Colorado Department of Human Services
Division of Child Welfare
1575 Sherman Street, second Floor
Denver, CO 80203-1714

REPORT OF INSPECTION

Name of facility: ***El Pueblo Boys and Girls Ranch*** License #: ***45146***
Address:. ***One El Pueblo Ranch Way***
City :***Pueblo*** Zip code: ***81006*** County: ***Pueblo***
Purpose of Visit: ***Complaint 18163*** ***Date: 5-2-13***
Division Representative: ***Barry Schultz, Adrienne Battreall, Susy Tucker, Debra Lawrence, and Julia Blomberg***
Person Interviewed: ***Sheri Baca and Jimmy Cardinal*** Title: ***CEO and COO***

The following items were observed and are violations of the Minimum Rules and Regulations for: ***7.701 General Rules for Child Care Facilities, 7.705 Rules Regulating Residential Child Care Facilities, 7.714 Quality Standards for 24 Hour Child Care, and 7.719 Rules Regulating Special Activities.***

The investigation was conducted at the facility on April 15th, 23rd, 24th and 25th. Additional investigation tasks were conducted on April 26th from the office. The investigation included interviews of day staff assigned to cottage 4 and cottage 30 (Reflections cottages), interviews with Sheri Baca, CEO; Jimmy Cardinal, COO; Melissa Mayhan-Hall, therapist for cottages 4 and 30; and Heidi Boswell-Pasic, school Principal. Twenty three (23) youth were interviewed including those currently placed and those that have been discharged. Seventeen (17) were conducted in person and six (6) were conducted over the phone. The youth were interviewed regarding their experiences in the general program and Reflections Cottages (#4 for boys and #30 for girls) in reference to supervision, recreation, education, meals, bedding and comfort, rights, therapy, treatment, discipline, and emergency interventions. Cottages 4 and 30 were inspected including bedrooms, staff office, food supplies, restroom, storage, and outside recreation area. Policies were reviewed including the Reflections policy and procedures and physical management policy. Five youth files were reviewed including specific reports describing youth treatment activities and locations during their placement as well as treatment planning information and reviews. Fifteen-minute location/check sheets were reviewed for cottages 4 and 30 for every youth placed there from 1-1-13 to 4-15-13. Several personnel files were reviewed to assess qualifications of staff assigned to Reflections Cottages.

Allegations

1. It is alleged that the Reflections cottages are not heated in the youth bedrooms. **Unfounded**
2. It is alleged that youth are not provided recreation, exercise, or outside activity. **Founded**
3. It is alleged that youth are not provided adequate educational programming when in the Reflections Cottages. **Founded**

I have read and understand the above violations. I will send written verification of the correction of these violations by *6-2-13*. If I have any problems completing the corrections by this date, I will respond in writing and state the planned date of completion. At that time a follow-up letter will be sent stating all corrections have been made.

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4. It is alleged that youth in the Reflections Cottages are not provided any bedding until late at night. **Unable to Confirm**
5. It is alleged that youth in the Reflections Cottages were not provided access to phones to call their caseworkers or GAL's. **Unfounded**
6. It is alleged that youth in the Reflections Cottages do not receive adequate food portions. **Unable to Confirm**
7. It is alleged that the Reflections Cottages are locked and youth are placed in "solitary confinement" in their rooms. **Founded**
8. It is alleged that a youth was not provided medical care in a timely manner in accordance with medical needs. **Unfounded**

Allegation-#1: It is alleged that the Reflections Cottages are not heated in the youth bedrooms.

Investigation: All rooms in the Reflections cottages were observed and all have heat ventilation and the Reflections cottages were observed to be comfortable.

Finding: Allegation #1 is **Unfounded**.

Allegation #2: It is alleged that youth are not provided recreation, exercise, or outside activity.

Investigation: Several of the youth interviewed confirmed that they were not often provided opportunities for recreation, exercise, or outdoor activity. It was observed there is a locked, fenced-in recreation area in the rear of the Reflections cottages with a basketball hoop. Some youth stated they were there for several days in a row without access to recreation, exercise, or outside activity. The policy for use of the Reflections cottages states that youth will receive 30-minutes to one-hour of outdoor recreation/exercise time. The day staff in cottage 30 stated during the interview that if one youth is unsafe none will be able to go outside. The Reflections

policy also states there will be a one/four staff to student ratio due to the acuity or higher supervision needs of these youth. However, the cottage 30 day staff stated that an additional staff is only provided when there are more than six youth in the cottage and the day staff in cottage 4 indicated he is typically alone with up to eight youth. He also indicated that prior to school starting that there may be up to 11 youth in the cottage.

Finding: Allegation #2 is ***Founded*** and a violation of ***7.714.4.D.2.e***-specification of daily activities to achieve recreation goals and objectives as stated in the treatment plan.

Correction: EPBGR shall submit written documentation to ensure compliance with regulations. Due by **6-2-13**

Allegation #3: It is alleged that the youth are not provided adequate educational programming when in Reflections.

Investigation: It was observed on 4-15-13 that while inspecting the Reflections cottages between 10-11 AM, that youth were not engaged in school work. The staff member stated that they have not had an English teacher since the end of spring break (2 weeks). An interview with the school principal indicated that they did hire an English teacher on 3-20-13 but he called in sick on 4-11, 4-12, 4-15, and 4-16. Youth did not receive education in that subject those days. Interviews with day staff in the Reflections cottages indicated that youth have 4 core subjects (social studies, math, English, and science for 4 hours). The Principal stated that this was all that was required under CDE's home hospital requirements. The day staff indicated that teachers come and stay for 30 minutes to provide education and work. The day staff are substitute teacher qualified and can provide education assistance. A review of the day staff personnel file for cottage 4 indicated that his substitute certification expired in November of 2012. A renewal was not observed. Interviews with youth provided a different description. Many of the youth interviewed stated that often only one or two teachers may come to provide educational guidance and homework and that day staff seldom assisted. It

was also reported by several youth that when teachers did not provide work that the day staff may download educational worksheets (not specific to youth educational plan) to keep them busy. One youth described this as "little kid's work". Several youth stated that they were relegated to their rooms to complete assignments if they had any. The rooms had no furniture and only a concrete slab to sit on. There was very little evidence that youth were receiving the required educational programming when assigned to the Reflections cottages during the day. Several of the youth interviewed stated that prior to December of 2012 that teachers did not come to the Reflections cottages at all and this practice was initiated when the new school principal was hired. Prior to December 2012 youth may or may not have been provided generic educational worksheets to keep them busy.

A telephone call was held with Kama Linscome and Robin Singer of the Colorado Department of Education (CDE). They are both involved in reviewing and licensing facility schools. Kama stated that the home hospital rules do not apply to EPBGR because the facility is not licensed as a hospital. Kama further stated that EPBGR, in accordance with the facility license, must provide six (6) hours of educational programming per day for youth. Furthermore, there must be teacher instruction provided and the instruction and material must be individualized for the youth. There must be enough licensed special education teachers to meet the needs of the students. There was additional discussion regarding whether those youth that are being billed for excess costs (IEP), and are placed in the Reflections cottages for more than a few days of crisis management, are receiving the required special education services.

Finding: Allegation #3 is ***Founded*** and a violation of ***7.714.31.A.9***-right to participate in educational program designed to maximize one's potential in accordance with existing law. ***7.705.83***-youth shall receive educational programming in accordance with state and local law. ***7.714.6***-educational programming shall have adequate space, materials, and teachers in accordance with the Exceptional Children's Education Act.

Correction: EPBGR shall submit written documentation to ensure compliance with regulations. Due by **6-2-13**

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Allegation #4: It is alleged that youth are not provided any bedding until late at night.

Investigation: It was observed that the mattress provided was quite thin (approximately 3-inches and plastic covered) and the mattress was removed during the day and evening and provided at bedtime. It was observed that a number of mattresses were in poor condition with holes and/or tears in them. It was observed that both cottages had more that enough fitted and flat sheets and comforters for the youth. Interviewed youth did typically indicate they were provided bedding when they went to bed with exception of one youth who stated he was not provided either a mattress or bedding. Day staff from both cottages 4 and 30 stated that all bedding is laundered each day and mattresses are removed and placed in another room for storage until bedtime.

Finding: Allegation #4 is **Unable to Confirm**.

Allegation #5: It is alleged that youth were not provided access to phones to call their caseworkers or GAL's.

Investigation: Several phone logs for youth in the Reflections cottages were reviewed and documentation indicated that youth made several phone calls to those parties. Interviews with youth supported that they were able to make phone calls when requested to those parties and parents/guardians as well.

Finding: Allegation #5 is **Unfounded**.

Allegation #6: It is alleged that youth do not receive adequate food portions.

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Investigation: It was observed when inspecting the Reflections cottages that each had a fully stocked refrigerator as well as fresh fruits and vegetables. Day staff stated they often order additional lunches for youth they know may require additional food. This last statement conflicts with many of the youth that were interviewed. Most indicated that though they received all meals and snacks it was not filling. However, some of the youth indicated that even when going to the cafeteria they do not receive second helpings. The meals provided were in accordance with the menus as approved by a licensed dietician.

Finding: Allegation #6 is **Unable to Confirm**.

Allegation #7: It is alleged that the Reflections cottages are locked and youth are placed in "solitary confinement" in their rooms.

Investigation: This aspect of the investigation covers several sets of rules and regulations, including seclusion, youth rights, treatment, and discipline. The Reflections cottages have two exit doors that are equipped with time delay-lock mechanisms that are timed to open in response to continual pressure on the door-bar in 18 seconds. It was observed during the cottage inspection that all bedrooms have no locking mechanisms on the doors. There is no way to mechanically lock the bedroom doors. However, despite this observation of the non-locking bedroom doors there was evidence that youth were being secluded in their rooms. "Seclusion" is defined as "placement of a youth alone in a room from which egress is involuntarily prevented". Interviews with youth indicated that there were several approaches used by staff to keep youth in their rooms. There was much consistency with descriptions by the youth interviewed. Many youth indicated that staff will physically escort or "push" youth in their rooms and then hold the door shut with their foot or by sitting against the door. Additional approaches included threatening youth with "0" points or a "no", which would result in staying longer in the Reflections cottages. Other youth described threats of losing their home visits and extending their discharge dates if they left their rooms. A reasonable person may define "threats" to an at-risk or traumatized youth as "involuntarily preventing egress". However, the

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act of physically holding the door clearly does meet the definition of seclusion. There are other concerns that cut across the rules in reference to the use of these cottages. A review of the 15-minute check and location logs (the youth location; bedroom, commons area, other cottage, school, etc) indicated that there were several days in the past 4 months in which youth were in their rooms 24-hours a day. Several of the youth interviewed stated they spent 7-14 days in the Reflections cottages, in their rooms almost all of the time. This was usually in response to a run from campus or other behaviors considered as safety risks. The logs indicated that for one male youth and one female youth that each spent more than 30 per cent of the past four months in either cottage 4 or 30. These youth were both developmentally disabled. To be fair, the female youth requests to go to Reflections where she reports feeling safer. However, all youth would benefit from treatment planning that promotes feeling safe in their assigned cottage. Another pattern that became evident over the course of the interviews with the youth was that youth either experienced being restrained for leaving their rooms or attempting to leave the building, or observed other youth being restrained for the same reason. One observation was that many of the rooms in the Reflections cottages had the paint worn off the door frames, on each side, at the height of the window suggesting many of the youth are leaning on the door frame with their hands and looking out of the window. It was also observed that the bedroom doors had some scratching and graffiti marking on the inside, also indicating that youth are standing behind the bedroom doors for extended periods of time. Some of the youth stated that restraints often occur in the bedrooms, outside of the view of the cameras. The interviewed youth indicated that many restraints had been conducted for youth being oppositional or wanting to AWOL, both of which violate the rules of physical management. Many of the youth (both discharged and currently in placement) interviewed stated they were placed in the Reflections cottages upon admission and several remained in placement in those cottages for 7-14 days. The COO stated that high-risk admissions are often placed there to better assess their safety. Based on interviews and observations, youth were often secluded, prohibited from interacting with others, had little education programming, little clinical intervention, and no opportunity for recreation. This brings to question the validity of the high-risk safety assessment of youth for placement in a non-crisis cottage. The Reflections cottage policy indicated that treatment staff review the youth's progress every 24-

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hours and rehabilitative services meetings are held twice a week. However, if a youth is placed longer than 7 days the reviews may take place *less* frequently according to observed EPBGR policy. This suggests clinical oversight decreases with a longer stay and may contribute to a longer stay and fewer services being provided despite higher identified needs.

Finding: Allegation #7 is ***Founded*** and are violations of the following: ***7.714.31.A.5,6, and 13*** - youth rights to be free of neglect, to participate in the least restrictive treatment setting, and have the same treatment considerations regardless of disability, ***7.714.52.B,D,F.13, and F.19*** - discipline shall be constructive and educational, separation should be brief and appropriate to the youth's age and circumstances, remaining silent should not be used if inconsistent with a youth's development, and seclusion should not be used as discipline, and ***7.714.533.D,E.7 and 8 and 7.714.534*** - covers the use of seclusion including licensed approval, philosophy of use, and documentation of use. ***7.714.533 and 537***- adhering to physical management and restraint criteria and appropriate documentation. ***7.714.2.A*** - admission of a youth must be in accordance with the stated purpose of the child care facility and provided in the least restrictive and most appropriate setting in order to meet the youth's needs.

Action taken: At time of visit on 4-24-13 this Department requested that the operations of the Reflections cottages be suspended.

Correction: EPBGR shall come into full compliance with 7.714 and develop a clinical and educational foundation for the Reflections cottages, in accordance with rules and regulations. Suspend operation of the Reflections cottages until full compliance is achieved. Written approval from this Department must be provided to EPBGR prior to use of the Reflections Cottages (#4 and #30). Due by **6-2-13**.

Allegation #8: Youth was not provided medical care in a timely manner in accordance with medical needs.

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Investigation: Child 1 for this complaint was diagnosed with scabies and also a broken finger when taken for medical care by the father of child (FOC). The nursing notes were reviewed and Shawna, one of El Pueblo's two RN's, was interviewed by phone on 4-25-13. According to documentation and the interview, the youth was given a diagnosis of allergic dermatitis by both Pueblo County Health Care (urgent care) and by Dr. Patel who is an allergist. It is reported the FOC was not satisfied and took her again to the urgent care and she was diagnosed with scabies. Shawna indicated it was very possible she had both dermatitis and scabies. However, scabies is very contagious and none of the other female residents had scabies (all girls were assessed by nursing). It is very probable she may have contracted scabies elsewhere. It was reported that she (child 1) was injured in gym class or a recreation activity and injured her finger. It was triaged by the nurse on campus and put under observation. It was during the visit to urgent care with the FOC that the break in her finger was diagnosed. According to Shawna, the RN, there was no complaint of pain and swelling was low.

Finding: Allegation #8 is **Unfounded**.

Other Violations: ***7.714.53*** - Physical Management, Restraint, and Seclusion. It was observed that the EPBGR policy for physical management, restraint, and seclusion was last reviewed by the facility administration on 7-19-11. The State Volume VII rules for physical management, restraint, and seclusion were comprehensively revised in June 2012. The new rules prohibit prone restraint, which is not included in the EPBGR policy. The EPBGR policy uses the language of a "locked quiet room" (which is prohibited in their policy) rather than the revised language of seclusion.

Correction: Revise the above policy to be in compliance with the current rules in the Quality Standards for 24-Hour Child Care, 7.714. Revise and provide a copy to the Monitor and Licensing worker. Due by **6-2-13**.

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Please sign and fax or scan and email to Barry Schultz and Susy Tucker

Thank you

Barry Schultz
Division of Child Welfare
24-Hour Monitoring Specialist

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