

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

Name and Location of Facility: Tenkiller Adventure Program
Park Hill, Oklahoma

Date of Visit: March 27, 2007

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Subject: Unannounced Visit, 2007

Date: April 30, 2007

General Information

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on March 27, 2007, at the Tenkiller Adventure Program, located in Park Hill, Oklahoma. The Office of Juvenile Affairs contracts with Southwestern Oklahoma State University for the operation of the program. The program was licensed for eighteen residents by the Division of Child Care of the Department of Human Services (DHS). On the day of the visit, the census was eighteen.

Persons Interviewed

- Entry interview and an exit conference with the acting Program Administrator
- Four residents
- Two direct care staff members

Documentation Reviewed

- Files on eight residents
- Two personnel files
- Grievance log
- Office of the Oklahoma State Fire Marshal inspection report, dated December 28, 2006
- Oklahoma State Department of Health inspection report, dated May 22, 2006
- DHS Division of Child Care inspection report, dated February 22, 2007

Areas Toured

- Entire facility

Overview

Interviews

The OJSO interviewed four residents. The interview questions pertained to the residents' perceptions of safety, program services, the rights of residents, discipline practices, and other residential program issues. Discipline practices reported were:

- Residents described being put “on the rope.” The residents gave the example that if two residents had a conflict, each had to hold onto one of the ends of the rope and stay together until staff allowed them to come off the rope. The residents stated that they must stay together at all times, even when going to the bathroom. The residents reported that if a resident let go of his end of the rope, the resident received sanctions. The residents stated that the longest they had observed residents on the rope was for six days.
- Residents stated that if a resident witnessed another resident violating a rule, the witnessing resident was required to request permission to “square up” the offending resident. The residents described being squared up as having the resident who violated the rule stand at attention, while another resident tells him what he did wrong and which rule he violated. All other residents must stop what they are doing and listen to what is being said. The staff member then sanctions the offending resident. The offending resident then must shake the hand of the staff member who sanctioned him and the resident who squared him up, and thank them both. The residents stated that if they did not square up residents for rule violations, they received worse sanctions than the offending residents.

It was concerning that there was no documentation when staff placed a resident “on the rope.” The OJSO interviewed two staff members. One confirmed that staff put residents “on the rope” as a form of discipline. There were no other concerns noted from the resident and staff interviews.

File Reviews

The OJSO reviewed the files on eight residents. The files were well organized, and the materials were easy to locate. The OJSO noted:

- Two files did not contain school history/education program information.
- The treatment plan in one file was not signed by the parent/custodian.
- The ninety-day reviews in six files were not signed by the parents/custodians, nor were the reasons for non-participation documented.
- The ninety-day reviews in the files were not individualized to meet the specific needs of the residents. All contained identical goals and objectives. The evaluation of progress was listed as continue objective or objective complete, without giving any information as to why the resident needed to continue the objective. One resident had failed a urinalysis test, and when staff completed his ninety-day review approximately two weeks later, the drug/alcohol section stated that the resident was

meeting his objectives. The failed test was not documented on the ninety-day review.

The OJSO reviewed the personnel files of two direct care staff members. The files were well-organized, and the materials were easy to locate. There were no concerns noted during the staff file reviews.

Grievance Log Review

The OJSO reviewed the facility grievance log for the time period of November 1, 2006, through March 7, 2007. The OJSO was informed the facility had appointed a new grievance coordinator as of March 1, 2007. Prior to that date, the OJSO noted:

- Grievances forms were mis-numbered and were not in correct order.
- Many of the grievances were not legible, due to poor penmanship and spelling.
- The resolutions on most of the grievances stated, "Met with (staff name) and discussed the problem," or "Will have 1:1 with staff and juvenile." The resolutions did not specifically address the problem stated in the grievance or what specific action was taken by the facility.

The facility had appointed a new grievance coordinator, and the mistakes in the grievance logs were being corrected. There were no other concerns noted with the grievance log.

Observational Tour

The OJSO conducted a tour of the facility. The physical plant consisted of a main building, which housed the administrative offices, day room, and dining facility, and a dormitory that housed the sleeping quarters. On the day of the OJSO visit, both buildings were spacious and clean.

The OJSO reviewed the most recent inspection reports by the Office of the Oklahoma State Fire Marshal, the Oklahoma State Department of Health, and the DHS Division of Child Care. No violations were noted on the reports. The OJSO did not identify any concerns from the facility tour.

Conclusion

The OJSO was informed that the program director, counselor, and Juvenile Specialist IV had all resigned their positions. The OJSO is concerned with the behavior management practices of the facility, the development of the treatment plan reviews, and the grievance process. According to interviews with both staff and residents, these practices have been in place for several years. The acting facility director was responsive to all of the concerns addressed by the OJSO and agreed to review the facility's policies, procedures, and practices.

The Southwestern Oklahoma State University administration is in the process of filling the positions of director, counselor and Juvenile Specialist IV. The OJSO noted that all the violations and concerns cited in this report occurred under the former administration.

Concern

1. The facility requires residents to confront other residents for rule infractions, and if residents refuse, they are punished. In having a resident “square up” another resident, which results in punishment, the facility could be placing the resident in danger of retaliation. This system can create an adversarial atmosphere among the residents.

Findings

1. The facility staff uses behavior management techniques that are degrading, cruel, and non-therapeutic. Department of Human Services licensing standards, Section 154.2, Behavior management, (b), Prohibitions, (1), states, “Facility policy prohibits shaking, striking, spanking, or other cruel treatment.”
2. The files on two residents did not contain school history/education program information. Department of Human Services licensing standards, Section 154, Social services, (a), Admission, (1), (E), in part, states, “An admission assessment includes the resident’s school history, including current educational level, special achievements, and any school problems.”
3. The treatment plan in the file on one resident was not signed by the parent/custodian. Department of Human Services licensing standards, Section 154, Social services, (b), Service planning, (1), Comprehensive service plan, (A), states, “The facility involves the resident and parents or custodian in the development of the service plan. If the parents or custodian do not participate in the development of the service plan, the reason for non-participation is documented in the service plan.” At the same cite, paragraph (b), (1), (B), (vi), states, “The service plan identifies and includes the names and signatures, with the date, of those participating in developing the service plan.”
4. The ninety-day reviews in the files on six residents were not signed by the parents/custodians, nor were the reasons for non-participation documented. Department of Human Services licensing standards, Section 154, Social services, (b), Service planning, (2), Service plan review, (B), 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.” At the same cite, paragraph (b), (2), (C), (v), states, “The service plan review includes the names, and signatures, with the date, of those participating in the review.”
5. The ninety-day reviews in the files on six residents were not individualized to meet the specific needs of the residents. Department of Human Services licensing standards, Section 154.1, Program, (a), Rights of residents, (2), in part, states, “Each resident has a right to an individualized plan of care or treatment that focuses the services of the facility toward meeting the resident’s needs. . . .”

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