



Facility Inspection Report Issued By The Minnesota Department of Corrections Pursuant to MN Statute 241.021, Subdivision 1

Inspection and Enforcement Unit, 1450 Energy Park Drive, Suite 200, St.Paul MN 55108
Telephone: 651-361-7146 Fax: 651-642-0314 Email: ie-support.doc@state.mn.us

INSPECTION DETAILS FOR:

Bar-None Residential Treatment Services

Address: 22426 St. Francis Boulevard, Anoka, MN 55303

MN Governing Rule: 2960 Children's Residential Facility

Inspection Type: Annual **Inspected By:** Lisa Becking – Senior Detention Facility Inspector

Inspected on: 03/21/2019 to 03/27/2019

Inspection Method: On-site inspection and unannounced.

Officials Present During Inspection: Program Director Stephanie Devries

Officials Present for Exit Interview:

Issued Inspection Report to: Director Kelly Wesner; Program Director Stephanie Devries; Regional Manager Sherry Hill

RULE COMPLIANCE SUMMARY

Rule Chapter	Requirement Type	Total Applicable	Total Compliance	Total Non Compliance
2960	Mandatory	316	304	12

TERMS OF OPERATION

Authority to Operate: conditional approval

Begins On: 04/02/2019 **Ends On:** 05/17/2019

Facility Type: Non-Secure Juvenile Residential Facility

Placed on Biennial Status: No

Biennial Status Annual Compliance Form Due On:

Delinquent Juvenile Hold Approval:

Certificate Holder: Volunteers of America

Special Conditions: None.

Approved Capacity Details **Operational Capacity is calculated as a percent of Approved Capacity beds.*

Bed Type	Gender	Approved Capacity	%Operating Capacity	Operational Capacity	Pre 96 LTSR	Post 96 LTSR	Bed Details	Conditions
Non-secure residential	Male	26	100	26.00	0	0	Evergreen unit - 12 beds, MSU - 14 beds.	None.

RULE COMPLIANCE DETAILS

Chapter 2960 - Mandatory Rules Not In Compliance

Total: 12

1. 2960.0050 RESIDENT RIGHTS AND BASIC SERVICES. Subpart 1. Basic rights.

A resident has basic rights including, but not limited to, the rights in this subpart. The license holder must ensure that the rights in items A to R are protected: A. right to reasonable observance of cultural and ethnic practice and religion; B. right to a reasonable degree of privacy; C. right to participate in development of the resident's treatment and case plan; D. right to positive and proactive adult guidance, support, and supervision; E. right to be free from abuse, neglect, inhumane treatment, and sexual exploitation; F. right to adequate medical care; G. right to nutritious and sufficient meals and sufficient clothing and housing; H. right to live in clean, safe surroundings; I. right to receive a public education; J. right to reasonable communication and visitation with adults outside the facility, which may include a parent, extended family members, siblings, a legal guardian, a caseworker, an attorney, a therapist, a physician, a religious advisor, and a case manager in accordance with the resident's case plan; K. right to daily bathing or showering and reasonable use of materials, including culturally specific appropriate skin care and hair care products or any special assistance necessary to maintain an acceptable level of personal hygiene; L. right of access to protection and advocacy services, including the appropriate state appointed ombudsman; M. right to retain and use a reasonable amount of personal property; N. right to courteous and respectful treatment; O. if applicable, the rights stated in Minnesota Statutes, sections 144.651 and 253B.03; P. right to be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation; Q. right to be informed of and to use a grievance procedure; and R. right to be free from restraint or seclusion used for a purpose other than to protect the resident from imminent danger to self or others, except for the use of disciplinary room time as it is allowed in the correctional facility's discipline plan.

Inspection Findings:

(D.) Resident was left alone on a unit while acting out aggressively. Resident destroyed a chair and was standing on the broken pieces while staff watched the resident through the office window. This is not consistent with positive, proactive adult guidance and supervision.

(E.) Resident was held in a prone position while staff were seen pushing on the residents neck with their forearm. Although there may have been a need for a restraint in this incident, the use of a staff forearm across the neck is extreme and appears abusive.

Corrective Actions:

(D.) Proper training for staff including how to be positive and proactive while providing adult guidance, support and supervision needs to be completed. Staffing plans need to be modified based on the needs of the youth on the unit. Discontinue the use of the "Planned Ignoral" technique. It appears to be nothing more than a means to escalate behavior, and is not therapeutic or beneficial for youth in placement.

(E.) The use of prone restraints has been known to contribute to positional asphyxia and can be considered abusive and neglectful if not used properly. Explore alternative methods of restrictive procedures. Best practices that consider past trauma experienced by residents prior to placement should be considered. Alternative certified methods that take these factors into consideration are available.

Response Needed By: 05/15/2019**2. 2960.0080 FACILITY OPERATIONAL SERVICES, POLICIES, AND PRACTICES. Subpart 16. Resident records.**

A license holder must: A. maintain and make available to the commissioner of human services and corrections sufficient documentation to verify that all requirements of the rules governing the care of the resident have been met; B. maintain and make available upon request the resident's records according to the requirements of rule and statute; C. comply with the requirements of the case manager for the release of information about the resident, unless prohibited by law; and D. use forms approved by the commissioner of human services or corrections and collect demographic information about residents and their families and outcome measures about the success of services that meet the requirements of Laws 1995, chapter 226, article 3, section 60, subdivision 2, clause (1)(iii).

Inspection Findings:

(A.) Documentation in incident reports, restrictive procedures and disciplinary actions do not meet rule requirements. Review of incident reports show that administrative reviews are not completed. Restrictive Procedures processing form provides little useful documentation. Incident reports are not signed. It appears that persons composing the report were not involved with that specific individual.

Corrective Actions:

(A.) Train staff on documentation expectations, including accuracy, content and timelines.

Response Needed By: 05/15/2019**3. 2960.0080 FACILITY OPERATIONAL SERVICES, POLICIES, AND PRACTICES. Subpart 4.D.. Facility rules and due process system for residents.**

The license holder must communicate verbally and in writing to a resident who is capable of understanding the facility's rules and the details of the due process system used in the facility. The rules must address the following topics: D. the due process system that governs the facility's use of disciplinary consequences;

Inspection Findings:

Residents were given Disciplinary Room Time (DRT) without Due Process. Documentation is missing on forms where the residents were to acknowledge their right to appeal. If resident refused- there is not documentation of said refusal.

Corrective Actions:

Train staff on the practice, procedures and importance of Due Process. Train Unit Supervisors and Program Director on the policies and procedures for Due Process when using Disciplinary Room time as a consequence.

Response Needed By: 05/15/2019

4. 2960.0080 FACILITY OPERATIONAL SERVICES, POLICIES, AND PRACTICES. Subpart 5.D.. Discipline policy and procedures required.

The license holder must have discipline policies and procedure that require the resident's abuse history and developmental, cultural, disability, and gender needs be taken into consideration when deciding the disciplinary action to be taken with a resident. The policy must include the requirements in items A to E. D. The license holder must meet the following requirements for the use of time out: (1) time out must be used as a nonemergency behavior management technique which is used to intervene in a resident's undesirable behavior and to allow the resident to reflect and become calm before returning to ongoing activities at the facility; (2) time out must be used under the direction of a mental health professional, the facility director, or the program manager; (3) the use of time out must be consistent with the resident's treatment plan; (4) staff must escort a resident to an unlocked room or other separate living space in the facility that is safe; (5) staff must assess the resident in time out at least every 30 minutes and determine when the resident may return to ongoing activity at the facility; (6) staff must have completed at least the following training before they use time out with a resident: (a) the needs and behaviors of residents; (b) building relationships with residents; (c) alternatives to time out; (d) de escalation methods; (e) avoiding power struggles with residents; and (f) documentation standards for the use of time out; (7) the treatment team must include and document the review of the use of time out for each resident during the review of the resident's treatment plan; and (8) staff must document the use of time out in the resident's record and include the information in units (a) to (d): (a) the factors or circumstances which caused the need for the use of time out; (b) the resident's response to the time out; (c) the resident's ability to de escalate during the time out procedure; and (d) the resident's ability to maintain acceptable behavior after the time out.

Inspection Findings:

Time out is not being used according to the rule requirements. The "calming rooms" are used as a time-out, however documentation and practice fails to identify this as a time-out and fails to provide proper documentation when the calming areas are used.

Corrective Actions:

Follow time-out policies and procedures when using the calming room.

Response Needed By: 05/15/2019

5. 2960.0270 FACILITY OPERATIONAL POLICIES AND PROCEDURE REQUIREMENTS, SERVICES, AND PROGRAMS. Subpart 6.D.. Discipline plan.

The license holder must have a discipline plan that includes the requirements in items A to F. D. Disciplinary room time must be used according to due process procedures reflected in the facility's discipline plan. The status of a resident placed in disciplinary room time after a due process hearing must be reviewed by the facility administrator or the administrator's designee at least once every eight hours. Each review of the need for continued disciplinary room time must be done according to the facility's due process system and must be documented.

Inspection Findings:

DRT is used in this program. The DRT documentation submitted by the facility and reviewed on site does not show that any eight hour reviews by an administrator or administrator's designee were completed.

Corrective Actions:

Administrator or the administrator's designee must complete eight hour reviews as set forth in this rule part. Review must be documented.

Response Needed By: 05/15/2019

6. 2960.0560 PERSONNEL STANDARDS. Subpart 5. Individual staff development and evaluation plan.

The license holder must ensure that an annual individual staff development and evaluation plan is developed and implemented for each person who provides, supervises, or directly administers correctional program services. The plan must: A. be developed within 90 days after the person begins employment and at least annually thereafter; B. meet the staff development needs specified in the person's annual employee evaluation; and C. ensure that an employee who provides, supervises, or directly administers program services has sufficient training to be competent to deliver the correctional services assigned to the employee.

Inspection Findings:

Documentation provided by facility provided recent/current individual development and evaluation plans for all staff, however none of said evaluations were signed by staff or with any staff involvement. Also- some evaluation dates were missing.

Corrective Actions:

Bring all staff individual development and evaluation plans up-to-date. Create a plan to assure individual development and evaluation plans are completed within 90 days on new employees and annually on all other staff.

Response Needed By: 05/15/2019

7. 2960.0570 FACILITY OPERATIONAL POLICIES AND PROCEDURES. Subpart 3. security policies and procedures.

The license holder must have security policies and procedures that include the topics in items A to K: A. control and recovery of contraband; B. delivery and service procedure; C. prohibition of firearms and other weapons in resident areas; D. search procedures; E. escort of residents outside security area; F. one half hour interval security inspection routines when residents are not under direct supervision; G. lock and key procedures; H. inspection of physical plant procedures; I. count procedures; J. weapons, tools, equipment, medications, and hazardous substances; and K. use of chemical irritants.

Inspection Findings:

(F.) Camera review shows staff leaving the resident unit unattended for three minutes. Upon returning to the unit staff waited nine minutes before conducting a resident well-being check. Although that is within the 30 minute interval, during that three minute time frame, staff were not there to directly supervise residents (or their doors). Upon the staff's return to the unit, for the safety and the security of all residents, there should have been an immediate well-being check.

Corrective Actions:

(F.) In the event staff need to leave the unit unattended for any reason, a well-being check should be conducted immediately upon their return to assure all residents are safe and secure. Additional training for over night staff is required.

Response Needed By: 05/15/2019

8. 2960.0710 RESTRICTIVE PROCEDURES CERTIFICATION. Subpart 10. Administrative review.

The license holder must complete an administrative review of the use of a restrictive procedure within three working days after the use of the restrictive procedure. The administrative review must be conducted by someone other than the person who decided to impose the restrictive procedure, or that person's immediate supervisor. The resident or the resident's representative must have an opportunity to present evidence and argument to the reviewer about why the procedure was unwarranted. The record of the administrative review of the use of a restrictive procedure must state whether: A. the required documentation was recorded; B. the restrictive procedure was used in accordance with the treatment plan; C. the rule standards governing the use of restrictive procedures were met; and D. the staff who implemented the restrictive procedure were properly trained.

Inspection Findings:

Based on documentation it appears that administrative reviews were not completed in two recent/significant incidents at the facility as required by the rule.

Corrective Actions:

Train Unit Supervisors and Program Directors on this rule part.

Response Needed By: 05/15/2019

9. 2960.0710 RESTRICTIVE PROCEDURES CERTIFICATION. Subpart 2. Restrictive procedures plan required.

The license holder must have a restrictive procedures plan for residents that is approved by the commissioner of human services or corrections, and the plan must provide at least the following: A. the plan must list the restrictive procedures and describe the physical holding techniques which will be used by the program; B. how the license holder will monitor and control the emergency use of restrictive procedures; C. a description of the training that staff who use restrictive procedures must have prior to staff implementing the emergency use of restrictive procedures, which includes at least the following: (1) the needs and behaviors of residents; (2) relationship building; (3) alternatives to restrictive procedures; (4) de escalation methods; (5) avoiding power struggles; (6) documentation standards for the use of restrictive procedures; (7) how to obtain emergency medical assistance; (8) time limits for restrictive procedures; (9) obtaining approval for use of restrictive procedures; (10) requirement for updated training at least every other year; and (11) the proper use of the restrictive techniques approved for the facility; D. the license holder must prepare a written review of the use of restrictive procedures in the facility at least annually; and E. the license holder must ensure that the resident receives treatment for any injury caused by the use of a restrictive procedure.

Inspection Findings:

(C.11)Based on camera review of a resident in a prone restraints, staff's forearm is pushing down on the neck of the resident. This not an approved technique and would not be considered proper use of the prone restraint.

Corrective Actions:

Submit an updated Restrictive Procedures Plan and provide updated training records show that staff have been retrained in your restrictive procedures.

Response Needed By: 05/15/2019

10. 2960.0710 RESTRICTIVE PROCEDURES CERTIFICATION. Subpart 6. Use of physical holding or seclusion.

Physical holding and seclusion are behavior management techniques which are used in emergency situations as a response to imminent danger to the resident or others and when less restrictive interventions are determined to be ineffective. The emergency use of physical holding or seclusion must meet the conditions of items A to M: A. an immediate intervention is necessary to protect the resident or others from physical harm; B. the physical holding or seclusion used is the least intrusive intervention that will effectively react to the emergency; C. the use of physical holding or seclusion must end when the threat of harm ends; D. the resident must be constantly and directly observed by staff during the use of physical holding or seclusion; E. the use of physical holding or seclusion must be used under the supervision of a mental health professional or the facility's program director; F. physical holding and seclusion may be used only as permitted in the resident's treatment plan; G. staff must contact the mental health professional or facility's program director to inform the program director about the use of physical holding or seclusion and to ask for permission to use physical holding or seclusion as soon as it may safely be done, but no later than 30 minutes after initiating the use of physical holding or seclusion; H. before staff uses physical holding or seclusion with a resident, staff must complete the training required in subpart 2 regarding the use of physical holding and seclusion at the facility; I. when the need for the use of physical holding or seclusion ends, the resident must be assessed to determine if the resident can safely be returned to the ongoing activities at the facility; J. staff must treat the resident respectfully throughout the procedure; K. the staff person who implemented the emergency use of physical holding or seclusion must document its use immediately after the incident concludes. The documentation must include at least the following information: (1) a detailed description of the incident which led to the emergency use of physical holding or seclusion; (2) an explanation of why the procedure chosen needed to be used to prevent or stop an immediate threat to the physical safety of the resident or others; (3) why less restrictive measures failed or were found to be inappropriate; (4) the time the physical hold or seclusion began and the time the resident was released; (5) in at least 15 minute intervals during the use of physical holding or seclusion, documentation of the resident's behavioral change and change in physical status that resulted from the use of the procedure; and (6) the names of all persons involved in the use of the procedure and the names of all witnesses to the use of the procedure; L. the room used for seclusion must be well lighted, well ventilated, clean, have an observation window which allows staff to directly monitor a resident in seclusion, fixtures that are tamperproof, with electrical switches located immediately outside the door, and doors that open out and are unlocked or are locked with keyless locks that have immediate release mechanisms; and M. objects that may be used by a resident to injure the resident's self or others must be removed from the resident and the seclusion room before the resident is placed in seclusion

Inspection Findings:

(K.) Review of documentation revealed that reports are not being written by the staff person who implemented the emergency use of physical holding. The documentation fails to include: (1) a detailed description of the incident which led to the emergency use of physical holding or seclusion; (2) an explanation of why the procedure chosen needed to be used to prevent or stop an immediate threat to the physical safety of the resident or others; (3) why less restrictive measures failed or were found to be inappropriate; (6) the names of all persons involved in the use of the procedure and the names of all witnesses to the use of the procedure.

Corrective Actions:

(K.) Re-train staff on how to properly document the use of physical holding and seclusion, as listed in the rule provision.

Response Needed By: 05/15/2019

11. 2960.0710 RESTRICTIVE PROCEDURES CERTIFICATION. Subpart 8. Disciplinary room time use.

Disciplinary room time must be used only for major violations and be used according to the facility's restrictive procedures plan. In addition to the restrictive procedures plan requirements in subpart 2, the license holder who uses disciplinary room time must meet the following requirements: A. the license holder must give the resident written notice of an alleged violation of a facility rule; B. the license holder must tell the resident that the resident has a right to be heard by an impartial person regarding the alleged violation of facility rules; and C. the license holder must tell the resident that the resident has the right to appeal the determination made by the impartial person in item B internally to a higher authority at the facility.

Inspection Findings:

Documentation of disciplinary room time does not support compliance with all items in this rule provision.

Corrective Actions:

Train staff in this rule part.

Response Needed By: 05/15/2019

12. 2960.0710 RESTRICTIVE PROCEDURES CERTIFICATION. Subpart 9. Training for staff using physical holding or seclusion.

In addition to the training in subpart 2, item C, staff who use physical holding or seclusion must have the following training before using physical holding or seclusion with a resident: A. documentation standards for physical holding and seclusion; B. thresholds for employing physical holding or seclusion; C. the physiological and psychological impact of physical holding and seclusion; D. how to monitor and respond to the resident's physical signs of distress; . symptoms and interventions for positional asphyxia; and F. time limits and procedures for obtaining approval of the use of physical holding and seclusion. Training must be updated at least once every two years.

Inspection Findings:

Video surveillance of an incident shows that staff had put their forearm across the neck of a resident in a prone restraint. Based on that video it is apparent that staff have not been properly trained on the use of restrictive procedures. Specifically letter (A), (D) & (F) of this provision. One paragraph describing an incident that spans over four hours is insufficient.

Corrective Actions:

All direct care staff must complete training in this area prior to using a physical hold. There is evidence that prone holds have contributed to positional asphyxia and has contributed to death of persons subjected to prone holds. Explore alternative methods of restrictive procedures. Best practices that consider past trauma experienced by residents prior to placement should be considered. Alternative certified methods that take these factors into consideration are available.

Response Needed By: 05/15/2019

INSPECTION COMMENTS

Sections of 2960 that are applicable to your facility included: Administrative Standards, Group Residential, Detention, Corrections, and Restrictive procedures certifications. Inspection results are contained in the various sections of this report.

This report is based on the documentation provided on March 21, 2019 and the scheduled site visit on March 26, 2019. The scheduled visit was a follow-up to the March 13, 2019 unannounced visit, in which significant corrective action was required.

Physical plant improvements have been made, including new paint, carpet and cleaning. Medication errors have been addressed and a corrective action plan has been implemented. However, the scheduled site visit identified additional violations pertaining to resident safety and well-being. The severity of the violations continues to be a serious safety concern.

JJDP A Compliance

Bar-None has two DOC licensed units. Both units are non-secure.

Report completed By: Lisa Becking – Senior Detention Facility Inspector

Signature:


