not have progress notes that contained a brief description of what the client and provider plan to work on during the next session. There was often language such as “client will attend the next IOP group” or “Client will schedule another individual session in two weeks”.

9. <u>Continued Service Criteria (67:61:07:07)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Client meets continued service criteria, and is documented every:			
i. Two calendar days (3.2D)	_____	_____	<u>✓</u>
ii. Fourteen calendar days (0.5, 2.1, 2.5, 3.7)	<u>✓</u>	_____	_____
iii. Thirty calendar days (1.0, 3.1)	<u>✓</u>	_____	_____
b. Progress and reasons for retaining the client at the present level of care	<u>✓</u>	_____	_____
c. An individualized plan of action that addresses the reasons for retaining the individual in the present level of care	<u>✓</u>	_____	_____

Comments:

10. <u>Transfer or Discharge Summary (67:61:07:10)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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: Four of nine reviewed discharge summaries were not completed within five working days of discharge.

11. <u>Tuberculin Screening Requirement (67:61:07:12)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. A tuberculin screening for the absence or presence of symptoms shall be conducted for each new client within 24 hours of onset of services	<u>✓</u>	_____	_____

Comments:

12. <u>Intensity of Services</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. The outpatient program provides less than 9 hours per week of counseling services for adults and less than 6 hours for adolescents. (67:61:13:03)	<u>✓</u>	_____	_____
b. The intensive outpatient program provides counseling at least two times per week. Each adult should be provided with at least 9 hours of services. Adolescents shall be provided at least 6 hours of services.	<u>✓</u>	_____	_____

- c. The day treatment program shall provide at least 15 hours per week of services for adults and adolescents. For adults, the program shall provide an additional 5 hours on specialized topics. ____ _ ✓
- d. The clinically-managed low-intensity residential treatment program shall provide at least 5 hours of services. ____ _ ✓
- e. The clinically-managed residential detoxification program shall provide at least 30 minutes of services per day within 48 hours of admission, and an additional 30 minutes for each subsequent 24 hour period. ____ _ ✓
- f. The medically-monitored intensive inpatient program shall provide at least 21 hours of services per week. The program shall also provide at least 9 hours of additional services on specialized topics. ____ _ ✓

Comments:

13. Signatures

	Three Year Accreditation (100%-90%)
X	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 13, 2024
Date

January 17-19, 2024
Date of Site Visit

Muriel Nelson
Muriel Nelson, Program Manager

February 13, 2024
Date