

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

Name of Location of Facility: Norman Adolescent Center
Norman, Oklahoma

Dates of Visit: March 28, 2007, April 5, 11, 13 and 18, 2007

Oversight Reviewers: Jenifer K. Cooks, Oversight Specialist, Lisa Smith, Assistant Director, and Dana Holden, Oversight Specialist

Focus of Visit: Unannounced Routine Visit and one complaint received by the Office of Juvenile System Oversight between March and April 2007

Date: August 1, 2007

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit on March 28, 2007, at the Norman Adolescent Center (NAC). Subsequent visits took place on April 5, 11, and 18. On April 13, 2007, the OJSO reviewed personnel files in the Department of Mental Health and Substance Abuse Services (DMHSAS) Central Personnel Office in Oklahoma City. The purposes of the visits were to assess the facility's compliance with established responsibilities and to investigate complaint allegations the OJSO had received regarding NAC. The complaint allegations will be addressed in a separate report. The facility was licensed by the Division of Child Care of the Department of Human Services (DHS) for twenty-three beds, with eight of the beds reserved for female residents. On the first day of the OJSO visit, the census was sixteen.

Interviews Conducted

- Entry interview regarding oversight with Performance Improvement Coordinator
- One recreational therapist
- Three patient care assistants
- Two chemical dependent counselor trainees
- Six residents
- One brief interview with a counselor

- Exit conference with NAC Director, DMHSAS attorney, Director of Treatment Services and Interim Commissioner of Mental Health and Substance Abuse Services

Documents Reviewed

- Plan for Development dated December 10, 2006, submitted to the OJSO by the Program Director
- Agenda for staff meeting dated November 27, 2006, at 3:00pm
- S.E.L.F./ A Trauma-Informed Psycho-educational Group Curriculum
- Facility Number One Reports from February 23, 2007, through April 5, 2007
- Seven resident charts
- Six personnel files
- Medication Record
- Dorm count book
- Direct Care Schedules for February-March 2007 and April-May 2007
- Spring 2007 Resident Schedule
- P.C.A. Training Manual and Resource Guide
- Resident/Family Informational packet regarding NAC
- Grievances for 2007
- Critical Incident Reports from January 2, 2007, through April 13, 2007
- NAC Client Lists dated March 28, 2007, April 5, 2007 and April 18, 2007
- Written correspondence among clients
- Resident Information Form
- Updated Development Plan, dated May 8, 2007

Findings

Staff Interviews

The OJSO interviewed a total of six staff members. The interviews focused on quality of life, safety, and health of residents. Five staff stated that sexual acting out behavior among residents continued to be an issue at the facility. Staff reported these issues were addressed numerous times in the documentation on the facility Number One Reports. The OJSO reviewed the facility's Number One Reports, which documented continued concerns of staff regarding this behavior among residents.

Staff discussed their understanding of the Sanctuary Model. Four staff members voiced concerns regarding the Sanctuary Model. Some concerns expressed were the lack of understanding by staff, the feeling that staff has to be submissive and the residents never do anything wrong, there are no consequences, and the kids do what they want. All of the staff have not been fully trained in the Sanctuary Model.

The staff could not consistently provide a standard protocol for how medications were dispensed to the residents. All six staff provided various procedures for administering medication.

Only one staff member was able to accurately describe the resident grievance process. Three of the six staff members stated they do not feel as if the grievance procedure is working, as the residents do not always receive feedback regarding their grievance, and the residents do not understand their rights or the grievance process.

The Grievance Coordinator first reported to the OJSO that grievances were logged quarterly. The Grievance Coordinator later stated they were not put in the log until the end of the year. As of March 28, 2007, no grievances had been logged into the grievance log book.

Resident Interviews

The OJSO questioned residents regarding the quality of life, safety, grievance procedures, and health related issues. Two of the six were able to explain the grievance procedure from beginning to end. Three residents had no idea what happened after the grievance was put into the box. Four of the six residents reported the milieu as loud and chaotic. Four of the six residents also reported that the staff sit in the room behind the nurses' desk or in the back room talking, and do not provide appropriate supervision of the residents. The facility Director has emphasized, as documented in the Patient Care Assistant's Training Guide, the need for staff to stay in the day area at all times while on the dorm unit. Two of the six residents also reported that staff were not consistent in applying the rules and were critical of the residents for rule violations.

Documents Reviewed

In the NAC Plan for Development dated December 10, 2006, it was documented that "A training schedule will be created to cover the following areas. All staff will be required to attend. OCCY will be notified of the schedule so one of their representatives might attend". The following areas were to be addressed as stated in the Plan for Development dated December 31, 2006 provided by NAC:

- All staff will attend a protocol review of the urinalysis (UA) process by December 31, 2006
- All staff will attend a protocol review of the client census report by December 31, 2006
- NAC implemented the procedure for reporting critical incidents to DHS in an all staff meeting Monday, November 27, 2006
- A review of the medication process will take place by Friday, December 8, 2006 to ensure the medication protocol is being followed
- An effort will be made to increase the structure in the evenings without compromising the clients' ability to relax and enjoy personal time
- A review of the protocol for contraband will be conducted with staff by December 31, 2006

- An intensive review of the Sanctuary Process at NAC began Wednesday, December 6, 2006

During the oversight visit in April 2007, OJSO followed up with NAC to verify the plan provided in December 2006 had been implemented and changes had occurred. As of April, NAC had not provided the OJSO with a training schedule. It is impossible to verify what training has actually occurred and who attended, as there is no documentation to verify attendance.

The next updated plan of correction received from the Director of NAC was dated May 8, 2007. The plan stated two trainings were held in January and February 2007, for Direct Services Staff to address the UA Screening Process, NAC Schedule, Clients leaving ACA, and Contraband. The Director documented in the plan that future meetings would be recorded in a log, with sign-in sheets provided. The plan of correction listed some trainings have occurred. The trainings listed included Cultural Diversity, Bullying, Communicating with Troubled Children, Adolescents and Adults by Understanding Their Developmental Stages, Innovative Information for Stress Management, and Play Therapy and Behavioral Problems with Children and Adolescents. Staff from the Office of Client Advocacy (OCA) provided training on April 30, 2007, on referral protocol. All Direct Services Staff were required to be in attendance for the OCA training. The information regarding trainings did not verify what staff attended.

Resident Charts

The OJSO reviewed seven resident charts. The following treatment plans did not have required signatures: initial treatment plan dated 2-15-07 did not contain a doctor's signature or a DHS signature; treatment plan review dated 3-15-07 was not signed by the doctor, case manager, or DHS personnel; a treatment plan review dated 3-29-07 did not contain a parent signature; treatment plan review dated 2-22-07 did not contain a parent, doctor, case manager, school representative, triage specialist, SCDC, or recreation therapist signature; an initial treatment plan dated 2-8-07 did not contain a doctor, case manager, school representative, parent, recreation therapist, SCDC, or triage specialist signature; an initial treatment plan dated 12-19-06 did not contain a parent's signature; initial treatment plan dated 3-14-07 lacked a signature from the case manager and the triage specialist; a review dated 3-28-07 did not have a signature from the parent or the school representative and a review dated 3-27-07 lacked a parent's signature.

A review of client charts, the discharge log, and available incident reports was completed. The facility was not completing critical incident reports on all qualifying events. There were a total of thirteen critical incident reports written between the dates of January 2, 2007, and April 13, 2007. Of the thirteen, one documented two clients leaving against counselor's advice (ACA), however, documentation during that time period showed a total of fourteen clients left ACA. There were no incident reports for any of the fourteen residents who left ACA.

Personnel Files

The OJSO reviewed six personnel files. One file contained a Performance Management Process (PMP) evaluation with a close-out date of October 31, 2006. The PMP was signed by the employee and supervisor on October 26, 2006. On October 31, 2006, this same PMP was signed by the reviewer with the attached note "This PMP was signed by staff and supervisor before I received it. I made corrections and will have both parties acknowledge the adjustments". The reviewer reduced the employee's performance ratings. There was no documentation that the employee and supervisor were notified of the changes. None of the six PMP evaluations had designations listed regarding the importance of job accountabilities, such as critical or important. Three of the six files reviewed did not contain any references. The OJSO requested these while on site viewing personnel files, however, they were not available. At a later date, the facility was contacted and the references were provided for the three files. The references provided were not complete, in that they were missing dates of contact, and questions asked of the references. All six of the staff files lacked complete information on references.

Two files did not document current First Aid certification. A copy of the facility's email (sent to the two employees needing First Aid) was provided to OJSO. A First Aid class was scheduled for 4/26/07. OJSO had requested NAC to provide copies of the First Aid cards after training had been completed for the two employees. Copies of the certification cards have not been received to date. Six files reviewed did not have verification of Tuberculin tests being performed. The OJSO was told that the health nurse at Griffin Hospital maintained the information regarding TB test and results. NAC did provide verification on two of the six files.

Grievance Forms

As of March 28, 2007, a total of three grievance forms had been completed for the 2007 calendar year. Two of the three forms did not have a client signature to indicate the grievance coordinator had discussed issues with them. In addition, the date of the meeting held between the Risk Manager and Resident was left blank. One of the two grievance forms did not have a year, only the day and month. The "grievance received by" line was blank.

Dorm Count Book

The OJSO reviewed the Dorm Count Book, which was kept at the residents' dormitory. The items listed in this book were items that could be hazardous to the safety of the community such as tools, hazardous materials, and sharp items. Other items listed in this book were the shift cell phones, both sets of van keys, and any medical bags associated with transporting youth. According to the Patient Care Assistant (PCA) Training Manual and Resource Guide, at the beginning of each shift, these items need to be counted to ensure they are all accounted for. The PCA will then document in the Dorm Count Book the number

of items that were counted as well as the number that was missing. These items are not being counted at each shift according to the lack of documentation.

Areas of Concern

Custody Youth

The OJSO was concerned that NAC did not have a current service agreement with the Department of Human Services or the Office of Juvenile Affairs and was accepting custody youth for treatment. A service agreement would provide for specific expectations of services to be provided to custody youth. In addition, the OJSO had concerns that if a court-ordered youth left the facility against counselor's advice (ACA) this would not be reported to the Office of Client Advocacy (OCA) for investigation of possible staff neglect.

Violations

1. Sexually inappropriate behavior continued to be an issue among the residents. Residents continued to go into each other's rooms while not being monitored. According to Department of Mental Health and Substance Abuse Services (DMHSAS) Title 450, Chapter 15, Consumer Rights, Part 11. RESIDENT RIGHTS, MENTAL HEALTH RESIDENTIAL CARE FACILITIES 450:15-3-81. Resident rights, (a)(3) Each resident has the right to a humane psychological environment protecting them from harm, abuse, and neglect (9) No resident shall ever be neglected or sexually, physically, verbally, or otherwise abused. 450:15-3-8. Right to freedom from mistreatment, abuse and neglect (a) Staff shall not mistreat, physically, sexually, verbally or otherwise abuse any consumer. Visitors or other consumers shall not be permitted to physically, sexually, verbally or otherwise abuse any consumer. Staff shall not neglect any consumer.
2. Clients were not able to explain the grievance procedures. The grievance forms were not complete and did not verify a fair and timely procedure. DMHSAS Policy, Title 450, Chapter 15, Consumer Rights, 450:15-3-23.1, Right to assert grievances, (a) A consumer shall have a right to assert grievances with respect to an alleged infringement of his or her rights and shall have the right to have such grievances considered through a fair, timely and impartial grievance procedure. The Patient Care Assistant (P.C.A.) Training Manual and Resource Guide, page 20, 'What is the Client Grievance Procedure?' provides detailed steps in this procedure.
3. Treatment plans did not include signatures by the appropriate individuals. DMHSAS Policy, Title 450, Chapter 18, Standards and Criteria for Alcohol and Drug Treatment Programs, Subchapter 7. Facility Record System, Part 9. Treatment Planning 450:18-7-81 includes required signatures.

4. Incident reports are not being written for qualifying incidents. Between January 2, 2007 and April 13, 2007, thirteen residents left the facility ACA and incident reports were not completed. According to ODMHSAS Policy 6.3 "AWOL" is used when a consumer court ordered to residential treatment (e.g., drug court or court ordered substance abuse treatment) or admitted to an inpatient facility (regardless of admission status) leaves the facility property without authorization. Procedures: 1. Reporting a Critical Incident (a) When a critical incident occurs at a DMHSAS facility or the Central Office of DMHSAS, the incident shall be documented and reported in accordance with the procedures outlined in this policy. In part, (b) Using the DHHSAS Critical Incident Report Form 6.3(A).
5. An employee's PMP was changed by the reviewer after the employee and supervisor signed it. No verification was provided indicating the employee and/or supervisor had been made aware of the changes or given the opportunity to respond. Office of Personnel Management (OPM) policy in part states, 530:10-17-31. Employee performance management system (b) The employee performance management system shall provide for the following: (1) An objective evaluation by the immediate supervisor of the performance of the employee within the assigned duties of the job. The evaluation shall contain the agency number, date of review, and employee identification number; (4) Identification of performance strengths and performance areas for development; (5) A final interview with the employee by the immediate supervisor who shall provide the employee with a copy of the performance evaluation; and (6) The opportunity for the employee to submit written comments regarding the performance evaluation [74:840-4.17]. According to the State of Oklahoma Office of Personnel Management, Performance Management Process Handbook, March 1999, Phase III: Planning, page 51, During the Year-End Review/ Reviewer - Before meeting with the employee, the supervisor should discuss the ratings with the reviewer, so that there is agreement between them. After the supervisor and employee meet, the reviewer signs the Record of Meetings/Discussions section of the PMP form. The supervisor and reviewer share the responsibility of making sure the proper officials store the original and get copies of the PMP form.
6. The new PMP evaluations did not have designations listed regarding the Importance of Accountabilities, such as: critical or important. The OPM policy in part states, 530:10-17-31 (b) The employee performance management system shall provide for the following: (2) The identification by the immediate supervisor of accountabilities and behaviors upon which the employee will be evaluated.
7. References did not contain the required documentation. According to DHS Licensing Requirements, Section 340:110-3-153.1. Personnel (g) Employment Requirements. (1) References. The facility obtains a minimum of three references for all staff prior to employment. (A) References include

the date, interview questions, responses, and the interviewer's signature. (B) Copies of references are maintained in the employee's personnel record.

8. Two staff files did not contain First Aid certification. According to DHS Licensing Requirements, Section 340:110-3-153.1 Personnel (m) Staff training. (3) Training for child care staff. (E) 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 maintain current training in CPR and first aid thereafter.
9. Six staff files did not have verification of Tuberculin (TB) test being performed. After requesting this information, the OJSO was able to verify TB tests on two employees out of six. According to DHS Licensing Requirements, Section 340:110-3-153.1 (g) Employment requirements. (2) Tuberculin test. Upon employment, each employee has a documented mantoux (PPD) tuberculin skin test with a booster, if needed, within the previous 12 months, unless the employee shows medical verification of a previous positive skin test. (A) Only tests read by a physician or nurse are accepted.

JKC:lb

NORMAN ADOLESCENT CENTER

Date: August 28, 2007

RE: Response to Oklahoma Commission on Children and Youth oversight report dated August 1, 2007

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OCCY

Response to Findings:

1. **Sexually inappropriate behavior continued to be an issue among the residents.**

Staff is required to monitor clients on every shift. If staff neglects to monitor clients then disciplinary action is taken. Documentation exists that alleged sexual misconduct has occurred. If such an incidence of sexual misconduct is confirmed, the clients receive appropriate interventions.

2. **Clients were not able to explain the grievance procedures.**

NAC is required to provide ongoing orientation for all staff and clients regarding a client's right to file a grievance. The staff member assigned to this duty was released in June 2007. A grievance officer has been appointed to take on this job duty responsibly.

3. **Treatment plans did not include signatures by the appropriate individuals.**

According to ODMHSAS Administrative Rules, Title 450, chapter 18, required signatures include those professionals providing services as listed on the treatment plan. No other signatures are required, regardless of the format of the treatment plan. The AVATAR electronic record system will change the format of the treatment plans again and will have areas not required to be filled out completely by this level of care.

4. **Incident reports are not being written for qualifying incidents.**

NAC is required to fill out incident reports for qualifying events. The report specifically refers to clients leaving Against Counselor's Advice (ACA).

NAC is a III.5 clinically managed voluntary level of care and does not have court ordered or civilly committed individuals. The consumer may have a court order to attend treatment; however, they are not ordered to stay in our facility specifically. Incident reports are filled out for all clients leaving Against Counselors Advice (ACA). The term AWOL is not applicable.