

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

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**Name and Location of Facility:** Enid Adventure Program  
Enid, Oklahoma

**Dates of Visit:** October 28, 29 and 30, and November 3, 4, and 13, 2008

**Oversight Reviewer:** Dana S. Holden, Oversight Specialist

**Subject:** Second Biannual Visit for 2008

**Date:** February 23, 2009

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit at the Enid Adventure Program on October 28, 2008. The OJSO returned on October 29 and 30 and November 3 and 4 to resume the visit. The OJSO visit concluded on November 13, 2008. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The Office of Juvenile Affairs (OJA) contracts with Southwestern Oklahoma State University (SWOSU) for the operation of the program, which serves OJA-custody males. The program is licensed for twelve residents by the Oklahoma Child Care Services (OCCS) division of the Oklahoma Department of Human Services (OKDHS). On the day of the OJSO visit, the census was eleven.

### **Interviews Conducted**

- Entry interview with the Program Administrator
- Ten residents
- Three current direct care staff members and one former direct care staff member
- Exit conference with the SWOSU Dean of Professional and Graduate Studies

### **Documents Reviewed**

- Case records on nine current residents and one former resident
- OKDHS OCCS inspection report dated October 7, 2008
- Office of the Oklahoma State Fire Marshal report dated January 10, 2008
- Oklahoma State Department of Health Food Inspection report dated August 22, 2007
- Facility incident reports for May through October 2008

## Findings

### Resident Interviews

The OJSO interviewed ten 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:

- The majority of interviewees reported being cursed at, or hearing other residents being cursed at, by the facility director and/or staff members.
- The majority of interviewees reported being improperly restrained, or observing other residents being improperly restrained, by staff members. According to the interviewees, residents had received injuries during restraints, some of which required medical attention. Two examples of incidents in which interviewees said they had observed improper use of restraints were:
  - A resident who was accused by the facility director and a staff member of assaulting another resident became upset and cursed at the director and staff member when the resident was told he would be receiving a sanction for the assault. Allegedly, the facility director placed his arm around the resident's throat and pulled back, choking the resident.
  - The school teacher grabbed a resident by the arms and pulled the resident's arms behind the resident. Allegedly, the school teacher then picked up the resident and threw him to the floor. Reportedly, the resident had a cut lip, carpet burns on his face, and a cut on his nose, all from hitting his face on the floor when the school teacher allegedly threw the resident to the floor. Reportedly, the resident asked the teacher to take him for medical care for his injuries, but allegedly, the teacher refused.
- The majority of interviewees reported that they had not filed grievances because either they feared retaliation by staff members or they had been threatened by staff members after they had filed a grievance. Two examples of incidents in which interviewees said threats by staff members had occurred were:
  - Staff coerced a resident into withdrawing a grievance he had filed on the facility director and a staff member alleging the director and staff member had ridiculed the resident because of his disabilities. Reportedly, the staff member watched the resident complete the grievance form and then reported the information to the facility director. Allegedly, the resident was called into the office and told by the director that he would be placed on Loss of Privileges (LOP) status if he did not withdraw his grievance.
  - The facility director told a resident that he would place the resident on LOP status if he continued to file grievances regarding unimportant issues.
- The majority of interviewees reported that residents were placed on LOP status for not informing staff when residents were absent from the facility without permission (AWOL status) or when residents violated rules.
- The majority of interviewees reported that they had observed staff members making embarrassing and humiliating remarks about a resident who had disabilities.

- Several interviewees reported that they were questioned by the facility director about what they had said in their confidential interviews with the OJSO and the OKDHS Office of Client Advocacy (OCA).
- Four interviewees stated that residents were placed on LOP status for talking among themselves about the use of restraints at the facility.
- Five interviewees named a specific OJA employee who had interviewed the residents and then had allegedly reported the interview information to facility staff. As a result, allegedly, facility staff made threats to the residents, because they had complained about the program to the OJA employee.
- Four interviewees stated that staff had refused or had delayed seeking medical attention for residents who had been injured during restraints.
- Four interviewees stated that some residents had left the facility without permission (AWOL status) to escape harassment by staff.
- The majority of interviewees reported observing the facility director and/or the case manager attempting to listen to the OJSO's confidential interviews with the residents.

No other concerns were noted from the resident interviews.

### Staff Interviews

The OJSO interviewed three current direct care staff members and one former staff member. The OJSO noted:

- One interviewee had never heard any of the staff members curse at the residents. The staff member did believe that some staff members assigned residents with LOP time for behaviors that did not meet criteria.
- One interviewee stated that rules were applied inconsistently and that “there are new rules every day.”
- One interviewee had received complaints in the past from residents stating that the grievance system did not work.

The OJSO noted information provided by two interviewees regarding an incident in which a resident went AWOL from the facility:

- One interviewee stated that the resident had been left unsupervised in the kitchen. It was later discovered that at this same time, the medicine cabinet had been left unlocked and the ignition keys had been left inside the facility's van. Reportedly, the residents all had gone to bed by 10 p.m., and a bed check was conducted at 10:15 p.m.
- The other interviewee stated that a bed check was conducted at 10:15 p.m., and that staff were required to conduct bed checks every fifteen minutes. This interviewee did not know any details of how the resident was able to leave the facility or how the resident came into possession of the keys to the van and a facility cell phone.

The OJSO noted information provided by three interviewees regarding an incident of restraint involving a former resident:

- One interviewee stated that the former resident had been restrained because he had refused to cooperate with staff's instructions to move to a different chair. Reportedly, the resident began to curse at staff. A staff member moved behind the resident, grabbed both of the resident's arms, and "lifted him from his chair." Reportedly, at that time, the resident agreed to move and asked that he be allowed to move his own books but was told by the staff member applying the restraint hold that "it's too late for negotiation." Reportedly, a takedown hold was applied, and as the resident was taken to the floor, "he hit his face on the floor and bloodied his lip." According to the interviewee, during the takedown, the resident's glasses were broken and he received a cut to his nose and suffered a carpet burn on the cheek of his face. The interviewee stated that the resident did not request medical attention for his injuries.
- Another interviewee stated that the former resident had been injured during the restraint. Reportedly, the resident's tooth had cut through his lip, and he had a cut on his nose and a carpet burn on his face.
- The other interviewee stated that the staff member "took hold of the resident's arms and the resident stood up," as the staff member tried to move the resident to another chair. Reportedly, the resident began to struggle. The interviewee was tending to other residents in another area and did not witness the restraint hold or the takedown to the floor; however, the interviewee did hear the resident request medical attention for his injuries. According to the interviewee, the resident had never threatened or acted out violently toward staff.

The OJSO noted information received in the staff interviews regarding other incidents of possible abuse/misconduct by staff:

- One interviewee stated that two residents had disclosed (to the staff member) that they had been assaulted by the facility director. However, according to the staff member, the allegations of abuse were not reported to the OCA, because the staff member did not think the residents' stories were credible.
- One interviewee reported hearing a staff member comment about a resident's disability; however, the interviewee believed the comments were made in a joking manner.

No other concerns were noted from the staff interviews.

### Resident File Review

The OJSO reviewed the files on nine current residents and one former resident. No concerns were noted from the resident files reviewed.

## Incident Reports Review

The OJSO reviewed the facility incident reports for May through October 2008. From review of the incident reports, the OJSO noted:

- One incident report stated that a resident was brought to the office because of physical aggression toward another resident. Documentation stated that the resident was told, "It was found to be true of him pushing the resident." The resident became non-compliant and cursed at the staff members and attempted to leave the office, whereby the resident was "physically assisted to an area of the office until he could calm down."

The OJSO noted that the incident report did not state how the resident was "physically assisted" to an area of the office. The incident report did not document witness statements to support that the resident had pushed another resident.

Four subsequent medical incident reports had been prepared regarding the resident. The medical incident reports were dated September 10, 11, 13, and 14, 2008. According to the documentation, the resident was not afforded medical attention, nor was the incident reported to the OCA. Following the oversight visit, the OJSO reported the incident to the OCA.

- Another incident report stated that a resident had been noncompliant when asked to move to a desk designated for serving LOP time. The report stated, "I (staff member) placed my hands on his arms and began to assist (resident's name) to stand up." According to the incident report, the resident "began to resist." The report continued, "I placed him in a standing Handle with Care PRT (primary restraint technique) restraint hold." Another staff member called a safety (staff person of the safety unit) and moved the other residents to another room. The report stated, "I (staff member) determined that for his safety and security that I should take him to a more secure location. Because he was struggling with me the move to the floor was very difficult and in the process he hit his face on the floor and cut his lip and the corner of his mouth and they began bleeding." According to the incident report, the resident's glasses were bent during the restraint, causing two scratches on the resident's right cheek and a cut on his nose. The resident was released from the hold after approximately fifteen minutes. According to the incident report, the resident was taken to the doctor the next day due to head and jaw pain. The doctor referred the resident to the hospital for x-rays of his jaw, the x-rays results were negative.

Additional incident reports stated that the resident was unable to eat after the incident occurred and into the next day, because of the injuries to his lip and mouth.

The facility reported this incident to the OCA on September 18, 2008. The OJSO noted from documentation that in reporting the incident to the OCA, the facility did not accurately report the severity of the resident's injuries. The injuries were listed

as “Scratch on nose area, scrape on right side of face and eye area, a bruised lip and pain to his jaw area.” After receiving the incident report from the facility, the OCA referred the report back to the facility for a Caretaker Conduct Review (CCR) investigation. The CCR investigation was conducted by the facility director. The OJSO noted that the CCR report did not document any statements made by other staff members and residents. The OJSO noted that the facility medical incident reports stated that the resident had refused to eat.

The OJSO interviewed residents at the facility and asked if they had been interviewed by any staff members or the facility director regarding the incident; all of the residents interviewed stated they had not been interviewed by the facility director or staff. The OJSO asked the facility director for a copy of his notes taken during his interviews with the residents and staff. The director stated he did not take any notes. When asked why, he stated that he “didn’t see the need.”

- An incident report dated October 31, 2008, stated that a resident went AWOL from the facility, and that staff did not realize until the next morning the resident was absent from the facility. The resident took a facility van and a facility cell phone when he left the facility. The resident was returned to the facility on November 2, 2008.

According to the incident report, the resident reported that at approximately 10:00 p.m., he moved a foosball table from in front of the back door. When outside, he pushed the facility van to the street and drove away. On his way to a metropolitan city in Oklahoma, the van developed mechanical problems, and the resident was forced to hitchhike for approximately six miles before a passerby gave him a ride. The resident turned himself in to a metropolitan shelter and was transported back to the adventure program on November 2, 2008.

- Incident reports documented that residents were placed on LOP status for not informing staff when other residents violated facility rules.
- An incident report stated that a resident received eighty-four hours of LOP time for not reporting that a resident was giving tattoos to other residents. According to documentation, information provided had indicated that a staff member was involved. The facility director increased the resident’s LOP time to ninety-six hours for accusing a staff member of wrongdoing.
- An incident report dated August 25, 2008, stated that a resident was restrained when he continued to ignore staff redirection and continued to escalate his behavior. The report stated that the resident “was asked to quit flinching and punching his fist into his other hand.” According to documentation, the resident was put into a “Handle with Care” restraint. The resident continued to curse at staff and to make derogatory comments until he was released. The resident was placed on seventy-two hours of LOP time. The incident report stated that the resident “had a scratch on his nose.”
- The OJSO noted four incidents that documented injuries to residents during restraints and alleged abusive behaviors by staff members. None of the incidents

had been reported to the OCA by the facility; during the OJSO visit, the OJSO reported all four incidents to the OCA. The OCA referred one of the incidents back to the facility for a CCR investigation. The OJSO became aware that the facility had not accurately reported the resident's injuries to the OCA. After the OJSO reported the extent of the resident's injuries to the OCA, the incident was redesignated as an OCA investigation. Another referral returned to the facility for a CCR investigation was assigned to a staff member who was not associated with the facility.

No other concerns were noted from the incident files reviewed.

### Review of Discipline Practices

The OJSO reviewed the discipline practices used by staff. The OJSO noted:

- Different amounts of LOP time were assigned to different residents for the same type of offense. Incident reports indicated that residents who had not reported to staff that another resident was giving tattoos to other residents received different LOP times: One resident was assigned eighty-four hours of LOP time, a second resident was assigned seventy-two hours of LOP time, a third resident was assigned ninety-six hours of LOP time, and a fourth resident was assigned twenty-four hours of LOP time, all for the same offense.
- Incident reports indicated that staff continued to assign large blocks of LOP time for what appeared to be minor rule infractions. During the OJSO's visits in November 2007 and May 2008, it was noted that staff were assigning large blocks of LOP time for minor rule infractions. On May 30, 2008, the facility director issued a corrective action plan that stated, "As of March 10, 2008, floor staff has not been able to assign more than 24 hours of LOP time for minor rule infractions." In the current visit, the OJSO noted several instances in which residents were assigned LOP time in excess of the twenty-four-hour time limit that had been imposed by the facility director.

### Inspection Reports Review

The OJSO reviewed the most recent inspection reports by the OKDHS OCCS, the Oklahoma State Fire Marshal's office, and the Oklahoma State Department of Health. The OCCS report did not cite any violations from the resident file reviews and the facility inspection. The fire marshal's office's report had cited one minor problem with the fire extinguisher mounts, which had been corrected. The last inspection by the health department had occurred on August 22, 2007. The OJSO had previously been advised that health department inspections to the facility were scheduled by the OCCS; the OJSO contacted the OCCS, who stated that the health department required that the OCCS make contact to schedule a visit by the health department since an annual inspection was a licensing requirement.

No other concerns were noted from the inspection reports reviewed.

## Areas of Concern

1. Residents were assigned LOP time for minor rule infractions.
2. Residents were assigned LOP time for not reporting when other residents violated the rules.
3. Allegedly, the facility director had questioned residents about their confidential interviews with the OJSO.
4. Allegedly, the facility director and the case manager attempted to listen to the residents' confidential interviews with the OJSO.
5. Allegedly, an OJA liaison had interviewed several residents about incidents at the facility and then had reported the residents' responses to the facility director. Allegedly, residents were threatened with sanctions for talking about incidents that had occurred at the facility.
6. Allegedly, residents had gone AWOL from the facility to escape harassment from staff.
7. Staff did not report to the OCA, reportedly because a staff member did not think the residents' stories were credible.

## Violations

1. Residents reported that the facility director and staff members cursed at the residents. 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."
2. Residents reported being improperly restrained, or observing other residents being improperly restrained. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154.2, Behavior management, (b) Prohibitions, (1), states, "Facility policy prohibits shaking, striking, spanking, or other cruel treatment."
3. Residents and a staff member reported that the facility director and a staff member had made embarrassing, humiliating, and derogatory remarks about a resident with disabilities. 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."
4. Residents reported that they did not file grievances, because they feared retaliation by staff or they had been threatened by staff for filing grievances. OJA policy, OAC 377:3-1-27, OJA grievance policy, (d), in part, states "Staff members shall not in any way discourage any juvenile from filing a grievance or appealing a grievance resolution."
5. Staff had refused or had delayed medical attention for a resident injured during a restraint. OJA policy, OAC 377:3-13-44, Security and control, (c), (8), Physical force, (H), states, "Medical attention shall be provided immediately upon the juvenile's release from restraint as a result of physical force even if there is not visible evidence or complaint of injury. Staff certified in first aid and CPR may provide medical attention and are responsible for referring the juvenile to licensed medical personnel, if warranted."

6. The facility staff did not take adequate measures to ensure the safety of the residents. A resident was able to obtain a facility van and a facility cell phone and to leave the facility. OJA policy, OAC 377:3-13-43, Staff requirements, (a), General provisions, (3), Supervision, states, "Sufficient staff shall be available to provide continuous day and night supervision of the residents and protection of the facility as well as to allow staff relief from duty."
7. Facility staff did not report promptly to the OKDHS OCA the incidents of restraints in which residents were injured. OKDHS policy, OAC 340:2-3-33, Procedure for reporting suspected abuse, neglect, verbal abuse, caretaker misconduct, and exploitation, (a), Reporting requirements and reportable incidents, (3), states, ". . . employees of OKDHS, Department of Rehabilitation Services (DRS), Department of Mental Health and Substance Abuse Services (DMHSAS), Office of Juvenile Affairs (OJA), and the J.D. McCarty Center who have reason to believe that caretaker misconduct, as defined in OAC 340:2-3-2, with regard to a client has occurred promptly refer it to OCA intake. This referring requirement also extends to employees of private facilities that contract with OKDHS, DRS, DMHSAS, and OJA to provide residential services to these clients." At the same cite, paragraph (7) states, "Promptly' reporting . . . means the same day or the next working day."
8. The facility director did not conduct a proper CCR investigation regarding the restraint and injury of a resident. OKDHS policy, OAC 340:2-3-37, Caretaker conduct review (CCR), (c), Protocol for conducting a CCR, in part, states, "A facility employee designated to conduct a CCR follows the investigative procedures described in OAC 340:2-3-36, with the exception of tape recording the interviews in OAC 340:2-3-36 (i) (1), including:
  - (3) obtaining written statements and conducting interviews with:
    - (A) each alleged victim;
    - (B) each eyewitness;
    - (C) other persons with knowledge relevant to the allegation; and
    - (D) each accused caretaker."

## Summary

The OJSO conducted six days of oversight at the facility. It appeared to the OJSO that in the course of its investigation, facility staff attempted to obstruct the oversight. It was reported that the facility director and the case manager attempted to listen to the confidential interviews conducted by the OJSO and questioned residents later about their statements, a violation of the residents' right to confidentiality. In addition, it is concerning that the residents feel threatened and are intimidated for filing grievances. In addition, the liberal use of LOP time seems to be a disproportionate consequence for the offenses committed. On the last day of the oversight, the OJSO noted that there were seven residents who had been assigned forty-eight hours of LOP time. The OJSO reviewed the incident reports for each resident. The information in the incident reports was identical for each resident, each stating that staff had confiscated "rap lyrics, letters and drawings from the resident book bags." The staff did not specify in the incident reports the contraband confiscated from each resident; rather, the same incident report

was used, and only the name was changed on the reports. Residents reported that they believed that facility staff had retaliated against them for cooperating with the OJSO during the oversight visit.

It is also concerning that the most recent annual inspection of the facility by the health department had occurred on August 22, 2007.

When the OJSO initiated the oversight visit, the Enid Adventure Program was located in Enid. It has since changed its name to Salt Fork Adventure Program and has relocated to Nash, Oklahoma.

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