



Southwestern Oklahoma State University
Salt Fork Adventure Program

TO: Dana S. Holden, Oversight Specialist
Oklahoma Commission on Children and Youth

FROM: George W. Jones Jr., Director
Salt Fork Adventure Program

DATE: March 20, 2009

RE: Response to Office of Juvenile System Oversight's Visit

cc: Dr. Ken Rose
Robert E. Christian
Mike Heath
Donna Glandon
Susan Case

In reference to your Oversight Report from October and November 2008, please find attached our written response to the findings in this report.

If you have any questions or concerns, please feel free to call me at 580-839-2320.

AREAS OF CONCERN:

1. Residents were assigned LOP time for minor rule infractions.

Response #1: This issue has been addressed with staff and we are currently identifying time limitations.

2. Residents were assigned LOP time for not reporting when other residents violated the rules.

Response #2: This issue has been addressed with staff that it is not the responsibility of residents to report other residents for rule violations

3. Allegedly, the facility director had questioned residents about their confidential interviews with the OJSO.

Response #3: The Facility director during the Investigation has resigned from SFAP.

4. Allegedly, the facility director and the case manager attempted to listen to the residents' confidential interviews with the OJSO.

Response #4: The facility director during the investigation has resigned from SFAP. This issue will be addressed with the case manager.

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.

Response #5: The facility director during the Investigation has resigned from SFAP

6. Allegedly, residents had gone AWOL from the facility to escape harassment from staff.

Response #6: Facility has gone thru some staff changes as well as a new director.

7. Staff did not report to the OCA, reportedly because a staff member did not think the residents' stories were credible.

Response #7: New memo has been distributed among staff, identifying who to notify in Emergency situations. (See attached)

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."

Response #1: The facility director during the investigation has resigned from SFAP. The new director has addressed this issue with staff during March 18, 2009 meeting and staffing notes were issued to those not in attendance.

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."

Response #2: This has been addressed with staff during March 18, 2009 meeting and staffing notes were issued to those not in attendance.

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.

Response #3: The facility director during the investigation has resigned from SFAP. The new director has addressed this issue with staff during March 18, 2009 meeting and staffing notes were issued to those not in attendance.

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.”

Response #4: This director has addressed this issue with staff during March 18, 2009 meeting and staffing notes were issued to those not in attendance.

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.”

Response #5: Policy had been addressed with staff during March 18, 2009 meeting and memo has been distributed among staff, identifying who to notify in Emergency situations. (See attached)

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, OAC377:3-13-43, 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.”

Response #6: Since the incident, the program has been moved to a more secure facility with minimal access to equipment.

7. Facility staff did not report promptly to the OKDHS OAC the incidents of restraints in which resident 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.”

Response #7: Policy had been addressed with staff during March 18, 2009 meeting and memo has been distributed among staff, identifying who to notify in Emergency situations. (See attached)

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 interview 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

Response #8: The facility director during the investigation has resigned from SFAP.