



Office of Licensing and Accreditation

Accreditation Survey Report for Substance Use Disorder Treatment Providers ARSD 67:61 August 21-23, 2023

Human Service Agency

123 19th St. NE

Prevention

Outpatient Services (0.5, 1.0, 2.1)

Clinically-Managed Low Intensity Residential Treatment (3.1)

Clinically-Managed Residential Detoxification (3.2)

1. Governance

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

Comments:

2. Program Services

	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Schedule of fees based on client ability to pay (67:61:04:06)	<u>✓</u>	<u> </u>	<u> </u>
b. Policy prohibiting client abuse, neglect, and exploitation (67:61:06:03)	<u>✓</u>	<u> </u>	<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, | <u>✓</u> | _____ | _____ |

volunteers, and interns (67:61:05:06)

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

Comments:

4. Case Record Management **Yes** **No** **N/A**

- | | | | |
|---|--------------|-------------|-------------|
| 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> | <u> </u> | <u> </u> |
| b. Policy for case records to be retained for at least 6 years [67:61:07:04(3)] | <u> ✓ </u> | <u> </u> | <u> </u> |
| c. Established ongoing compliance review process (67:61:04:03) | <u> ✓ </u> | <u> </u> | <u> </u> |

Comments:

5. Environmental/Sanitation/Safety/Fire Prevention **Yes** **No** **N/A**

- | | | | |
|--|--------------|-------------|-------------|
| a. Health, safety, sanitation, and disaster plan (67:61:10:01) | <u> ✓ </u> | <u> </u> | <u> </u> |
|--|--------------|-------------|-------------|

Comments:

6. Dietary Services

	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Written plan for meeting basic nutritional needs as well as special dietetic needs, including 3 meals per day with snacks (67:61:09:01)	<u>✓</u>	<u> </u>	<u> </u>
b. Sanitation and safety standards are met for food service (44:02:07); completed sanitation inspection by the Department of Health (67:61:09:02)	<u>✓</u>	<u> </u>	<u> </u>

Comments:

7. Medication

	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Policies and procedures on control, accountability, administration, and storage of client medication (67:61:08:02)	<u>✓</u>	<u> </u>	<u> </u>
b. Maintains a separate log book to record the receipt and disposition of all schedule II drugs; client case record must include receipt and administration of schedule II, III, and IV drugs (67:61:08:04)	<u>✓</u>	<u> </u>	<u> </u>
c. Policy and procedure for destruction and disposal of medication (67:61:08:05)	<u>✓</u>	<u> </u>	<u> </u>
d. Policy regarding only RNs, LPNs or UAPs administering and recording medication (67:61:08:08)	<u>✓</u>	<u> </u>	<u> </u>
e. Policy and procedure regarding medication errors (67:61:08:08)	<u>✓</u>	<u> </u>	<u> </u>
f. If 3.7 is not employing RNs, LPNs, or UAPs, medications are made available to clients for self-administration, with instructions from a physician and under the supervision of staff	<u> </u>	<u> </u>	<u>✓</u>

(67:61:08:10)

- | | | | |
|--|----------|-------|-------|
| g. In 3.1 that allows clients to possess and self-administer medication, a list is developed for the client, in consultation with a physician, which is reviewed at least annually (67:61:08:10) | <u>✓</u> | _____ | _____ |
|--|----------|-------|-------|

Comments:

8. Emergency Kit

- | | <u>Yes</u> | <u>No</u> | <u>N/A</u> |
|--|-------------------|------------------|-------------------|
| a. Emergency kit is stored in a sealed emergency box and maintains a complete inventory every six months [67:61:08:03(1-2)] | <u>✓</u> | _____ | _____ |
| b. No more than five different controlled drugs, no more than five doses of an injectable schedule II, III, or IV drug, and no more than twelve doses of an oral schedule III or IV drug stored at one time [67:61:08:03(3)] | <u>✓</u> | _____ | _____ |
| c. After use of the emergency kit, standing and verbal orders are verified in writing by the physician within 72 hours [67:61:08:03(03)] | <u>✓</u> | _____ | _____ |

Comments:

9. Initial Screening and Planning (67:61:12:02) (0.5 only)

- | | <u>Yes</u> | <u>No</u> | <u>N/A</u> |
|---|-------------------|------------------|-------------------|
| a. Initial screening and planning completed within 48 hours of initial contact. Includes: | _____ | _____ | <u>✓</u> |
| i. Client's problems and needs | _____ | _____ | <u>✓</u> |
| ii. Client's emotional and physical state | _____ | _____ | <u>✓</u> |
| iii. Client's drug and alcohol use | _____ | _____ | <u>✓</u> |

iv. Statement of intended course of action	___	___	✓ ___
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Comments:

10. Assessment (67:61:07:05)

	<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	✓ ___	___	___
b. Presenting problems or issues	✓ ___	___	___
c. Identification of readiness for change in problem areas	✓ ___	___	___
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	✓ ___	___	___
e. Relevant family history, including family relationship dynamics and family psychiatric and substance use history	✓ ___	___	___
f. Family and relationship issues along with social needs	✓ ___	___	___
g. Educational history and needs	✓ ___	___	___
h. Legal issues	✓ ___	___	___
i. Living environment or housing	✓ ___	___	___
j. Safety needs and risks with regard to physical acting out, health conditions, acute intoxication,	✓ ___	___	___

or risk of withdrawal

- | | | | |
|--|----------|-----|-----|
| 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:

11. Treatment Plan (67:61:07:06)

- | | <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: Five out of six reviewed low-intensity residential treatment program files did not have treatment plans completed within ten days of admission.

12. Progress Notes (67:61:07:08)

- | | <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 | <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
|--|---|

Comments: **Ten out of sixteen applicable outpatient treatment files did not have descriptions of what the client and provider plan to work on consistently documented in progress notes. Many notes had statements such as “client will schedule treatment for next week” or “client will continue to attend sessions”. These statements do not indicate what the client plans to work on.**

13. <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)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Fourteen calendar days (0.5, 2.1, 2.5, 3.7)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Thirty calendar days (1.0, 3.1)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Progress and reasons for retaining the client at the present level of care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. An individualized plan of action that addresses the reasons for retaining the individual in the present level of care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

14. <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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Summary of the client’s problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | | | |
|---|----------|-------|-------|
| 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:

15. <u>Tuberculin Screening Requirement (67:61:07:12)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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- | | | | |
|---|----------|-------|-------|
| 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:

16. <u>Intensity of Services</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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- | | | | |
|--|----------|-------|-------|
| 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. | _____ | _____ | <u>✓</u> |
|--|-------|-------|----------|

- | | | | |
|---|----------|-------|-------|
| d. The clinically-managed low-intensity residential treatment program shall provide at least 5 hours of services. | <u>✓</u> | _____ | _____ |
|---|----------|-------|-------|

- | | | | |
|---|----------|-------|-------|
| 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 | <u>✓</u> | _____ | _____ |
|---|----------|-------|-------|

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. | _____ | _____ | <u>✓</u> |
|--|-------|-------|----------|

Comments:

17. Initial Screening and Planning (67:61:12:02)(0.5 Only) **Yes** **No** **N/A**

- | | | | |
|--|-------|-------|----------|
| a. The early intervention program provides initial screening and planning, which includes: | | | |
| i. The client's problems and needs | _____ | _____ | <u>✓</u> |
| ii. The client's emotional and physical state including screening for the presence of cognitive disability, mental illness, medical disorders, collateral information, and prescribed medication | _____ | _____ | <u>✓</u> |
| iii. The client's drug and use including the types of substances used, frequency of use, date of last use, and duration of use | _____ | _____ | <u>✓</u> |
| iv. A statement of intended course of action | _____ | _____ | <u>✓</u> |

Comments:

18. Medical Requirements **Yes** **No** **N/A**

- | | | | |
|---|----------|-------|-------|
| a. Clinically-Managed Low Intensity Residential Treatment | | | |
| i. Medical exam conducted by or under the supervision of a licensed physician within three months before admission or five calendar days after admission. (67:61:16:04) | <u>✓</u> | _____ | _____ |

Comments: **Two out of six reviewed clinically-managed low intensity residential treatment program files did not have evidence of completed admission medical examinations.**

b. Clinically-Managed Residential Detoxification Program

i. The agency shall obtain the following information at the time of admission: (67:61:17:02)

- | | | | |
|---|----------|-----|-----|
| a) Blood pressure, pulse and respiration. | <u>✓</u> | ___ | ___ |
| b) Presence of bruises, lacerations, cuts, or wounds | <u>✓</u> | ___ | ___ |
| c) Medications the client is currently taking | <u>✓</u> | ___ | ___ |
| d) History of diabetes, seizure disorders, convulsive therapies, and exposure to TB | <u>✓</u> | ___ | ___ |
| e) History of medical, psychological, or psychiatric treatment | <u>✓</u> | ___ | ___ |
| f) Any symptoms of mental illness currently present | <u>✓</u> | ___ | ___ |

ii. Written agreement to provide emergency, inpatient, and ambulatory medical services with a licensed hospital serving the area where the program is located. (67:61:17:03)

✓ ___ ___

iii. Written agreement with a licensed physician, physician assistant, or certified nurse practitioner to serve as medical director or employ a licensed physician who is primarily responsible for providing medical care to clients. (67:61:17:04)

✓ ___ ___

iv. Policy and procedure concerning the steps staff shall take when assessing and monitoring a client's physical condition and responding to medical

✓ ___ ___

complications throughout the detoxification process (67:61:17:05)

- | | | | |
|---|--------|---|---|
| a) Blood pressure, pulse, and respiration
a minimum of two additional times in the first 8 hours after admission and at least once every 8 hours thereafter. | ✓
— | — | — |
| b) Physical, mental and emotional state | ✓
— | — | — |
| c) Type and amount of fluid Intake | ✓
— | — | — |

c. Medically-Monitored Intensive Inpatient Treatment

i. At minimum, the program shall complete the following:
(67:61:18:02)

- | | | | |
|---|---|---|--------|
| a) Blood pressure, pulse, and respiration at the time of admission | — | — | ✓
— |
| b) Within 8 hours of admission a medical evaluation conducted by an RN or LPN including a second reading of blood pressure, pulse and respiration, mental and emotional status, presence of bruises, cuts, or lacerations, current medication use, and history of diabetes, seizure disorders, or convulsive therapies. | — | — | ✓
— |
| c) Within 72 hours of admission a complete blood count and urinalysis | — | — | ✓
— |
| d) A complete physical examination by a licensed physician | — | — | ✓
— |

19. Prevention

	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. Encompass current research, theory, and practice-based strategies and activities implemented through structured prevention strategies. Delineate a work plan to outline scope of services. Found on evidence-based programming list. Made available to the public and staff (67:61:11:01).	<u>✓</u>	_____	_____
b. Will offer one or more of the following, with written description available to staff members, the public and DSS. Includes target population, program goals, scope of services, measurable objectives, program evaluations and outcomes (67:61:11:03)			
i. Information dissemination services	<u>✓</u>	_____	_____
ii. Education services	<u>✓</u>	_____	_____
iii. Alternative services	<u>✓</u>	_____	_____
iv. Problem identification and referral services	<u>✓</u>	_____	_____
v. Community-based services	<u>✓</u>	_____	_____
vi. Environmental services	<u>✓</u>	_____	_____
c. Evidence based interventions (67:61:11:05)	<u>✓</u>	_____	_____
d. Database of information and referral sources that is posted publicly (67:61:11:05)	<u>✓</u>	_____	_____
e. Maintains a record of all prevention activities including: (67:61:11:07)			
i. Record of presenters and participants	<u>✓</u>	_____	_____
ii. Demographics of participants including age, race, gender	<u>✓</u>	_____	_____
iii. Record of all program activities	<u>✓</u>	_____	_____
iv. Copies of all programmatic materials	<u>✓</u>	_____	_____

- | | | | |
|--|----------|-------|-------|
| f. Conducts annual satisfaction surveys (67:61:11:08) | <u>✓</u> | _____ | _____ |
| g. Conducts participant evaluations after each presentation (67:61:11:08) | <u>✓</u> | _____ | _____ |
| h. Conducts pre- and post-tests for all presentations (67:61:11:08) | <u>✓</u> | _____ | _____ |
| i. Completes a quality assurance review of its programming with an annual summary report made available to the board of directors, agency staff, and DSS | <u>✓</u> | _____ | _____ |
| j. Staff have completed Substance Abuse Prevention Skills Training or Foundations of Prevention within one year of hire (67:61:05:04) | <u>✓</u> | _____ | _____ |

Comments:

20. Signatures

Chris Kenyon
Chris Kenyon, Program Specialist

9/20/2023
Date

August 21-23, 2023
Date of Site Visit

Muriel Nelson
Muriel Nelson, Program Manager

9/20/23
Date