

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

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

**Date of Visit:** June 3, 2009

**Oversight Reviewer:** Harold Jergenson, Oversight Specialist

**Focus of Visit:** First Biannual Visit, 2009

**Date:** August 20, 2009

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit on June 3, 2009, at the Tenkiller Adventure Program (TAP), located in Park Hill. The purpose of the visit was to conduct a focused oversight of the facility procedures regarding medication administration, grievance processes, Office of Client Advocacy (OCA) records, and employee training. The office of Juvenile Affairs (OJA) contracted with the Southwestern Oklahoma State University for the operation of the program to serve OJA-custody males. The TAP was licensed for eighteen male residents by the division of Oklahoma Child Care Services (OCCS) of the Oklahoma Department of Human Services (OKDHS). On the day of the OJSO visit, the census was sixteen.

### **Interviews Conducted**

- Entry interview and an exit conference with the program director

### **Documents Reviewed**

- Grievance log
- Seven employee training records
- OKDHS Office of Client Advocacy (OCA) referral reports and caretaker conduct review (CCR) report
- Four resident medication administration records (MARs)

### **Findings**

#### Grievance Log Review

The OJSO reviewed the grievance log for January 1, 2009, through April 30, 2009. Thirty-six grievances had been filed by residents during that time period.

Documentation indicated that all of the reviewed grievances had been withdrawn voluntarily by the residents or had been resolved informally by staff. No concerns were noted from the grievance log review.

#### Employee Training Record Review

The OJSO reviewed seven employee training records for calendar year 2008. The OJSO noted:

- Two training records did not contain documentation that staff had completed cardiopulmonary certification (CPR) within ninety days of employment. Both staff have since been certified in CPR.
- Two training records did not contain documentation that staff had completed first aid training within ninety days of employment. Both staff have since been certified in first aid.
- Three training records documented that staff members completed Behavior Management Training more than thirty days after employment.

No other concerns were noted from the employee training record review.

#### OCA Investigative Report and CCR Report Review

The OJSO reviewed one OCA investigative report and two CCR reports for January 1, 2009, through April 30, 2009. According to documentation, the facility had reported each incident in a timely manner and had taken corrective action, if warranted. No concerns were noted from the OCA investigative report and CCR reports review.

#### MAR Review

The OJSO reviewed the MARs of four residents who had physician orders for prescription medicines. Documentation indicated:

- Based on the medication counts, either record keeping was inaccurate, medication was missing, or residents were overmedicated in seven instances.
- Examples:
  1. The resident's prescribed dosage was one capsule, at bedtime, daily. The morning count of the medication was nineteen capsules; however, after the resident received the daily dosage, the count was seventeen capsules.
  2. The resident's prescribed dosage was three capsules twice daily. The 8:30 a.m. count was one hundred and thirty capsules while the 8:30 p.m. count was one hundred and twenty-four capsules.
  3. A resident was prescribed and had filled an antibiotic medication on May 21, 2009; the physician had ordered one capsule three times a day until gone. The resident did not receive the first dose of this medication until June 1, 2009

#### **Areas of Concern**

1. Documentation revealed discrepancies regarding medication administered as recorded on the MAR and the number of remaining dosages. Documentation did not explain the discrepancies.
2. Medication was not administered as prescribed by the physician.

## Violations

1. Two of the seven employee training records reviewed did not contain documentation of current CPR certification and first aid. OKDHS Licensing Requirements for Residential Child Care Facilities, OAC 340:110-3-153.1, Personnel, (m), Staff training, (3), Training for child care staff, (E), in part, states, "Within 90 days of employment, all child care staff complete training in first aid and cardiopulmonary resuscitation (CPR), including infant and child, if appropriate. Child care staff maintain current training in CPR and first aid thereafter."
2. Three of the seven employee training records reviewed documented that staff members completed Behavior Management Training more than thirty days after employment. OKDHS Licensing Requirements for Residential Child care Facilities, OAC 340:110-3-153.1, Personnel, (m), Staff training, (5), Behavioral intervention techniques, (A) through (E), states, "Within 30 days of employment, all child care staff and those support staff who occasionally provide instruction or training to residents complete training in behavioral intervention techniques that include: . . . rules and appropriate consequences of various interventions; . . . techniques for early de-escalation and preventive intervention; . . . team approaches to behavior management; . . . verbal crisis intervention; and . . . safe and appropriate physical restraint."

## Summary

The OJSO conducted a focused oversight to review the facilities procedures regarding medication administration, grievance process, OCA records, and employee training. The OJSO is concerned with the facility's medication administration procedures. The staff administering the medications made incorrect entries in the MAR, miscounted the amount of medication remaining, and did not administer medication as prescribed by the physician. Reasons were not documented when medication was unaccounted for or when medication had not been administered.