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
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INSPECTION DETAILS FOR: Dakota County Juvenile Services Center

Address: 1600 Highway 55, Hastings, MN 55033

MN Governing Rule: 2960 Children's Residential Facility

Inspection Type: Biennial **Inspected By:** Lisa Becking – Senior Detention Facility Inspector **Inspected on:** 09/15/2020 to 09/17/2020

Inspection Method: The scheduled inspection visit consisted of a physical plant, safety and security inspection. The physical plant inspection included all resident bedrooms, holding rooms, resident living areas, resident shower areas, bathrooms, the intake area and shower/bathroom room, visiting/meeting/group rooms, gym/recreation areas and classroom and school areas. The sally port and outside perimeter were also included.

Officials Present During Inspection: Director Matt Bauer

Officials Present for Exit Interview: Director Matt Bauer

Issued Inspection Report to: Director Matt Bauer; Regional Manager Dayna Burmeister

RULE COMPLIANCE SUMMARY

Rule Chapter	Requirement Type	Total Applicable	Total Compliance	Total Non Compliance
2960	Mandatory	311	306	3

TERMS OF OPERATION

Authority to Operate: approval **Begins On:** 07/01/2020 **Ends On:** 06/30/2022 **Facility Type:** Secure Juvenile Detention/Residential Facility

Placed on Biennial Status: Yes **Biennial Status Annual Compliance Form Due On:** 06/30/2021

Delinquent Juvenile Hold Approval:

Certificate Holder: Dakota County
1600 W Highway 55
Hastings, MN 55033

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
Interchangeable secure residential/detention	Coed	40	100	40.00	10	0	None.	None.

RULE COMPLIANCE DETAILS

Chapter 2960 - Mandatory Rules Not In Compliance **Total: 3**

1. 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:

At the time of the inspection, review of Disciplinary Room Time (DRT) documentation identified that some resident files lacked the 8 hour reviews required by this rule part.

Corrective Actions:

DRT documentation must include 8 hour reviews that clarify why the resident will remain on DRT. Also, documentation must verify that resident rights were followed during the DRT.

Response Needed By: 11/20/2020

2. 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:

Physical holding may only be used according to the resident case plan or treatment plan. Case plans/treatment plans are created within three days of admission. However this leaves a gap in the use of physical holding if resident is in imminent danger of harm to self or others.

Corrective Actions:

The facility has immediately created case/treatment plans for current youth and new youth entering the facility. They will now assure that all staff are trained on the significance of this plan and will modify the plans based on the needs of the residents. This will also be added to policy and procedure. Physical holding will be used in accordance with the residents' case/treatment plans which will be created upon intake.

Response Needed By: 11/20/2020

3. 2960.0710 RESTRICTIVE PROCEDURES CERTIFICATION. Subpart 7. Use of mechanical restraints.

Mechanical restraints are a behavior management device which may be used only when transporting a resident or in an emergency as a response to imminent danger to a resident or others and when less restrictive interventions are determined to be ineffective. A facility that uses mechanical restraints must include mechanical restraints in its restrictive procedures plan. The emergency use of mechanical restraints must meet the conditions of items A to J: A. an immediate intervention is necessary to protect the resident or others from physical harm; B. the mechanical restraint used is the least intrusive intervention that will effectively react to the emergency; C. the use of mechanical restraint must end when the threat of harm ends; D. the resident must be constantly and directly observed by staff during the use of mechanical restraint; E. the use of mechanical restraint must be supervised by the program director or the program director's designee; F. mechanical restraint may be used only as permitted in the resident's treatment plan; G. as soon as it may safely be done, but no later than 60 minutes after initiating the use of a mechanical restraint, staff must contact the facility's program director or the program director's designee to inform the program director about the use of a mechanical restraint and to ask for permission to use the mechanical restraint; H. before staff uses a mechanical restraint with a resident, staff must complete training in the use of the types of mechanical restraints used at the facility; I. when the need for the use of mechanical restraint ends, the resident must be assessed to determine if the resident can safely be returned to the ongoing activities at the facility; and J. the staff person who used mechanical restraint 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 or situation which led to the use of the mechanical restraint; (2) an explanation of why the mechanical restraint chosen was needed to prevent 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 when the use of mechanical restraint began and the time when the resident was released from the mechanical restraint; (5) in at least 15 minute intervals during the use of mechanical restraints, documentation of the observed behavior change and physical status of the resident that resulted from the use of mechanical restraint; and (6) the names of all the persons involved in the use of mechanical restraint and the names of all witnesses to the use of mechanical restraint.

Inspection Findings:

Mechanical restraints may only be used according to the resident case plan or treatment plan. The case plan /treatment plans are created within three days of placement. This leaves a potential span of time where facility may not have the ability to use the mechanical restraint with resident in the event of imminent harm to self or others.

Corrective Actions:

The facility has immediately created case/treatment plans for current youth and new youth entering the facility. They will now assure that all staff are trained on the significance of this plan and will modify the plans based on the needs of the residents. This will also be added to policy and procedure. Mechanical restraints will be used in accordance with the residents' case/treatment plans, which are created upon intake to assure safety for all when there is an imminent threat of harm to self or others.

Response Needed By: 11/20/2020

Chapter 2960 - Mandatory Rules In Compliance With Concerns Total: 2

1. 2960.0080 FACILITY OPERATIONAL SERVICES, POLICIES, AND PRACTICES. Subpart 5.A.. 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. A. The license holder must not subject residents to: (1) corporal punishment, including, but not limited to: rough handling, shoving, ear or hair pulling, shaking, slapping, kicking, biting, pinching, hitting, throwing objects, or spanking; (2) verbal abuse, including, but not limited to: name calling; derogatory statements about the resident or resident's family, race, gender, disability, sexual orientation, religion, or culture; or statements intended to shame, threaten, humiliate, or frighten the resident; (3) punishment for lapses in toilet habits, including bed wetting and soiling; (4) withholding of basic needs, including, but not limited to: a nutritious diet, drinking water, clothing, hygiene facilities, normal sleeping conditions, proper lighting, educational services, exercise activities, ventilation and proper temperature, mail, family visits, positive reinforcement, nurturing, or medical care. However, a resident who destroys bedding or clothing, or uses these or other items to hurt the resident or others, may be deprived of such articles according to the resident's case plan; (5) assigning work that is dangerous or not consistent with the resident's case plan; (6) disciplining one resident for the unrelated behavior or action of another, except for the imposition of restrictions on the resident's peer group as part of a recognized treatment program; (7) use of restrictive techniques or procedures as punishment, for convenience of staff, to compensate for not having an adequate number of staff, or to substitute for program services; (8) restrictions on a resident's communications beyond the restrictions specified in the resident's treatment plan or case plan; and (9) requirements to assume uncomfortable or fixed positions for an extended length of time, or to march, stand, or kneel as punishment.

Inspection Findings:

Review of policy and procedure identified this practice at the facility, however, there was no documentation or system in place to assure this is practiced with each resident.

Corrective Actions:

Consider adding the "resident's abuse history and developmental, cultural, disability, and gender needs" to the DRT form as a way to document that these areas have been taken into consideration when deciding the disciplinary action to be taken.

Response Needed By:

2. 2960.0160 ADMISSION POLICIES AND PROCESS. Subpart 3. Privacy.

All admission procedures must be conducted in a manner and location that ensures the personal privacy of the resident.

Inspection Findings:

Current intake situation may be perceived as not completely private due to sight and sound.

Corrective Actions:

Facility is actively attempting to correct this concern and has a plan in place to correct it.

Response Needed By:

INSPECTION COMMENTS

The Dakota County Juvenile Service Center biennial inspection was conducted on September 15-17, 2020, using Minnesota Rules, Chapter 2960, governing juvenile residential facilities. Sections of the 2960 standards that are applicable to this facility include: Administrative, Group Residential, Secure, Detention, Corrections and Restrictive Procedures. This inspection was conducted by both of the Inspection and Enforcement Unit, Juvenile Inspectors.

NOTE: This facility since originally opened, had been inspected by the same inspector. This was the first inspection completed by different inspectors.

This inspection included discussions with administrative staff, supervisors, direct care staff, training coordinator, and nursing staff. Resident interviews were conducted in a private area without staff present. Documentation review included staff personal and training files, resident files, daily logs, treatment plans, menus, recreation schedules, grievance documentation, well-being checks and other pertinent documentation. There was also discussion and review of the facility policy and procedure manual.

The following comments and concerns are a result of the inspection. While these may not be specific rule violations, these are areas that provided constructive feedback to help address potential facility issues.

Comments:
1. The facility response to COVID-19 follows CDC guidelines and included masks for residents and staff, ample amounts of hand sanitizer, temperature checks and screening questions for all staff and visitors prior to entering the secure areas.
2. Facility has actively pursued a more private and confidential area to conduct intakes- this project it still being fine-tuned and will be completed soon.
3. The new well-being check system uses cell phone technology and assures checks are being conducted within the time constraints indicated in this rule part. The system also has an alarm system that assures staff conduct the well-being check within the 15 or 30 minutes.
4. Many facilities are struggling to complete training requirements due to COVID-19. This was not the case at this facility. Staff appear to be on track and should have their hours completed on schedule.
5. The facility response to suicide attempts has been improved with mental health staff and a crisis unit. This is all being documented with a formal process.

Concerns:
1. Consider a plan for staff to identify when sheets, blankets and mattresses need to be replaced. The new items are available in the storage room, but staff are not relaying the need/request to the supervisors when necessary.
2. Secure detention resident living areas and bedrooms need to be maintained to provide all residents a clean and safe environment. The graffiti must be identified and addressed by staff on a daily basis to assure that it doesn't get out of control. This is a significant concern in resident bedrooms and appears to be a non-issue in the other parts of the building.
3. You may wish to consider resident and staff surveys on a monthly or quarterly basis as a way to provide better services to youth and a better working environment for staff. This may also be a way to identify concerns quickly and shows residents and staff that their opinions are relevant.

Overall I think the inspection went very well. We were able to have great discussions with all unit supervisors. Staff and administration appeared appreciative to all feedback provided over three very long working days.

I would like to sincerely thank you for your cooperation during this licensing visit.

Please contact me if you have any questions regarding any licensing or this this inspection report. I can be reached at 507-382-9791.

JJDPA Compliance

Upon review of admissions to the Dakota County Juvenile Services Center beginning October 1, 2019 through September 15, 2020, there were no JJDP violations of the core requirements of the JJDP act. This facility meets Federal Compliance Standards.

Report completed By: Lisa Becking – Senior Detention Facility Inspector **Signature:**