

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

MEMORANDUM

Name of Facility: Westview Boys' Home

Oversight Person: Dana Holden, Oversight Specialist

Focus of Visit: Announced Visit, 2005
Compliance with Department of Human Services' licensing standards for residential child care facilities and facility policy and procedures

Date: August 17, 2005

General Information

The Office of Juvenile System Oversight (OJSO) conducted an announced visit to the Westview Boys' Home in Hollis, Oklahoma, on March 23, 2005. At the time of the oversight visit, there were ten residents living on campus.

Persons Interviewed

- Executive Director
- Three staff members
- Three residents

Documents Reviewed

- Three personnel files
- Files on four residents
- Most recent inspection reports by the Office of the Oklahoma State Fire Marshal and the Oklahoma State Department of Health
- Inspection report, dated February 17, 2005, by the Division of Child Care of the Department of Human Services (DHS)

Area Toured

Saunders Cottage

Overview

Interviews

The three staff members interviewed were familiar with policy and procedures and expressed appropriate knowledge regarding allowable forms of discipline. The staff appeared to work well together as a team.

The three residents interviewed:

- reported feeling safe at the facility;
- described appropriate medical and dental care; and
- reported meeting with their workers on a regular basis.

The OJSO noted the following concern during the resident interviews:

- All three residents stated that they did not know if treatment plans had been developed for them and that they had not participated in the development of treatment plans.

Review of Files

The staff files reviewed were complete and well-organized. The staff members were current on all required training. The criminal record background checks were in order and were filed separately from the personnel files. The OJSO did not note any concerns.

The files reviewed on the four residents also were complete and well-organized. The OJSO noted in two files that the residents had been fined large amounts of money for rule violations. One resident was fined \$150 and the other resident was fined \$200. The residents received an allowance of \$3 to \$5 per week, depending on their levels. No other areas of concern were noted with the resident files.

Review of Discipline Practices

The OJSO noted the following from the review of discipline practices:

- Fines were collected as a means of discipline.
- The fines are placed in the general fund of the Westview Boys' Home.
- Any resident who is removed from the program "will forfeit all money in his account, regardless of the amount or source of money." (Facility Handbook)
- File reviews indicated fines have been levied as high as \$200. At least two fines were levied equaling or exceeding \$150 (out of four files reviewed).
- Interviews with residents and staff indicated a resident was locked out of his cottage until approximately 11 p.m. because the resident had not finished digging a hole.

The resident was required to dig a hole 4 feet wide by 6 feet deep because he was caught buying cigarettes.

- Telephone contact is denied for boys on Level One. (Facility Handbook)

Observational Tour

The facility consists of an administrative office and five cottages. The cottages are located in different areas in the town of Hollis. At the time of the OJSO visit, only two of the cottages were being used to house residents. The OJSO conducted a tour of Saunders Cottage. The cottage appeared clean and in good repair. The State Fire Marshal's report, dated October 15, 2004, stated that the cottage did not have a smoke alarm. The OJSO noted that a smoke alarm had been installed and was in working order. No concerns were noted during the observational tour.

Findings

The following findings were immediately reported to the DHS Division of Child Care and the Office of Client Advocacy for review:

1. Fines of \$150 and \$200 were levied against residents as disciplinary procedures.
2. A resident was locked out of his cottage until 11 p.m.
3. A resident was required to dig a 4 foot wide by 6 foot deep hole as a form of discipline.

In addition to the referrals to the DHS Division of Child Care and the Office of Client Advocacy, the OJSO also identified:

1. Residents were not aware of their treatment plans. Department of Human Services licensing standards, Section 154, (b), (1), (A), states, "A written service plan is developed and documented for each resident within 30 days of admission. 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."

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