SITE VISIT REPORT OF

ENID STATE SCHOOL: June 7-8, 1982

PAULS VALLEY STATE SCHOOL: June 9-10, 1982

DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES

and

OFFICE OF THE CHIEF MEDICAL EXAMINER

(STATE OF OKLAHOMA): June 11, 1982

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for the

UNITED STATES DEPARTMENT OF JUSTICE-CIVIL RIGHTS DIVISION

SPECIAL LITIGATION SECTION

320 First Street Northwest

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request of the United States ...

facilities noted on the preceeding page. During the visit at Enid State ...or interviewed the Superintendent, the Clinical Director, the Medical Laboratory ...or, the Nursing Service Director, the Charge Nurse on the Acute Care Unit, two of the Resident Physicians, the Dental Clinic Director and the Dental Assistant, the Pharm Director, Ruth Duggan, RN from the Staff Development Office, Coordinator-Therapies and Unit Directors of Units I, III and V. In addition, I toured the Pharmacy, Dining Area, Medical Clinic, Acute Care Unit in the Hospital, the Hospital Complex as well as 1 Wes 1 East, and Pansy, Lily, Oak, Elm, Maple, Rose, Canna and Begonnia Cottages. I reviewe the Minutes of the Infections and Sanitation Committee, the Hospital Formulary, the Medical Laboratory Test Load Report and an Administrative Directive dated June 24, 1976 regarding Annual Staffings and Monthly Review. Finally, in addition to observing a la proportion of the approximately 660 residents, I reviewed the records of 28 residents general detail paying attention to their Annual Habilitation Plan, medications and current functional status. I also reviewed 15 records, selected at random, from among those who had expired at the facility since 1979.

GENERAL IMPRESSIONS:

The administration and staff at Enid State School appear to have the best interes of the residents at a high priority level in the institution's operations. Unfortunat the institution is grossly understaffed and in an abhorent physical condition. Thus it is unable to provide adequate sanitation and infection control, general health surveillance, coherent and integrated individual habilitation plans, a home like and normalized environment not to mention treatment in a least restrictive manner. I did not witness any incidents of active physical or verbal abuse of the residents. Howeve given the circumstances of staffing and physical plant, passive neglect and an inabil to provide privacy during even the most mundane of bodily functions such as having a movement is rampant. It would appear that a large number, perhaps 50% or more of the residents are not in need of and do not benefit from being in this institutional sett

tionalized behaviors, making them even more difficult to habilitate and reintegrate into the community as they grow older.

SPECIFIC OBSERVATIONS AND RECOMMENDATIONS:

Medical Supervision and Quality Assurance:

Dr. Simons is a highly qualified physician and provides excellent services to selec residents of the facility. Unfortunately his limited availability prevents adequat supervision of the facility's physicians who are not fully licensed. While he does directly examine those residents who are severely ill, time limitations prevent implementation of a workable plan to provide the medical component to individual habilitation plans, attendance at annual team meetings, overseeing other physician prescribing profiles and assuring a regular schedule of preventive health services Considering the fact that approximately 190 of the residents are receiving major t quilizers, 150 residents have special diets and 107 residents are non ambulatory increased activity in health planning and medical supervision is imperative. Reac as he does to acute catastrophic health problems does not meet minimal standards o care.

Random observations revealed no toilet paper holders and toothbrushes hanging with bristles touching each other in Lilly Cottage. In Oak there was dirty laundry on floor next to clean towels in the adjacent area. In Elm, sheets were laying on th bathroom floor, apparently to absorb urine. During an evening visit, residents we all naked, lined up and milling around to be toileted and bathed. A medication tr was in the clothing room adjacent to the bathroom. In Maple, food was in paper cu in the clothing room adjacent to the bathroom and next to disinfectant solutions. In Begonnia Cottage, clean linen in large quantities sat upon open shelves in a ve dusty and dirty hallway.

The recent outbreak of Shigellosis, and his report that half of the residents had amebiasis when 10 percent of the population was screened by the medical school cle indicates that preventive medicine should be raised to a higher priority. In one

despite a 5 hour period elapsing between recognition of the deteriorating condition death, a physician did not see the resident until after death. It was clear from th nursing notes that efforts had been made to have a physician reexamine the resident throughout the evening hours. In 5 death records, it was clear that a working diagn had not been documented and timely medical intervention implemented. These observa taken together leads to the impression that overall, there is a substandard level of medical care available at Enid State School.

Recommendations:

To bring the level of medical care up to minimal standards there should be:

1) the equivalent of 6 full time fully licensed physicians or 3 full time fully licensed physicians and 3 physician extenders (Registered Nurse Practitioners and/o Physicians Assistants).

2) increased medical supervision by either an administrative or peer review mechanism (see appendix A).

3) established criterion mandating the presence of a physician at the Annual Interdisciplinary Habilitation Planning Meeting (see appendix B).

4) clear cut medical responsibility for overseeing a regular schedule of preven medicine (sanitation) area inspections as well as vigilant attendance to subtle sig or symptoms of communicable disease amongst staff and residents.

5) plans for Medical Staff's direct involvement in Staff Development, particula in the area of Sanitary Practices Training.

Psychiatric and Psychopharmacological practices:

Considering the large number of residents receiving psychotropic drugs, the availat of psychiatric consultation (approximately 30 hours per month) and integration into the habilitation plan is woefully inadequate. Although one resident, Jimmy A. in Lilly Cottage had both physical restraint and psychotropic medications prescribed, neither the Annual Plan, including the Health care portion nor the monthly reviews adequately addressed his aggressive behavior. The statement "on routine chemical

Care Unit for psychotropic medication adjustment is archaic since the behavior to modified is exhibited in an entirely different environment. Hence, Brenda H. who identified as having a "behavior problem" was lying in bed, looking calmly around rather than being in the program area in which the behavior had an opportunity to emitted. Discussion with her attending physician regarding the rationale for pres Sinequan prn failed to elicit any response to suggest knowledge of this psychotro medication. Random record surveys of residents in Oak Cottage revealed 50 percent major tranquilizers. Ronald J., a resident in Elm was observed asleep at 8:00 p.m He was receiving Mellaril 150 mgm q.i.d. Staff reported that the last attempt to less intrusive behavior modification training methods to habilitate him occurred o 2 years ago. Lack of psychologists knowledgeable in these teaching methods leads using psychotropic medication as a substitute for habilitation programming. His Individual Annual Plan listed sitting at the table, staying dressed and having a p appetite as his major problems. Aggression was not addressed. The Mellaril was l ordered on March 23, 1982 "indefinitely." A random survey of every 7th chart in M Cottage revealed 4 residents on psychotropic medications. One was on polypharmacy. Four residents in Canna Cottage were on polypharmacy also. This is a practice th is now in disrepute and can only be justified after intensive program efforts and maximal doses of a single drug have been demonstrably ineffective. None of the Pro Plans, monthly reviews or progress notes documented that this was the case. For e Fred W. who was receiving 4 different psychotropic medications had "decrease incid of verbal aggression when angry" and "converse with teacher and staff in acceptable language" as his major identified problems. The administration and the Clinical Director claimed they knew of no cases of dyskinesia. I observed 2 residents in R Cottage, Green Ward, 1 resident in Yellow Ward and 1 resident in Canna Green who h obviously disordered movements. Questioning of Certified Medication Aides revealed that they knew nothing about dyskinesia nor were there any written materials avail on the wards for them to use as reference. In summary, psychiatric consultation is relatively unavailable, integration of psychiatric practices including psychotropic

during the other time periods except for Acute Care Unit which should not drop below 1 LPN per each 12 residents.

4) adequate numbers of housekeeping staff to maintain a sanitary environment in Unit V so that health service personnel can provide direct resident care.

Physical Therapy:

There are approximately 107 non ambulatory residents at Enid State School. A large proportion of these residents are not only multiply handicapped but also severely or profoundly retarded. Due to this they receive almost no public school services so they are even more in need of traditional physical therapy, environmental stimulation and custom designed modified wheelchairs. I saw a number of factory manufact wheelchairs of varying sizes, most with thin cloth strap restraints but none which showed any evidence of individual modifications which would maximize positioning for appropriate body growth and/or provide the ability to maximally utilize existing extremity functions. There is 1 physical therapy consultant available 1 day per wee This is grossly insufficient and could not allow for individual assessments and reassessments, design of modified wheelchairs, on the job training and supervision of physical Therapy aides, let alone make significant contributions to the Annual Interdisciplinary Team.

Recommendations:

In order to meet minimal standards in the physical therapy area, there should be:

1) 1 Registered Physical Therapist for every 50 non ambulatory residents.

2) sufficient physical therapy assistants to provide 1 assistant for every 30 non ambulatory residents.

3) criterion established for the Registered Physical Therapist and aide's attendance at Annual Interdisciplinary Team Meetings.

4) sufficient supplies and materials purchased to allow the development of individualized modified wheelchairs.

5) sufficient support staff (craft trades) hired to produce the wheelchair modifications.

6) an exploration of the possibility of obtaining physiatry consultation from one of the excellent teaching hospitals in Oklahoma City.

Occupational Therapy:

There are 150 residents on modified diets at Enid State School. Even allowing for 20% of these diets being content modified that still leaves 120 residents who receiv consistency modified diets. There are a surprisingly large number of residents with gastrostomy feedings and at least one on nasogastric tube feedings. While observing feeding on East Ward of the hospital I noted at least 2 residents whose wheelchairs were tipped backward so that the head-neck-trunk position of the resident was essentially prone. This is an extremely dangerous position in which to position someone who already has a neurologic impediment of the swallowing structures. The two other residents I observed were fed their entire meal within 10 minutes. The spoonfuls were heaping and delivered at the rate of 1 every eight seconds and the fo was cold. This is much too rapid as well as unsafe for a person with problems in mastication and swallowing behaviors. I did not witness any feeding training or swallow reflex stimulation programs. There is one consultant occupational therapist who feeds 2 residents each morning, 5 days a week. This is a grossly insufficient number for providing on the job training, evaluations and re-evaluations, sensory stimulation, reflex training, feeding and mastication training not to mention providing meaningful input to the Annual Program Planning Interdisciplinary Team.

Recommendations:

In order to meet minimum standards for safety and habilitation, there should be:

1) sufficient numbers of occupational therapists hired to provide 1 occupational therapist for every 50 residents with either special consistency modified diets or with neurological/functional/anatomical impairment of the upper extremities.

2) sufficient numbers of COTA's hired to provide 1 COTA for every 30 similarly handicapped residents.

3) criterion established mandating one or the other above listed personnel's attendance and participation in the Annual Program Meeting Team.

4) sufficient funds expended to provide adequate supplies of materials for the above mentioned training activities.

Pharmacy:

Generally, the pharmacy is well staffed, adequate managed and has sufficient space. The resident drug profiles were somewhat unwieldly to use but present. Preadmissio drug histories were being obtained. The formulary was up to date. The routing of medication error reports was rationally designed. There is no Kardex on each ward maintaining current Medication Administration Records in one central place. The us of medication cards is appropriate but does not allow a rapid scan for completeness Thus, if a card is dropped or inadvertently misplaced the only way to discover this by consulting the pharmacy or the resident's record. The stop orders on major tranquilizers (6 months) is too long. Dispensation of a 28 day supply of medicat: is too long compared to the safeguards built into a 24 hour unit dose system. The: is no functional Pharmacy and Therapeutics Committee. In Pansy I observed that th were bulk medications of the over the counter variety being dispensed without indi labels on the containers. Pharmacists have no criterion established for being on Annual Program Planning Teams.

Recommendations:

Pharmacy practices meet minimal standards. Consideration of the above mentioned items could improve pharmacy services.

Dental Services:

Dr. Davis and his one dental assistant have been attempting to provide at least mi mally adequate dental services. This has been possible because most of the sign: cases of restorative dentistry are being sent to Oklahoma City. Unfortunately th services are about to suffer a marked dimination in quantity when modern and curr standards of care would mandate an increase. This is due to Dr. Davis' imminent retirement. One especially important area of dental care which should be improve that of preventive oral hygiene. That would take the form of intensive training [illegible] teeth and intensive training of staff who are teaching

inadequate numbers of certified dental assistants and dental hygienists. With the present dental assistant losing her certification because of inadequate funding of continuing education and Dr. Davis' retirement, the dental care program will be be minimal standards.

Recommendations:

In order to maintain minimal standards of care there should be:

1) at least 2 full time Dentists on Staff at all times.

2) at least 2 and preferably 4 full time certified dental assistants or 2 certified dental assistants and 2 dental hygienists.

3) developed an intensive training program for staff who brush teeth and for s who teach and supervise residents who brush their own teeth (see Appendix E).

4) dental staff involved in infection and sanitation control activities.

Habilitation Programming:

There is an obvious effort to provide educational services to those residents who of school age except for those who are severe or profoundly retarded and for those are multiply handicapped. It appears that academic training is the primary emphas and the remaining areas of habilitation are essentially unaddressed probably due t the paucity of appropriately trained staff. Consequently there are residents mill about their ward dayrooms throughout the waking hours who are being deprived of mu needed self help, social, prevocational and community adaptive skills. There is n emphasis on taking the residents into the community even though many are capable o engaging in and learning from many activities such as clothing purchasing, restaur dining, laundromat operations, cosmetics and toiletries purchasing, just to mentio few. During the evening hour visits to Maple, I did not see any evidence of bathi shower training but rather, custodial hosing down of residents with hoses some of didn't even have shower heads. In the Pine Dining Room, the tables are set with carousels which prevents residents from grabbing other's food and makes them atten to their own plate but does not present an opportunity for habilitation. For exam

In the record of Steven S. and Teresa

program; the Annual Habilitation Plan is vague and the goals so general that no one working with him would have any notion of mechanisms for staff intervention when he sits in a chair, eats on his shoe and cries as he was doing at the time he was obser In the record of one resident, Lynda H. who resides in Maple Blue, a mitten restrair was present. Despite this, there was no plan to address her handbiting in her recor Thus, the restraint becomes an end in itself and a substitute for program. Conseque the data leads to the conclusion that severely and profoundly retarded residents arc being systematically discriminated against by not having even minimally adequate prc gramming, the available staff is in insufficient in numbers to implement meaningful habilitation programs and those staff that are presently engaged in program planning could benefit from further academic preparation in this area.

Recommendations:

In order to bring habilitation programming up to minimal levels there should be:

1) additional professional staff hired to design and oversee the development of habilitation plans (see recommendations related to psychologists mentioned above).

2) additional professional staff including but not limited to Speech Therapists Physical Therapists, Occupational Therapists and Recreational Therapists should be employed to implement habilitation in specific areas. Physical therapy and occupational therapy recommendations have been mentioned above. Recreation therapi should be hired in the ratio of 1 therapist per 45 residents. Speech therapists should be hired in the ratio of 1 therapist per 45 non verbal residents.

3) Additional Resident Life Staff Aides should be hired in order to provide sel help skills, social skills and communication skills practice and follow through und the supervision of the professional staff.

4) increased hours of schooling for the severe and profoundly retarded school a residents. There may be some multiply handicapped residents who cannot tolerate a 6 hour school day but this should not exceed 1% of this population subgroup. Obvic the school curriculum for these residents will require alteration so the content is appropriate to each resident's functional level.

planning to other institutions for the retarded outside of Oklahoma so they can re
further educational experience in this vital area.

Normalization:

The physical plant at Enid State School does not now provide an opportunity for no
zation. The buildings are totally obsolete in this regard. The dayrooms, sleepi
areas and dining rooms are mostly large undecorated and noisy bays. Many of the d
rooms have only picnic tables. The bathrooms are incapable of providing any sembl
of privacy. The geographic deficiencies seem to have permeated the staff's sensi-
tivities to this entire area. Residents are identified both by name and privilege
level through the use of colored badges (the staff were not). The canteen has seg
gated serving lines separating the staff from the resident counter areas. The res
mill around in groups, often naked, especially near bedtime. The furniture such a
it is is obviously institutional in design. Tennis shoes seem to be a standard is
differing only by whose name is inscribed therein. In many areas there were no dr
or shades and in many others, those that had been there were either missing or par
destroyed.

Conclusion:

It is not easy under the best of circumstances to operate an institution which is
charged with the delivery of habilitation services for the retarded. It is even m
difficult when confronted with little or no control over admissions and discharges
available network of community living and educational services and an obvious hist
of fiscal neglect by the funding authorities. Those staff to whom I talked have
However, the situation at Enid State School can be best summed up in a paraphrase
a statement by one of the Unit Directors; i.e., there aren't enough therapists for
the number to serve and we don't have enough staff to go around. The result is t
minimally adequate standards of care have not and are not being met.

Following the visit at Enid State School I then visited Pauls Valley State School on June 9-10, 1982. During this tour I interviewed the Superintendent, Social Services Director, Professional Services Director, Medical Services Director, one Staff Physician, Staff Development Director, Psychological Services Director, Nursing Services Director, Occupational Therapy Director, Pharmacy Services Director and one of the part time consulting dentists. I also reviewed meeting minutes of the Medical Staff, Nursing Staff and Human Rights Committee. I was in the Turner Clinic units, Nursing I and II, the 4 North Multiple Units, Gary East, Gary West and Kerr I. While there I observed several hundred residents and reviewed 12 resident records in detail with regard to current functional status, as well as medical and psychiatric integration into the Annual Interdisciplinary Treatment Plan. I also reviewed 5 records chosen at random from amongst those deaths occurring at Pauls Valley State School since 1979.

GENERAL IMPRESSIONS:

The staff at Pauls Valley State School have a high level of espirit de corps and pride themselves on delivering the best services possible given the available resource. They express a kindly protective attitude toward the residents in their care. The physical plant, though of varying ages is in reasonably good repair. The newer buildings provide some degree of privacy at least in the bathrooms. The institution is grossly understaffed and consequently there is little in the way of integrated and comprehensive habilitation planning and program implementation. Sanitation and infection control is at a level close to minimally acceptable standards but general health surveillance and medical quality assurance also suffers from lack of available staff. The institutional emphasis severely detracts from normalization and the facility's inability to control either admissions or discharges does not permit treatment in the least restrictive environment. I did not witness any incidents of physical abuse. On one occasion one Resident Life Staff Aide ineffectively told some residents to "be quiet" as they were noisy just prior to lunch time. The gross insufficiency of numbers of staff prevents implementation of relevant habilitation programs and the lack of specific professional

results in not so benign neglect. As a consequence, the client ... appear institutionalized. This eventually hampers successful community placement.

SPECIFIC OBSERVATIONS AND RECOMMENDATIONS:

Medical Supervision and Quality Assurance:

Dr. Lindsey is a highly qualified physician with several generations of familial devotion to Pauls Valley. He and Dr. Meinders, a local Family Practitioner each come to the school 1½ hours, 2 days a week. The two full time staff physicians are not fully licensed to practice medicine. Supervision occurs only if the staff physicians ask him to see a particular patient. There is no review of physician prescribing profiles. Only occasionally does a physician review an Annual Inter-disciplinary Treatment Plan and they never attend an Annual Team Meeting. There is no psychiatric consultation available and there hasn't been for nearly two years The Medical Staff is dependent upon the Resident Life Staff Aides calling medical problems to the nurse's or physician's attention. Most specialities are available in Oklahoma City but transportation adds another large burden to an already insuff staff. There are insufficient numbers of qualified physicians to provide the att tion required to adequately monitor and treat the nearly 100 residents receiving m tranquilizers, the 67 who are non ambulatory and the over 120 who receive special The lack of medical supervision, at least in so far as documented evidence of care concerned has been commented upon by the State Medical Examiner. The lack of read available licensed care results in the type and kind of problems generated by the deaths of Linda J. and Jody M.

Recommendations:

To bring the level of medical care up to minimal standards there should be:

1) the equivalent of 5 full time fully licensed physicians or 3 full time full licensed physicians and 2 physician extenders (Registered Nurse Practitioners and Physician Assistants).

2) increased and documented medical supervision by either an administrative o review mechanism (see Appendix A).

3) [illegible]

Interdisciplinary Habilitation Planning Meeting (see Appendix B).

4) further development of infection and sanitation control procedures. This wo include staff training as well as protocols for the identification and treatment of communicable diseases.

Psychiatry and Psychopharmacologic Practices:

In view of the 100 residents receiving major tranquilizers, 10 of whom are reported on 2 or more, the unavailability of psychiatric consultation for nearly 2 years is clearly neglectful and in view of the known long term irreversible side effects, a hazard to these residents' continued well being. There are no established written protocols for the use of psychotropic medication and from the charts reviewed, no evidence of a long range integrated plan to alter the doses or change medications w they are no longer ineffective. The use of Resident Life Staff Aides' reports is fraught with danger since traditionally, referral for medication adjustment only oc when a resident's behavior is increasingly aversive. Under these conditions, both number receiving medication and the doses increase. An example of many of these pr can be seen in the record of Laura R. a resident of North Multiple Unit as well as the record of Tom F. who resides in the same complex. He also shows evidence of di ordered movement visible to the casual observation of a trained observer. In addi he is receiving polypharmacy. This is an outmoded and generally discredited pract When it is required, it should only be after exhaustive programatic efforts in con tion with utilizing single medications in maximal doses. All of this should be do in the record. There was no such documentation and, considering the severity of h clinically described behavior, there was no evidence that contingency management t ques directed toward aggression and hyperactivity was a high priority in his habil plan. Questioning of the staff regarding why Alice A. who resides on Kerr I was r ceiving Mellaril 25 mgm t.i.d. failed to evoke any more meaningful response than t she was receiving it when she was admitted a year ago. The general terms "hyperac aggressive and explosive" in the psychological assessment done in December, 1981

is scant justification for [illegible]

only has 5 hours of scheduled active habilitation training each week, none of which directly addresses her behavior problems, not even the school plan.

Recommendations:

To bring the practice of psychotropic medication use up to minimal standards there should be:

1) additional psychologists at the Masters or higher level hired to develop integrated habilitation plans. There should be 1 psychologist for every 45 residen

2) acquisition of 1 full time equivalent consulting psychiatrist who can provid rational recommendations on psychotropic medications, direct treatment services and staff training.

3) a written protocol for regularly monitoring and adjusting the doses of psych tropic medication. Particular emphasis on efficacy evaluations is imperative (see Appendix D).

4) Resident Life Staff Aide and nursing staff training in the side effects of psychotropic medication with particular emphasis on movement disorders (see Appendi

General Health Surveillance:

Nursing:

There are so few Registered Nurses at Pauls Valley that even under the best of circ stances there is not one on the grounds during each shift. This is a situation th results in below survival level standards. Utilizing LPN's interchangeably is far below acceptable standards of care. The RN's and LPN's (13 full time equivalents) work loads are unreasonably large and thus provide only emergency services for tho residents the Resident Life Staff Aides identify as being ill. Consequently, regu scheduled health care maintenance and surveillance become the responsibility of Re Life Staff Aides who are not trained to perform these important duties. This lead to delayed recognition and delayed medical treatment. While transfer to Oklahoma City of critically ill residents is commendable, it was too late for Jarold F. and Teresa T. who expired. The Nursing Staff who are currently employed by the facili

are working under conditions that are [illegible]

sense of professional standards. They are amazingly dedicated and show every indication of high morale despite the problems they face daily.

Recommendations:

To bring the practice of nursing up to meet minimal standards of health care and safety there shoule be:

1) immediate employment of 1 RN per each 45 residents. These RN's should be ass to resident living areas, deployed during regular working hours Monday - Friday and be responsible for health care maintenance, health surveillance, regular nursing assessments, annual habilitation program planning and attendance. They should be involved in monthly team reviews and provide Quarterly Health Reviews for the attend physicians.

2) immediate employment of sufficient RN's to work out of Central Nursing so tha 2 RN's are on the grounds during 3-11, 11-7 shifts as well as all shifts on weekends and holidays.

3) immediate employment of sufficient LPN's in the Medical Units to cover all shifts. There should be a ratio of 1 LPN to each 4 residents during the early AM t post evening feedings and 1 LPN to each 16 residents during the other hours.

4) no Resident Life Staff Aides providing direct care in the Medical Units. Th are without formal training and even though well intended, they should not have to assume this responsibility.

5) adequate housekeeping staff to allow the LPN's to devote full time to the re dents' direct care needs.

Physical Therapy:

There are 67 non ambulatory residents at Pauls Valley State School. Many of these residents are multiply handicapped. Many are also severely or profoundly retarded This particular group of residents receives only very minute public school trainin Consequently they need much more in services from the State School. I did not see any custom designed modified wheelchairs though there were a number of size variat

of the commercial variety. In order to keep the residents [illegible] were restrained with narrow cloth belts. Thus maximizing physiologic growth by pro positioning was neglected. I was informed that there was 1 physical therapist cons who visited on Saturday mornings every other week. This is insufficient to provide needed services of assessment, design of modified wheelchairs, attend specific Annu Team meetings, provide feedback on a quarterly basis, develop environmental stimula programs and supervise the physical therapy aides.

Recommendations:

In order to meet minimal standards in the physical therapy component there should b

1) at least 1.5 full time equivalent Physical Therapists.

2) at least 2 Physical Therapy Aides (as at present).

3) criterion for Registered Physical Therapist attendance at Annual Team Meetir

4) supplies and materials purchased to allow the development of individually modified wheelchairs.

5) sufficient support staff (craft trades) to build the wheelchair modificatior

6) an effort to obtain physiatry consultation from one of the teaching hospital in Oklahoma City.

Occupational Therapy:

From the data supplied there are 88 residents at Pauls Valley State School who are receiving consistency modified diets. Seven additional residents are being fed by gastrostomy tube. While observing 1 small resident at Turner Clinic I noted he wa: being fed at the rate of 1 large spoonful every 6 seconds. This is much too rapid rate for safety. Some residents were fed in bed. I saw no evidence of feeding training being taught. These residents have mastication dysfunction and glutition dysfunction problems but no effort is being made to retrain or alter these reflexiv anomalies as is being done in other facilities habilitating residents with similar problems. The occupational therapy staff consists of one person delivering traditional arts and crafts directly to an average of 25-30 residents for one session c week. This is a commendable active leisure time activity for those residents over

school age even with the proviso that the resident exhibits no behavior problems.

However, this service alone leaves a major gap in sensory stimulation, integration, reflex education and upper extremity habilitation. As a result, most residents rema without adequate evaluations and totally without service.

Recommendations:

In order to meet minimum standards for safety and habilitation, there should be:

1) at least one occupational therapist for every 50 residents with either consistency modified diets or neurological/functional/anatomical impairment of the uppe extremities.

2) at least 1 COTA for every 30 similarily handicapped residents.

3) sufficient funds to provide adequate supplied of materials for the above mentioned habilitation activities.

4) criterion established mandating either an occupational therapist's or COTA's participation in the Annual Habilitation Program Team.

Pharmacy:

The pharmacy is understaffed with one pharmacist and 2 pharmacy technicians, even using the modified unit dose dispensing system. If the pharmacist is sick or on vacation, it is technically illegal to fill prescriptions, even in an emergency. There is no consulting pharmacist to provide relief so it is fairly evident that this situation must occur on occasion. Discontinued medications are reissued. This may be legal, depending upon State Law but is not a generally acceptable practice because of sanitation as well as pharmaceutical safety considerations. Prescription ointments without individual names are dispensed and were observed in North Multiple Unit. There are no criterion for pharmacist participation on the Annual Team. Ther is no functional Pharmacy and Therapeutics Committee.

Recommendations:

In order to meet minimum standards there must be:

1) a minimum of two Registered Pharmacists.

. 2) individual labeling on prescription containers.

Consideration of the other above mentioned items would improve pharmacy services.

Dental Services:

There are 3 Dentists performing the services of 1 full time equivalent. This is inadequate for the number of residents requiring services. The 2 Dental Assistants are not certified and have had no formal training. As far as could be ascertained, there is no formal program of preventive oral hygiene. Dental staff are not involv in training the Resident Life Staff Aides who are responsible for oral care. There are no Dental Hygienists employed by the facility. Despite adequate toothbrush hol toothbrush bristles were cross contaminating during the tour of North Multiple Unit G - 1.

Recommendations:

In order to meet minimal standards of care there should be:

1) at least 1 full time dentist added to the present part time staff.

2) at least 2 Dental Hygienists added to the Dental Staff.

3) certification for the presently employed Dental Assistants.

4) a program developed for training Resident Life Staff Aides who brush teeth a another program for Resident Life Staff Aides who teach residents to brush their ow teeth (see Appendix E).

5) dental involvement in sanitation and infection control monitoring.

Habilitation Programming:

There are school programs for school age residents, especially those who can benefi from reading, writing and numerical concepts. For those who are severely or profc retarded or multiply handicapped, the offering of services is drastically curtailed For instance, Dana C. who, though blind knows her doctor's name and that doctors perform examinations receives only 2½ hours of school per day. Ralph G., residing at North Multiple Unit wears mittens, but the program goals were diversional activi such as walks and small toy manipulation. Okko S. who also resides in North Multi Unit wears mittens plus stove pipe arm restraints (although I noted he did not emi

appears that the restraint has become an end in itself and is used as a substitute for programming. This is the result of a totally inadequate number of appropriately trained staff at all levels of habilitation programming ability. Consequently, other than occasional planned leisure time activities the residents can be observed milling around aimlessly in their ward dayrooms. They are being deprived of communi adaptive skills, self help skills, social interaction skills and pre-vocational skil which many could use to considerable learning advantage. For reasons that are not clear other than a paucity of staff the severely and profoundly retarded are systema cally discriminated against in this regard.

Recommendations:

In order to meet minimum habilitation programming standards there should be:

1) additional professional staff to design and oversee the development of habilitation plans (see recommendations on psychologists above).

2) additional speech therapists, physical therapists, occupational therapists and recreational therapists who can implement habilitation in specific areas. Physi cal therapy and occupational therapy recommendations have been mentioned above. One recreation therapist should be employed for every 45 residents. There should be one speech therapist for every 45 non-verbal residents.

3) more Resident Life Staff Aides should be employed to provide self help skill social skills, and communication skills training under the supervision of the professional staff.

4) increased school opportunities for the severely and profoundly retarded as w as for the multiply handicapped school age residents. There may be 1% of the multi handicapped who cannot benefit from a full 6 hour school day. The curriculum for t residents will have to be individually designed and will obviously be different fr that now being offered more generally.

Normalization:

The physical plant at Pauls Valley State School is in generally good repair. Some areas provide for toileting in private (or would if there were front curtains on the stalls). Some areas have 4 bed bedrooms. The institutional furniture is modular synthetics and of such similarity, non-retarded persons would have difficulty distinguishing one ward area from another. I note that staff and residents eat in segregated dining rooms and also have different menus. It was reported that only about half of the residents' clothing is purchased in town and the remainder at the "company store."

Conclusion:

Parks Valley State School staff are making valiant efforts to provide adequate services. They are severely hampered by inadequate numbers of staff in almost ever area. Were these deficiencies corrected, there is no doubt that the services provi could meet minimal standards. Until this occurs, the residents will continue to be deprived of their rights to habilitation and the staff will continue to know, in t words of one, "we could obviously use a little more."

One cannot help but be favorably impressed with the tremendous strides the State f Oklahoma has made with its teaching hospitals and child development institute in klahoma City. These facilities are equal to any in the country. At the same time, here is an obvious discrepancy between the resources invested in these and the resour llocated to the habilitation of the mentally retarded citizens of the State. This is pparent, not only in the two State Schools but also in the absence of serious impleme ion of P.L. 94-142 in the local communities. There is no network of community resour uch as group homes, day activity centers, foster care or parent care stipends. Despi he commonality of State administration, there is only a tenous link between the teac ospitals and the two State Schools. To bring the State Schools up to minimal standar he State is faced with a large investment of money to hire staff and further develop he physical plants. This must be done or the retarded youngsters of today will be th older, unsocialized chronically institutionalized of tomorrow. One avenue worthy of exploration is that of making the State Schools integral components of the teaching hospitals. This would help attract staff since adjuctive appointments would be possib This constellation could then be used as a training nucleus to develop the expertise needed to operate a network of community facilities including group homes and DAC's which, along with full implementation of P.L. 94-142 would prevent the unnecessary and continued institutionalization of a majority of those citizens who now or in the futu will reside in the two State Schools.

U. S. JUSTICE DEPARTMENT SITE VISIT TO ENID STATE SCHOOL and PAULS VALLEY STATE SCHOOL

by Robert L. Carl, Jr., Ph. D.

During the period of June 7, 1982 through June 10, 1982, I participated in a site visit to Enid State School in Enid, Oklahoma, and Pauls Valley State School in Pauls Valley, Oklahoma. I was accompanied by Leonard T. Fielding, M. D., Medical Director of Brainerd State Hospital in Minnesota, and Messrs. Len Reiser and Robert Dinerstein of the U. S. Justice Department, Division of Civil Rights.

These written results of this site visit are my own, and are based upon my personal and professional observations.

This report is prepared in three sections: I. Enid State School; II. Pauls Valley State School; and III. Overall Conclusions.

I. ENID STATE SCHOOL (June 7 and June 8, 1982)

The visit to this facility for 662 clients started with a briefing about the facility by Howard Chinn, Superintendent. John McCormack, Attorney for the Oklahoma Department of Human Services was also present.

Mr. Chinn was very positive about Enid State School, citing ICF/MR certification of the entire facility with "only three deficiencies in the latest review" as his major criterion. When questioned regarding this finding, he identified numerous waivers or variances which had been granted. Examples of standards

not met and apparently not cited due to these waivers or variances include such items as having no more than four clients in a bedroom, privacy requirements in bathing/toileting areas, and life/safety requirements.

It is inconceivable to me that such basic requirements as these can be waivered or ignored by the ICF/MR survey team. In the ICF/MR facilities which I am now supervising or have had under my supervision in the past, I can state categorically that the federally-funded survey teams would not allow such waivers or variances. With these types of waivers, you have a traditional institution that is still unsafe, lacks privacy, and personalization, and yet Federal funds are supporting a program which is obviously not in compliance with the most basic Federal regulations.

Superintendent Chinn also discussed his perceived major problems, identifying the archaic buildings as one major weakness. The other problem he specified was a serious staff shortage in "direct care, nursing (R.N.'s) and physical therapy (R.P.T.'s)." The later visits to the residential buildings confirmed Mr. Chinn's assessment. The buildings, for the most part, are abominable, dehumanizing, crowded, lack personal space, are not particularly clean, and are certainly not homelike. Likewise, a serious staff shortage was obvious, both in the classifications Mr. Chinn specified and in other classifications as well.

Following are some observations from my personal visits to several of the living and program areas in the facility.

Unit I, Elm Building, Green Ward

This ward houses 21 men and boys. According to staff, 5 of the residents or students are over 21 years of age. Two direct care staff (Resident Life Staff Aides) were on duty for the 21 residents.

The visit occurred after supper during second shift. "Showering with assistance," an activity which appeared on each resident's individual program was observed. This procedure entailed a gang shower approach; 21 clients were undressed and then herded naked into the bathroom, where the two staff hosed the clients down with a large garden type hose. Given the lack of staff and the developmental levels of the clients, maybe this was the best the staff could do. In no way does this activity meet ICF/MR regulations nor accepted professional standards of practice!

There were no toilet seats on the toilets, nor any privacy partitions in the bathroom.

The sleeping room was a large dorm-type or ward facility. No privacy at all; just 22 beds in one large room. The staff cited the "need for supervision" and staff shortage as reasons why the large sleeping room was required. They also cited "10 seizure patients" as another example of why they had to use large sleeping areas.

In the sleeping room, a resident worker "on vocational training" was sweeping the floors and making the beds. This resident was not being paid nor was he being supervised nor trained. Again, this is another example of a violation of ICF/MR regulations.

According to staff, there is only one person on duty on third

shift in this area. Another violation of Federal regulations and of good professional practice.

Clients had no access to personal clothing or other effects. There seemed to be a strange mix of clientele in the ward; differing ages, varying functional levels were apparent.

According to staff, "13 or 14 go to school," and "2 or 3 go to therapy for approximately 1 hour a day." This means that several of the clients have no active treatment program whatsoever, and the rest get only an hour or so each day.

My impression is that this facility is not even a safe place to exist. There are just too few staff. In no way can this ward be in substantial compliance with Federal ICF/MR regulations.

Elm Building, Red Ward

Staff described this as "an aggressive ward" for 22 men. Seven of the students are under 21 years of age; the others are over 21. The age range according to staff was from 14 to 45.

There was very little furniture, no privacy, similar living arrangements to the Green Ward.

A review of some of the residents' records was revealing. The records showed very little active programming, generally no more than 1 hour per day for each client. There was a "paper compliance" program built on activities of daily living - such as showering with assistance which translates into gang hosing off. But there was no active treatment program for these clients in evidence. Again, this residential area simply does not comply with

minimal ICF/MR requirements nor accepted professional practice, in my opinion.

Unit IV, Halfway House

This facility was quite acceptable from a physical plant standpoint. The striking feature of the residents I observed is that they simply do not belong in nor can they be helped in this facility. Their functional levels and skills demand placement in a less restrictive environment.

For example, according to staff, about 25 of the clients are "older, don't require much supervision in activities of daily living. They come and go, attend industrial therapy. They have lived here all their lives."

Staff identified their major needs as "group homes and sheltered workshops in the community." I agree; all of these clients could better be served in community settings.

The programs described by staff which they use to improve behavioral and social skills seemed quite inappropriate for the institutional retarded persons. They cited such programs as "projective testing, counselling, and maturation or time" as the means they use to improve clients.

It is a tragedy to see such high functioning clients wasting away in this program. Even where staff recommended community placement for individual clients, the staff noted almost no community options available for these clients.

Unit IV, Linden Hall

This H-shaped building houses 56 men and 56 women, according to staff. Most are over 21 years of age; most appeared not to have a comprehensive individualized active treatment program, although many participated in industrial therapy or pre-vocational training of some sort.

Again the physical plant is not desireable. Too many clients, not enough staff, very few amenities.

Cherokee Park School

This special education program is operated by the Enid Public Schools, paid for by State and Federal education agencies. According to staff all 413 children at Enid State School between the ages of 6 and 21 attend school.

This sounded good, until I observed what passed for schooling. Several categories of schooling is available, according to staff and from reviewing records.

Borderline, mildly and some moderately retarded youngsters receive a fairly full day of academic programming daily.

Adolescents in these categories receive a half day of academic work and a half day of pre-vocational or vocational work daily.

Severely and profoundly retarded youngsters and adolescents get about one-half hour per day of gross motor training. This is given at the cottages.

The school program is offered 195 days per year, with little summer school available.

This program represents one of the worse distortions of P.L. 94-142 (Education of all Handicapped Children Act) that I have ever observed. The more severely impaired, the less access to school one has at Enid State School. Much of the so-called vocational appears to be geared to the operating needs of the institution.

Yet, according to the school staff, parents often send their children to Enid State School because there is little or no educational programming available for these children in most local schools.

We did not observe any actual school because it was closed for summer vacation.

UNIT II, Rose, Conna and Begonia

The clients in this unit, according to staff, must have basic self-help skills (toileting, eating, dressing).

Almost no individualized active treatment programs were evident here. There were some activities, such as chapel, music therapy, but a regularly scheduled program of active treatment was simply not available, according to my observations and a review of records.

There were a few group activities, but only pretend individualized activities, so-written to provide artificial compliance with ICF/MR regulations, in my judgment.

Staffing was simply insufficient to provide appropriate activities or programs.

Unit V, ACU and I W, 1 E

This unit was shocking. People are housed in the hospital "for their own protection, for isolation," and, apparently, for medical reasons.

The odor was bad throughout this unit, with the entire area smelling of feces, urine, and unchanged diapers.

Individualized programs were almost non-existent. Instead, clients languish in cribs and on mats all day with almost no stimulation or purpose to their life.

Insufficient nursing personnel was an obvious problem here, as well as throughout the entire facility.

Other Items of Note

Staff from Enid State School indicated several other major concerns during conversations with me in response to specific questior

For example, the community placement program is obviously chaotic and poorly conceived. Staff described four means out of the institution for the clients. First, returning to one's natural family. They estimated 2 or 3 per year leave via this route. Second, placement in nursing homes (ICF or SNF levels of care) has until recently been the primary placement option for institutionalized retarded adults. A recent "freeze" on this placement option was apparently mandated by the Department of Human Services. According to the Superintendent, 1,282 persons were placed from Enid State School into nursing homes since 1973. Third, about two persons a year have been placed in planned independent placements. Fourth, embryonic group home services are being started and 22 persons were placed

from Enid State School last year. Finally, last year 7 persons walked away from the facility for a life of their own.

The above is really unacceptable. To pretend that most retarded adults are appropriately placed in nursing homes is ridiculous at best. It is also probably a denial of needed active treatment services, and a method to save dollars by the state at the expense of retarded citizens.

Another major concern which surfaced is that some residents are in Enid State School either as an alternative to incarceration following alleged criminal acts, or because the local community refuses to allow a retarded person to remain in its midst. An ICF/MR facility is not supposed to be a secure facility nor used as a correctional center. Nor is an ICF/MR a place merely to convenience local communities by removing so-called undesireables from their presence. This is simply not a justification for institutional care under the Federal regulations.

II. PAULS VALLEY STATE SCHOOL (June 9 and June 10, 1982)

The site visit to this 577* client facility started with a briefing meeting by Superintendent Norman W. Smith, his key staff, and an attorney for the Department of Human Services.

Like Enid State School, Pauls Valley has two primary responsibilities: 1) serving as a Regional Evaluation Center for its catchment area, obligated to at least evaluate any retarded person

*According to staff the enrollment on June 9, 1982 was 577, with an additional 89 persons on vacation or leave.

who applies for services; and 2) serving as a residential treatment center.

One deficiency cited by staff was the lack of staff overall. A brief review of the staff patterns shows serious staff shortages, especially in nursing and in other professional classifications.

Staff said they "seldom admit a student for educational purposes; usually it is due to behavioral problems, emotional problems, or the family." Yet, staff also noted that at Pauls Valley, as had the Enid State School staff, there had been few hopes realized via the implementation of P.L. 94-142. They said that local "parents have no knowledge of the law, nor are they satisfied with local education programs" for retarded children.

Again, as at Enid State, staff of Pauls Valley State School felt their only role in community placement was "to refer a student, when you hear about an opening through the grapevine." About 25 persons have been placed into group homes from Pauls Valley "in the past few years."

Other problems indicated by staff was a shortage of direct care staff and remaining physical plant deficiencies. Most of the residential buildings are sprinklered at Pauls Valley State School, according to the Superintendent.

Following are observations in some of the living and program areas at Pauls Valley State School.

Halfway House

This program for 28 students serves both young men and young

women. Staff offer "minimal supervision" according to their own accounts. Very few staff are available here; in fact, there is no housekeeper or janitor assigned here. The residents must scrub and wax the floors in the entire facility here. In fact, these housekeeping duties are built into individual program plans. Yet the clients are not paid and this work, essential to the facility, seems to contravene ICF/MR regulations.

The major concern here is that the clients living in this facility simply should not be under institutional care. They should be in less restrictive environments if one hopes to optimize their potential for independent living.

Most residents seemed to have fairly full daily schedules, although some had daily routines which were somewhat skewed. For example, one person started an education program before 7:00 a.m. and yet had a great deal of dead time in the middle of the afternoon.

The records are clean, coherent, readable and there seems to be some relationship between needs and services. This was the first time I observed such a relationship in Oklahoma.

Hilltop School

Again, this special education program is operated by the local school department, not by the institution itself. It is a separate, segregated school only for Pauls Valley State School students, however. This program appears to be quite good academically for certain students, namely the borderline and mildly retarded youngsters

The program is unfortunately seriously deficient for the lower functioning students. Severely and profoundly retarded youngsters get about 1/2 hour per day of schooling, primarily from a teacher's aide.

The staff here seemed motivated and interested in the students. However, one has to question their expertise in working with severely and profoundly retarded youngsters.

My opinion about the school program is encapsulated in the following comment from my notes. "The kids for who the academic program is appropriate simply do not belong here (in the institution), while the lower functioning kids simply do not have an appropriate school program."

My notes also say "This (the school program and building) would have been one of the best facilities in the country in 1969." In other words, pre 94-142 and before the right to treatment suits, this program would have been considered pretty good. But in today's context, the program is not adequate.

Female Division, Calvert II

There are 38 young women here, mildly or moderately retarded, according to staff. This living area was pretty well organized, with 4 person sleeping arrangements, some privacy arrangements, and access to personal effects for the clients. All the clients here are ready for the"right kind of group home," according to staff.

Calvert I

This living area for 35 women, dubbed severely retarded by staff,

was a traditional dorm type or ward living arrangement. Staff said these clients required more "surveillance," supposedly justifying clearly inappropriate facilities.

Kerr I and Kerr II

These living areas for little girls and young ladies were very clean and fairly pleasant, with cubicle spaces set up to promote some privacy, etc.

These young ladies and younger girls were described as mildly, moderately retarded. They seemed happy, were nicely dressed, and in my opinion simply have no reason to be in an institution.

Junior Division, Junior Cottage, J-W, J-E

These cottages for young boys and adolescents were very traditional and certainly there was little indication of active treatment being available for these youngsters.

Some of the boys in J-E were described as being "too disturbed to go to school" by staff.

Medical Unit, Turner Clinic - Team Meeting

This visit probably was the most instructive of all the site visits because it demonstrated, in my opinion, that the staffwere uncomfortable with and did not know how to implement interdisciplinar professional processes.

Since the ICF/MR program, and, in fact, accepted professional practices for retarded citizens in service settings, are grounded in this interdisciplinary team planning process, it is clear that

dysfunction at this step causes major problems in trying to implement active treatment programs. In fact, the team meeting was disorganized, incoherent, unfocused and generally useless, in my opinion. Although the staff appeared to know the client who was being annually reviewed quite well, neither the client nor his mother was present.

There was no compilation of strengths and needs of the client, nor any overall plan of care nor prioritization of service needs. The physician attended, but had no notes, no evaluation material, no input and nothing to offer apparently.

Much of the conversation, which is mandated by regulation, was focused on the administrative problem of documenting client activities, such as going outdoors.

There was no real interdisciplinary meeting nor interaction. Goals and objectives were not specified. No overall plan of care or active treatment program emerged.

This points to an obvious weakness of the overall institution.

Turner Clinic - Nursery

A brief visit showed almost no activity except some basic custodial care services. Renovations were being done to improve the physical plant, but there were no provisions for privacy, small sleeping areas, or the like.

Physical Therapy Department

A therapy aide was present. She said a registered, physical therapist visits the institution every other Saturday morning.

There are supposedly 2 therapy aides, who serve "about 60" clients overall. "We try to see them twice a week for 30 minutes," she said.

This staffing level is so inadequate as to be ludicrous. I wonder what the state laws are regarding activities to be performed only by a registered physical therapist? It seemed to me that the therapist aide I met was ill-prepared to perform some of the activities she described (e.g., "range of motioning, positioning, ambulation, adjust bracing") unless she were directly supervised by a registered person.

South Multiple Unit, G-1

This very traditional program for 18 young ladies was very unimpressive. Staff cited shortages in direct care staff, and indicated that there were few active treatment programs regularly scheduled. The clients were grouped, with 6 clients assigned to each direct care staff person. There were no sign language nor language development programs available. The staff couldn't remember when they last saw the unit psychologist. They did have "some music therapy" and occassionally a movie for the clients.

I saw little indication of purposeful activity or active treatment programs.

Multiple North

This building offered a fairly good institutional physical plant It was not very homelike, however, lacking pictures on walls, persona effects, appropriate furniture.

A review of some records, discussion with staff, and personal observation revealed not much purposeful activity except custodial care for these clients.

III. OVERALL CONCLUSIONS

The main impression one gets is of ad hoc, traditional institutional care. Where the staff works hard, despite what seems to be inadequate direction from the administrative leadership, some fairly adequate custodial care is given. This particularly true at Pauls Valley State School. Frankly, even the custodial care offered at Enid State School is often seriously inadequate, even dangerous, in my opinion.

This is not to criticize the staff, who seemed to be typical institutional staff. Instead, it is to highlight the extreme staff shortage of direct care and nursing personnel throughout both facilities.

The physical-plant in Enid State School is abominable at best. Although Pauls Valley State School also has serious physical plant problems, it appears that the administrative staff have shown more vigor and creativity in making the best of a bad situation.

Staff shortages are so serious in the direct care areas that client neglect and abuse are almost natural responses for the staff. It is absolutely impossible to render safe and adequate custodial care services given the staffing ratios, let alone provide active treatment. Yet in chasing the Federal reimbursement for ICF/MR facilities, both of these institutions pretend to offer individualized active treatment programs. This is a sham in my opinion.

Almost as critically, the staff shortages in physical therapy, occupational therapy, psychology, social work, recreation, vocational services, education, and, especially nursing, are almost overwhelming. There simply are not enough staff to perform professionally competent annual evaluations and provide critical care to prevent regression and deterioration, let alone to provide a full active treatment program for all of the residents.

Of course, it seems that there is no real intent to provide meaningful active treatment services for the severely and profoundly retarded residents.

Another obvious systems failure centers on the admissions and community placements aspects.

Literally hundreds of the persons I saw in these two institutions simply would not be in residence in a state facility elsewhere in the country. Staff did say that there were almost no other options available, so admissions were impossible to prevent. Worse, staff said that professional judgement re admissions was often over-ridden by political intervention at the Central Office level.

There is no real placement program, now that a "freeze" on nursing home placements has been initiated. Interestingly, no one could tell me why this freeze was initiated, nor could they show me a written communication ordering the freeze.

Group homes and other community service settings are apparently almost non-existent in Oklahoma. Worse, the Superintendents of the two institutions said they had no role in procuring or encouraging placements. They described themselves as administrators, and said they had no impact on policy decisions.

The intent of the ICF/MR regulations and of good professional practice is to provide individually appropriate services while one lives at the institution and to develop plans for less restrictive settings when appropriate. Even though many of these plans appear in writing in the client records, there is no vehicle for this information to impact on Department of Human Service policy re community services.

The educational programs call for some specific attention at both facilities. Since the bulk of the institutionalized clients are children, one would expect the school programs to be exemplary. Instead, for the severely and profoundly retarded youngsters, these programs are simply inadequate. In no way do these programs comply with my understanding of the intent of P.L. 94-142 nor with acceptable standards of professional practice.

Interdisciplinary activity is almost non-existent throughout. Of course, the lack of staff exacerbates this, but in fact more staff doing more of the same would not suffice either.

Another major problem is the use of clients to perform what seems to be essential institutional work without compensation. Also, in my judgement there is simply no way that these facilities comply with the rudiments of ICF/MR regulations.

In conclusion, let me say that immediate efforts must be taken in three veins. First, more staff must be hired and trained, especially direct care, nursing and professionals (in this priority order). Second, physical plant modifications to promote safety, privacy and dignity (and compliance with Federal regulations) must be undertaken at once. Third, an aggressive plan to develop and fund

appropriate community alternatives must be developed and initiated concurrently with the first two priorities.

Frankly, Enid State School is not a safe place for many of the clients in residence there at this time, in my opinion. Pauls Valley State School is not providing quality care, but I must say that custodial care practices there offer me some greater comfort.

I cannot stress strongly enough my belief that action must be taken post haste to avoid more serious problems relating to the health, safety, and progress of the clients, particularly at Enid State School, but also at Pauls Valley State School.

The State of Oklahoma, through the Department of Human Services, has provided services for persons who are mentally retarded primarily through a system of out-of-home institutional placements including Pauls Vally State School, Enid State School, and Hissom Memorial Center. Medicaid-subsidized care in private nursing homes and room and board facilities can also be included in this system. As recent DHS reports, evalutions[1] and news reports[2] have shown there are serious deficiencies in this system, some life threatening and all adversely affecting the quality of life of the persons served by this system.

Many states are deinstitutionalizing persons of all ages, even the most severely handicapped, by offering a comprehensive system of community-based services.[2a] This community-based system is generally acknowledged by experts in the field to be superior to the institutional system in quality of life provided and cost effectiveness.[2b] These services first promote the acceptance of these persons who are mentally retarded into existing services and, when this is not feasible, then by developing services. Primary services may include the following; housing, education, employment, recreation, and transportation.

As of January 1982 on a per capita basis Oklahoma had the lowest utilization rate of group homes in the nation and was one of six states in the nation having no one under the age of eighteen in group homes.[3] Although Oklahoma has begun some minimal efforts to deinstitutionalize those persons who are high functioning, the funding is minimal-$1.5 million for a two year period- and places too much responsibility for the newly developing service system on local agencies and groups. Not only is a larger percentage per home of state funding and ongoing funding for existing homes needed but also more technical assistance from DHS to promote and aid the implementation of a community-based system to serve persons functioning at many different levels of development. This assistance must also include legislation and licensing to facilitate services and include the range of services listed earlier.

Because of Oklahoma's emphasis on institutions our state lags far behind in these areas. There is funding available for these services obtained by applying for a Medicaid waiver to the federal government.[4] This waiver funding became available in 1981. Up to this time the State of Oklahoma has chosen to not apply for this funding.

footnotes

1 The Review of Oklahoma's Three State Schools for the Retarded
Site Visit report of Enid State School and Pauls Valley State School and accompanying correspondence

2 news articles

2a New Directions Institutions: Close Them Down, the State Says

2b Programs for the Handicapped The Cost of Community Residential Care for Mentally Retarded Persons

3 Table 1: Rates and Age Distribtution of People Living in Group Homes as of January, 1982

4 Changes in Federal Medicaid Policy The Omnibus Reconciliation Act of 1981
Intelligence Report