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: Southwestern Youth Services

Address: 401 W Luverne, PO BOX 40, Magnolia, MN 56158

MN Governing Rule: 2960 Children's Residential Facility

Inspection Type: Annual **Inspected By:** Monaie Hebert – Detention Facility Inspector **Inspected on:** 02/16/2022 to 02/17/2022

Inspection Method: This annual inspection consisted of a tour of the facility, interviews with staff, administration and youth, review of employee and youth files, a review of the policy and procedure manual and other related documentation review.

Officials Present During Inspection: Executive Director Jeremy Hough

Officials Present for Exit Interview: Executive Director Jeremy Hough

Issued Inspection Report to: Executive Director Jeremy Hough; Regional Manager Dayna Burmeister

RULE COMPLIANCE SUMMARY

Rule Chapter	Requirement Type	Total Applicable	Total Compliance	Total Non Compliance
2960	Mandatory	315	308	2

TERMS OF OPERATION

Authority to Operate: approval **Begins On:** 03/01/2022 **Ends On:** 02/28/2023 **Facility Type:** Non-Secure Juvenile Detention/Residential Facility

Placed on Biennial Status: No **Biennial Status Annual Compliance Form Due On:**

Delinquent Juvenile Hold Approval:

Certificate Holder: Southwestern Youth Services Inc.
401 W Luverne
Magnolia, MN 56158

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 non-secure residential/detention	Male	42	100	42.00	0	0	None.	None.

RULE COMPLIANCE DETAILS

Chapter 2960 - Mandatory Rules Not In Compliance **Total: 2**

1. 2960.0150 PERSONNEL POLICIES. Subpart 4.B.. Personnel training.

The license holder must develop an annual training plan for employees that addresses items A to D. B. Staff who have direct contact with residents must complete at least 24 hours of in service training per year. One half of the training must be skill development training. Staff who do not have direct contact and volunteers must complete in service training requirements consistent with their duties, directly related to the needs of children in their care.

Inspection Findings:

Some employees had not met minimum training requirements for the past year. There have been some concessions around training hours through COVID, however some employees had training hours significantly lower that expectations. They did improve their tracking system which was suggested in their last inspection. This is a repeat violation.

Corrective Actions:

The facility will need to develop a system for follow up with employees who are not meeting minimum training requirements.

Response Needed By: 04/22/2022

2. 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:

A review of restrictive procedures practices revealed that the facility is tracking and reporting seclusion procedures, however, due to confusion, they have not been completing the administrative reviews on the process. The facility has very few of these incidents.

Corrective Actions:

Ensure that administrative reviews are completed on all restrictive procedures processes.

Response Needed By: 04/22/2022

Chapter 2960 - Mandatory Rules In Compliance With Concerns **Total: 5**

1. 2960.0080 FACILITY OPERATIONAL SERVICES, POLICIES, AND PRACTICES. Subpart 11.D.5.. Health and hygiene services.

The license holder must meet the conditions in items A to F. D. The license holder, in consultation with a medically licensed person, must have a plan for the safe storage and delivery of medicine. The license holder must meet the requirements in subitems (1) to (5). (5) Facility staff responsible for medication assistance, other than a medically licensed person, must have a certificate verifying their successful completion of a trained medication aide program for unlicensed personnel offered through a postsecondary institution, or staff must be trained to provide medication assistance according to a formalized training program offered by the license holder and taught by a registered nurse.

Inspection Findings:

The facility has an LPN providing the on site care and medication training due to the geographic location and staffing issues. They have been unable to hire an RN and have been granted a variance, which expires on February 28, 2022. The LPN's process has been completely reviewed and her files, processes and organization are excellent.

Corrective Actions:

The facility will need to submit a new variance for 2023 to the DOC.

Response Needed By:

2. 2960.0120 PHYSICAL PLANT STANDARDS. Subpart 2.A.. Code compliance.

A facility must comply with the applicable fire, health, zoning, and building codes and meet the physical plan and equipment requirements in items A to I. A. A sleeping room must not be used to accommodate more than four residents. Multibed bedrooms must provide a minimum of 60 square feet per resident of useable floor space with three feet between beds placed side by side and one foot between beds placed end to end for ambulatory residents. For nonambulatory residents, the multibed bedrooms must provide 80 square feet per resident of useable floor space.

Inspection Findings:

The sleeping rooms are dorm style in which all residents share the same sleeping quarters.

Corrective Actions:

When the facility was approved for licensure, this was an acceptable room style. Therefore they were approved for this room style at the time the new rules went into effect in 2005. It has been 17 years since then. They should make plans to rectify the sleeping areas and provide appropriate separated rooms so that residents can experience more privacy. The facility should begin to develop a plan that accomplishes compliance with current 2960 rules. Since the last inspection, there have been conversations surrounding revision. Should this facility continue to operate long term, this issue will need to be readdressed.

Response Needed By:

3. 2960.0150 PERSONNEL POLICIES. Subpart 4.C.. Personnel training.

The license holder must develop an annual training plan for employees that addresses items A to D. C. The license holder must provide orientation and training to staff and volunteers regarding: (1) culturally competent care; (2) racial bias and racism issues; (3) gender issues, including the psychosocial development of boys and girls; (4) sexual orientation issues; and (5) physical, mental, sensory, and health related disabilities, bias, and discrimination.

Inspection Findings:

The facility appears to have a comprehensive orientation training program, however does not specify some elements of the required training per this rule part in the orientation. These elements are included in their regular training program.

Corrective Actions:

Document the trainings specified by this rule part in the orientation training list and ensure that staff is provided these training components during orientation.

Response Needed By:

4. 2960.0190 DISCHARGE AND AFTERCARE. Subpart 1.B.. Discharge.

The license holder must meet requirements of items A and B. B. The transition services plan must include at least the elements in subitems (1) to (7): (1) housing, recreation, and leisure arrangements; (2) appropriate educational, vocational rehabilitation, or training services; (3) a budget plan and a description of the resident's financial and employment status; (4) transportation needs; (5) treatment services; (6) health services; and (7) personal safety needs. For a resident with a disability, the transition services plan must address the resident's need for transition from secondary education services to postsecondary education and training, employment provider participation, recreation and leisure, and home living according to Minnesota Statutes, section 125A.08.

Inspection Findings:

A review of recently released resident files revealed that there are transitional plans created for every resident, however these plans do not include portions of the required elements per this rule part. A review of past resident files suggests that the facility was compliant for part of this inspection period and staffing changes likely impacted how these reports are now being completed.

Corrective Actions:

Ensure that all transitional plans for residents meet all appropriate elements of this rule part. 1) housing, recreation, and leisure arrangements; (2) appropriate educational, vocational rehabilitation, or training services; (3) a budget plan and a description of the resident's financial and employment status; (4) transportation needs; (5) treatment services; (6) health services; and (7) personal safety needs.

Response Needed By:

5. 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:

A review of employee files revealed that two of the annual reviews were missing from the files. All other employee evaluations were completed on schedule. Administration completed the evaluations prior to the completion of the inspection. These evaluations were one month behind schedule.

Corrective Actions:

Ensure that employee evaluations are completed on time, on an annual basis.

Response Needed By:

INSPECTION COMMENTS

The Southwestern Youth Services Center annual inspection was completed on February 16 - 17, 2022, using Minnesota Rules, Chapter 2960, governing juvenile residential facilities. Sections of the 2960 standards that are applicable to the programs at this facility include: Administrative, Group Residential, Corrections and Restrictive Procedures.

This scheduled inspection visit consisted of a physical plant safety and security inspection. The physical plant inspection included intake, medical area, resident living areas, resident bedrooms, bathrooms, visiting/meeting/group rooms, gym/recreation areas, kitchen and classroom areas of the facility. The inspection also included discussions with staff, supervisors, direct care staff, nursing staff, education staff and administration, as well as discussions with and observation of staff interactions with residents. 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 facility documentation. There was also a review of the facility policy and procedure manual, resident handbook and overviews for the program.

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

Comments:

1. The facility response to COVID-19 follows CDC protocol and guidelines for staff and residents who test positive. The accommodations for quarantined youth (either positive or pending test results) and PPE for staff is good.

2. The facility has significantly improved their treatment plans since the last inspection.

3. The facility has been improved and been creative in their cultural programming absent the opportunity to utilize volunteers.

4. The facility does not use disciplinary room time for residents. They utilize time-out primarily, and have made significant improvements in de-escalation skills for staff leading to less time-out usage and shorter durations.

Concerns/suggestions not noted in formal inspection:

1. The building is aging and requires a significant ongoing maintenance.

2. The facility had one maltreatment determination in 2021, in which maltreatment was determined due to training provided by former administration. The staff did not follow policy, however, inadequate training was provided.

3. The facility has extremely low enrollment and facility closure is being considered.

Overall, the inspection went well. There have been noted improvements over the past two years and some areas of continued challenge. Administration and staff appear open and appreciative of feedback.

On behalf of the Department of Corrections Inspections and Enforcement Unit, I would like to sincerely thank you for your cooperation during this licensing visit. Please contact me if you have any questions regarding this report, at 651-261-1657.

JJDPA Compliance

This is a nonsecure facility and youth have free egress at all times.

Report completed By: Monaie Hebert – Detention Facility Inspector **Signature:** Monaie Hebert