

**OKLAHOMA COMMISSION ON CHILDREN AND YOUTH  
OFFICE OF JUVENILE SYSTEM OVERSIGHT**

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**Name and Location of Facility:** Cedar Canyon Adventure Program  
Weatherford, Oklahoma

**Date of Visit:** October 15, 2009

**Oversight Reviewers:** Dana S. Holden and Janice Sharp, Oversight  
Specialists

**Focus of Visit:** Second Biannual Visit, 2009

**Date:** January 26, 2010

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**General Information**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on October 15, 2009, at the Cedar Canyon Adventure Program, located in Weatherford, Oklahoma. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures and to conduct a complaint investigation. The complaint alleged that the facility had administered medication to a resident without proper authorization. The Office of Juvenile Affairs (OJA) contracted with Southwestern Oklahoma State University for the operation of the program, which serves OJA-custody males. The program was licensed by the Oklahoma Child Care Services (OCCS) division of the Oklahoma Department of Human Services (OKDHS) for twenty-four residents as a residential child care facility. On the day of the OJSO visit, the census was nineteen.

**Persons Interviewed**

- Entry interview with the staff supervisor
- Exit telephone conference with the program director
- Five residents

**Documents Reviewed**

- Two resident files
- OKDHS OCCS Residential Child Care Facility Inspection report dated July 16, 2009
- Office of the Oklahoma State Fire Marshal report dated July 6, 2008
- Oklahoma State Department of Health Food Inspection report dated July 7, 2008
- Facility grievance log for March 1, 2009, through October 15, 2009

## Findings

### Interviews

The OJSO interviewed five residents. The interview questions pertained to the residents' perceptions of safety, program services, resident rights, discipline practices, and other residential program issues. The OJSO noted:

- Four of the five residents stated that they felt safe at the facility; two of those four residents attributed their reasons for feeling safe to staff supervision, and the other two residents stated that there was nothing at the facility to harm them. The remaining resident interviewed reported not feeling safe because he believed that some residents were aggressive and that some staff allowed the residents to fight among themselves.
- When asked if there was anything that could be done to make the facility safer or to make the facility better overall, three of the five residents responded that installing cameras in the facility would help to monitor what was going on in the facility; one of these three residents suggested that cameras with audio recording would help to alleviate hearsay regarding conflicts among residents at the facility. The majority of the residents interviewed spoke of fights occurring frequently among residents at the facility.
- Four of the five residents reported having been restrained by staff.
- When asked about the food, three of the five residents responded that the food tasted "good", and the other two residents responded that the food tasted "great". All five residents stated that additional helpings of food were allowed at mealtime.
- Three of the five residents stated that being assigned to the treatment team was the worst punishment they had received for breaking a rule at the facility; one resident stated that being placed on the redirection phase of the program was the worst punishment he had received, and the other resident stated that being on loss of privileges status was the worst punishment he had received.
- All five residents could name at least one resident who had been injured at the facility; four of the residents interviewed could name more than one resident who had been injured at the facility.
- Four of the five residents could name at least one resident whom they believed had been mistreated by a staff member. Three of these four residents stated that the mistreatment had occurred during restraints. The OJSO did not discover any other information that corroborated mistreatment.
- All five residents reported recreation occurred daily, and each resident interviewed stated that some of the recreational activities provided were activities that they otherwise would not have had the opportunity to do. The examples of recreation that were given by the residents included hiking, rappelling, scuba diving, flag football, softball, basketball, horseback riding, workouts in the gym and the weight room, fishing, volleyball, bat caving, lifeguard certification class, and camping.
- The majority of the residents interviewed made negative comments regarding their interactions with staff. A common thread in the interviews was that staff liked to

horseplay with the residents, but when the residents responded back with horseplay, the staff's reactions were that the residents had misbehaved, and they were assigned punishment. Some of the residents interviewed believed that favoritism was shown to some residents by some staff members.

- All five residents were able to explain the facility's grievance procedures. Four residents had filed grievances and reported knowing the outcomes of their grievances. The majority of the residents interviewed had not been satisfied with the resolutions of their grievances, as they stated that they had completed the sanction assigned before the resolution had been determined.
- All five residents had participated in community activities. Examples of the community service provided were lawn work and picking up trash in the community.
- All five residents named at least one staff person with whom they felt comfortable talking regarding a concern or problem.
- The majority of the residents interviewed reported having heard staff curse at residents and/or having heard staff curse among themselves.

No other concerns were noted from the resident interviews.

The OJSO did not interview staff as the staff members on-duty were staff the OJSO had previously interviewed.

#### File Review

The OJSO reviewed two resident files. Both files were well organized and complete for the items reviewed. No concerns were noted from the resident files reviewed.

The OJSO did not review any personnel files. The OKDHS OCCS recently had reviewed the personnel files, and the documented deficiencies had been corrected prior to the OJSO's visit. No other areas of concern were noted.

#### Grievance Log Review

The OJSO reviewed the grievance log for March 1, 2009, through October 15, 2009. Fifty-eight grievances had been filed by residents during the reporting period. The log recorded the required documentation. No concerns were noted from the grievance log review.

#### Inspection Reports Review

The OJSO reviewed the most current inspection reports by the Office of the Oklahoma State Fire Marshal, the Oklahoma State Department of Health, and the OKDHS OCCS. The OKDHS licensing unit had cited the facility for lack of documentation of required staff training, which had been corrected prior to the OJSO's visit. Upon the OJSO's request for the inspection reports for review, the administrative assistant offered that the facility was overdue for inspections by the health department and the fire marshal's

office and that the OKDHS licensing unit was responsible for contacting both offices to schedule inspections. In March 2008 when the OJSO visited the facility, the health department inspection was past due for an inspection and the administrative assistant had advised at that time that the facility had reported the overdue inspection to the OKDHS licensing staff and were told that licensing staff would schedule an inspection as soon as possible; the health department conducted the inspection in August 2008.

### **Additional Observations**

The OJSO conducted the confidential interviews and the file reviews in the facility's conference room. In the course of the resident interviews, the interviewees had spoken about frequent incidents of horseplay initiated by staff and fights among residents occurring in this conference room. The OJSO noted several of the chairs in the conference room had broken arm rests that posed a dangerous risk to the safety of the residents and the staff. For each of the chairs with broken arm rests, the portion of the arm rest cover that was missing exposed two long, jagged pieces of metal that protruded out from the chair.

Leaving the facility, the OJSO observed a female staff person and a male resident walking on the road that led up to the facility. They were walking back to the facility and were approximately a quarter of a mile from the facility.

### **Summary**

The program director was away from the facility at the time of the OJSO visit; therefore, a telephone exit conference was conducted with the program director on November 23, 2009, to discuss OJSO's oversight and complaint investigative findings. The OJSO did not substantiate the complaint allegation.

### **Areas of Concern**

1. Annual inspections by the health department and the fire marshal's office were past due. It remains concerning that the facility has to rely on the OKDHS licensing worker to schedule inspections by the health department and the fire marshal's office rather than scheduling the inspections itself.
2. A female staff member and a male resident were walking alone on the country road. A safety risk was posed when a female staff member and a male resident separated from the general population in an uncontrolled environment.

### **Violations**

1. The majority of the residents interviewed spoke of horseplay initiated by staff and fights among residents occurring frequently. Statements by the interviewees indicated that staff initiated horseplay with the residents and when the residents responded back with horseplay, the staff assigned sanctions to the residents for misbehavior. Statements also indicated that some staff members did not always

intervene when residents fought and allowed the residents to fight among themselves. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154.1, Program, (a), Rights of residents, states, "The facility has current, written clients' rights policy that supports and protects all residents . . . ." At the same cite, paragraph (a), Rights of residents, (3), (M), Safety, states, "Adequate measures are taken to prevent accidents and to avoid health and safety hazards."

2. Chairs in the conference room were not in good repair and created a serious risk to the safety of the residents and staff. The exposed metal rods protruding from the arm rests of the broken chairs could cause serious injuries to the residents or staff should they fall or be pushed during a scuffle. The broken chairs could be used as a weapon. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-157, Physical facility and equipment, (k), Furnishings and décor, (3), states, "Broken, defective, or recalled furnishings and equipment are repaired or replaced."
3. The majority of the residents interviewed reported having heard staff curse at residents and/or having heard staff curse among themselves. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154.2, Behavior management, (b), Prohibitions, (2), states, ". . . facility policy prohibits harsh, humiliating, cruel, abusive or degrading language. . . ."

### **Recommendation to the OKDHS division of Oklahoma Child Care Services**

1. Consider allowing the facility itself to request and schedule the inspections conducted by the health department and the fire marshal's office.

DSH:JS

