



Office of Licensing and Accreditation

Accreditation Survey Report for Community Mental Health Centers

**ARSD 67:62
April 15- 17, 2024**

Dakota Counseling Institute

910 W Havens Street
Mitchell, SD 57301

Children, Youth & Family Services
Outpatient Mental Health Services
Comprehensive Assistance with Recovery and Empowerment

1. Governance	Yes	No	N/A
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:

2. Program Services	Yes	No	N/A
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:

3. Personnel	Yes	No	N/A
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	_____	<u>✓</u>	_____

to maintain those records (67:62:06:06)

Comments: Some personnel files contained applications for employment, while others contained resumes. Those that contained resumes did not also contain transcripts. The Office of Licensing and Accreditation recommends requiring the same documentation for every employee, so as to ensure all personnel files meet all requirements.

4. <u>Case Record Management</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Procedures for closure and storage of case records (67:62:08:03)	<u>✓</u>	___	___
b. Policy for case records to be retained for at least 6 years (67:62:05:04)	<u>✓</u>	___	___
c. Established ongoing compliance review process (67:62:05:03)	<u>✓</u>	___	___

Comments:

5. <u>Environmental/Sanitation/Safety/Fire Prevention</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Health, safety, sanitation, and disaster plan (67:62:09:01)	<u>✓</u>	___	___

Comments:

6. <u>Assessment (67:62:08:05)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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>	___	___
d. Current substance use and relevant treatment history, including mental health history and	<u>✓</u>	___	___

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:

7. <u>Treatment Plan (67:62:08:07)</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 30 days of intake	<u>✓</u>	_____	_____

Comments:

8. <u>Progress Notes (67:61:07:08)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Progress note for each billable service	<u>✓</u>	_____	_____
b. Information identifying the client receiving <ul style="list-style-type: none"> i. services – name, unique ID number, service ii. activity code, title describing the service, or both, iii. date, time met, units of service, and length of iv. session 	<u>✓</u>	_____	_____
c. Brief assessment of the client's functioning	<u>✓</u>	_____	_____

- | | | | |
|--|----------|-----|-----|
| d. Description of what occurred during the session,
i. including action taken or plan to address
ii. unresolved issues | <u>✓</u> | ___ | ___ |
| e. Brief description of what client and provider
i. plan to work on during the next session | <u>✓</u> | ___ | ___ |
| f. Signature and credentials of staff providing the
i. services | <u>✓</u> | ___ | ___ |

Comments:

9. <u>Treatment Plan Review (67:62:08:08)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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 six applicable reviewed CYF files and two of four applicable reviewed outpatient mental health files were missing six month reviews. Dakota Counseling Institute must outline a plan to complete six month treatment plan reviews on time.

10. <u>Supervisory Review (67:62:08:09)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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: Three of five applicable reviewed CYF files were missing supervisory reviews.

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

12. <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:

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

May 10, 2024

Date

April 15-17, 2024

Date of Site Visit

Muriel Nelson

Muriel Nelson, Program Manager

May 10, 2024

Date