

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

Name and Location of Facility: Foss Lake Adventure Program
Foss, Oklahoma

Date of Visit: April 3 and April 8, 2008

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Focus of Visit: First Biannual Visit for 2008

Date: May 19, 2008

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit on April 3, 2008, to the Foss Lake Adventure Program and returned on April 8, 2008, to complete the visit. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The program is licensed by the Division of Child Care of the Department of Human Services (DHS) for eighteen residents. On the day of the OJSO visit, the census was sixteen.

Interviews Conducted

- Entry interview with the Case Manager
- Eight residents
- Exit conference with the Program Director

Documents Reviewed

- Most recent inspection reports by the Office of the Oklahoma State Fire Marshal, the Oklahoma State Department of Health, and the DHS Division of Child Care
- Two personnel files
- Files on four residents
- Three caretaker conduct reviews

Findings

Interviews

The OJSO interviewed eight 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:

- All eight interviewees stated they felt safe at the facility (two interviewees attributed those feelings to the care staff provided).
- All stated the food tasted good and that second servings were allowed.
- All eight demonstrated knowledge of the facility's grievance system.
- All described appropriate forms of discipline.
- All reported receiving appropriate amounts of recreation time.
- Four of the eight interviewees reported they had been cursed at or had observed other residents being cursed at by staff.

During the interviews, the OJSO became aware of incidents in which two staff members assigned residents, who were on Loss of Privilege (LOP) status, to wash their personal vehicles. Five residents stated that a resident stole a lighter and cigarettes from the vehicle and some of the residents smoked the cigarettes. Additionally, four residents stated that a staff member allowed residents to place personal phone calls from his cell phone. The OJSO discussed the allegations with the program director during the exit conference. He was aware of the incidents involving the washing of cars, allowing residents to use a staff member's personal cell phone, and cursing at residents. The program director stated he had addressed these incidents with both staff members, who, according to the program director, were new employees. The program director stated that staff had recovered the lighter and cigarettes from a resident. Both employees received counseling on the program rules and procedures, and both received a verbal reprimand for their actions. None of the resident interviewees reported having to wash the staff members' cars or using the staff member's personal cell phone since these issues were addressed by the administration. No other concerns were noted from the resident interviews.

The OJSO did not interview the staff members on duty. Both staff members had been interviewed by the OJSO on previous oversight visits, and the resident interviews did not indicate any problems concerning staff other than those addressed above.

File Reviews

The OJSO reviewed the files on four residents. The files were well-organized, and the materials were easy to locate. One resident file did not contain a copy of the resident's immunization record. No other concerns were noted from the resident file reviews.

Two personnel files were reviewed. The OJSO noted that one employee received 22 hours of training for 2007 and the other employee did not have any training hours documented for 2007. DHS licensing standards require each direct care employee to receive 24 hours of training per year. No other concerns were noted from the review of the staff files.

Caretaker Conduct Reviews

The OJSO reviewed three randomly selected caretaker conduct reviews (CCRs). The OJSO noted that two of the three incidents had not been referred to the DHS Office of Client Advocacy (OCA) in a timely manner. One was referred nine days after the alleged incident, and one was referred twelve days after the alleged incident.

Documentation did indicate the facility conducted thorough investigations and returned the reports to the OCA within proper time frames. The facility confirmed allegations in one of the investigations. The employee received counseling on the proper supervision of residents and a reprimand for improper supervision of residents. No other concerns were noted from the review of the CCRs.

Concern

1. A staff member allowed residents to make unmonitored phone calls from his personal cell phone.

Violations

1. Two facility staff members assigned residents, who were on LOP status, to wash their personal vehicles. DHS licensing standards, Section 154.2, Behavior management, (b), Prohibitions, in part, states, "Facility policy prohibits: (4) work tasks that are degrading or unnecessary and inappropriate to the resident's age and ability."
2. Four of eight residents reported that staff members cursed at the residents on a regular basis. DHS licensing standards, Section 154.2, Behavior management, (b) Prohibitions, in part, states, "Facility policy prohibits: (2) harsh, humiliating, cruel, abusive or degrading language;"
3. One resident file was missing documentation of the resident's immunization record. DHS licensing standards, Section 154.3, Health and medical services, (d), Immunizations, states, "Each resident is immunized against communicable diseases in accordance with the rules and regulations of the Oklahoma State Department of Health."
4. One of the two personnel files reviewed documented the employee had received 22 training hours for 2007, and the other file did not document the employee had received any training hours in 2007. DHS licensing standards, Section 153.1, Personnel, (m), Staff training, (3), Training for child care staff, (A), in part, states, "Full-time child care staff obtain a minimum of 24 clock hours per calendar year of staff development courses."
5. The facility did not report two of three incidents of neglect regarding lack of supervision to the DHS in a timely manner. The Oklahoma State Statutes, Title 10, Section 7103, (A), 1, d, in part, states, "Every other person having reason to believe that a child under the age of eighteen (18) years is a victim of abuse or neglect, shall report the matter promptly to the Department of Human Services."

Summary

The facility administration, through its interaction with the residents, had addressed the incidents regarding staff neglect and abuse and had taken appropriate actions to ensure the behaviors were not repeated. The facility administration is to be commended on its quick actions to protect the residents.

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