

**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: May 12, 2009

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Focus of Visit: First Biannual Visit, 2009

Date: July 1, 2009

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit at the Foss Lake Adventure Program on May 12, 2009. The purpose of the visit was to conduct a focused oversight of the facility's procedures regarding medication administration, grievance procedures, and employee training. The program was licensed for eighteen male residents by the Oklahoma Department of Human Services (OKDHS) division of Oklahoma Child Care Services (OCCS). On the day of the OJSO visit, the census was thirteen.

Interviews Conducted

- Entry interview and an exit conference with the program administrator

Documents Reviewed

- Grievance log
- Eight employee training records
- OKDHS Office of Client Advocacy (OCA) referral reports and caretaker conduct review report
- Five resident medication administration records (MARs)

Findings

Grievance Log Review

The OJSO reviewed the grievance log for January 1, 2009, through April 30, 2009. Fifty-eight grievances had been filed by residents during that time period.

Documentation indicated that all of the reviewed grievances had been withdrawn voluntarily by the residents or had been resolved informally by staff, except for one grievance. That grievance alleged an inappropriate relationship between a staff member and a resident. Documentation indicated that the incident was reported to the OKDHS OCA and was being investigated. No concerns were noted from the grievance log review.

Employee Training Record Review

The OJSO reviewed eight employee training records for calendar year 2008. The OJSO noted:

- Four training records did not contain documentation of current cardiopulmonary certification (CPR).
- One training record did not contain documentation of current first aid training.
- Four training records did not document the required hours of annual training as having been completed.

No other concerns were noted from the employee training record review.

OCA Investigative Report and CCR Report Review

The OJSO reviewed two OCA investigative reports and one CCR report for January 1, 2009, through May 12, 2009. According to documentation, the facility had reported each incident in a timely manner and had taken corrective action, if warranted. No concerns were noted from the OCA investigative reports and CCR report review.

MAR Review

The OJSO reviewed the MARs on five residents who had physician orders for prescription medicines. Documentation indicated:

- Either recordkeeping was inaccurate, medication was missing, or residents were overmedicated in fourteen instances regarding the amounts of medications remaining for residents. Examples:
 1. The resident's prescribed dosage was two capsules daily. The evening count of remaining medication was forty-one capsules after the resident's last dosage was administered for the day. After the first dosage the following morning, the count of remaining medication was thirty-five capsules.
 2. The resident's prescribed dosage was two capsules daily. The evening count of remaining medication was fourteen capsules after the resident's last dosage was administered for the day. After the first dosage the following morning, the count of remaining medication was six capsules.

3. Staff recorded that on April 6, 2009, at 7:00 a.m., the count of remaining medication for a resident was twenty-one capsules. The following entries, in consecutive order, recorded the count of remaining medication: April 7, 2009, at 7:00 a.m., twenty capsules; April 6, at 8:00 p.m., nineteen capsules, and April 7, 2009, at 8:00 p.m., eighteen capsules.
- Documentation indicated that medication was not dispensed at the frequency ordered by the physician in four instances:
 1. A resident's medication was administered one time on February 8, 2009; the physician had ordered the medication dispensed twice per day.
 2. A resident's medication was administered one time on February 4, 2009; the physician had ordered the medication dispensed twice per day.
 3. A resident's medication was administered one or two times per day; the physician had ordered the medication dispensed three times per day.
 4. A resident's medication was administered one time per day; the physician had ordered the medicine dispensed two times per day.
 - Documentation did not record explanations for discrepancies in the amounts of remaining medication. Examples:
 1. The resident's prescribed dosage was two capsules daily. The evening count of remaining medication was forty-one capsules after the resident's last dosage was administered for the day. After the first dosage the following morning, the count of remaining medication was thirty-five capsules. Documentation did not record an explanation regarding the discrepancy in the amount of remaining medication.
 2. The resident's prescribed dosage was two capsules daily. The evening count of remaining medication was forty-one capsules after the resident's last dosage on February 9, 2009. After the first dosage the following morning, the count of remaining medication was thirty-five capsules. Documentation did not record an explanation regarding the discrepancy in the amount of remaining medication.
 3. The resident's prescribed dosage was two capsules daily. The evening count of remaining medication was fourteen after the resident's last dosage on March 28, 2009. After the first dosage the following morning, the count of remaining medication was six capsules. Documentation did not record an explanation regarding the discrepancy in the amount of remaining medication.
 4. The resident's prescribed dosage was one capsule daily. The evening count of remaining medication was twenty-seven after the resident's last dosage on April 21, 2009. After the first dosage the following morning, the count of remaining medication was twenty-one capsules. Documentation did not record an explanation regarding the discrepancy in the amount of remaining medication.
 - Documentation indicated that medications were not administered to two residents at the times prescribed:
 1. A resident had been prescribed a medication that was to be administered three times daily: breakfast, lunch, and bedtime. Documentation indicated that the resident had received his medication one or two times per day and at times other than those prescribed.

2. A resident had been prescribed a medication that was to be administered two times daily. Documentation indicated that the resident received one dosage of his medication per day, which was in the mornings.

Areas of Concern

1. Documentation revealed discrepancies regarding medication administered and the number of remaining dosages. Documentation did not explain the discrepancies.
2. Medication was not administered as prescribed by the physician.

Violations

1. Four of the eight employee training records reviewed did not contain documentation of current CPR certification. One employee training record reviewed did not contain documentation of current first aid training. OKDHS Licensing Standards for Child Care Facilities, OAC 340:110-3-153.1, Personnel, (m), Staff training, (3), Training for child care staff, (E), in part, states, "Within 90 days of employment, all child care staff complete training in first aid and cardiopulmonary resuscitation (CPR), including infant and child, if appropriate. Child care staff maintains current training in CPR and first aid thereafter."
2. Four of the eight employee training records reviewed did not document the required hours of annual training. OKDHS Licensing Standards for Child Care Facilities, OAC 340:110-3-153.1, Personnel, (m), Staff training, (3), Training for child care staff, (A), states, "Full-time child care staff obtains a minimum of 24 clock hours per calendar year of staff development courses. . . ."

Recommendations

To the Foss Lake Adventure Program:

1. Ensure that any staff member administering medication to a resident is trained by qualified medical personnel regarding medication administration and medical recordkeeping.
2. Establish procedures for ensuring the accuracy of the information recorded in the MAR and accountability for medication administration.
3. Establish procedures to ensure that a staff member administering medication follows the physician's orders regarding the time and frequency of dispensation.

To the Office of Juvenile Affairs:

1. Consider revising OJA policy OAC 377:30-3-17, Health care services, (f), to require that all facilities:
 - (a) establish who is qualified to provide staff training in medication administration and medical recordkeeping;

- (b) ensure that staff who dispense medications are certified in medication administration; and
- (c) establish procedures regarding recordkeeping of medication dispensation; medication count; and missed dosages, with explanation.

To the OKDHS division of Oklahoma Child Care Services:

1. Consider revising the licensing standards for medication administration (OAC 340:110-3-154.3, Health and medical services, (e), Medication) to require that all facilities:
 - (a) establish who is qualified to provide staff training regarding medication administration and medical recordkeeping;
 - (b) ensure that staff who dispense medications are certified in medication administration; and
 - (c) establish procedures for the recording of medication dispensation; medication count; and missed dosages, with explanation.

Summary

The OJSO conducted a focused oversight to review the facility's procedures regarding medication administration, grievance procedures, and employee training. The OJSO is concerned with the facility's medication administration procedures. The staff administering the medications made incorrect entries in the medication administration record, miscounted the amount of medication remaining, and did not administer medication as prescribed by the physician. Reasons were not documented when medication was unaccounted for or when medication had not been administered.

The OJSO is concerned that the OJA medication administration policy is vague, and therefore, does not provide facilities with proper guidance in medication administration training, medication administration procedures, and medical recordkeeping. The OJSO did not interview residents regarding the informal process for resolving grievances. The OJSO advised the facility director that residents will be interviewed during the next bi-annual visit to ascertain their perceptions of the informal grievance process and its effectiveness.

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