

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

Name and Location of Facility: Pauline E. Mayer Shelter
Oklahoma City, Oklahoma

Date of Visit: June 5, 2007 and June 6, 2007

Oversight Reviewer: April Simmons and Tina Pendergraft,
Oversight Specialists

Focus of Visit: Unannounced Routine Visit

Date: July 3, 2007

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on June 5 and 6, 2007, at the Pauline E. Mayer Shelter (PEMS) and the overflow building located at the PEM annex, located in Oklahoma City, Oklahoma. The annex building was used as additional space for the placement of residents admitted to the shelter. The purpose of the visit was to assess compliance with established responsibilities. The facility was certified by the DHS Division of Child Care for forty-two residents at the shelter and sixteen residents at the annex. On the day of the OJSO visit, the census was forty-five at the shelter and sixteen at the annex.

Interviews Conducted

- Entry interview and exit conference with the Director
- Thirteen residents
- Four staff members

Documents Reviewed

- Personnel files and training records for ten staff members
- Nine resident files
- Office of the State Fire Marshal Inspection form, dated July 7, 2006
- Oklahoma State Department of Health inspection report, dated April 26, 2007
- DHS Division of Child Care Facility inspection form, dated May 7, 2007
- DHS Office of Client Advocacy's quarterly report of incidents
- Tornado and fire drill log for 2007
- Resident Menu for June 2007
- Recreation schedule for June 2007

Findings

Persons Interviewed

The OJSO interviewed thirteen residents. The interview questions pertained to the residents' perceptions of safety, shelter program services, the rights of residents, discipline practices, and other residential issues. The OJSO noted:

- Six of the residents stated that the grievance process was not explained to them.
- Two residents reported one of the residents was grabbed by a staff member on the top of the arms and inappropriately handled on the evening of June 5, 2007. They also reported the resident had a red mark on the face the next day on June 6, 2007. The OJSO attempted to interview the resident regarding the incident, but was unsuccessful due to the developmental functioning of the resident. The OJSO did observe a red mark on the resident's face as indicated by the two residents interviewed.

The OJSO interviewed two staff members at the shelter and two staff members at the annex. There were only two available to interview at the shelter on the day of the visit, due to an resident outing. The interview questions pertained to the staff members' perceptions of shelter program services, the rights of residents, discipline policies, and other residential issues. No concerns were noted from the staff interviews.

Files Reviewed

The OJSO reviewed nine resident files for compliance with DHS licensing standards. The OJSO noted:

- Two resident files did not contain documentation of the immunization records.
- Two resident files were missing the initial service plan.

The OJSO reviewed the personnel files and training records of ten staff members hired in 2007, for compliance with DHS licensing standards. The OJSO also reviewed OSBI criminal background checks for all employees hired since October of 2006. The staff members prior to October of 2006 had already been reviewed on the last visit. The ten personnel files were in compliance for the items reviewed. In addition, all OSBI checks were in compliance with DHS licensing standards. No issues of concern were identified.

The OJSO reviewed the DHS Division of Child Care Facility inspection form, dated May 7, 2007. The OJSO reviewed records to determine if the deficiencies noted in the DHS inspection were corrected. All the deficiencies related to personnel files were corrected.

The OJSO did not review the grievance log, but all the resident files that were reviewed contained signed grievance forms. The OJSO will review the grievance log on the next oversight visit.

The OJSO reviewed the shift log notes for the alleged incident reported by the two residents. On June 5, 2007, the shift log notes documented an incident that occurred with the resident and staff members as indicated by the two residents interviewed. No other documentation regarding the incident was found.

The OJSO informed the Director about the incident and the mark on the face of the resident. The Director could not locate any incident reports and had not been notified about the mark on the resident's face. The Director informed the OJSO that the injury and incident would be reported to the Office of Client Advocacy (OCA). The OJSO contacted the OCA and confirmed the incident was reported to their office for investigation and was assigned as a Caretaker Conduct Review (CCR).

Violations

1. Two resident files did not contain documentation of the immunization records or documentation that the immunization records were requested. Department of Human Services licensing standards, Section 154, Social Services, (e), Resident's records, (1), (D) states, "The facility maintains a written record for each resident...The record includes medical records;" Section 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."
2. Two resident files were missing the initial service plan that is developed within three days of admission. Department of Human Services licensing standards, Section 167, Requirements for children's shelter, (f) Service Plan, states in part, "A written service plan is developed and documented for each resident within three days of admission."
3. The OJSO reviewed the facility population reports for the days of the oversight visit. The shelter was out of compliance with a total of sixty-residents. There were forty-five at the shelter and sixteen at the annex. Department of Human Services policy OAC 340:75-10-9, Admission and discharges, (b), Shelter capacity and length of stay in OKDHS operated shelters, in part, states, "The specified licensed capacity is 42 children at the Pauline E. Mayer shelter".... The additional sixteen beds at the annex brings the total licensed capacity to fifty-eight.

AS:lb

STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES

RECEIVED
JUL 16 2007
OCCY

TO: April Simmons
Oversight Specialist
Oklahoma Commission on Children & Youth

FROM: Anne Baker,
I/C Programs Administrator

DATE: July 11, 2007

Dear Ms. Simmons,

I received your oversight report for the visit in June 2007. As to the 3 violations, 2 have been corrected. The immunizations documentation for the 2 residents has been corrected and it is in their files. The initial treatment plans have also been addressed.

As to violations 3 having children over our licensed capacity, What is the answer? The obvious solution is to create more Shelter beds but I hope as a system we do not do so. We must have more placements for children. We desperately need more emergency foster homes.

Please advise if you have further concerns.

Sincerely,



Anne Baker
Anne Baker, I/C Programs Administrator

CC: Linda Smith, Director