

## MEMORANDUM

**To:** James Morrison, Executive Director  
Oaks Indian Center

**From:** Cliff A. Aldridge, Oversight Specialist  
Office of Juvenile System Oversight

**Reviewer:** Cliff Aldridge

**Subject:** Unannounced Oversight Visit and Complaint Investigation, 2005

**Date:** June 6, 2005

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### General Information

The Office of Juvenile System Oversight (OJSO) conducted an unannounced oversight visit to the Oaks Indian Center on February 10, 2005. The purposes of the visit were to conduct a routine monitoring visit and to investigate the allegations of a complaint regarding the facility. The census was thirty-one on the day of the OJSO visit.

### Persons Interviewed

- An entry interview with the Executive Director
- Four residents
- Three direct care staff members
- An exit conference with the Executive Director and the Assistant Director

### Documentation Reviewed

- The case records on two of the residents
- The personnel files of one houseparent couple
- Department of Human Services (DHS) Division of Child Care's inspection report dated October 27, 2004
- Office of the Oklahoma State Fire Marshal's inspection report dated June 21, 2004
- Oklahoma State Department of Health's inspection report dated March 11, 2004

- DHS residential child care facility license
- Facility's discipline policy
- Facility's staff and resident cottage assignment roster
- Facility's caretaker conduct review report to the DHS Office of Client Advocacy (OCA)

### Areas Toured

- Four residential cottages in use at the time of the OJSO visit

### **Overview**

### Interviews

One resident from each of the four cottages was selected to be interviewed. The residents gave positive responses to the interview questions about the facility, the staff, the food, participation in recreation, and other quality-of-life issues. All four of the residents were vague in their descriptions about the resident grievance procedure; however, each of them named the Executive Director or the Assistant Director as people they would go to if they had a problem.

The three staff members interviewed reported providing responsible supervision and the use of only appropriate disciplinary practices for rule violations. No issues of concern were identified from the staff interviews. One staff member was able to describe the resident grievance procedure. Another staff member could not remember the procedure but knew that grievances were to be written and signed. The remaining staff member said that the resident grievance procedure was in the staff manual and knew that the Assistant Director was the grievance coordinator and that appeals could be made to the Executive Director, but admitted to never having seen a grievance form.

### Documentation Reviews

One of the resident case records documented grievance procedure notification to the resident, but not to the custodian. The file documented provision of required facility policies in writing to the parent, but not to the resident. The file was complete for the other items reviewed. In the other file reviewed, the resident's immunization record was not found. The file did not document a grievance notification to the resident or the custodian. The second file documented an initial service plan within thirty days of the

child's admission to the program; however, the service plan did not document participation of the resident or the custodian in the development of the plan as required.

The personnel file of a houseparent couple hired in August 2004 was reviewed for compliance with DHS licensing standards. The couple had only two of the three required references documented in the file. One member of the couple had received orientation training; however, the orientation training was not dated to establish that it had occurred within the thirty days required by the standards. The other houseparent did not have documentation of orientation training. One member of the couple did not have documentation of required first aid and cardiopulmonary resuscitation training.

The DHS Division of Child Care's inspection report dated October 27, 2004, cited several facility maintenance issues. A letter of correction of the deficiencies was dated December 15, 2004. The Office of the Oklahoma State Fire Marshal's inspection report dated June 21, 2004, cited three minor items on one cottage, but found no other deficiencies in the other residential cottages. The Oklahoma State Department of Health's inspection report dated March 11, 2004, cited a dirty floor behind the freezer and cooler in the dining hall.

#### Facility Tour

No physical plant issues were observed on Cherokee or Vammen Cottages. There was an uncovered juice container in the refrigerator on Chickasaw Cottage. On Creek Cottage, there were burned food spills in the oven, broken floor tiles in the hall, a missing light cover from the east bathroom shower, and a cracked light cover in the west bathroom. The front entrance to Creek Cottage was cluttered with bikes, scooters, debris, and benches that needed repair.

#### Complaint Investigation

The OJSO received a complaint that a houseparent and the houseparent's child were using corporal punishment with some of the residents for their misbehavior. Corporal punishment is forbidden in residential facilities licensed by the DHS. Three allegations of use of corporal punishment were referred to the DHS OCA. The OCA had assigned the referrals to the Oaks Indian Center administration for caretaker conduct reviews.

The OJSO reviewer discussed the details of his caretaker conduct reviews with the Executive Director during the oversight visit and reviewed the facility's discipline policy. The policy clearly prohibited the use of corporal punishment. The administrator informed the OJSO reviewer that he had taken immediate action to suspend the staff member, pending the findings of his review. The administrator also told of attempts to locate former residents involved in the incidents and had interviewed two of the current

residents. The OJSO reviewer deemed the conduct of the investigation was proceeding properly and declined to replicate the complaint investigation.

Subsequently, the Oaks Indian Center has reported the outcome of the caretaker conduct reviews to the OCA. The houseparent was fired. The facility Executive Director appeared to have responded appropriately during the investigation and with the actions taken as a result of his finding. The OJSO complaint will be closed with the issuance of this report.

## **Conclusion**

The OJSO reviewer had concerns that the residents and staff members interviewed were not able to clearly identify the facility's resident grievance procedures. Overall, the administration and direct care staff demonstrated care for the well-being of the residents.

## **Findings**

1. Case record documentation did not document that all of the residents and their custodians were informed of the facility's resident grievance procedures, and the residents had difficulty in describing the grievance process. Not all of the staff members appeared to be familiar with the facility's resident grievance procedures. [DHS policies OAC 340:110-3-146; OAC 340:110-3-153.1, (l), (1), and (2), (A) and (B); OAC 340:110-3-154, (a), (7); and OAC 340:110-3-154.1, (a), (3), (J).]
2. One of the files did not document the resident's or the custodian's participation in the development of the initial individual service plan or the reason for nonparticipation by the custodian within thirty days of admission. [DHS policy OAC 340:110-3-154, (b).]
3. One file for a houseparent couple documented only two of the three required references upon employment. [DHS policy OAC 340:110-3-153.1, (g), (1), (A) and (B).]
4. Orientation training was not documented for one employee, and the orientation of the other employee was not dated to establish compliance with mandatory time frames. [DHS policies OAC 340:110-3-152, (e), (4), and OAC 340:110-3-153.1, (l) (1)-(4), and (n).]
5. One direct care staff member did not have documentation of required training in first aid and cardiopulmonary resuscitation. [DHS policy OAC 340:110-3-153.1, (m), (3), (E), (i)-(iii).]
6. One cottage was observed to have several minor maintenance issues and the front entrance was cluttered with bikes, scooters, debris, and benches that needed repair. [DHS policy OAC 340:110-3-157, (j)].

CAA:js