

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

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**Name and Location of Facility:** Children's Recovery Center of Oklahoma  
Norman, Oklahoma

**Dates of Visit:** June 18 and 19, 2009

**Oversight Reviewers:** Ellen Harwell and Sara Vincent Spain,  
Oversight Specialists

**Focus of Visit:** First Biannual Visit, 2009

**Date:** August 25, 2009

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) began an announced visit on June 18, 2009, at the Children's Recovery Center of Oklahoma (CRCO), located in Norman. The purpose of the visit was to assess compliance with established responsibilities. The Children's Recovery Center was licensed as a Residential Child Care Facility by the division of Oklahoma Child Care Services (OCCS) of the Oklahoma Department of Human Services (OKDHS) to provide services for fifty-five residents. The facility was operated by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), and was contracted with the OKDHS for acute and residential care. The facility was in the process of establishing contracts with the Office of Juvenile Affairs (OJA) for acute and residential care.

### **Interviews Conducted**

- Four employees
- Six residents
- Exit conference with facility administrative staff members

### **Documents Reviewed**

- Census for facility
- OKDHS OCCS license dated November 1, 2008, for a maximum of fifty-five residents
- OKDHS OCCS Residential Child Care Facility Inspection report dated March 31, 2009
- Grievances from January 2009 through May 2009
- One OKDHS Office of Client Advocacy (OCA) investigation from February 2009
- Contract between the facility and the OKDHS for acute and residential care
- Six resident files
- Three personnel files

## **Findings**

### Resident Interviews

The OJSO interviewed six residents. The interview questions pertained to the residents' perceptions regarding safety, program services, resident rights, discipline practices, and other residential program issues. Residents reported receiving appropriate care but did express concerns over food and recreational activities. Residents were concerned with the quality of food and types of food served. Five of the six residents responded to the question asking them to rate the food on a scale of one to five, where one = terrible and five = great. Two residents rated the food "three", one rated the food "two", one rated the food "one", and one rated the food "zero".

Residents also expressed concern with the lack of appropriate exercise opportunities. Three of the five residents that responded to the question regarding recreation reported running stairs as their recreational activity. One resident each reported that basketball, kickball, and football were also activities they engaged in, but these activities were weather permitting. The facility did not have indoor space for these activities. Residents reported that recreational activities were often cancelled with little to no notice. Some residents reported staff members used curse words although not necessarily directed toward residents.

### Staff Interviews

Four staff members were interviewed. The interview questions pertained to the staff members' perceptions regarding resident rights, discipline policies, and other residential program issues. One staff member interviewed also expressed concerns regarding facility environmental changes; one staff member reported rate of pay was low. Staff members also expressed concerns over recreational activities. All staff members reported to the OJSO that residents engaged in outdoor activities. Indoors, residents played board games or worked on arts and crafts. Staff members reported that more activities were needed for the residents. The opinion of staff members was that staffing issues contributed to this problem. One staff member reported the facility was understaffed, and one staff member reported that Recreational Therapists did not always show up to conduct recreational therapy.

### Personnel File Review

Three personnel files were reviewed. Three of the files reviewed contained references obtained after the employee's hire date, and one file contained three references that were not dated. One file did not contain documentation of a mantoux (PPD) tuberculin skin test.

### Resident File Review

Six resident files were reviewed which included one tribal custody resident file, four OKDHS custody resident files, and one OJA custody resident file. The OJSO noted the following in three of the six files reviewed:

#### File One - Tribal Custody Resident File

- Treatment plan reviews dated May 15, 20, 27, 2009, and June 3 and 10, 2009, were not signed by a parent or guardian.
- Treatment plan reviews dated May 27, 2009, and June 3 and 10, 2009, were not signed by the resident.
- A consent form for Prozac documented that verbal consent had been obtained from the resident's tribal worker, but the consent form did not have the signature of a witness to the verbal consent.

#### File Two - OKDHS Custody Resident File

- The initial treatment plan was not signed by the parent/guardian, the resident, or a licensed mental health practitioner.
- Treatment plan reviews dated May 15 and 20, 2009, and June 2, 2009, were not signed by a parent or guardian. The treatment plan review dated June 2, 2009, was reviewed by phone on the same date at 3:15 p.m. as documented on the review.
- Treatment plan reviews dated May 15, 20, and 26, 2009, were not signed by the resident.
- A consent form for Concerta documented that verbal consent had been obtained from the resident's child welfare worker, but the consent form did not have the signature of a witness to the verbal consent.
- An eye screening form documented on May 15, 2009, that a referral was needed for a more comprehensive eye examination. The form had space for the documentation of when and where the referral was made. The information had not been completed.

#### File Three – OKDHS Custody Resident File

- Upon admission, the resident signed the form outlining the grievance policy; however, the parent/guardian did not sign the form.
- The resident signed the family and child rights form; however, the parent/guardian did not sign the form.
- Physician orders contained the abbreviation "nte" to mean "not to exceed" although "nte" was not an approved abbreviation per the facility.
- A review of the physician's orders documented several instances in which medications were ordered for "severe agitation".
- Orders for medications were routinely written for medication to be given PO (by mouth) or IM (intramuscular, given by needle into the muscle) if the patient refused PO medication.
- On April 3, 2009, the physician ordered 50 mg of Vistaril to be given PO (by mouth) or "IM if refuses". The corresponding progress note states, "Pt would not stay in his room or be quiet enough for peers to sleep. R.N. called doctor. Pt given medication."
- On March 31, 2009, the physician ordered 50 mg of Vistaril to be given PO (by mouth) for "aggression, IM if refusing". The corresponding progress note states, "Pt was given many chances to cooperate [with] staff. Pt refused. Pt was sent to bed early. R.N. gave pt medication."

- On April 26, 2009, the progress note states:

Pt is given a x out & directed to sit quietly & find a toy to play [with]. Pt plays [with] a toy car on his bed until nurse returns [with] 50 mg Vistaril PO as ordered by the doctor.

### Grievances

Grievances from January 2009 through May 2009 were reviewed by the OJSO. The following was noted:

- A grievance filed on May 20, 2009, alleged that another resident had lifted his clothing causing the resident to feel uncomfortable. The resident alleged that staff members did not help him. There was no documentation this incident was reported to the OCA.
- A grievance filed on May 1, 2009, alleged that two staff members threw the resident on the floor on his hip and that he was still experiencing trouble using his leg as a result of the incident. There was no documentation this incident was reported to the OCA.
- A grievance filed on January 1, 2009, was filed by the mother of a resident and alleged that two peers had been assaulting the resident. The parent was concerned for the safety of the resident. Section two of the grievance form documented that the three residents met with a staff member. The staff member documented, "The mother is not satisfied with the outcome either & requests patient advocate involvement." The documentation indicated that the mother was allowed to meet with two peers of the resident.

### OCA Investigation

The OJSO reviewed one investigation completed by the OCA. In a response letter to the OCA, the director of the facility addressed an area of concern in the report regarding a delay in reporting the alleged incident to the OCA. The director cited a weekend and that "it may take a few days to ascertain when the alleged incident actually occurred, which staff members were involved directly in the alleged incident and who were witnesses, etc." The OJSO provided the OCA reporting requirements to the director at the time of the exit conference including the time frame requirement for reporting.

### **Areas of Concern**

1. Both staff members and residents expressed concern regarding the lack of consistent recreational activities. The facility layout did not allow for large motor activity when weather did not permit for outdoor activity.
2. Residents expressed concerns regarding food quality and food choices. Menus were not under the control of the facility and were provided by another facility. Residents were concerned about weight gain due to unhealthy meals provided by the facility.
3. Verbal consents for medications were obtained without documenting the presence of a witness to the consent.

4. Facility documentation indicated that a parent had been permitted to meet with peers of a resident. The OJSO found no documentation the peers' parents/guardians had given consent for them to meet with the parent.

## Violations

1. Three personnel files contained references obtained after the employees' date of hire. The facility had been cited for this issue on March 31, 2009, by the OKDHS OCCS program field representative. All personnel files reviewed by the OJSO were for employees hired after March 31, 2009. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-153.1, Personnel, (g), Employee requirements, (1), References, states, "The facility obtains a minimum of three references for all staff prior to employment."
2. Two personnel files did not contain documentation of a mantoux (PPD) skin test upon employment. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-153.1, Personnel, (g), Employee requirements, (2), Tuberculin test, states, "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."
3. The medical exam of a resident indicated the resident required vision correction. An eye appointment and/or referral was not documented. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154.3, Health and medical services, (c), Medical care, in part, states, "Each resident receives proper medical and dental care."
4. Two resident files contained treatment plan reviews that were not signed by the parent/guardian and/or the resident. Oklahoma Health Care Authority requirements, OAC 317:30-5-95.33, Individual plan of care for children, (b), (9), in part, states:

each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, [licensed behavioral health professional], [patient], parent/guardian (for patients under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. . . .

5. Treatment plan reviews were reviewed via phone without obtaining signatures. Oklahoma Health Care Authority requirements, OAC 317:30-5-95.33, Individual plan of care for children, (b), (9), in part, states, "The Provider must obtain the original signature for the clinical file within 30 days. . . ."
6. In one resident file, the Family and Guardian Rights/Child and Adolescent Rights form and the grievance notice was not signed by the parent/guardian. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154, Social services, (a), Admission, (7), states, "The facility documents, by the resident's and parents' or custodian's signatures, that the resident and parents or custodian have been provided written copies of the facility's policies, which includes, but is not limited to, resident's rights, grievance procedures, behavior management policies,

trips away from the facility, use of volunteers, and frequency of reports to the parents or custodian.”

7. Documentation of physical restraints, physician orders, and progress notes failed to document the emergency need for medications. PO (by mouth) medications were ordered for “agitation.” Attachment “A” to the OKDHS contract for Acute Psychiatric Care Involving Children and Youth in the Legal Custody of OKDHS, Part III Restraint, (C), (1), in part, states, “Restraints (physical, mechanical or drug) may only be utilized in emergency situations, when a patient is violently and acutely out of control, and poses a serious and immediate physical danger to self or others, provided that: . . . All less restrictive methods of control have been attempted and failed . . . .”
8. Documentation showed IM (intramuscular, given by needle into the muscle) medications were ordered and given without documentation of the serious need, without documentation that the patient’s right to refuse medication had been considered, and in the absence of documentation that the administration of the medication met criteria outlined in the OKDHS contractual agreement. Attachment “A” to the OKDHS contract for Acute Psychiatric Care Involving Children and Youth in the Legal Custody of OKDHS, Part II Patient Rights, (J), states:

The patient has the right to refuse medications and such medications cannot be administered to the patient unless a court order is obtained authorizing its forcible administration; except that in situations that pose a serious threat to life or health of the patient, necessary medication prescribed by a physician may be forcibly administered by staff trained in the administration of medication who are familiar with the patient’s condition.

9. Allegations made by residents were not promptly reported to the OCA. Title 10A, Oklahoma Statutes, §1-2-101(B), Duty to Report Abuse or Neglect of Child Under Eighteen – Statewide Centralized Hotline – Failure to Report – False Reports, states, “Every 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.”<sup>1</sup> Further, the Office of Client Advocacy, OAC 340:2-3-33, Procedure for reporting suspected abuse, neglect, verbal abuse, caretaker misconduct, and exploitation, (a), Reporting requirements and reportable incidents, (3), in part, 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.

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<sup>1</sup> The citation for the statute in effect on the dates of this oversight visit, June 18 and 19, 2009, was 10A Okla. Stat. §1-2-101(A). The substance of former §1-2-101(A) is the same as the substance of current §1-2-101(B).