

**STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES
LAURA DESTER SHELTER**

619 S. Quincy
Tulsa, OK 74120
918-560-4881

July 15, 2010

Oklahoma Commission on Children and Youth
Janice Sharp, Oversight Specialist
500 N. Broadway, Suite 300
Oklahoma City, OK 73102

Dear Ms. Sharp:

Please accept my apologies for failure to send you the documents requested during exit interview. Please note the "plan of correction" is the dates that the correction was made on the left hand column of the inspection form. That is sent by OKDHS Facilities Management staff to the Fire Marshal.

I know that you have since reviewed those documents during a subsequent visit but I am attaching them to this response with the exception of the OCA referral paper log. The CWS-IV is responsible for this log and he is on leave. When he returns, the paper log will be forwarded for your review by August 15, 2010. The OCA referral log was computerized in June 2010 so all new referrals are now entered in this format so that administrators have access.

This letter is in response to violations and concerns noted during the December 2009 oversight visit.

1. Incidents of AWOL behavior by two residents were not documented adequately. OKDHS licensing Requirements for Residential Care Facilities, OAC 340: 110-3-154, Social Services, (e), Residents records, (1), (G), states, "The record includes reports of serious incidents, which include, but are not limited to, suicide attempts, allegations of abuse, neglect, or abusive treatment. The report includes the date and time of the incidents, the names of all persons involved, the nature of the incidents, and the circumstances surrounding them."

All Direct Care Staff and the staff responsible for completing the AWOL incidents have been re-trained in the correct, complete and adequate incident reporting, including AWOL reporting.

2. Two residents who remained on AWOL status for more than three days were allowed to re-enter the shelter without having been re-admitted. Facility policy, AWOL, states, "if a custody child goes AWOL and does not return for three calendar days, the child is dismissed (from the shelter). If a non custody child goes AWOL and does not return for three court days, the child is dismissed from the shelter."

As I stated at exit interview the policy changed many years ago to five calendar days to allow adequate time for a bench warrant to be requested and filed. The policy manual did not reflect this change. We are currently re-writing the policy manual which will show all current policy. This will be complete by 8-10-2010.

3. Facility Staff reported to the OJSO when the OJSO requested to interview one of the residents that the resident, who had returned to the shelter after having been AWOL, had smelled of alcohol and possibly marijuana. Reportedly, the juvenile was not taken for medical care upon the resident's return to the shelter. Facility policy, AWOL, states, "If the returning resident is intoxicated or shows signs or has suffered a drug overdose, consult the shift supervisor, shelter social worker, contact the Social Worker and request that they meet you at the emergency room and transport the resident to Tulsa Regional medical Center Emergency Room...."

We are in the process of re-training on this policy with all staff but will not be complete until August 2010.

4. The resident's signature was not dated on the grievance notification form in two of the seven resident files reviewed, and grievance notification form was not signed by the parent/guardian in one resident file reviewed. OCA 340:110-3-154, Social services, (e), Resident's records, (1), (J), states, "The facility maintains a written record for each resident....The {resident} record includes... signed documentation that the resident and parents or custodian have been provided written copies of the facility's policies on ...grievance procedures...."

The CWS-IV will do training during the CWS monthly meeting in August 2010 to review policy on this. The CWS-IV will audit files weekly for correct documentation and report in writing to the ICPA-III monthly his findings and corrective action taken.

5. The grievances were not recorded in numerical order on the grievance log for the period of July 1, 2009, through December 20, 2009. One

grievance did not indicate the date the grievance was received for processing. None of the grievances listed on the log indicated at what level the grievances were resolved. Final outcomes were documented inadequately. One grievance was listed on the log that was for another time period. OKDHS policy and procedures, OAC:2-3-45, Grievance system protocols, (h) Grievance records, logs and quarterly reports, states, "The LGC (local grievance coordinator) maintains an accurate and complete record of each grievance filed as well as summary information about the number, nature, and outcome of all grievances filed...." At the same cite, subparagraph (1), states, "Each LGC tracks grievances as they progress through the system and keeps a log of every numbered grievance form issued by OCA (OKDHS Office of Client Advocacy).... For grievances submitted by a client, the tracking log includes: the grievance number; the name of the grievant given the form; was submitted by the grievant; the nature and outcome of the grievance, the date of final resolution, and the level where it was resolved. If a grievance form is provided to a client and not turned in, the facility tracks only the number on the form, the name of the client to whom the form was given, and the date it was given to the client."

New procedures have been implemented to assure a more orderly tracking of grievance forms and outcomes. The Shelter Director will monitor the tracking process and take appropriate corrective measures to insure proper documentation.

6. Six grievances listed on the grievance log with resolution dates had not been resolved within the required timeframe. OKDHS policy and procedures, OAC:2-3-45, Grievance system protocols, (i), Processing the grievance form, (j), Informal resolution of grievance, and (k), First level problem resolution, (L), Second level problem resolution, (1), states, "After completing Form 15GR001P, if the grievance has not been resolved to the decision maker's satisfaction, the LGC fills out Form 15GR001E, Local Grievance Coordinator (LGC) Worksheet.... If the grievance is not resolved at the first level of problem resolution the LGC processes it in accordance with this subsection within three business days of the grievant requesting the second level of problem resolution...."

Local Grievance Coordinator will provide training for all staff with grievance resolution responsibilities on July 27, 2010 to assure timeframes are met according to policy.

7. The resident's signature was not dated on the service plan in one resident file reviewed. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154, Social services, (b), Service planning, (1),

Comprehensive service plan, (B), (vi), states, "The service plan identifies and includes the names and signatures, with the date, of those participating in developing the service plan".

The CWS-IV reviewed this policy at his monthly meeting with the CWS to assure that all signatures and dates of receipt are secured on the service plan. The CWS-IV will also include this in his weekly audit of resident records. Cases will be audited weekly to insure all needed items are in the records. A written report of this audit with appropriate corrective measures will be provided monthly to the Director.

8. Three of the seven resident files reviewed did not indicate clearly whether or not the residents and custodians received a copy of the resident handbook, and signatures were missing and not dated on the forms regarding receipt of the resident handbook. OKDHS Licensing Requirements for Residential Care Facilities, OCA 340:110-3-154, Social services, (e), Resident's records, (1), (J), states, " The record includes signed documentation that the resident and parents or custodian have been provided written copies of the facility's policies on resident's writes, grievance procedures, behavior management policies, trips away from the facility, use of volunteers, and frequency of reports to the parent or custodian."

CWS-IV reviewed this policy at the monthly meeting with the CWS to insure that all signatures and dates of receipt are secured on the receipt for handbook. The receipt was also re-written to acknowledge all of the above stated information is contained in the handbook.

9. Six of the seven resident files reviewed did not document immunizations for the residents. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154.3, 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."

The LDS Nurse Practitioner or her designee will print all available immunization records and place in client files. If immunizations are not available on computer, a letter requesting the immunizations or other documented efforts to obtain them will be placed in the resident records.

AREAS OF CONCERN

1. Documentation was incomplete and inadequate in the seven resident files reviewed. Forms in the resident files reviewed did not contain all

required information. The information in the progress notes was insufficient.

Please refer to responses in Violations 1, 4, 7, 8 and 9 as they all address this concern.

2. The facility activity schedule was incomplete for the month of December 2009.

The recreational schedule is a "living" document that is adjusted due to changes that arise. Activities are adjusted due to weather, event cancelations, etc. December is busy with numerous changes due to the various community groups providing activities and some with short notice. However, staff will accurately document activities that have been scheduled and reflect changes within 48 hours.

3. The facility grievance log was incomplete.

Please refer to responses to Violations 5 and 6 as they both address this concern.

4. The facility policy and procedures manual was not current.

The policy and procedures manual will be current by 8-10-2010.

5. Documentation in one resident file reviewed indicated that a resident complained of not feeling well and that staff had observed the resident as acting sad. Documentation did not indicate that the resident was assessed for mental health or medical care.

Staff have been trained to refer the resident to the nurse or to their supervisor when the resident expresses health concerns. They are also trained to report concerns to the CWS on duty when observing concerning emotions. Please refer to Violation 1 which addresses documentation of behaviors and responses to these behaviors. Weekly review of treatment plans also addresses these issues and will contain medical and psychological referrals and/or appointments made to address these issues.

6. The resident files reviewed did not always contain copies of the incident reports or restriction reports to correlate with the incidents and restriction of privileges documented in daily progress notes.

Documentation of violations and consequences is in the Journey Log and on the "white" boards in each resident house. We have now trained all DCS staff to add the consequence to the incident report.

7. Documentation regarding two residents' behaviors indicated that the residents had gone AWOL on several occasions and that their behaviors at the facility had escalated to "threat" and "assaults".

When behavior escalates children are always gate kept for a higher level of care but not always approved for a higher level. All assaults are reported to the Tulsa Police Department.

8. Documentation indicated that a resident who had displayed inappropriate behaviors was not engaged in the program and was not attending school; according to documentation, the resident had been allowed to sleep during waking hours.

We inform residents that sleeping is not allowed during the day. If problem continues we consult with our contract Psychologist or member of his team for suggestions and assistance. Documentation of our efforts was addressed in Violation number 1.

9. Documentation indicated that a bag of marijuana was found on the floor of the facility. When a resident was searched during this incident, staff found a lighter. The incident report documenting the incident did not indicate that a consequence was given to the resident for having contraband.

Please refer to response to concern number 6 which addressed this issue.

10. All three personnel files reviewed contained documentation of staff development training for 2009; however, the clock hours were not indicated for each training, and therefore, it was not easily discernable the number of training hours the employee had completed for the year.

We have changed the way that we document training hours for employees so that the time is accurately reflected. This has corrected the issue.

Your assistance and recommendations are appreciated.

Sincerely,

Marshall Tyner, ICPA-III

c: Howard Hendrick
Marq Youngblood
Deborah Smith
Kelly Johnson
Sara Vincent-Spain