

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

Name and Location of Facility: Deborah Rothe Group Home

Date of Visit: April 17, 2008

Oversight Reviewer: Sara Vincent-Spain, Oversight Specialist

Focus of Visit: Unannounced Routine Visit

Date: May 13, 2008

Introduction

The Office of Juvenile System Oversight (OJSO) conducted a routine, unannounced visit to the Deborah Rothe Group Home on April 4, 2008. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The group home was licensed by the Department of Human Services (DHS) Office of Child Care Services (OCCS) for eight female residents, ages thirteen to seventeen. At the time of the oversight visit, the census was eight.

Interviews Conducted

- Entry interview and exit conference with the Program Director
- One direct care staff member
- The group home social worker
- Four group home residents

Documents Reviewed

- Three personnel files
- Four resident files
- Four Winter weekly menus and four Summer weekly menus
- Recreation schedule for January, February, March and April
- State of Oklahoma Fire Marshal Inspection Report dated March 5, 2007
- State of Oklahoma Department of Health Food Safety Inspection Report dated May 17, 2007
- Department of Human Services Licensing Visit Report dated February 2, 2008

Areas Toured

The OJSO conducted a facility inspection, and no issues were noted. However, the OJSO did note the State of Oklahoma Fire Marshal Inspection Report dated March 5,

2007, was slightly out of date. The OJSO contacted the State Fire Marshal's office on April 28, 2008, and requested a fire inspection be completed at the group home as soon as possible. The state fire marshal representative stated that the inspection would be scheduled within seven to ten business days.

Findings

Resident Interviews

Four of the group home residents were interviewed. All reported they felt safe; however, two residents identified the same direct care specialist as using harsh, abusive and degrading language, as was identified in the OJSO's last oversight visit, and noted in the OJSO report dated January 8, 2008.

Staff Interviews

The OJSO interviewed the program director, the group home social worker and one direct care specialist. No new issues were identified.

Review of Resident Files

Four resident files were reviewed. No policy violations were noted

Review of Personnel Files

Three personnel files were reviewed. No policy violations were noted.

Area of Concern

The OJSO noted an area of concern as a result of the interviews conducted by the OJSO. The direct care specialist identified in the interviews as using harsh, abusive and degrading language was the same staff member that had been identified in the OJSO report dated January 8, 2008, which noted that this staff member's personnel file contained a written reprimand that documented this staff member had used inappropriate/angry comments while addressing a resident.

Violation

1. Based on the interviews conducted by the OJSO, the facility violated Licensing Standard Section 154.2(a)(4) by failing to monitor and document the use of its behavior management policy, and Section 154.2(b)(2) which states, "[f]acility policy prohibits harsh, humiliating, cruel, abusive or degrading language."

Summary

The OJSO and the Program Director discussed the mutual concern regarding this staff member's ability to provide appropriate care for the residents. Based on the interviews conducted and the documentation reviewed, the OJSO recommends the facility administration continue with appropriate personnel action in an effort to achieve acceptable staff to resident communications.

