

MEMORANDUM

Name of Facility: Pauline E. Mayer Shelter

Dates of Visit: April 5, 6, and 12, 2005

Reviewer: Chris Fiesel, Oversight Specialist

Focus of Visit: Unannounced visit
Compliance with licensing standards for residential child care institutions and facility policies

Date: May 27, 2005

Introduction

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit to the Pauline Mayer Shelter in Oklahoma City on April 5, 6, and 12, 2005. The purpose of the oversight visit was to assess compliance with Department of Human Services' (DHS) licensing standards for emergency shelter care and facility policies.

Persons Interviewed

- Programs Manager
- Programs Administrator
- Eight residents
- Four staff

Documents Reviewed

- Department of Human Services (DHS) Division of Child Care's inspection report dated January 12, 2005
- Oklahoma State Department of Health's inspection report dated April 22, 2004
- Office of State Fire Marshal's inspection report dated February 5, 2005
- DHS Office of Client Advocacy's monthly reports of incidents for the period of November 11, 2004, through February 28, 2005
- DHS Office of Client Advocacy's quarterly report of incidents dated March 7, 2005

Areas Toured

- Dormitory rooms
- Kitchen area
- Common areas
- Walkways
- Bathrooms
- Nurse's station
- Play area for the older children
- Area for infants

Overview

The shelter is licensed by the DHS Division of Child Care for a total of forty-two residents. The census on April 5 was sixty-six, with twenty-eight of the children under the age of six. The census on April 6 was sixty, with twenty-six children under the age of six; however, six of the infants were physically housed at the Pauline Mayer Group Home, which accommodates girls under the age of eighteen and their children. The shelter's census on April 12 was forty-four.

Resident Interviews

The OJSO noted the following information from the resident interviews:

- All of the interviewees expressed one specific complaint regarding certain staff members who worked the 3:00 p.m. to 11:00 p.m. shift. Allegedly, direct care workers often aggravated the children, resulting in one or two residents responding with negative behaviors or attitudes. None of the residents interviewed suggested that the residents were violent or disruptive in their responses during this shift but merely questioned the comments and intonation of certain staff. Consequently, reportedly, the entire group was routinely denied telephone privileges, games, and access to the television or stereo for one hour to several hours.
- Three residents interviewed stated that they did not feel safe at the shelter. Two children said they were afraid because of their new environment, and one stated that staff did not intercede when some residents threatened peers. The remaining five interviewees expressed a feeling of security within the facility.
- Five interviewees claimed to have witnessed peers with cigarettes on the facility's playground area. None of the five, however, identified any youths involved in smoking cigarettes or in the possession of cigarettes. Neither were they specific of when the incidents occurred.
- Four interviewees said they had not spoken with a caseworker on a weekly basis, and three stated they had visited with their workers within the past seven days. One child was admitted only the night before the OJSO visit.

Staff Interviews

The OJSO interviewed three direct care staff and a teacher. The OJSO noted the following information from the staff interviews:

- All staff said that their main concerns were to ensure the safety of the children, to ensure the basic needs of the residents were being met, to assist the residents in the development of life skills, and to provide comfort to the residents.
- One direct care worker stated that there was a problem with group punishment.

Shelter Education Review

The OJSO conducted a cursory education review with a shelter teacher. The following information was noted from the review:

- Three instructors worked on-site to provide for the residents' education needs.
- All of the teachers were certified in special education by the Oklahoma State Department of Education and were contracted for through the Oklahoma City public school system.
- Four core subjects were offered: English, science, mathematics, and social studies.
- Each child of school age was assessed using the Wide Range Achievement Test (WRAT). After three days in residence at the shelter, the child was placed in the appropriate classroom.
- Students attended school from 8:00 a.m. to 11:30 a.m. during the week.
- No summer session of school was offered at the shelter.
- Individualized education programs (IEPs) were developed, were implemented, or were reviewed pursuant to the required standards of the Oklahoma State Department of Education and the federal Individuals With Disabilities Education Act.
- Curriculum was implemented with minimal individualization, considering the variance in ages, number of children attending classes (between eight to sixteen students), and the short duration of residents' stay at the shelter.
- Academic progress was monitored on a daily basis, with a minimum of three grades per week documented.
- Grades were submitted to the Oklahoma City public schools' district office in Spencer and available to DHS caseworkers when children were discharged from the shelter.

Review of Personnel Files

Areas of compliance in the five staff files reviewed included, but were not limited to, current tuberculin testing, education backgrounds, criminal history background checks through the Oklahoma State Bureau of Investigation, personal and/or professional reference checks, orientations, special certifications, training records, age requirements, and incident reports. One employee's current evaluation was missing upon the OJSO's

initial review; however, a copy of the evaluation was received by the OJSO verifying a current annual assessment.

The OJSO did not note any other concerns during the personnel files review.

Review of Files on Residents

The files reviewed on eight residents contained service plans, including discharge information; consent forms; grievance information; and other required documentation. The OJSO did not note any concerns with the resident files review.

Facility Inspection

The OJSO noted the following during an observation of the facility:

- A closet door needed adjusting in dorm room No. 18, located downstairs at the south end of the facility.
- A deep fryer in the kitchen had considerable grease buildup behind it, presenting a health concern and possibly a fire hazard.

Summary

The OJSO could not determine the exact number of incidents of group punishment that had occurred at the facility; however, similar accounts by the residents interviewed, as well as a statement by one staff member, indicated that this was a consistent or frequent problem.

The program was in compliance with policies regarding staff ratios during the OJSO's visit on April 5 and 6; however, this was accomplished by several direct care staff working double shifts, one employee from the DHS State Office assisting in the reception area (infants and toddlers area) throughout the day, and one DHS State Office worker helping in the elementary unit during non-school hours.

The OJSO met with the DHS Director, two State Office administrators, and the Pauline Mayer Shelter's Programs Manager and the Programs Administrator on April 5 during the OJSO visit to discuss concerns of overcrowding. As of April 13, 2005, the shelter staff has submitted daily census sheets to the OJSO, which allowed the OJSO to track trends in populations.

Findings

1. All residents interviewed and one staff interviewed indicated the use of group punishment. Department of Human Services licensure standards, Section 154.2, Behavior management, (b), (12), states, "Facility policy prohibits group punishment."

2. The closet door in dorm room No. 18 did not allow easy access by the residents in that room. Department of Human Services licensure standards, Section 157, Physical facility and equipment, (k), (3), states, "Broken, defective, or recalled furnishings and equipment are repaired or replaced."
3. The food preparation area was not clean, especially behind and around the stoves and deep fryers. Department of Human Services licensure standards, Section 164, Food service and sanitation requirements, (14), (E), states, " All areas where food is prepared and served are kept clean, neat, and free from litter and rubbish." Under the same section, (10), (F), states, "Non-food contact surfaces of all equipment . . . are cleaned as often as necessary to keep them free of accumulations of dust, dirt, food particles, and other debris."

CF:js

