

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

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

**Dates of Visit:** September 18 and 19, 2007

**Oversight Reviewer:** Tina Pendergraft, Oversight Specialist

**Focus of Visit:** Second Biannual Visit for 2007

**Date:** October 16, 2007

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) began an unannounced visit to the Pauline E. Mayer Group Home on September 18, 2007, and returned on September 19, 2007, to complete the visit. The purpose of the visit was to assess compliance with established responsibilities. The group home serves a maximum of six adolescent mothers, thirteen to eighteen years of age, who are adjudicated Deprived and in the custody of the Department of Human Services (DHS). On the days of the OJSO visit, the census was five adolescent residents and five children.

### **Interviews Conducted**

- Entry interview with the Direct Care Supervisor
- One direct care staff member
- One Social Worker
- Two adolescent residents
- Exit conference with the Group Home Supervisor

### **Documents Reviewed**

- Files on four residents
- Three staff files
- DHS Division of Child Care inspection report, dated September 11, 2007
- DHS Office of Client Advocacy monthly incident reports, dated June 5 and July 3, 2007
- Oklahoma State Department of Health inspection report, dated December 11, 2006
- Office of the State Fire Marshal inspection report, dated October 11, 2006
- Medication log
- Grievances filed by residents in the past six months

## Areas Toured

- Five resident rooms
- Four bathrooms
- Kitchen and dining area
- Laundry room
- Study
- Toy room

## **Findings**

### Interviews

The OJSO interviewed two adolescent residents. The other three adolescent residents were away from the facility at the time of the visit. Any concerns or issues that might have been reported and any comments or statements that might have been made will not be discussed in this report. Because there were only two residents available for interviews, any information reported from the interviews could be identified back to the two residents, and therefore, confidentiality would not be maintained.

The OJSO interviewed one direct care staff member and the new social worker for the group home. No concerns were identified from the staff interviews.

### Files Reviews

The OJSO reviewed the files on four residents. One file did not document that the resident and the resident's custodian had received copies of the resident handbook. No other concerns were identified from the resident files reviewed.

Three staff files were reviewed. Two files did not contain current annual job performance evaluations. No other concerns were identified from the staff files reviewed.

### Observational Tour

The OJSO conducted a tour of the facility for compliance with standards related to safety, security, quality of life, and other items. The OJSO found that the refrigerator did not have a thermometer. After the deficiency was brought to the attention of staff, the direct care supervisor advised the OJSO on a later date that a thermometer had been placed in the refrigerator. The OJSO noted that violations cited from the inspection tour during the OJSO's visit in February 2007 had been corrected: Exit signs were installed at the exit doors to indicate means of egress for safe evacuation and an emergency evacuation plan was posted. The sprinkler system had been completely installed.

## Summary

The group home moved to the present location in September 2006. The OJSO perceived the staff as more satisfied this visit than in previous visits after the relocation; staff morale appeared better.

In the exit conference, the OJSO and the group home supervisor discussed the facility's actions to address issues reported in previous oversight visits. Residents reported to the OJSO in the February 2007 visit that some of the staff members cussed at and were rude to the residents. The group home supervisor advised that residents are now allowed to address concerns anonymously on paper, and that residents had since reported on staff members cussing and acting rudely. Staff members reported to the OJSO in the October 2006 visit that they did not have input into the development of the residents' treatment plans. The group home supervisor informed the OJSO that staff members now participated in the discussion of treatment plans.

## Violations

1. Two of the three staff files reviewed did not contain annual job performance evaluations. When brought to the attention of the direct care supervisor, she presented the evaluation forms on the two employees and stated that she had not had the time to complete the evaluations with the group home supervisor. The OJSO requested facsimiled copies of the completed evaluations. At the time of the writing of this report, the requested copies had not been received. DHS licensing standards, Section 153.1, Personnel, (o), Personnel records, (2), (E), in part, states, "The personnel record includes annual performance evaluations and any reports and notes relating to the individual's employment with the facility."
2. One of the four resident files reviewed did not document the resident's and custodian's signatures to indicate receipt of written copies of the resident handbook. DHS licensing standards, Section 154, Social services, (e), Resident's records, (1), (J), states, "The [resident] record includes signed documentation that the resident and parents or custodian have been provided written copies of the facility's policies on resident's rights, grievance procedures, behavior management policies, trips away from the facility, use of volunteers and frequency of reports to the parent or custodian."

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