

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

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

Dates of Visit: November 18 and November 20, 2009

Oversight Reviewers: Janice Sharp, Oversight Specialist, and Joanne Verity, OJSO Programs Manager

Focus of Visit: Second Biannual Visit, 2009

Date: February 5, 2010

Introduction

The Office of Juvenile System Oversight (OJSO) initiated an unannounced visit at the Pauline E. Mayer Group Home on November 18, 2009, and returned to the facility on November 20, 2009, to conclude the oversight visit. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The group home was licensed and operated by the division of Oklahoma Child Care Services (OCCS) of the Oklahoma Department of Human Services (OKDHS) and had capacity for twelve residents. On the day of the OJSO visit, the census was five adolescent residents and five children.

Interviews Conducted

- Entry interview with the facility social worker
- Two direct care staff members: one staff member from the 7:00 a.m. to 3:30 p.m. shift, and one staff member from the 3:00 p.m. to 11:30 p.m. shift; another direct care staff member declined to be interviewed
- Two adolescent residents
- Exit conference with the group home supervisor

Documents Reviewed

- Three resident files
- Two personnel files and training records
- OKDHS OCCS Residential Child Care Facility monitoring report dated October 28, 2009
- Oklahoma State Department of Health Food Inspection report dated December 11, 2008
- Office of the Oklahoma State Fire Marshal report dated August 18, 2009

- Facility medication administration record (MAR) regarding three residents
- Log for the facility regarding OKDHS Office of Client Advocacy (OCA) investigative reports and facility caretaker conduct review (CCR) reports
- Facility Incident Report and Restriction Log and corresponding incident and restriction reports
- List of residents
- Staff roster
- OJSO report from the oversight visit conducted on June 1, 2009

Findings

Resident Interviews

The OJSO interviewed two adolescent residents. The interview questions pertained to the residents' perceptions of program services, resident rights, discipline policies, and other residential issues. The OJSO noted:

- One interviewee stated that she felt safe at the group home; the other interviewee stated that she felt "somewhat" safe.
- Both interviewees stated that the food tasted good, they received enough to eat, and residents were allowed additional servings of food.
- Each interviewee stated that a restriction from an activity was the worst punishment she had received for breaking a rule at the group home.
- Both interviewees stated that they had not been physically restrained at the group home.
- Neither interviewee knew of any resident who had been assaulted at the group home.
- Neither interviewee knew of any resident who had been injured at the group home.
- When asked what they liked most about the group home, both interviewees stated that the group home placement provided a home setting and allowed the mothers to spend time and build relationships with their children.
- Both interviewees demonstrated knowledge of the facility's grievance procedures; one interviewee had filed a grievance and she indicated knowing the outcome.

Staff Interviews

The OJSO interviewed two direct care staff members; another direct care staff member declined to be interviewed. Both interviewees stated that they would report suspected abuse and/or neglect of a resident to a supervisor; neither interviewee demonstrated a clear understanding of abuse and neglect reporting responsibilities, per Title 10A, Oklahoma Statutes, Section 1-2-101. No other concerns were identified from the staff interviews.

Resident File Review

The OJSO reviewed three resident files. The OJSO noted:

- One resident file contained a service plan review in which the resident's signature was not dated; another service plan review did not document the staff supervisor's signature to indicate participation by the staff supervisor or document a reason for non-participation; and nine of the ten service plan reviews in the file did not document a custodian's signature to indicate participation by the custodian or document reasons for non-participation.
- In the same resident file as above, four treatment plan reviews documented that the resident had signed the reviews for January, February, and March 2009 on the same date that she had signed the treatment plan review for April 2009.
- The service plan in another resident file did not document the resident's signature. A treatment plan review did not document the OKDHS worker's signature to indicate participation by the OKDHS worker or document reasons for non-participation.
- The service plan reviews in all three resident files reviewed did not document adequately the residents' progress toward meeting the goals listed in the reviews. The service plan review forms provided lines on which to write an evaluation of the resident's progress. Sometimes staff wrote "see above", or the sections for documenting were left blank. When progress was documented, it was not always measurable.

No other concerns were identified from the resident files reviewed.

Staff File Review

The OJSO reviewed two personnel files and training records at the Pauline E. Mayer Shelter (PEMS), the location where personnel files were maintained for the group home. The files were complete for the items checked, except that one personnel file contained only a copy of the employee's driver license with an expired expiration date. No other concerns were noted from the staff files reviewed.

Incident Report and Restriction Log Review

The OJSO reviewed the facility Incident Report and Restriction (from privileges) Log. The OJSO noted:

- An original restriction report dated September 12, 2009, contained in the log book was not being maintained in the respective resident file.
- An original restriction report or a copy of the report was not being maintained in the log book to correspond with the copy of a restriction report dated October 8, 2009, found in the respective resident file.
- Both restriction reports documented that the resident had refused to sign the reports; however, neither report documented a supervisor's signature.

No other concerns were identified from the Incident Report and Restriction Log review.

MAR Review

The OJSO reviewed the MAR regarding three residents. The MAR indicated that on November 11, 2009, two adolescent residents each had missed a dosage of medicine and that a child of one of these two residents had missed a dosage of medicine on that same day. No other concerns were identified from the MAR review.

OKDHS OCA Investigative Report and CCR Log Review

The OJSO reviewed the OKDHS OCA investigative and CCR reports log at the PEMS, the location where the log was maintained for the group home. The OJSO noted that in 2008 one incident pertaining to the group home had been reported to the OCA for determination as to whether an OCA investigation was warranted; documentation indicated that the incident was reported to the OCA three days after the incident.

During the oversight visit, the OJSO became aware of an incident alleging mistreatment of an adolescent resident by a direct care staff person that had not been reported to the OKDHS OCA.

Inspection Reports Review

The OJSO reviewed the most recent reports by the OKDHS OCCS, health department, and the fire marshal's office. The facility had submitted a plan of correction to the OKDHS OCCS report that was accepted regarding a repair to a ceiling. The deficiencies cited in the fire marshal's office report had been corrected; the two minor deficiencies cited in the health department report also had been corrected.

Observational Tour

The OJSO conducted a tour of the facility. The OJSO noted:

- The expiration date for inspection of the fire extinguishers had expired. Documentation indicated that the fire marshal's last visit had occurred on August 18, 2009; the inspection of the fire extinguishers was current through October 2009.
- The OJSO observed an infant left unattended in a swing in the day room for approximately ten minutes.
- The carpet in the dayroom appeared worn and dirty.
- The door to a lower cabinet in the hall would not stay closed, and the cabinet contained litter.
- The electrical outlet in the hall was missing a child safety outlet protector.
- The plastic cover for the central heat/air thermostat in the hall was missing; the cover was located on the hall corner counter.
- The cabinet over the commode in the hall bathroom contained razors and steel wool pads.
- The cabinet under the sink in the hall bathroom contained litter; this cabinet was unsecured and contained a bottle of cleaner.

- Notification of the grievance process and the name and contact information for the local grievance coordinator was not displayed in the facility.

The OJSO provided the group home director with a written list of the above deficiencies. The group home director agreed to correct the deficiencies.

Areas of Concern

1. Facility policy instructs staff to report suspected abuse and neglect to a supervisor. The group home is under the auspices of the OKDHS-operated PEMS, whose policy states that the PEMS director acts as an OKDHS representative for the reporting of suspected abuse and neglect. The OJSO, however, recommends that the Pauline Mayer Group Home apprise staff of their individual responsibility to report suspected abuse and neglect, per Title 10A, Oklahoma Statutes, Section 1-2-101.
2. One of the three resident files reviewed documented that the resident signed four treatment plan reviews all on the same date. According to OKDHS licensing requirements, the group home exceeded its responsibility to provide service plan reviews when it conducted reviews every month for four consecutive months. However, it concerned the OJSO as to whether the resident had actually reflected on the information provided in the monthly treatment plan reviews or if the resident was only meeting the requirement of a signed service plan review. The group home director advised that a verbal discussion was conducted with residents at the time of their service plan reviews. In this specific case, the group home director stated that the concerns and goals listed in each service plan review were discussed with the resident after each review, and that the resident had signed off on the reviews at a later date.
3. The facility Incident Report and Restriction Log and a resident file were missing reports regarding two incidents involving the resident. The reports documented that the resident had refused to sign the restriction reports; however, a supervisor's signature was not documented on either report to acknowledge that the resident had refused to sign. The group home director provided the OJSO with the reports: One report was provided during the oversight visit and the other report was provided at the exit conference. The OJSO noted that both reports documented a supervisor's signature.
4. An incident of alleged neglect was not reported to the OKDHS OCA for determination of whether an OCA investigation was warranted. The OJSO requested that the incident be reported immediately to the OCA. Also, the OJSO suggested that the facility amend its incident report form to reflect whether an alleged incident was reported to the OKDHS OCA.

Violations

1. The service plan in one of the three resident files reviewed did not document the resident's signature. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154, Social services, (b), Service planning, (1), Comprehensive service plan, (A), and B, (vi), states, "A written service plan is

developed and documented for each resident within 30 days of admission. The facility involves the resident . . . in the development of the plan. . . . The service plan identifies and includes the names and signatures, with the date, of those participating in developing the service plan.”

2. Two of the three resident files reviewed contained service plan reviews that did not document all of the required signatures to indicate participation in the review or reasons for non-participation. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154, Social services, (b), Service planning, (2), Service plan review, (B), and (C), (v), states, “The facility involves the resident and parents or custodian in the service plan review. If the parents or custodian do not participate in the service plan review, the reason for non-participation is documented in the service plan. . . . The service plan review includes the names, and signatures, with the date of those participating in the review.”
3. The service plan reviews in all three resident files reviewed did not document adequately the residents’ progress. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154, Social services, (b), Service planning, (2), Service plan review, (C), (i), states, “The service plan review includes an evaluation of progress toward meeting identified needs.”
4. An incident of possible caretaker misconduct had not been reported to the OCA in the required timeframe. OKDHS policy OAC 340:2-3-33, Procedure for reporting suspected abuse, neglect, verbal abuse, caretaker misconduct, and exploitation, (a), Reporting requirements and reportable incidents, (3), states, “. . . [E]mployees of OKDHS . . . 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. . . .” At the same cite, paragraph (7) defines “promptly” in this subchapter to mean the same day or the next working day.
5. The MAR indicated that two residents and the child of one of these two residents had missed a dosage of prescription medication on the same day. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-154.3, Health and medical services, (e), Medication, (1), states, “The facility has current, written medication policy. On each shift, a staff member is designated to ensure compliance with the facility’s medication policy.”

Summary

The OJSO discussed its findings with the group home director during the exit conference. The OJSO encouraged the group home director to ensure that the program rules were applied consistently by all staff on all three shifts to lessen any misunderstandings about the program rules. The OJSO and the group home director discussed the appropriateness of some staff’s verbal interactions with the residents. The group home director advised that training had occurred and more training was scheduled to assist in better communication between the residents and the staff and among staff members.

The OJSO discussed obtaining the OCA’s approval of the facility’s resident grievance process, in accordance with OKDHS policy, OAC 340-2-3-45(d)(2). The OJSO is aware

that the PEMS director had sought previously to obtain approval of the resident grievance process for the facilities under the PEMS auspices; the PEMS director provided the OJSO with documentation to indicate that the PEMS director was advised by the OCA that as an OKDHS-operated facility, approval of its resident grievance process was not required. The OJSO will follow-up with the OCA regarding approval of the resident grievance process for OKDHS-operated facilities. The OJSO requested that the group home director ensure that staff had a clear understanding of the resident grievance process. The group home director agreed to conduct training on the grievance process.

The OJSO asked the group home director to review its policy and procedures regarding sight checks of residents during sleeping hours. The OJSO suggested that staff document the sight checks.

The OJSO suggested that the facility amend its incident report form to reflect whether an alleged incident was reported to the OKDHS OCA.

During the observational tour, the OJSO observed an infant left unattended in a swing in the day room for approximately ten minutes. The OJSO spoke with the group home director regarding the safety of a small infant left unattended in a portable swing.

The group home director was provided with resource assistance regarding the Oklahoma Department of Rehabilitative Services' transition services for any OKDHS-custody residents with individualized education programs (IEPs).

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