South Dakota Department of Social Services

Corrective Action Plan
Our Home Parkston

The Department of Social Services, Office of Licensing & Accreditation is requiring the implementation of a Corrective Action Plan (CAP). The CAP is established to ensure changes are made to achieve and maintain compliance with the identified Administrative Rule(s) of South Dakota (ARSD).

Agency: Our Home Parkston

ARSD – Out of Compliance

Our Home was found to be out of compliance with the underlined portion of the following Administrative Rules of South Dakota:

1) **ARSD 67:42:01:06. Ability to provide care.**
An applicant shall demonstrate the ability to provide care to a client which meets the client's intellectual, physical, social, and emotional needs. The applicant's ability is determined by the capacity to provide the following:

(1) An understanding of, and encouragement and emotional support to, the client;
(2) Assistance to the client in coping with daily living experiences;
(3) Supervision of the client;
(4) If working with children, an understanding of child development and appropriate use of discipline; and
(5) Ability to apply the reasonable and prudent parenting standard for the participation in age- or developmentally-appropriate activities.

The applicant must also be able to participate with the department or a responsible party in devising and executing a case plan for a client.

Source: 4 SDR 2, effective July 25, 1977; 7 SDR 66, 7 SDR89, effective July 1, 1981; 12 SDR 4, effective January 25, 1985; 39 SDR 220, effective June 27, 2013; 42 SDR 97, effective January 4, 2016.
General Authority: SDCL 26-6-16.
Law Implemented: SDCL 26-6-11, 26-6-16.

2) **ARSD 67:42:08:03. Staff-child ratio.**
Child care staff must be employed to maintain daily living conditions for all children in care. There must be at least one staff member to supervise each 6 children or fraction thereof during waking hours whenever children are present. During sleeping hours, there must be at least one staff member present and awake in each separate sleeping unit to supervise children, but not less than one staff member for each 12 children or fraction thereof in the building. There must be a minimum of two adults on the grounds at all times. Additional child care staff must be on call. A list of the staff members on call must be posted by the facility's telephone in case of an emergency. The facility must have a written plan to ensure that staff, law enforcement, or appropriate emergency responders

are available at the center within a reasonable time in the event of an emergency. Arrangements must be made for employing substitute staff to serve children in emergencies, during vacations or illness of regular staff, and during the time when regular staff is off duty. Auxiliary staff members, such as certified special education teachers, mental health professionals, and physical or occupational therapists, must be provided according to the defined purposes of the center.

The department may require a higher adult-child ratio if on-site visits indicate a need for more supervision to maintain control and discipline.

Source: 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 4, effective July 25, 1985; 34 SDR 200, effective January 30, 2008; 39 SDR 220, effective June 27, 2013.
General Authority: SDCL 26-6-16.
Law Implemented: SDCL 26-6-16.

3) **ARSD 67:42:08:09. Written Policy Requirements.**
The facility must develop written policies that address:
(1) Intake.
(2) Treatment.
(3) Discharge.
(4) Discipline.
(5) Confidentiality.
(6) Reporting suspected child abuse and neglect within the facility.
(7) Emergency safety interventions.
(8) Health care of children; and
(9) Emergency and safety procedures.

The facility must inform the child's parent or guardian of the facility's policies, including the individuals or agencies to whom required reports must be made. The child's parent or guardian must sign and date a statement that lists the specific policies covered as verification that the facility provided the required information. The facility must make copies of these policies available on request.

Source: 34 SDR 200, effective January 30, 2008; 47 SDR 24, effective September 10, 2020.
General Authority: SDCL 26-6-16(6).
Law Implemented: SDCL 26-6-16(6).

Non-Compliance Finding:
A suicide attempt occurred on March 12, 2021. During this incident, staff were not positioned on the living unit to provide adequate supervision, even though there was sufficient staff available in the facility. One staff was tasked with supervising eleven residents on one unit. Due to lack of communication by staff members, the supervising staff was unaware of the resident being alone in her bedroom at the time of the incident and was not able to implement Our Home Parkston's practice of keeping the door closed for a specified amount of time.

Action Needed:
Submit a plan to:

1) Review and revise policies and procedures to address supervision, to include, but not limited to:
   - Correct positioning of staff in the facility to adequately supervise residents.
   - Supervision of residents while in bedrooms.
   - Communication between staff during times of transition.
   - Residents' movement within the facility.
2) Review and revise policies related to safety to ensure the agencies agreed upon practices are documented as written policies.
3) Ensure all staff are aware of and trained on policy and procedure changes.

Submit plan by: July 23, 2021

Corrective Action Plan (Attach documents if needed):

- To assure the appropriate number of assigned staff per number of residents in each area that youth are present are available and to enhance communication on each shift, a Shift Lead role was created for shifts during normal waking hours. The Shift Lead is responsible for ensuring that the necessary monitoring and over-sight is met each shift which entails directing where staff are on shift and making changes to assure appropriate supervision levels are being met at all times during shifts. Shift Lead role training has been provided to current employees in person and via the agency's online communication and training platform by 3/20/2021. This Shift Lead process is accessible to all staff in the facility operations section of the agencies online training and communication platform. Facility operations are included in new employee orientation and receipt and understanding are acknowledged through dated employee signatures.

- To increase communication and clearly identify roles and responsibilities for each shift, a Shift Lead board was installed at the central control center by 3/20/2021. This board identifies who is currently on shift, who is in the role of the Shift Lead, and who is assigned to which groups for the shift. All current employees have been trained on location of the Shift Lead board and its use. Use of the shift lead board procedures were written and are accessible to all staff in the facility operations section of the agencies online training and communication platform. Facility operations are included in new employee orientation and receipt and understanding are acknowledged through dated employee signatures.

- All employees, whom as part of their regular job duties are required to perform on-call or shift lead, are required to complete on-call training and then complete a competency based on-call test and show 90% proficiency prior to being able to fill these roles. This competency based training encompasses scenarios to include ratio compliance, medical emergencies, and emergency safety intervention. Individuals who fail to meet 90% proficiency will not be allowed to serve in the role of on-call/shift lead. QA Proficiency results for competency are stored in the employees training file. As of 3/24/2021, Competency based on-call training and testing is required on an annual basis for current employees and prior to performing the duties of shift lead or on-call as a regular part of their job duties for new hires. The Executive Director, Associate Director and Program Coordinator may at any time request additional competency based testing be completed.

- Job descriptions for positions, who as part of their regular job duties are required to perform on-call or shift lead, were updated by 3/24/2021 with language to include shift lead/on-call responsibilities. Job descriptions are reviewed annually. Performance Appraisals for positions, who as part of their regular job duties are required to perform on-call or shift lead responsibilities, assess for competency in performance of on-call/shift lead duties. Performance Appraisals are reviewed on an annual basis.

- Staff Announcements for Purpose of Supervision procedures were added to facility operations on 3/20/2021. When supervising youth, staff who are considered in ratio for the purpose of supervision shall make notifications to staff they are working with as part of ratio and the shift lead that they are leaving an area and will no longer be considered part of ratio. The employee will not be able to leave the area until ratio is observed. Notifications shall be made verbally, over the radio or via phone. Staff Announcements for Purpose of Supervision procedures are accessible to all agency employees in the facility operations section of the agencies online training and communication platform. Facility operations are included in new employee orientation and receipt and understanding are acknowledged through dated employee signatures.

- Immediate steps were taken to enforce and ensure compliance of Privacy behind Bedroom Door processes. The process was studied and monitored for effectiveness, safety, and to determine a minimum time frame. Quality assurance began 4/14/2021 at a minimum of 4 days per week to monitor for desired proficiency and finalized on 7/21/2021. In the spirit of normalcy, and to continue to meet the federal reasonable and prudent parenting standard, all current and future youth will continue to have times of privacy behind closed bedroom doors after receiving permission. The expectation is that doors may be closed for a period of up to 5 minutes with staff available walking the halls. This is the only time that doors are allowed to be closed. While doors are closed, staff walking the halls engage in verbal interactions for safety cues while youth are behind closed bedroom doors. If youth do not respond verbally to staff cues, staff announce to youth they are going to enter the room. Staff child ratio will determine the number of staff that must be walking the hallway. E.g. 4 youth in bedrooms, 1 staff; 8 youth in bedrooms, 2 staff. Youth who have displayed or been identified to have high-risk behaviors, their restrictions on privacy will be determined by the Clinical Psychologist and treatment team. Privacy behind Closed Bedroom Doors processes are accessible to all staff in the facility operations section of the agencies online training and communication platform. Facility operations are included in new employee orientation and receipt and understanding are acknowledged through dated employee signatures.

- Our Home, Inc. Parkston will continue to staff shifts at a minimum ratio of 5:1, but at no time fall below SDARSD residential treatment licensing requirements for staff to child ratio of 6:1. Identified Parkston PRTF professional staff monitor for ratio compliance throughout shifts utilizing an unannounced monitoring of direct supervision form. Measuring of performance in relation to this plan of correction will be monitored through analysis of the unannounced monitoring form. Beginning April 14, 2021, audits were conducted at a minimum of 4 days a week. Quality assurance reviews for proficiency of competency at a level of 90% were conducted bi-weekly for a period of 60 days. At the conclusion of those 60 days after proficiency levels were attained, audit frequency levels were moved to twice weekly. Quality assurance continues to be monitored bi-weekly with 90% as the competency expectation for an additional 60 days period. If proficiency is continuously met throughout this identified period, unannounced monitoring frequency will be allowed to return to agency policy levels. Policy levels state that monitoring shall be conducted at

least monthly, once on each shift (7am – 3pm, 3pm – 11pm, & 11pm – 7am). Staff eligible to conduct a monitoring include Executive Director, Associate Director, Licensing & Accreditation Manager, Childcare Coordinator, Group Leader/Counselor, or Program Coordinator. Information received through the unannounced monitoring forms is reviewed in Group Leaders meeting led by Program Coordinator or designee biweekly for quality assurance.

- Through internal process analysis, which involved input from Administrative staff, Professional Staff, Youth Supervisors, and youth served, Our Home, Inc. has concluded that procedural use of the High-Risk Feelings Sheet each evening had lost its desired value. The High-Risk Feelings list has been replaced with an interventions sheet as of 3/19/2021. The youth in the evening during medication pass, will gather in their respective lounges and provide staff with what interventions they are wanting to utilize for the evening. The staff will document on the intervention sheet what interventions the youth have chosen for the evening to help them better prepare for bedtime. During this time, the youth are only to leave the lounge when they are called by other staff working with them to take their medication. Youth will be encouraged as they are throughout the day to utilize the Positive Peer Culture programming model to talk about any feelings they may have throughout the day. Staff will continue to utilize training to help identify stressors, patterns and red flags, which would warrant additional concern. Information about youth that staff identify as needing additional monitoring, will be provided to the Shift Lead in the evenings who will then contact the Clinical Psychologist for directives. After implementation of the directives from the Clinical Psychologist, the Program Coordinator will be notified of actions taken. Use of the intervention sheet procedures were written and are accessible to all staff in the facility operations section of the agencies online training and communication platform. Facility operations are included in new employee orientation and receipt and understanding are acknowledged through dated employee signatures.

- Suicide and Self-harm training were provided by the Clinical Psychologist and completed by all Parkston PRTF employees. This training included competency-based testing for staff's roles in mitigation of self-harm in a high-risk population. This training is taught annually, with a competency test to follow. All staff completed Suicide and Self-Harm training on April 20, 2021, with the exception of one staff who was medically unable to attend. Before that staff took the floor for their next shift on April 21, 2021, the missed training was completed. Situational development was assessed for all current employees using a tabletop suicide/self-harm scenario drill. Table top suicide/self-harm drills with all employees in attendance were completed by April 20, 2021. Situational table top and live drills are completed following attendance of suicide/self-harm training at minimum on an annual basis. Suicide/self-harm mock live scenarios will be included in agencies suicide/self-harm trainings on at minimum an annual basis.

- The agencies Emergency Preparedness Committee met on March 24, 2021 to review Parkston's Hazard Vulnerabilities. This team identified suicide in addition to medical emergencies as additional vulnerability and added each to the facilities Hazard Vulnerabilities Assessment Tool.

- The agencies drill sheets have been updated as of 4/14/2021 to include scheduled suicide/self-harm drills three times yearly, once per shift. Quality Assurance reviews are conducted during the triannual Health & Safety committee meeting where recommendations for improvements are made if applicable.

- An AED machine has been purchased and placed in the emergency supply room in the basement as of 6/16/2021, which is attached to an area where youth are regularly present. This is in

addition to the AED machine on the main level of the facility located at the central control center and allows for quicker staff access on both levels of the facility.

- All pertinent policy and procedures have been reviewed for relevancy and to assure they reflect current agency practice.

Date Corrective Action Plan Implemented: 07/21/2021

Date of Expected Completion: 07/23/2021

Your signature below certifies you have read and understand the non-compliance findings and submitted a plan to comply with the identified portions of ARSD to the Department of Social Services, Office of Licensing and Accreditation.

Jamin Fischer, MSE — **Signature of Agency Director**

7/23/2021 — **Date**

The Department of Social Services, Office of Licensing and Accreditation has reviewed and accepted the above plan.

Kevin Kanta — **Signature of Licensing Staff**

8/2/21 — **Date**