



Office of Licensing and Accreditation

**Accreditation Survey Report
for Community Mental Health Centers
ARSD 67:62
December 4-6, 2023**

Southeastern Behavioral Health

2000 S Summit Ave
Sioux Falls, SD 57104

Outpatient MH
CYF
CARE
IMPACT

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	<u>✓</u>	___	___

exploitation (67:62:07:03)

- | | | | |
|---|----------|-----|-----|
| 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. <u>Personnel</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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>	___	___

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|---|---------------------|
| f. Staff providing direct mental health services have at least a high school diploma or equivalency (67:62:06:03) | <u>✓</u> ___ ___ |
| g. Complete employee records; policies to maintain those records (67:62:06:06) | <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 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>
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| a. Health, safety, sanitation, and disaster plan (67:62:09:01) | <u>✓</u> ___ ___ |
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Comments:

6. <u>Assessment (67:62:08:05)</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 ✓

Comments: Three of eighteen reviewed integrated assessments were not completed within thirty days. While this does not show a significant pattern of non-compliance those numbers contribute to a larger pattern of non-compliance across all document types.

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>	<u> </u>	<u> </u>
b. Diagnostic statement and statement of short and long-term goals	<u>✓</u>	<u> </u>	<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>	<u> </u>	<u> </u>
d. Statement identifying staff member responsible for facilitating treatment methods	<u>✓</u>	<u> </u>	<u> </u>
e. Signed and dated by addiction counselor or addiction counselor trainee, and credentials	<u>✓</u>	<u> </u>	<u> </u>
f. Evidence of the client’s meaningful involvement in formulating the plan	<u>✓</u>	<u> </u>	<u> </u>
g. Completed within 30 days of intake	<u> </u>	<u>✓</u>	<u> </u>

Comments: Nine of eighteen reviewed treatment plans were not completed within 30 days of intake.

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>	<u> </u>	<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: Seven of eight CYF files did not have descriptions of what the client and provider planned to work on during the next session in most progress notes.

9. <u>Treatment Plan Review (67:62:08:08)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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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:

10. <u>Supervisory Review (67:62:08:09)</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
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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>	___	___
e. Reviewed at least yearly	___	<u>✓</u>	___
d. Staff signature, credentials and date of review	<u>✓</u>	___	___

Comments: Nine of twenty supervisory reviews were not completed at least yearly.

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

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

Signature will be in template

Chris Kenyon, Program Specialist

Date

Date of Site Visit

Signature will be in template

Muriel Nelson, Program Manager

Date