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RE: Ocean Tides Residential Treatment Center-Site Visit

Dear Mr. Sullivan,

On behalf of Katelyn Medeiros and the Office of the Child Advocate (OCA), thank you for your time and attention during our five (5) visits to Ocean Tides Residential Treatment Center (OT RTC) located at 635 Ocean Road Narragansett, RI. Please extend our gratitude to your staff for making the OCA feel welcome and for the work that they do on behalf of the children placed in your agency's care.

Pursuant to Rhode Island General Law § 42-73-7(4), the OCA periodically reviews the facilities and procedures of any and all institutions and/or residences public and private, where a juvenile has been placed by the family court or the Department of Children Youth and Families (DCYF). The OCA reviews the facility's physical condition, overall operations, resident care practices, and evaluates overall compliance with relevant regulations and policies. The OCA reviews documentation for residents, meets with residents, and speaks with staff. The OCA's primary objective is to ensure the safety and well-being of youth and young adults involved with DCYF and ensure overall agency compliance with all regulatory and contractual obligations.

Upon arrival the OCA staff was greeted by Kailiana Dunlap, Director of Administration. Brian Sullivan, President and CEO also joined our conversation intermittently throughout our visit. The first portion of our visit started with a meeting to answer questions pertaining to the structure of the agency and its programs and was followed by a tour of the facility, then interviews with staff and youth. Multiple meetings were held with Ms. Dunlap over the course of the OCA's five (5) day site visit and additional information was requested as needed.

Program Review & Population

Ocean Tides Residential Treatment Center (OT RTC) describe themselves as a juvenile justice focused residential treatment program and school for twenty-four (24) male youth between thirteen (13) and eighteen (18) years old, though the program has the ability to accept youth who are not involved in the juvenile justice system. OT RTC reports they utilize trauma informed neuroscience aligned services provided in a Lasallian Culture of Care. Information regarding Lasallian education and child welfare work was provided to the OCA and states, "It is a model of care built on developing trust in our youth. It encourages the practice of developing position encouragement, building self-esteem, knowing individual needs and developing a sense of family and community. It is a model that emphasizes correction rather than punishment. It asks staff to consider themselves mentors and role models working 'together and by association' to care for youth and to consider their work part of their personal vocation or call."

OT RTC reports accepting youth who acknowledge they will be safe in a non-violent, restraint-free, and non-secure RTC. Youth are expected to function in a large peer group setting and acknowledge they are ready to address behaviors and issues. The average length of stay is nine (9) months.

OT RTC reported their program is unique because they work mostly with adjudicated youth. They report having an emphasis on home passes and reunification goals. The program includes anger management education, independent living and life skills development, and employment skills development. Substance use treatment can reportedly be provided by the on-site clinicians, as needed. Youth live and attend school in the same building.

OT RTC uses the Boys Town On the Way Home Aftercare Services for youth who are reunifying with family and are still working towards their high school diploma. Services begin six to eight (6-8) weeks prior to discharge.

Physical Plant

The facility is one building that houses the resident dorms, onsite school, kitchen, gym, and other amenities including a wood shop, gaming, music, and TV rooms. The De La Salle Christian Brothers live in a building that is attached to the facility. There is a chapel at the main entrance that is open to the public and holds mass every week. Ms. Dunlap stated there are very few people aside from the Brothers who attend mass. The entrance to the building does not lock because of this public chapel and there are no locked doors preventing the public from accessing the parts of the building utilized by residents.

The residence is dorm-style with two (2) hallways. In total, there are twenty-seven (27) single bedrooms in each wing. There are two (2) bathrooms connecting the hallways. There is ample outdoor space for recreation and the youth have access to the beach across the street when accompanied by staff.

Each single bedroom contains a bed, closet, desk and chair. The bedroom windows fully open and are a few feet above the ground outside. There are screens on the windows. While the majority of the bedrooms were decorated appropriately with colorful lights, artwork, family photos, and written

compliments received by staff, the OCA observed inappropriate content in two (2) bedrooms. One (1) room had a handmade poster on the wall depicting gang violence and another room had personal photos displayed of a young female wearing minimal clothing. These were brought to the immediate attention of Ms. Dunlap, and Mr. Sullivan was later informed by the OCA.

Staffing Patterns & Staff Training

The required staffing pattern for first and second shift is a 1:3 staff to resident ratio. Third shift requires 1:6 staff to resident ratio. Overnight staff remain awake and are required to complete hourly checks.

The OCA reviewed the overnight logs for December 2024 through February 2025. The December log revealed approximately thirty-one (31) instances of staff not checking on youth within a one-hour timeframe over the course of twenty-three (23) days. The overnight logs for January include approximately thirty-six (36) checks beyond one (1) hour over the course of nineteen (19) days. The overnight logs for February include approximately thirty-three (33) checks beyond one (1) hour over the course of nineteen (19) days.

OT RTC reports the bedroom doors must remain closed overnight. Staff open the door to observe the youth but do not enter the room. During the night, staff sit in the office at the end of the hall and view the hallway cameras on a screen.

The term "senior staff" is used to describe those in a supervisor role and there are currently three (3) senior staff at OT RTC. At least one (1) senior staff is scheduled for every evening shift. Their responsibilities include but are not limited to, attending monthly treatment meetings, contributing to staff evaluations, orientation of new residents, and sending out nightly emails to Administration summarizing the shift. The senior staff walk throughout the facility monitoring the youth and are available for crisis intervention.

One (1) staff on each shift is also designated the Shift Manager. The Shift Manager is also known as the "board person" because they are responsible for completing all of the documents on a clipboard for their shift. This is a rotating role and staff decide amongst themselves who will be assigned Shift Manager that day. In addition to completing documentation, the Shift Manager assigns staff to different areas of the facility and ensures the residents adhere to their schedule.

A list of required staff trainings was provided to the OCA for review. Employees attend an initial orientation to discuss handbooks, policies, documentation, identification of critical incidents and suicide prevention training, amongst other topics. Required certifications and trainings include First Aid and CPR, Youth Mental Health First Aid, PREA, and Therapeutic Crisis Intervention (TCI).

The TCI model states the "TCI system assists organizations to prevent crises from occurring, de-escalate potential crises, manage acute physical behavior, reduce potential and actual injury to children and staff, and teach children emotional regulation skills and coping strategies." The training focuses on verbal and physical techniques and interventions, including restraints. TCI defines a physical restraint as "the use of trained and competent staff members to hold a child in order to contain acute physical behavior." TCI defines acute physical behavior as "behavior likely to result in physical

injury." Though OT RTC staff are trained, OT Administration reports they do not use physical restraints.

OT RTC's training checklist states a supervisor is to work with the new employee to complete the trainings as early in employment as possible though no later than thirty (30) days. Mr. Sullivan stated that TCI training is offered quarterly, and they would not provide the training when there is only one (1) new staff. Mr. Sullivan added that new staff are not usually alone. OT RTC's Safety Plan dated 2023-2026 states "all staff members are certified in Crisis Prevention Intervention." The OCA was informed that OT RTC transitioned to TCI within the past couple years and the 2023-2026 plan had not been updated to reflect this.

Administration stated, "OT RTC is a unique setting where gang-involved youth may be living in close proximity to youth who belong to a rival gang that has injured or killed a family member or someone close to them." OT RTC does not offer gang-related education or training to their staff or youth.

Emergency Preparedness Plan

OT RTC's Safety Plan is dated 2023-2026. It contains a safety committee, fire and emergency drills, lock-down procedures, response to natural disaster, an emergency drill code, transportation, self-inspection of the site, and staff training.

Education & Vocational

OT RTC includes a Rhode Island Department of Education (RIDE) licensed and New England Association of Schools and Colleges (NEASC) accredited on-site Junior/Senior High School. The school provides regular and special education services along with the opportunity to earn high school credit or complete a GED. Youth are offered career education and on-site employment. Youth attend the on-site school and begin attending classes as soon as they complete intake. The school is run by the Special Education Director, Principal, and Dean of Students.

OT RTC pays for youth to earn certifications for specific jobs such as being a forklift operator. The program reported forty-two (42) work-related certificates were earned between July 2024 and the beginning of May 2025. Staff can assist youth with writing a resume and can transport youth to their jobs in the community. The youth have bank accounts through Washington Trust that are set up within ninety (90) days prior to transitioning out of the program.

Facility Records & Treatment Plans

The OCA reviewed resident binders. Information contained in the binders includes but is not limited to, psychosocial information, treatment plans and reviews, clinical notes, medical, dental and mental health information, parental consents, and incident report (IR) summary lists. This is a list of IRs involving the youth and includes the date the incident occurred and the type of incident. The actual IR documents are located in an electronic system.

Service plans are created by the clinician and Care Team. Care Teams are made up of one (1) representative from each facet of the program, including a residential supervisor, the youth's clinician,

education leadership, and Ms. Dunlap. Each youth has four (4) people sitting on their Care Team. There is a thirty (30) day initial assessment, ninety (90) days from intake a more thorough assessment is completed and then updated every ninety (90) days. The youth, their parents, and the assigned probation officer or DCYF worker are included in creating the treatment plans. When reviewing one youth's binder, the OCA observed two (2), ninety (90) day treatment plans missing.

Substance use treatment is reportedly facilitated by clinicians Susan Vogl and Jason Lawry. The Substance Abuse Education, Counseling & Screening Policy states that youth are enrolled in the substance use program by Family Court, DCYF/Probation, parent/guardian, or by OT RTC. The youth are to participate in education and/or group or individual counseling. These sessions are noted in the policy as being conducted during school in addition to being a part of the Health Education curriculum.

The Substance Abuse Education, Counseling & Screening Policy states, "youth enrolled in the program will successfully complete six (6), twelve (12), or more consecutive weeks of drug screens as determined by their Care Team based on input of Probation and Family Court." The Substance Abuse Education, Counseling & Screening Policy states that youth are added to the testing program by the Director of Social Services, Susan Vogl. A copy of the urine screen policy was requested but was not provided.

In one youth's binder, a document titled "Urine Screen Procedures" was included. The document states, "You are expected to empty all of your pockets, lift your shirt and pull out your waistband prior to the screen. You are (to) provide a screen with the door open and your DOMINANT hand behind your back." This document lists several instances in which the youth will automatically be considered testing positive such as, refusing to provide a screen in the allotted time, leaving the room without providing a screen, if the screen does not meet the necessary temperature, and if the youths' behavior indicates they are attempting to tamper with the specimen.

The OCA was provided with the Anger and Substance Use Behavior Change Class curriculum used for youth enrolled in the substance use program at OT RTC. The curriculum agenda identifies topics discussed over the course of eight (8) weeks however the curriculum provided includes information for only seven (7) classes. Each class is forty-five (45) minutes long. Substance use is not introduced until the fifth (5^{th}) class. Class number five (5), six (6), and seven (7) discuss substance use. The introduction for class five (5) states, "This isn't an AA or NA group where either the group members or the group facilitators talk in specifics about their past use. Instead, we are going to present and discuss some general information about what we know from the research on substance use/abuse." The sixth (6^{th}) class discusses actively changing behavior, and the youth complete a final assessment to determine where they are in terms of "readiness to change."

The final review in the seventh (7^{th}) class summarizes the substance use portion stating, "We spent the last few classes talking about substance use—the consequences of our use, the areas of our lives affected by it, a model for understanding our behavior, solutions for cutting back or stopping our substance use, and we talked about relapse." The bottom of each lesson and at the end of each class the instructor is advised to "Encourage students to come back next week."

Some youth have documented substance use diagnoses and have goals related to substance use. The OCA found no documentation or evidence of substance use treatment being provided or referenced in clinical notes.

An inventory of residents' belongings is completed at intake. Not all binders contained an inventory sheet. Ms. Dunlap stated inventories do not get updated.

There is no written communication log for each shift. Daily communication regarding updates on the youth and their behavior each shift is done through emails.

There is a designated Shift Manager on each shift who is also referred to as the "board person." The Shift Manager utilizes a clipboard referred to as "the board." The clipboard holds several documents including a list of each youth's sanction time, a trip and activities log that documents when youth leave and return from a trip off campus, and a roster titled Narragansett Residential Roster that staff utilize to document youth are where they are supposed to be at each check. This roster is completed when youth are not in school.

Information provided to the OCA regarding rosters refers to the Narragansett Residential Roster as the "Residential Services Daily Roster." The information states, "In the extreme left column of the sheet, the resident's name is to correspond with his respective room number. Visual checks are to be made and annotated every fifteen minutes by the Staff Manager, more commonly referred to as 'The Board Person."

The OCA observed two (2) blue rosters on the clipboard labeled "Narragansett Residential Roster" but did not observe any forms titled "Residential Services Daily Roster."

The first column of both rosters has each youth's name, the second column has their room number, and the remaining columns are labeled 3:30-4:30, 5:00-6:15, 6:40-7:30, 7:30-8:30, and 8:30-9:30. It is unclear why these timeframes are used when staff are to be completing visual checks of the youth every fifteen (15) minutes as noted above. It is also unclear why there are gaps of thirty (30) and twenty-five (25) minutes between timeframes. On one roster, staff are putting two (2) checkmarks, one (1) at the beginning and one (1) at the end, of each timeframe. This indicates youth were where they were supposed to be at the time of their visual check.

The other roster is used to document the number of minutes of "time" a youth was given during each timeframe. OT RTC disciplines youth by requiring them to sit in a chair and complete chores for a designated amount of "time". The OCA observed the numbers, 15, 30, 45, and 60 written multiple times across each youths' row under various timeframes.

The OCA noted inconsistencies when reviewing the rosters. There is no procedure for how to complete the rosters. Some staff highlight the names of youth who are present and other staff do not. Some staff write letters in a youth's row at various timepoints, for example "S," with no explanation as to what "S" means. Some staff include a key at the bottom of the page explaining what the letters mean, other staff do not. Administration stated documentation completed by OT RTC staff is only meant to be understood internally and is not completed for the purpose of regulatory review.

Personal Care Services

Youth are given the Resident Handbook at intake along with a laundry basket and hygiene necessities. They can have their own products stored in the medication room and they request to use them during shower time. Culturally appropriate products are reported to be provided.

Youth do their own laundry and are assigned a schedule. They rotate other chores. While OT RTC is rooted in the Lasallian ministry, there is no expectation that youth attend church services and there is no faith-based programming.

Kitchen staff prepare meals, and youth can sign up to work in the kitchen. It was reported there is often a waitlist for this job. Menu planning must follow specific nutritional guidelines for lunch and breakfast.

Tri-County Community Action is an agency that is available to residents, providing employment opportunities outside of OT RTC. These jobs pay fifteen dollars ($15) per hour. OT RTC offers paid jobs onsite including washing dishes, landscaping, working in the greenhouse and garden, and small random jobs around the facility, for example, hanging posters.

Youth are given $30 in cash from OT RTC and can take at least $25 in cash of their own money when leaving for a visit.

Youth must remain on campus during their first week at OT RTC. After the first week, they can have a day pass with family. The following week they have an overnight visit home and then they can begin their weekend passes home. Youth can have weekly onsite visits. These visits typically occur on Sundays though alternate arrangements can be made through the youth's clinician.

Onsite visits occur in the main dining room. The OCA was informed OT RTC staff do not always check visitors' IDs. Additionally, visitors not on a youth's approved list are sometimes allowed to visit. DCYF is not informed when an unapproved visitor meets with a youth, but staff would call the hotline in the event a visitor brings in contraband. The OCA reviewed documentation that involved a THC cartridge being brought in during a visit in 2024.

Medical and Clinical Services

OT RTC reports providing individual, family, and group counseling. Evidence-based practices used in the clinical setting include Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Mindfulness, Solution-Focused Brief Therapy (SFBT), and Trauma Informed.

Group therapy includes The Equine Assisted Growth and Learning Association which involves horse therapy.

There are three (3) full-time clinicians, and each has a caseload of eight (8) youth. Each youth has one (1), fifty-five (55) minute session per week and they attend one (1) group. There are no on-call clinicians. Daily schedules are not required to be consistent. Clinicians work eight (8) hour days and can flex their time as needed. Youth know what day and time they meet with their clinician each week.

Clinicians are responsible for facilitating youths' phone calls. Administration reported youth are allowed to call family after 3:30pm each day and the call must be facilitated by a clinician. Youth can utilize their scheduled clinical session to make a call or can do so at another time if a clinician is available. Due to the clinicians' ability to flex their schedule, they are not always available at the same time each day.

OT RTC contracts with Dr. Elizabeth Lowenhaupt to provide psychiatric services to youth who do not have a community provider. Dr. Lowenhaupt meets with the youth monthly.

OT RTC utilizes the residents' community providers for medical care. Administration reported struggling to find dentists because of insurance issues. Youth have been seeing random dentists who are able to see their youth though there are often waitlists for new patients. The administrative assistants are responsible for scheduling medical appointments.

Policies & Procedures

The OCA requested and received the following documents from OT RTC:

- AWOL Policy
- Resident and Room Searches
- Restraint and Crisis Intervention; including all methods utilized ie; physical, mechanical, medical and/or chemical restraints
- Time/Out Seclusion Room
- Medication Administration and Storage
- Self-Harm/Self-Injurious Behaviors
- Resident Grievance
- Emergency Preparedness Plan

Copies of the School Staff Handbook, Residential Counselor Handbook, Social Services Staff Handbook, and Resident Handbook were also provided.

The OCA found inconsistencies with information provided in the handbooks versus actual policies. OT RTC explained that the handbooks contain "old language" that will reportedly be updated by Administration. The "old language" describes protocols that are no longer used. Staff are advised to follow the policies. The OCA noted the current policies also contained what Administration described as "old language."

AWOL Policy

Information regarding OT RTC's AWOL policy and protocol can be found in the AWOL Resident Policy and in the Residential Counselor Handbook.

The AWOL Resident Policy states, "In the event a resident absents himself from the program by either running away or failing to return to the program from an approved pass or placement he is to be considered AWOL, and the following procedures followed." The listed procedures include a list of who to call and states that program staff will complete an incident report.

OT RTC could not verify how long a youth must be gone to be considered AWOL. When asked, Mr. Sullivan suggested a timeframe of one (1) hour that youth is out of sight to be considered AWOL or if a youth leaves the property, they are also considered AWOL. He described instances of youth making their bed appear as if they were still in it before leaving the building overnight and staff were unaware during their hourly checks. Staff are not required to observe any part of the youths' body in the bed during their checks and Mr. Sullivan stated that staff do not enter the bedrooms.

The Residential Counselor Handbook states that when a youth is AWOL, a "report of elopement is to be filled out along with an IR ASAP. It is self explanatory." When asked to review these reports of elopement, the OCA was informed that there is no elopement report. Instead, there is a section at the bottom of IRs to document AWOL information. OT RTC reported there were six (6) instances of AWOL in 2024. Of these six (6), four (4) of the IRs did not have any AWOL information completed at the bottom of the form. This was brought to Administration's attention.

Search Policy

OT RTC's Privacy and Search Policy explains protocol for searching a resident's possessions, their room, and their person.

Searches of a resident's room are completed when staff have reason to believe the youth is violating the law and in possession of contraband. Youth are given the opportunity to hand the contraband over to staff first. The policy states that whenever possible, the resident should be present while his room is searched. Mr. Sullivan advised youth are not always present.

The policy states, "Whenever a boy returns to campus from off grounds (e.g., family visit or meeting, court appointments, AWOL, etc.) any belongings he returns with are to be turned into staff to be searched. All contraband will be removed. The resident is to be told what items are removed. All items removed are to be entered into the Returning Resident Inventory and initialed by youth. Items will be labeled and secured by staff."

When returning from pass, the policy states all residents head directly to the "search room" when they enter the facility where staff scan them with a metal detector wand and further states residents are required to pack a towel and proceed to the shower. Per policy, all articles of clothing should be searched. It was further explained by Ms. Dunlap and Mr. Sullivan that searches require youth to "strip" down to their underwear. The policy does not include, or state youth must remove their clothing down to their underwear.

The OCA was provided the Residential Counselor Handbook. The handbook states, "When a resident returns to campus he must have a towel ready and be prepared to go to the shower before he is allowed to go to his room. For the search, he strips down to his underwear." The handbook states, "Female staff members are not to conduct strip searches."

Administration explained the reason the youth need to shower is for hygiene purposes. They explained that not all youth have the ability to shower while home on pass and described some homes as being unhygienic. They stated no youth have ever complained about showering. Mr. Sullivan stated showers have been part of the process upon returning to the program for fifty (50) years, although no soap is provided.

The "search room" is a staff office. In this office there are tape markings on the floor, indicating where a youth must place their feet while being wanded. The marks are a significant distance apart, positioning the youths' legs to be spread apart while standing. A camera in the office records the searches. Additionally, there is a door with a window on both sides of the office. While reviewing footage of medication passes, the OCA inadvertently observed video of a youth being searched in the staff office. One staff wands the youth who was standing in his underwear and another staff is observing. During this time, the OCA observed a staff searching a youth's bag.

The OCA was provided with the Resident Handbook which includes additional information about resident searches. It states, "You leave everything you brought back in the TV room, remove your clothes (except for your boxers,) and take a quick shower. Staff will search your belongings. You will later be told when to get your things from the game room." The Residential Counselor Handbook describes the shower as a "deterrent measure." The policy and handbooks contradict each other. Mrs. Dunlap and Mr. Sullivan previously denied the purpose of the shower was as a deterrent for contraband.

Administration explained that youth wear more than one pair of underwear to prevent the wand from detecting contraband.

The Privacy and Search Policy states that searches should only be done when there is reason to believe a youth has violated the law. The Residential Counselor Handbook says, "If you wish to search the residents prior to leaving to ensure safety, you may do so. It has nothing to do with trust or personal issues." The policy and handbook contradict each other.

Restraint and Crisis Intervention

OT RTC does not use mechanical, chemical or medicinal restraints and they do not use seclusion.

OT RTC Administration reports they are a restraint-free facility and their data for 2024 reflects zero (0) for the total number of restraints. Staff are trained in Therapeutic Crisis Intervention (TCI) which includes both de-escalation and restraint techniques.

The Seclusion and Restraint Policy states, "Ocean Tides does not believe in the use of seclusion and restraint in the treatment of its residents." It further states, "Staff will use the least restrictive TCI

intervention according to the circumstances of the crisis" and "If a therapeutic hold or restraint is performed" staff is to contact an administrator, complete an IR and a DCYF #203 form. Administration was adamant they do not do restraints no matter what. A restraint was defined as "a hold of any sort." The policy does not state staff are restricted from doing restraints or holds.

When reviewing IRs, there were several involving youths engaging in physical fights and staff intervening. The OCA asked OT RTC Administrators how staff are trained when breaking up fights and was told staff are told to "create space." To create space, staff are to insert themselves in between the youth who are physically fighting and put their arms out to keep the youth away from each other. This does not support TCI techniques of de-escalation and restraints.

The OCA was provided TCI training documents and videos. The training video specific to breaking up fights demonstrates staff approaching each youth from behind, placing their hands on the youth's hips (belt loops,) and pivoting the youth's body around and away. There is no documentation that staff are utilizing the trained TCI techniques.

A review of documentation from staff intervening in fights indicates staff used physical TCI and restrained youth. Administrators advised staff are not actually restraining youth and staff are using incorrect language to describe their intervention.

The OCA reviewed video footage of a fight. In the video, staff are seen using their bodies, arms and hands to push two youth backwards to prevent them from physically attacking each other. Staff are holding a youth's arms. One staff is using his body weight to push the aggressing youth away while a second staff is pulling the aggressing youth's arm to get him out of a doorway. Staff positioned their bodies to keep the youth against the wall in a staircase to stop him from accessing the other youth again. During this same incident, a third resident has intervened by wrapping his arms under the aggressive youth's armpits, holding him back. A staff is in front of the aggressing youth with his hands on the youth's shoulders. A fourth resident approaches while the aggressor continues to be held back by a resident. The video illustrated physical interventions that were not aligned with TCI training. There is no audio in any recordings.

The TCI training states effective TCI implementation includes a "post-crisis multi-level response timeline." First (1st), the immediate response is to ask if everyone is okay. Second (2nd), youth participate in a Life Space Interview (LSI.) Third (3rd), documentation is completed. The fourth (4th) and fifth (5th) steps involve reviewing the incident with staff then the "team" to identify what everyone can learn from the incident.

The TCI training explains how to complete a "Life Space Interview" with youth after a crisis. The "Steps to The LSI" are identified as, "Identify a place to talk, explore child's point of view, summarize feelings and content, connect trigger to feelings to behavior, alternative responses to feelings discussed, plan developed/practice, enter child back into routine." The training states the LSI is "conducted by a trusted adult who supported them throughout the event." The OCA did not observe documentation involving Life Space Interviews related to the IRs reviewed.

The TCI training states documentation should include, "Who, what, when, where? What were the antecedents? What action did staff take to de-escalate the situation? Describe physical contact, who

did what (be specific)? How long did the restraint last? Was the ICSP followed? If not, why? Staff/child injuries? Medical attention? What plan was developed in the Life Space Interview? When were staff debriefed? Was follow-up needed? When was the family notified? Statements of witnesses should be included." The training explains "ICSPs" are Individual Crisis Support Plans. The OCA did not observe ICSPs in residents' binders. Additionally, the OCA did not observe documentation related to the IRs as described by the TCI training.

Sanction Policy

The OCA reviewed OT RTC's Sanction Policy. This policy states, "Ocean Tides utilizes sanctions and consequences to develop the client's personal accountability, responsibility, self-control, and to maintain client safety, cooperation, participation, and compliance with program rules and DCYF regulations." There are four types of sanctions: Sanction Time, Loss of Privilege Sanctions, Weekend Sanctions, and Written Sanctions. Written Sanctions are specifically given by school staff. Sanction time involves sitting in a chair and completing chores.

The Sanction Policy explains that sanction time in a chair is to be completed in fifteen (15) minute intervals and used to reflect on the behavior that earned them the sanction. While the policy provides limited information about chair time, the Resident Handbook includes directives stating, "The proper way to do sanction time: Sit in a chair facing the wall. Both feet should be on the floor, your head should be up. You may not sleep. You must be quiet and cannot talk. You may read during this time. Do not ask the staff how much time is remaining; they will tell you when you are finished."

OT RTC Administration, staff, and youth report that all youth who are given a sanction of "time," must complete at least fifteen (15) minutes of "chair time." OT RTC confirmed that "chair time" is a form of behavior management. Staff and youth described "chair time" to the OCA as a time-out.

Ms. Dunlap described chair time as sitting in a chair in the hallway with staff nearby. Youth are allowed to speak with staff and play cards with them, but they are not allowed to interact with other youth. Mr. Sullivan stated he was unaware that youth were allowed to play cards and talk to staff and did not agree with this allowance.

While the OCA was reviewing video footage, the OCA observed a youth sitting in "chair time." In the footage, the youth is seen putting a chair in the hallway with staff sitting across from him and they are talking to each other on and off. At one point, there are two (2) staff sitting across from him, using their phones. The youth is in the chair for one (1) hour when the video ends.

Youth are required to complete fifteen (15) minutes of chair time. After fifteen (15) minutes, youth have the option to remain in the chair until their time is completed or they can complete chores. There is no explanation in the Sanction Policy of how many chores they must complete or how long they do chores. Staff use their discretion and youth don't always know how much time they will have taken off until chores are completed.

The Sanction Policy includes a "List of Common Sanctions" that provides examples of behaviors a youth can receive "time" for. The meaning of each behavior is not documented. Administration

reported this list is not exhaustive and can include additional behaviors observed by staff. No additional explanation of what behaviors would warrant a sanction was provided.

Within the Sanction Policy, the List of Common Sanctions does not specify how much "time" to give youth for each behavior. The Sanction Policy states that "No sanction should be more than one (1) hour, and this should be reserved for the most significant of infractions, e.g. fighting, AWOL, stealing, licit or illicit substance use, or possession of related contraband."

Administration provided the OCA with an identical "List of Common Sanctions" that does include recommended amounts of "time" a youth would get for each behavior. One (1) hour of time is recommended for smoking, threatening a resident or staff, hands on, out of staff sight, possession of contraband, fighting, instigation, and inappropriate off property behavior. Fifteen (15) minutes of time is recommended for lying to staff, shouting, taking two desserts, entering vehicle or facility before staff, poor housework, late from dormitory, messy room, unmade bed, inappropriate attire, cursing, inappropriate gestures, and misuse of gym equipment. Behaviors suggested to earn thirty (30) minutes of time include spitting on floor, "playing" staff, disrespect, continued disrespect, and disrespect of community environment. Behaviors suggested to earn forty-five (45) minutes of time include, not in attendance during recreation, in another resident's room, horseplay-no contact, out of room after/before 5, refusing staff request, inappropriate dining room/kitchen behavior, and inappropriate vehicle behavior.

Both this list and the one within the policy state, "Sanctioning is based upon the discretion of the individual staff member and the program's treatment guidelines."

The Sanction Policy does not identify a limit to how much "time" youth can accrue. The OCA reviewed sanction logs that indicate during one shift, one (1) youth received nine (9) hours and thirty (30) minutes, another youth received six (6) hours and forty-five (45) minutes, and several other youths earned more than six (6) hours in one shift. In one instance, a youth was sanctioned with over twenty (20) hours of time for one incident.

The Sanction Policy and Resident Handbook both state, "Willfully choosing not to complete sanction time may result in the sanction being doubled as well as earn them a weekend sanction" and "You must complete the sanctions the day you receive them or they double." Ms. Dunlap and Mr. Sullivan advised these were examples of "old language" that no longer reflects current policy. Ms. Dunlap and Mr. Sullivan clarified that the only instance in which sanction time would be doubled is if a youth received "time" due to poor behavior while in the community.

The Sanction Policy does not state what the protocol is if a youth did not complete their "time" for the week. Ms. Dunlap reported that on Thursdays, a youth's total amount of sanction time earned that week would reset to zero (0). In interviews with staff and youth, the OCA was informed that "time" does follow the youth into the next week and will accumulate until it is completely worked off. This transfer of time is noted as "X transfer" on the sanction log.

The OCA reviewed documentation with examples of youth being given an excessive amount of time compared to what is recommended on the List of Common Sanctions. The list suggests fifteen (15) minutes for messy room and documentation shows youth being given forty-five (45) minutes. The list

suggests fifteen (15) minutes for misuse of gym equipment and documentation shows youth being given sixty (60) minutes.

The Sanction Policy states sixty (60) minute sanctions should be reserved for the most significant behaviors such as going AWOL and possessing contraband however there are instances of youth being given sixty (60) minutes for no shower, music in the dorm, poor choice, and pants too low. When brought to Ms. Dunlap and Mr. Sullivan's attention, they suggested the youth may have had ongoing issues with these behaviors, leading to a higher amount of time given however staff did not document that information. Mr. Sullivan expressed that there is no need to document those specifics because "everyone here already knows what's going on."

Documentation revealed youth received separate "time" sanctions for the same incident. A youth earned thirty (30) minutes for "staff disrespect." The youth earned another thirty (30) minutes for "poor staff" for the same incident for a total of sixty (60) minutes. Staff reported to the OCA "staff disrespect" and "poor staff" are the same thing. One (1) youth was given sixty (60) minutes for "horseplay" and another sixty (60) minutes for "hands-on" equaling two (2) hours for the same incident. Another youth was given thirty (30) minutes for refusing to leave the dorms and an additional thirty (30) minutes for "refusing staff request" totaling (60) minutes for the same incident.

OT RTC's Sanction Policy also includes weekend sanctions. Administration explained every Thursday, information about the youths' behavior is compiled from Residential, Education, Social Services, and youths' family. A meeting is then held by Administration each Thursday to determine whether a youth will be allowed to go on a weekend pass or must remain at OT RTC. Administration decides if a youth is allowed to leave for pass on the first van, Friday at 4:00pm or if they receive a "late van" due to poor behavior during the week. If Administration gives youth one (1) "late van," the youth must wait to go on their weekend pass until Saturday at 9:00am. Two (2) late vans means the youth must wait until Saturday at 1:00pm to leave for pass, and three (3) late vans means the youth must wait until 4:00pm on Saturday to leave for their pass. OT RTC staff transport youth to two drop-off locations, one in Warwick and one in Providence.

The Sanction Policy does not define how much "time" will result in the loss of a weekend pass. Administration reported if a youth still owes ten (10) hours of "time" on Thursday, they will lose their weekend pass. Youth who lose their weekend pass are allowed a family visit on Sunday between 1:00pm-3:00pm.

Youth can lose up to four (4) weekend passes at one time due to their behavior, totaling one (1) month without a home pass. If youth incur additional infractions during those four (4) weeks on campus, additional weekend passes may be taken away.

Youth who are not allowed to go on a weekend pass and youth who are allowed on pass but were given a "late van," are required to participate in the Weekend Work Program. The Sanction Policy states, "The Work Program consists of general maintenance and chores with the intention of improving the upkeep of the facility/property utilized by the residents." The Sanction Policy states if youth received 2 "late vans" they must complete one (1) hour of Work Program. If youth received three (3) "late vans" they must complete two (2) hours of Work Program. If a youth lost the ability to go home that weekend at all, they must complete four (4) hours of Work Program. This is in addition to any

sanction "time" they earned that week. Youth also have rotating, assigned chores throughout the week. There is no full-time janitorial staff.

For youth who did not receive any sanction "time" during the week, they are rewarded with a "no time trip" on Monday which typically involves getting dinner off campus. Mr. Sullivan expressed disagreement with this reward, as he believes all youth should be receiving time throughout the week given the fact they are at the program for behavioral issues.

Written sanctions are given by teachers and education staff. A written sanction is a form that is filled out with the youth's name, the date the sanction was applied, the date the sanction is due, the content that has to be written in the sanction, how many times the sanction is to be written, and the teacher who applied the sanction. The Sanction Policy states, "If the student does not turn in a sanction the day it is due he receives a yellow copy the next day, doubling the sanction and the boy also will earn a weekend sanction. If the youth again fails to complete the written sanction he receives the pink copy that will earn him a greater weekend sanction."

Teachers choose the statement the youth must write, and it is up to the teachers' discretion how many times the youth must write the statement. Examples of written sanctions are, "I will not" and include the behavior the youth exhibited, writing a life lesson statement provided by the teacher, writing "I will not skip shop class" ten (10) times, writing "Don't take out your feelings on others" three (3) times, and writing "I will have more appropriate conversations in class" thirteen (13) times.

Residential staff reported sanction time has the potential to be manipulated by staff to punish a youth unjustly. Sanctioning gives staff the power to impact a youth's weekend passes home in addition to preventing them from participating in off-campus activities and having to complete additional chores. Youth and staff agreed that a staff's mood or rapport with a youth impacts the amount of "time" given. Senior staff have the ability to review the Sanction Log and alter the amount of "time" given youth if they disagree with a staff's decision. Senior staff "white-out" the amount of time staff gave a youth if they disagree with the amount. This is not documented in the policy.

The OCA reviewed a report made to the DCYF Child Protective Services (CPS) hotline regarding a youth being given sixty (60) minutes of time for refusing a staff request. The youth reported he felt this was unfair because another youth who did the same thing was not given any time.

Another report to the DCYF CPS hotline stated a youth completed a chore to "work off his time." Youth said he took out the trash and staff told him his "time" would be taken away. Staff then put his time back up on the board, and his chore was marked as undone. When he asked staff why this happened, they were unable to give him an answer.

Medication Policy

OT RTC's medication policy states the program does not provide direct medical services and does not prescribe or dispense medication to residents. OT RTC assists with self-administration of medications. Administration explained that "self-administration" means staff hand the youth their medication for them to put in their mouth then swallow. The medication policy states, "Control substances will be

counted and documented by 1 oncoming and 1 off going staff member assigned for medication administration."

When dispensing medication, staff are to follow the Medication Use Procedure. The Medication Use Procedure is as follows: "Care is taken not to handle the medications. The name, medication, dose and frequency are to be cross referenced with the label on the medication first when taken from stock, second when poured into a cup, and third before given to youth for self-administration. Care is taken to observe that the resident swallows his medication. Staff will monitor youth at all times during self-administration of medication and must ask the youth to open their mouth to ensure the medication was swallowed. Staff are to ask youth to lift their tongue to preclude hiding their medicine. Staff must ensure that no other youth are in or around the office when medication boxes are unlocked, and medication is being self-administered."

Ms. Dunlap described the passing of medications as a consistent process that involves an assigned staff walking from the medication room to each youth's location to hand him his medication or at times, a youth will stand outside of the medication room door. The names of each youth are written on a plastic cup and their medication is put in their labeled cup. The cups are then placed on a small tray. Certain medications such as Trazadone and Clonidine are crushed and put in yogurt or apple sauce. This is to prevent youth from hiding the medication in their mouth in order to accumulate it or disperse it to other youth. Separate pill crushers were observed for these medications.

The OCA observed the medication room which is a small room with metal lockers. The medication room is next to the staff office. There is no camera inside the medication room. A camera only shows who is standing at the doorway outside of the medication room. The staff office has two (2) doors. One (1) door is directly next to the medication room. The OCA was shown a plastic storage bin that held a large Ziploc bag for each youth, containing their medication. The medications are secured in a locker, inside the locked medication room.

Staff informed the OCA whenever possible, medications are prepared at the beginning of the shift, at approximately 2:00pm, so they are ready for medication pass around 8:30pm. Staff further informed the OCA they do not count controlled substances. Staff do not initial the medication log until all medications have been passed. The OCA did not observe a controlled substance count within the medication log.

Due to inconsistencies in the medication pass process received from Administration and staff, the OCA requested video footage of medication passes. Video footage reviewed by the OCA confirmed there is no consistent procedure followed when passing medications.

Numerous hours of video footage was reviewed by OCA staff. Video footage showed staff not wearing gloves, pills being placed in staff's hand, placed on a desk and then put back in pill bottles. Video shows staff scooping yogurt with a spoon, pouring a crushed medication onto the yogurt, then using another spoon to spread the medication into the yogurt. The spoon that was used to spread the medication was then used to scoop yogurt for a different youth's medication. This was done repeatedly without the spoon being cleaned prior to using it for another youth. This is concerning for possible cross-contamination of medications. Video showed staff dispense medication into clear plastic cups and the cups are placed on a small tray.

On one occasion, staff stood in the medication room and passed medications to youth at the doorway. On another occasion, staff took the medication box into the staff office, put the medications into the clear plastic cups, and put the tray of pill cups on a desk in the office. Other staff are seen bringing the medications in plastic cups directly to the youth in other parts of the dorm or allow youth into the staff office to get their medications. Video showed a tray of cups filled with medications left unattended on a desk in the staff office while the office doors remained open, and the medications were accessible.

Video showed cups being handed to youth to self-administer and staff never checking to ensure youth swallowed their medication. Also, during this time video showed staff and youth moving in and out of the staff office and youth standing at both entrances of the staff office engaging in conversations with staff. Video showed multiple staff involved in the medication passing process despite the Medication Use Procedure stating one staff is assigned and responsible for medication pass. Additionally, the OCA was informed personal hygiene products are kept in the medication office. Video footage shows youth interrupting medication pass from the medication room to request their personal hygiene products in addition to footage showing searches of youths' belongings and body searches of youth occurring during medication pass in the staff office, further disrupting the medication pass process.

Self-Harm & Injurious Behavior Policy

OT RTC has a Resident Safety & Suicide Prevention Policy which includes residents completing a Personal Safety Plan with their clinician in their first thirty (30) days of their stay. The policy states they use information from the resident's referral packet, Victim/Aggressor Screen, ACE's inventory, Initial Assessment, youth input, and staff observations to develop the safety plan. This plan is for the resident to identify feelings that can trigger negative behaviors and identify coping skills. This plan is shared with Residential and Educational staff to give them a better understanding of each resident's triggers and coping skills. The policy lists the steps to be taken if a youth expresses suicidal ideation or displays suicidal behaviors which includes assigning a staff to stay with the resident, contacting the Director of Social Services Susan Vogl, and President or Director of Residential Services. A mental health status and risk assessment will then be done by a qualified and immediately available professional. When appropriate, a specific safety contract is entered whereby the child indicates a commitment not to harm themselves.

OT RTC could not provide a protocol used if there is a mental health emergency and there is no clinician available. Additionally, no suicide prevention training for staff was provided to the OCA.

Grievance Policy

OT RTC has a Client Grievance Policy that includes the process of filing a grievance, and the procedure for calling the child abuse hotline. There were no formal grievances filed in 2024. The policy states "Clients and families are encouraged to address these complaints" prior to filing a formal grievance.

Telephone Policy

The Resident Telephone Policy states youth are allowed to make phone calls to family and approved contacts. The policy states calls are made through the youths' clinician and the Director of Social Services, Susan Vogl, will coordinate a youth's phone call if their clinician is not available.

The policy further states, "While it is not standard procedure for youth to make phone calls with residential staff, to accommodate parent work schedules a clinician may request that a senior staff arrange for youth to contact family by phone."

For "security reasons," youth cannot receive incoming calls, but staff can take a message and forward it to the clinician. The policy states, "Except when reporting abuse or neglect, there is no expectation of privacy. Clinician or staff should be present in the room for the phone call, and it should be conducted on speaker phone when possible." All phone call information is to be documented in a clinician's progress note or the residential shift log.

The Residential Counselor Handbook states, "Residents are not allowed to make or receive phone calls." This does not correspond with the policy.

Social Media Policy

This policy includes rules for staffs' use of social media as it relates to confidentiality and presenting themselves appropriately online. The policy states staff must respect intellectual property and copyright laws, must use a disclaimer to make it clear their views are not reflective of OT RTC, never use their OT RTC email to register for social media, never discuss details relating to a resident or their family, and never post photographs or video of OT RTC employees, residents or families without written permission or consent. Staff are advised not to communicate with coworkers through social media regarding work-related issues and social media cannot interfere with work performance or productivity.

The policy states, "No Ocean Tides staff shall "friend" on any social media platform any current client or family receiving services. Nor shall they "friend" or interact with any former client until that client has turned 18 or been out of placement for at least 4 years, whichever is longest." The policy states that misuse or errors in judgement on social media are mistakes that cannot easily be undone, and all violations will be referred to the President-Executive Director for review.

Residents are prohibited from using social media while at OT RTC.

The OCA reviewed a report to the DCYF hotline stating a staff member called a former resident and allowed him to speak with a current resident. The resulting investigation concluded the staff provided the former resident with his personal phone number and had been in communication with the youth after his discharge from OT RTC.

An additional DCYF investigation involved one (1) current and one (1) former staff maintaining communication with a resident through Snapchat and Instagram. The messages on Snapchat could not be viewed in full as they are automatically deleted by the app. The youth communicated with one (1)

staff using social media while on home passes from OT RTC and continued communication after discharge from the program. Messages were sent back and forth over several months. The youth communicated with a second staff through social media after discharge from the program. The youth and staff discuss sending each other letters. The OCA received copies of messages and a photo of a handwritten letter to the youth that included a staff's phone number. Staff messaged the youth on social media asking, "Should I meet your mom so she isn't worried I'm Yakking with you." Staff told youth they think of him often and worry about him. Staff and youth used numerous emojis including hearts and smiley faces when communicating with one another. Staff confirmed she still works at OT RTC and told youth she is happy he isn't "trapped there anymore." Staff further gave the names of two (2) youth, that recently returned to OT RTC. Staff relayed messages between the discharged youth and current OT RTC residents. Staff shared information about a youth who went AWOL from OT RTC. Staff also discussed another youth who had been "locked up." Staff later admitted to knowing their conversations about the residents were a breach of confidentiality.

This youth's mother expressed significant concern for these interactions and expressed the behavior on behalf of the staff member is inappropriate. Youth's mother reported her concerns to OT RTC, DCYF and her attorney. Mother reportedly did not sign any documentation giving staff permission to communicate with her son after discharge from the program, nor did she approve of the communication.

Incident Reports

OT RTC utilizes incident reports (IRs) to document various types of information. The OCA requested all IRs for the year 2024 and subsequently received and reviewed approximately seven-hundred-eighty (780) IRs.

At the top of the IR forms, staff are to write the date, time, and location of the incident in addition to writing the name of the youth and staff involved. There are four (4) columns of checkboxes with a short description of the incident for the staff to choose from. Options include out of staff sight, disruptive conduct, property damage, bullying, aggression/intimidation-staff, aggressive/intimidation-peer, stealing, threat to harm-self, threat to harm-others, use of illicit substances, use of licit substances, assault-peer, assault-staff, accident with injury, possession of a weapon, use of a weapon, suicide/attempted suicide, medication error, medication refusal, infection control, communicable disease, biohazardous accident, tampered or refused drug screen, self-harm/endangerment, vehicular accident, arson, police involvement, contraband, and informational. Options in the fourth column note that additional reporting is required and include, AWOL no return from pass, AWOL from home pass, AWOL from OT, neglect, abuse, restraint, seclusion, sexual assault, and sexual harassment.

The form prompts the writer to "Provide a brief description of the incident, including what lead up to the incident, how staff intervened, any sanctions given." Once the incident is identified, there are checkboxes for staff to identify what actions were taken. Actions taken may include youth counseled, medical care provided, conflict resolution, de-escalation, or additional procedures followed. Next on the form is an area for staff to write information about what follow-up occurred.

The bottom of the form specifies this area is to be completed specifically for AWOLs and includes a space to document the method of determining the student's absence, circumstances and background

information, name of Administrator contacted, and time the Administrator was contacted. Next, there are checkboxes under a section labeled "AWOL Procedure Check List" for staff to check off when they've contacted the residential director, probation, master control center, local police, social services, parent, president, and when staff has secured the residents' personal items. A supervisor's name is then written at the bottom of the form and dated after review. The OCA remains unclear as to the "master control center" and what this in reference to at OT RTC. Additionally, it is unclear how and/or why staff secure the residents' personal items. Only two (2) AWOL IRs have "Secure Residents Personal Items" checked off as being completed.

Upon reviewing the IRs from 2024, there were several categories the reports fell under. Categories include youth appearing under the influence of drugs, AWOLs, contraband being found or suspected, staff intervening during fights between youth, suicidal behaviors or threats, incidents involving medication being found or misused by youth, informational reports regarding youth behavior resulting in a sanction, inappropriate behavior by youth, and gang related concerns. Administration advised IRs are internal documents and are not completed for the purpose of outside review.

IRs involving youth under the influence:

IRs documented for youth appearing under the influence were not consistent. Some staff checked off "use of illicit substances," some chose "informational," and other staff checked off "disruptive conduct."

In the narrative portion of the IRs, youth are described as having, "extremely muted demeanor," "droopy appearance," "slurred speech," "behavior very strange and a departure from baseline," "erratic behavior," and being "very disoriented in terms of time." One (1) IR indicates a resident was overheard saying he has been going through "withdrawals" that involve "routine headaches and constant profuse sweating." IRs include staff describing youth as being "under the influence" or being "high" and indicate staff "suspect marijuana."

None of the IRs have the action "Medical care provided" checked off. Additionally, it is not documented that nursing was notified. Eight (8) of these IRs note that a room or person search will be or was conducted. Three (3) IRs note the youth will be referred for a tox screen the next day or following week. Some IRs have nothing written under "Follow Up." Several IRs are missing the time the incident occurred.

IRs involving youth going AWOL:

OT RTC reported there were six (6) AWOLs in 2024. The OCA reviewed at least ten (10) IRs that have "AWOL from OT" checked off. The OCA reviewed approximately twenty-two (22) IRs that mention AWOL behavior. Only three (3) IRs have the AWOL information at the bottom of the form completed.

One (1) IR states police notified staff at 2:30am that two (2) youth had left OT RTC and were currently with officers. Staff reviewed camera footage showing the two (2) youth leaving through their windows at 11:05pm and 11:11pm. Staff did not notice until 2:23am because the youths had "fake beds made."

Another IR notes two (2) youth went AWOL. The IR was not completed until one (1) day later. Youth were returned by police. Their return from AWOL is not documented in RICHIST.

One (1) IR has the "Out of staff sight" box checked off and states, "While reviewing the footage of last night's incident, we could observe (youth) entering his room through the window at 2:10am. North Ext #2 camera 2:16:35am – you can see (youth) walking near the greenhouse." There is no information stating when the youth came back inside. The follow up section states, "Upon further review, (youth) left at 11:07pm." The youth was AWOL, not out of staff sight, for at least three (3) hours. No other information is documented on the IR. There is no documentation in RICHIST indicating the hotline or the youth's assigned worker was notified of this AWOL.

One (1) IR states a youth was seen wearing a heavy coat and had packed a large luggage bag. Staff wrote, "Appears to be getting ready to go AWOL. After redirecting (youth) to go back into his room, (youth) continues to walk out of the south hall, appearing to be preparing to go AWOL." Follow up states, "Senior staff notified." There is no additional information in the IR.

Some IRs state a youth was seen on camera coming back into the property or that staff observed a youth walking outside when they should be inside. There is no information regarding how long the youth was unsupervised.

IRs involving contraband:

The OCA reviewed approximately two hundred (200) IRs involving contraband. The most common contraband found is vapes, charging cables, and frayed wires. These items were found in the program's van, on a youth's person or their belongings, outside on OT RTC's property, and in various rooms in the facility.

Of the two hundred (200) incidents reviewed, seven (7) searches of a youths' person when wanded in their underwear resulted in contraband being found. Random searches of a youths' person without undressing resulted in contraband being found thirteen (13) times. Searches of a youth's bag resulted in contraband being found five (5) times. One (1) of the bag searches revealed an unconcealed pocketknife. There were no instances of a weapon being found during a person search in 2024.

The OCA reviewed a report made to the DCYF hotline involving a youth disclosing a peer poked him with a weapon made from a comb.

IRs state youth wear multiple pairs of underwear to prevent the wand from detecting contraband. One (1) IR states a youth "refused to remove one of the underwear" he was wearing and was pushing contraband further into his underwear which resulted in him being sanctioned.

IRs involving staff intervening during youth altercations:

IRs regarding staff intervention during fights include language such as, "I removed (youth) from the gym," "(Staff) and I physically separated the students," "I was holding his arms to guide him out and away," staff used "minimal physical TCI," "Staff engages physical TCI leading him out of the room,"

"(Youth) had to be restrained from going after another resident," staff was "restraining/getting between the two," and "it became necessary to physically restrain (youth)."

IRs involving the management of youths' mental health:

The OCA reviewed IRs involving youth making suicidal statements. In one (1) IR, a youth stated, "I'm just gonna kill myself tonight. I should just hang myself later." Staff wrote, "He also made comments about wanting to go back to the "T" in tangent with comments of self-harm." This youth was asked by a second staff if he was suicidal, and youth said no. Staff wrote, "follow-up with social worker."

One (1) IR stated the youth, "said he was suicidal 3x and was pretending to/trying to open the van door. He was also hitting his head on the van window while the van was in motion." It further notes youth continued to insult staff. No additional information noted. Youth was sanctioned for this incident.

Another IR describes a youth refusing to go to bed. Youth was seen on camera, putting a trash bag over his head. Staff saw him on camera removing the bag and tying it around his neck. The IR states when staff arrived in the laundry room, the youth was "intensely tightening the garbage bag around his neck." Staff wrote, "My first interaction was him stating, 'I am trying to get someone's attention.' Resident confirmed he has no serious thoughts of harming himself. Monitored for the rest of the night."

Another IR describes a youth stating under his breath that he was going to kill himself when back in the dorms. Staff followed up with him and the resident indicated he was not planning on harming himself. No further documentation or follow up noted.

The OCA reviewed an IR with the incident summary descriptions "Threat to Harm Others," "Assault-Peer," and "Police Involvement" checked off. The IR states a youth was upset about losing his weekend visits and wanted to speak with his social worker and mother. While walking down the hall, a resident "exchanged words" with the youth and the youth punched the resident's face. Staff described the youth screaming and trying to force a door open to get to the resident again. Police were called and staff described the youth as "struggling to communicate" with police and being "very adversarial and dismissive" of police. The youth was brought to the hospital for an evaluation. Once he returned to OT RTC, he was sanctioned with "time."

The OCA reviewed the corresponding police report for this incident. Police described the youth "in a corner hysterically crying. It was clear (youth) was having a panic attack as he was unable to speak, taking rapid shallow breaths, and shaking." The youth "repeatedly stated he was being bullied by the other students." Police spoke to the senior staff who completed the IR. Staff told police that since the youth arrived at OT RTC, he has been getting made fun of by numerous residents. Staff reported the resident who walked by the youth prior to the incident made a comment directed towards him. Staff told police the youth was "highly emotional screaming he couldn't take it anymore."

There is no documentation regarding the youth being bullied or any documentation that OT RTC staff followed up with the youth accused of bullying.

IRs involving medication:

The OCA reviewed approximately ten (10) IRs involving medication.

One (1) IR states a youth refused his medication and told staff he didn't take his medications for the weekend then took them all that night. He would not say how many he took. Staff wrote, "(Youth) appeared tired but, not seriously under the influence." The IR concludes that the youth would be monitored for the rest of the night. The IR does not state nursing was notified.

One (1) IR states a youth presented as "under the influence with slurred speech, shaky hands, and slow to respond." Staff heard him tell two youth that he took an extra Clonidine he got from one of them. The youth he got the Clonidine from said, "I gave you my applesauce." Clonidine is crushed and put in apple sauce for medication pass. This statement is indicative of the youth receiving the Clonidine from another youth. One (1) resident stated he saw seven (7) Clonidine in the bedroom of one (1) of the youth. The follow-up portion of the IR states, "Senior staff notified." There is no documentation this youth was checked by nursing or that he was medically evaluated. There is also no information the youth's room was searched for additional Clonidine.

One (1) IR states residents were overheard talking about a youth who "might be sniffing his own medication when he is in his room all day." The "Youth Counseled" box is checked off. There is no further information in this report.

Other medication-related IRs involve a Trazadone pill found in a hallway, a resident's three-day weekend packet of medication found in the center console of a van, a staff accidentally giving a resident the wrong medication, a youth missing a dose of medication due to running out, youth hiding Clonidine in their hand, and staff finding a cup with three (3) pills in it on a youth's dresser during a room search.

IRs involving disruptive behavior:

One (1) IR involved a youth waiting to be picked up by a family member for weekend pass. The youth was brought to the drop-off area by OT RTC staff. Staff described the resident as becoming "extremely frustrated as he was waiting upwards of an hour to leave the stop and continue home." The IR continues, "With miscommunication between family, social services, and group living, the resident became increasingly aggravated with the rate at which the issue was being resolved. The resident used profanities when conversing with senior staff and took quite a while to de-escalate." Staff ordered the youth an Uber home. Follow up states, "Resident sanctioned and reminded of expectations."

A majority of IRs reviewed document residents' disruptive behavior and notes they were sanctioned. Behaviors include going into each other's rooms, residents assaulting each other, not following a staff's directions, youth antagonizing each other, being disrespectful specifically to female staff, using inappropriate language, acting aggressively, and youth informing staff a resident bullied or assaulted them. In some of these instances, staff reviewed footage and confirmed an incident took place.

Some IRs indicate that staff were made aware of an incident occurring only after reviewing camera footage. This raises concern for lack of supervision of youth. One (1) IR states video footage showed the youth "looking around to confirm there were no adults around before fighting." An IR documents a youth "with his face bloodied." It continues, "While staff tried to figure out what happened, I overheard (youths) bragging about beating (him) up while he was asleep." The police were then called and those two (2) youth were arrested. Staff were unaware this assault had occurred.

Several IRs involve youth making serious threats to other youth and staff including threats to kill everyone, stab, and shoot them. There is no further information.

Nearly all of these IRs note the youth was sanctioned. The amount of sanction "time" given is not documented.

IRs involving residents' inappropriate behavior:

Numerous IRs involve youth using sexual language, derogatory language and gestures towards other youth and staff. IRs involve youth using the phrase, "take your/their butt" and staff documented this as being said in a sexual way. One (1) youth was overheard saying, "You either take someone's butt or you get your butt taken. That's the way it works here." Staff documented telling the youth what he said was incredibly serious, the youth said, "Don't worry, it's going to happen at 9pm tonight." Follow up states, "senior staff notified."

Another IR states a youth was, "talking about rape and in context stating threats of another resident wanting to be raped."

Additional IRs state youth pulled their pants down showing their "undershorts" and opened their towels around their waist, exposing themselves to other youth. Other IRs note residents opening the shower curtain while another resident is showering. Some IRs document youth being observed urinating in other youth's bedrooms or youth throwing what staff identified as a bottle filled with semen or urine into a bedroom. Another incident involved a youth repeatedly touching another youth's chest, neck and face "in a rather strange way."

One (1) IR states a youth was "pulling on" another youth's nipples while in the hallway. That youth "demanded they stop touching him before he calls PREA." Another IR states two (2) youth were instigating each other after showering. When staff turned their back, one (1) youth "reacted to something (the other youth) did when I wasn't looking and said, 'that's a PREA charge." Staff reviewed camera footage and saw one of the youth opening his towel.

One IR (1) states a youth was asked why he was being disrespectful, and the youth said, "you PREA'd me." Staff told him that is "an extremely serious thing to say when it is untrue" and the youth called staff a "child predator multiple times while smiling." Staff stated the resident's claim stems from an incident the night before when the youth was "forcing his way into the room in which he did not have permission to enter." Staff held the door and asked him to allow staff to shut it. The youth was then sanctioned. The follow-up section of this IR states "Senior staff asked (youth) if he wanted to make a PREA claim three separate times but he explained to senior staff that there was actually nothing to report."

The OCA reviewed a report made to the DCYF hotline involving a seventeen-year-old (17) youth rubbing his penis on a fourteen-year-old (14) youth's "butt" as he was drinking from a water fountain. The resulting investigation states the older youth admitted to rubbing his penis against the other youth "as a joke" and he reported other residents have done the same to him. The youth further reported, "Everyone does that. They rub against each other, slap each other on the butt and talk dirty all the time."

Mr. Sullivan told the DCYF investigator, "it is not uncommon for residents to rub against one another or slap each other's buttocks in an attempt to make other residents laugh."

Despite the youth admitting to rubbing his penis against the youth "as a joke," Mr. Sullivan additionally reported to a Licensing worker, "after reviewing the incident on camera it appeared to be an accident."

IRs involving gang-related activity:

The OCA reviewed IRs that involve "G Way kids" telling youth they must fight one or all of them or else the youth will get jumped. One (1) IR states staff observed gang affiliated vandalism in the gym. Another IR involved staff overhearing youth discussing how to wear a handkerchief to properly represent a gang.

Youth Interviews

The OCA interviewed residents. All youth spoke about issues regarding sanctions, the inability to make phone calls, searches, and youth intervening during fights.
Youth consistently reported some staff do not give out time equally and stated staff "abuse their power" when giving sanctions.

Youth reported being given "time" does not prevent poor behavior and only makes them angry. Some stated staff, "make up new rules all the time." All youth confirmed there is little consistency amongst staff when staff give consequences of "time." All youth reported the amount of "time" they receives varies depending on the mood the staff is in at the time.

Some youth said they try not to misbehave in fear of losing their weekend pass. Youth who do not have visiting resources stated the loss of weekend passes has no impact on their desire to follow rules because they have nothing to lose. Youth reported the "no time" trip does not motivate them to do better or follow the rules. One (1) youth interviewed by the OCA stated he has not been able to participate in any off-campus activities for four (4) months due to how much "time" he has.

Additionally, some youth reported being aware that written sanctions require writing a phrase fifteen (15) times, twenty (20) times, and fifty (50) times.

Youth reported they have voluntarily spent several hours in a chair to work off their time. One (1) youth stated he completed ten (10) hours of chair time in one day on a weekend, with a break for lunch halfway through. Another youth reported choosing to sit in a chair for two-and-a-half (2 ½) hours with

a break to use the bathroom. There is no indication that staff are requiring youth to sit in chair time beyond fifteen (15) minutes. Some youth reported doing chores to work off their time without being told how much time would be taken off until they were finished.

Youth expressed frustration about not being able to call home whenever they'd like. They explained they share a clinician with several other residents who may also want to make a call in the evening. Youth explained only some residential counselors allow calls in the dorm. This was confirmed by staff. All youth report their phone calls are always on speakerphone.

Youth described the search process consistently. Youth describe going into the staff office, taking off all of their clothes except their underwear, putting their feet on the marked areas on the floor, being wanded, then going to the shower. All youth described the shower as less than five (5) seconds and denied it was for the purpose of getting clean. Staff and youth confirmed there is no soap provided and youth are wearing their underwear in the shower. The water in the shower stall stays on while youth rotate in and out. All youth and staff interviewed unanimously reported the purpose of the shower was to destroy contraband that may be concealed in the youth's underwear. When youth were asked if they've ever refused a shower, they all stated no, because that would be a search refusal which may result in losing a weekend pass home.

Youth described staff breaking up fights as staff "bear hugging" them, "grabbing" them, "holding their arms," and "grabbing who's on top and dragging them away." Youth stated sometimes staff have to hold a youth for several minutes until they calm down. Youth denied ever seeing staff putting a youth down on the ground to be restrained.

Youth further reported residents often help staff break up fights because they see staff struggling. Youth described holding one of the residents back or pulling one of them off and away. Youth explained if they assist staff by intervening during a fight, Mr. Sullivan gives them their weekend pass back if it was previously taken away. Staff confirmed youth are rewarded when they help staff break up fights. One (1) staff stated he gives youth a special drink, praise them, or gives residents a movie night. All youth denied staff put their hands on residents for any reason aside from breaking up fights.

Some youth have worked in the kitchen. One (1) youth reported he has worked in the kitchen often while others reported it is difficult to get a job in the kitchen.

Youth explained their schedules. They are given five (5) minutes to shower and get back to their dorm and stated they struggle to finish within the allotted time.

One youth reported, "Lots of us feel we have more freedom in the RITS than here."
Most youth reported school is "good" and one youth stated school was the "best part" of OT RTC. The residents talked about going to the movies, rock climbing, and swimming at URI. Some youth said they did not enjoy these activities. They also spoke about earning "Student of the Week" and being given written compliments.

Findings and Recommendations

The OCA's site review consisted of five (5) site visits, reviewing numerous documents and hours of camera footage, in addition to conducting several interviews. As a result, the OCA has identified the following concerns and recommendations.

Findings related to overnight checks: OT RTC's policy is to complete overnight checks of youth, hourly. The OCA found staff did not follow the policy and check on youth every hour. In December 2024 there were thirty-one (31) instances of staff not completing hourly room checks. In January 2025 there were thirty-six (36) instances of staff not completing hourly room checks and in February 2025 there were thirty-three (33) instances of staff not completing hourly room checks. There were incidents of youth exiting their bedroom window during the night for the purpose of going AWOL and to exchange contraband. Staff rely on watching cameras from the staff office as opposed to being posted outside of the youths' bedrooms.

Recommendation: The OCA recommends completing overnight checks of youth at least every thirty (30) minutes. Staff must see the youth in their bed. Staff must be positioned in the dorm hallways to monitor any activities that may occur in addition to watching cameras in the office. The OCA further recommends oversight by Administration to ensure checks are completed every thirty (30) minutes.

Findings related to supervision: After numerous hours of reviewing video footage and hundreds of pages of documentation the OCA identified significant issues with staff supervision of youth. Video footage revealed youth walking around various areas of the facility without staff and no indication of staff nearby. IR's clearly indicate staff being unaware of assaults, AWOLs, sexualized behaviors and other incidents involving youth until a review of video footage by one or more staff members. Video footage shows youth looking around the area before leaning into a bedroom, staff using their cell phones and being pre-occupied with tasks in and out of the staff office while youth congregate in hallways and other areas unsupervised.

Recommendation: The OCA recommends in-person visual monitoring of youth at all times and staff must not rely on video cameras to monitor the youth. Administration and senior staff must ensure adequate supervision is occurring.

Findings related to gang involvement: OT RTC reportedly accepts violent, gang-involved youth. Administration stated, "OT RTC is a unique setting where gang-involved youth may be living in close proximity to youth who belong to a rival gang that has injured or killed a family member or someone close to them." The OCA observed a hand-made poster in a youth's bedroom related to gang violence. IRs indicate there has been gang-related vandalism and staff have heard youth discussing how to wear a handkerchief to represent a gang. There is no staff training or curriculum related to gangs. There is no gang education or support for youth.

Recommendation: The OCA recommends identifying a comprehensive training related to gangs that will be provided to staff upon hire and annually thereafter. Support and education regarding gang involvement should be provided for all youth.

Findings related sanctions: Inconsistencies were noted between the handbooks, policy, and administrative understanding of sanctioning. This creates confusion and concern regarding the program's use of discipline.

OT RTC reports providing services aligned with a Lasallian Culture of Care which involves encouraging youth and building their self-esteem while emphasizing correction rather than punishment. This model of care also entails knowing individual needs and developing a sense of family and community. The Sanction Policy and punitive measures conflict with the Lasallian Culture of Care used by OT RTC.

Staff have the discretion to give varying amounts of sanction "time" which results in youth being treated unjustly. The Sanction Policy does not indicate how much "time" staff should give a youth for various behaviors. The Residential Counselor Handbook states, "All sanctions must be consistent with those given by fellow staff members. Communicate." It is evident by reviewing sanction logs and speaking with youth staff do not give youth consistent amounts of sanction time and there is little communication between staff around this.

Youth are accumulating twenty (20) or more hours' worth of "time" in one day. Staff and youth reported "time" carries over from one week to the next which makes it difficult to work off.

The Sanction Policy and Resident Handbook do not provide consistent information regarding chair time. The Resident Handbook describes chair time as, "Sit in a chair facing the wall. Both feet should be on the floor, your head should be up. You may not sleep. You must be quiet and cannot talk. You may read during this time. Do not ask the staff how much time is remaining; they will tell you when you are finished." The Sanction Policy does not contain any of the same information as the Residential Handbook. One (1) Administrator reported youth are allowed to speak with staff while completing chair time. Another Administrator did not agree with youth being allowed to speak.

The Sanction Policy does not state that youth are required to complete the first fifteen (15) minutes of their sanction time in a chair however Administration, staff, and youth reported this is a rule.

Youth are voluntarily spending several hours a day in chair time in order to reduce how much "time" they have. Youth sitting in a chair for extended periods of time is not therapeutic. The form used for chair time is not used consistently by staff and youths' time is not accurately reflected.

Chore time is not consistently calculated and is based on staff discretion. There is no full-time janitorial staff at OT RTC. Youth are responsible for cleaning the facility through assigned daily chores, working off their sanction "time" doing chores, and being required to participate in the Weekend Work Program for poor behavior which also involves cleaning the facility.

OT RTC revokes weekend visits home as a result of poor behavior during the week. Administration reports their program's emphasis on weekend passes is unique and their services help youth prepare for successful reunification. In documentation provided to the OCA, weekend passes are referred to as a "privilege." Staff threaten to take this "privilege" away for poor behavior. According to youth, the risk of having one (1) or several weekend passes revoked is the biggest, if not only, motivator for youth to behave. For youth who cannot go home, it is evident by numerous IRs and excessive

accumulation of "time" these sanctions are ineffective and violates the trust that should be built within the Lasallian Culture of Care.

OT RTC's program is heavily focused on sanctioning youth. The OCA's interviews, review of IRs and sanction logs indicates the use of "time" as a negative consequence does not improve behavior. Youth and staff deny receiving "time" is an effective form of discipline and it does not deter youth from misbehaving again. An IR involving youth who went AWOL states, "The boys do not do written sanctions so none were delivered. The boys are already at the maximum of lost weekend consequences." This further reiterates the ineffectiveness of sanctioning and lack of therapeutic interventions and conflicts with the Lasallian Culture of Care.

Recommendations: The OCA recommends a comprehensive list of sanctions be defined. Expectations and specific "time" are to be outlined and defined in protocol that all staff are required to follow. This should be available to all youth upon admission. This protocol must be included and consistent with the Sanction Policy. Any additional "time" given to youth must be documented in an IR, the sanction log, and in accordance with policy/protocol.

The Sanction Policy must identify a clear limit of how much "time" a youth can accrue.

The OCA recommends identifying a specific, and clear number of minutes taken away from youth's "time" for individual chores. This will ensure all consequences are consistent for all youth. Youth are responsible for daily chores and should not be solely responsible for the cleanliness of the entire facility. Documented protocols will ensure consistency within the program for youth and staff.

The OCA recommends staff are consistent in filling out the chair time log with a start and end time. This will ensure OT RTC is in compliance with DCYF regulations regarding time-outs and ensure youth are being given credit for every minute spent in the chair. The OCA further recommends youth are informed they do not have to exceed twenty (20) minutes sitting in the chair. If a youth chooses to remain in the chair, this is limited to no more than one (1) hour daily.

The OCA recommends individualized, therapeutic motivators for youth, particularly for those who are unable to go home on weekend passes to align with the Lasallian Culture of Care as described by the information within the Lasallian education and framework.

The OCA recommends OT RTC develop a pro-social behavior modification system for youth that is evidence based for positive outcomes. Consequences and corresponding behavior modification must be consistent and clearly defined for all youth and staff. Additionally, the OCA recommends more positive reinforcement tools be used with youth to encourage engagement in youths' treatment plan and goals. This should align with the Lasallian Culture of Care.

Findings related to person searches: The initial Privacy and Search Policy provided to the OCA is as follows: "For the safety and security of residents and staff all residents returning from weekend pass are searched. Except in exigent circumstances, search of a resident's person are to be conducted in the presence of two staff. Female staff never conduct searches of male resident's person. Any exception to this policy is to be justified in writing. All residents head directly to the 'search room' when they enter the facility. Staff scan residents using a metal detector wand. All residents are required to pack a towel

and leave all items in the search room and proceed to the shower. All articles of clothing, pockets, socks, inside of sneakers, belt buckles, underneath the hat's brim, shirt pockets, etc. should be searched. All contraband will be labeled and secured by staff. It is important for staff to be sensitive. Searches can be embarrassing for the residents in question. Take steps not to embarrass residents around their peers. Staff is not to search the resident's body and are never to search a resident for the sole purpose of determining a resident's genital status. In addition to residents returning from weekend pass residents may be searched whenever they return to campus from being outside of staff supervision or staff has reason to believe they are in possession of contraband or stolen property. These searches should only be conducted when necessary and never to harass a resident. A resident may be searched when staff believes that the resident is violating the law, in possession of contraband or stolen property. If a resident refuses to be searched he will receive the consequences of having been in possession of the contraband or stolen property."

OT RTC's search protocol required youth to strip down to their underwear to be wanded on camera in a staff office. Both doors of the office have large windows allowing others to look inside while youth are searched. This process did not consistently prevent contraband from entering the facility and no weapons were found during a person search in 2024.

The search process required youth to shower in their underwear. The Privacy and Search policy did not state the purpose of the showers. Statements from OT RTC Administration contradict the information about showers in the Residential Counselor Handbook and the information reported by youth and staff. Based on conversations with staff and youth it was determined this process of having youth shower with no soap for less than a minute was to destroy contraband youth may be attempting to conceal. Inconsistencies between policy, procedures, and handbooks were noted regarding person searches.

Residents report they do not refuse to shower because they do not want to lose their weekend passes. The policy does not state what, if any, consequences youth may receive for refusing to shower.

In accordance with the Children's Bill of Rights, youth have the right to be treated with dignity. The person search process conducted by OT RTC is not dignified and is a violation of the youths' rights.

Recommendation: The OCA recommends the practice of youth removing clothing for person searches and videotaping person searches cease immediately. Additionally, youth must not be required to shower as part of the search process.

The OCA raised significant concerns with OT RTC's search policy and practice. The OCA was provided an updated policy which states, "All residents are required to pack a towel and leave all items in the search room and proceed to the dorm." All language in the updated policy remained the same as the original policy aside from instructing youth to proceed to the dorm rather than the shower. The dates on the updated policy reflect the same dates as the original policy.

The OCA recommends the removal of requiring youth to pack a towel. The OCA further recommends staff search youth's belongings with youth present and provide youth an opportunity to hand over any items that may be considered contraband prior to searching their belongings. Body searches should not

be allowed by staff at any time. If there is any concern a youth is concealing dangerous items, the local police should be notified immediately.

The OCA notified DCYF and requested OT RTC to cease these "strip searches" immediately on April 8, 2025. To date, the OCA has received no information from OT RTC as to their current search process.

Findings related to room and belonging searches: The Privacy and Search Policy and handbooks state that upon returning to OT RTC from weekend pass, youth are to leave their belongings with staff to be searched and the youth will be told when they can retrieve the belongings at a later time. Mr. Sullivan also advised that youth are not always present during room searches. These processes are in violation of the RI DCYF Licensing Regulations.

The OCA reviewed video footage of staff searching through a youth's belongings. The staff was engaged in conversation, looking at another staff while his hand was moving around inside the youth's bag. The staff did not remove all of the items or properly search the inside of the bag. The OCA reviewed numerous IRs related to contraband being brought into the program.

The Privacy and Search Policy states items removed from youths' belongings are to be entered into a resident inventory. Administration reported inventories are not updated when youth return with new items and the OCA did not observe updated inventories in youths' binders.

Recommendation: The OCA recommends the search policy be in compliance with the Licensing Regulations. The OCA recommends using consistent and specific language within the policy and handbooks of when searches are permitted.

The OCA recommends staff thoroughly search residents' belongings when returning from off campus, searches are done in the youths' presence except in the case of an emergency or unauthorized absence, and a protocol clearly defines how to conduct a search of youths' belongings. Staff responsible for bag searches must focus solely on this search in order to be thorough.

The OCA further recommends that every youth's case record include a regularly updated inventory of personal belongings to be in compliance with Licensing Regulations.

Administration must ensure strict adherence to policies and procedures by staff.

Findings related to medication distribution and handling: Based on a review of video footage and discussions with Administration, staff, and residents, the OCA found there is no consistent protocol for passing medications. There are numerous distractions during med pass including youth and staff in and out of the office, searches being completed, youth requesting hygiene products stored in the med room, staff observing the cameras while preparing medications, and youth speaking to staff from the door. These distractions create ample opportunity for med errors. Staff did not cross check the medications as stated in the policy to ensure the name of the medication and the dose being dispensed matches information in the medication log. Staff did not ensure residents are swallowing their pills, medications were left unattended in the open staff office, medications were mishandled, and staff were

not consistently wearing gloves while touching medications. Controlled substances are not being counted.

The OCA observed a rolling cart in the medication room that had a loose pill on it. This was pointed out to Ms. Dunlap who handed the pill to staff. This staff told Ms. Dunlap that the pill was a Clonidine.

Recommendation: The OCA recommends a consistent policy, protocol and procedure for dispensing and passing medications. Staff must put all of their attention on safely completing this process. One staff must be assigned and responsible for medication pass. This staff should not engage in any other duties during the medication pass process. Re-training staff on handling medications properly in addition to keeping medications secure at all times is recommended. Additionally, the OCA recommends storing residents' hygiene and other personal products in a location that will not interfere with medication management. Controlled substances must be counted and accounted for each shift. Administration must ensure adherence to all policies and procedures by staff.

Findings related to the Resident Handbook: The Children's Bill of Rights within the Resident Handbook is incomplete. Information in the Resident Handbook does not align with policies and protocols.

Recommendation: The OCA recommends updating the Resident Handbook to include a complete Children's Bill of Rights. All information in the Resident Handbook must be consistent with policy and protocol.

Findings related to crisis intervention and prevention: Staff are trained in Therapeutic Crisis Intervention (TCI) which includes techniques for preventing a crisis, restraints and holds to be used during a crisis, and steps to be taken after a crisis. OT RTC's Seclusion and Restraint Policy does not align with TCI training. The OCA did not observe documentation indicating the post-crisis timeline outlined in TCI training is completed by staff.

Though staff are taught how to restrain youth, Administration stated they do not do restraints under any circumstances.

The OCA reviewed video footage involving numerous instances of physical fights between youth. Footage showed staff struggling to hold youth back, using their own body weight to physically intervene and grabbing youth's arms inappropriately. In one (1) video, staff places their arm near a youth's throat to prevent the youth from charging forward. OT RTC Administration advised staff are told to "create space" by inserting their own body in between youth fighting. This is not an approved TCI method.

Several IRs use language such as "physical TCI," "holding his arms" and "restrained" to describe how staff manage youth fighting. Administration denied staff have ever restrained or held onto a youth despite staff documentation.

Recommendation: The OCA recommends when youth are in crisis, staff only utilize TCI techniques including de-escalation and approved holds and restraints, to ensure the safety and appropriate hands-

on of youth. Administration must allow staff to use their TCI training to safely manage unsafe behavior, including the use of TCI restraints and holds.

The Seclusion and Restraint policy must include the post-crisis timeline and documentation protocols outlined by the TCI training. Documentation must be reviewed by Administration. In the event techniques that do not align with TCI are used to manage a crisis, Administrative actions should include but are not limited to, documenting the discrepancies, disciplining staff, and re-training staff on proper techniques.

Findings related to youth intervening in fights: Youth have expressed often times staff are unable to successfully break up fights. Youth report they feel they must intervene.

Youth and staff report youth are rewarded for intervening during fights. Youth are aware they may earn their weekend passes back by assisting staff to break up a fight between others.

Recommendation: The OCA recommends youth are not permitted or utilized to assist staff in breaking up fights for any reason. Youth should not be rewarded for assisting. Staff should be utilizing the appropriate TCI intervention.

Findings related to crisis training timelines: Administration reported TCI training is typically offered quarterly and new hires need to wait until there are multiple staff in need of certification before scheduling the training.

Recommendation: All staff working directly with the youth must be fully trained in TCI within thirty (30) days of hire to align with Licensing Regulations and ensure the safety of staff and youth.

Findings related to documentation: Documentation lacks pertinent information. IRs do not include all details related to the incident or information regarding follow-up. According to OT RTC's AWOL Resident Policy, any time a youth is AWOL, staff are required to complete an IR. All sections of the IR are to be completed. The OCA reviewed numerous IRs that were missing important information regarding the youth and their AWOL.

There is no protocol for how to complete logs or rosters. When reviewing logs and rosters, it was unclear what information is being collected. On the rosters, some staff write letters next to youths' names to identify their location at each check. Some staff include a key indicating what the letters stand for and other staff do not.

The back of the rosters are to be used to document the time a youth begins working off their sanction "time" and the time they stop. This is not consistently being done. Staff do not document what youth are doing to work off their sanction time.

Administration advised IRs and logs are "internal documents", and Administration does not consider that outside agencies may review this documentation. Administration reported everyone within the facility who needs to know information will know about it, despite documentation lacking pertinent information. The OCA requested follow-up information regarding IRs. Administration needed to go through emails to find the information requested by the OCA. Incomplete and inadequate

documentation proved problematic for the OCA in determining what took place during specific incidents and determining if OT RTC is in full compliance with Licensing Regulations.

Administration reported that some documents contain "old language" that do not reflect current practice. Information describing "chair time" did not align with how this sanction is currently completed. The Sanction Policy mentions youth making phone calls when in Gallogly House. Gallogly House has been closed since 2014.

Staff decide amongst themselves who will be the Shift Manager each shift. The Shift Manager is responsible for completing all documentation for their shift.

Recommendation: The OCA recommends IRs include all pertinent information including but not limited to what follow-up occurred as a result of the incident and who was notified. All AWOLs must be properly documented and all follow-up after the incident should be noted.
A protocol must be developed regarding completing all logs and rosters. Staff must complete these forms fully and consistently. Staff must document how much sanction time a youth has worked off and whether they sat in a chair or did specific chores. Any shorthand used by staff should be explained on the document and used consistently amongst staff.

Administration must review and ensure documentation adheres to policies and procedures. Any language that does not reflect current practice and protocol should be removed and/or updated in all policies and handbooks.

The OCA recommends senior staff assign the role of Shift Manager at the beginning of each shift.

Findings related to the grievance policy: The Client Grievance Policy states clients and families are "encouraged" to address complaints prior to filing a formal grievance. The school staff and student handbooks state the student "shall" attempt to resolve the dispute informally prior to filing a formal grievance.

Recommendation: The OCA recommends the Client Grievance Policy and the handbooks are written using consistent language. By stating youth "shall" attempt indicates they must do this prior to filing the grievance. Youth have the right to file a grievance at any time and should have the option.

Findings related to visitation: The OCA was informed staff do not consistently check the IDs of people visiting youth. Administration stated "ideally" staff check IDs but reported this is not always done. Visitors who are not on a youth's approved visitor list are allowed into the facility. Administration stated if a visitor brings in contraband, this information is called into the hotline. An IR from 2024 indicates a visitor brought in a THC vape cartridge and there is no corresponding hotline report.

Staff are described as "passively supervising" the visits and there are cameras in the room. An IR from 2024 noted a "teenage girl" accompanied a resident's mother on a visit. The girl and the resident entered a men's bathroom together. Staff entered the bathroom and confirmed they were in the same stall. The youth was sanctioned for "shady behavior" and "out of staff sight" and was reminded of visitation expectations. There is no documentation that identifies the teenage girl or whether she was

on the approved visitor list. The Parent Handbook states, “This is family time, and no friends or girlfriends are allowed to visit.” It is concerning that the girl and resident were unsupervised in the bathroom.

Recommendation: The OCA recommends that OT RTC only allow approved visitors into the facility. If someone who is not on the list attempts to visit they should be denied entry. Youth’s DCYF worker along with any assigned CASA, GAL, and/or Probation Officer must be notified of any unapproved visitors attempting to enter the facility. If a visitor brings in contraband, this information must be called into the hotline and the assigned DCYF/Probation/CASA worker must be notified. Police should also be notified when a visitor brings in illegal contraband.

Findings related to residents’ phone calls: The Resident Telephone Policy states, “Except for instances of reporting abuse and neglect there is no expectation of privacy. Clinician or Staff should be present in the room for the phone call, and it should be conducted on speaker phone when possible.” This is in violation of the Children’s Bill of Rights and Licensing Regulations.

The policy states “Residents are permitted to make phone calls to family and approved contacts through their assigned clinician. The Director of Social Services will coordinate a youth’s phone call if their assigned clinician is not available. While it is not standard procedure for youth to make phone calls with residential staff, to accommodate parent work schedules a clinician may request that a senior staff arrange for youth to contact family by telephone.” Clinicians are shared amongst multiple youth, and they do not have a set schedule. The OCA was informed some staff allow youth to make calls in the dorm and other staff do not.

The policy states, “For privacy and security reasons youth will not receive incoming phone calls. If a call is received for a resident and their clinician is unavailable staff will take a message or forward the call to the clinician’s voicemail.” The Residential Counselor Handbook states, “Residents are not allowed to make or receive phone calls.”

The OCA has addressed the violation of the Children’s Bill of Rights with OT RTC Administration. There has been no follow up from OT RTC to the OCA, to date.

Recommendation: Any youth denied a reasonable expectation of privacy during phone calls must have supporting written documentation in their clinical treatment plan. This decision must be made and agreed upon by the youth’s entire treatment team and reviewed every thirty (30) days as a team. The OCA further recommends a phone call schedule be available to youth and include flexibility outside of their clinical session. The language used in the Residential Counselor Handbook must match the Residential Telephone Policy.

Findings related to youth substance use: The OCA reviewed numerous IRs that described youth being under the influence of a substance. IRs describe youth presenting with concerning symptoms such as “droopy appearance,” “erratic behavior,” “very disoriented in terms of time” and “behavior very strange and a departure from baseline.” One (1) IR indicates a youth said he has been going through “withdrawals” that involve “routine headaches and profuse sweating.” There were no follow up actions documenting youth were seen by a medical professional or appropriately cleared by medical personnel.

IRs include staff describing youth as being "under the influence or being "high" and others indicate staff "suspect marijuana." Administration reported staff are not trained to identify signs a youth is under the influence of drugs or alcohol. Ms. Dunlap explained that follow-up depends on the severity of the symptoms the youth is displaying, and staff sometimes mistaken a youth who is overly tired as being high. She further stated if there is concern for the youth's well-being, they will notify nursing and the hotline. None of the IRs document nursing was notified. Most incidents involving suspicion of substance use resulted in a room search or tox screen. Other IRs do not mention any follow-up.

Contraband including marijuana vapes are reported to be an ongoing problem within the program. Youth reportedly have access to drugs and alcohol while on pass. OT RTC has denied youth from being accepted into their program due to having substance abuse histories. There are youth at OT RTC with diagnosed substance use disorders as indicated in their clinical documentation and assessments.

Some youth have documented substance use diagnoses and have goals related to substance use. The OCA found no documentation or evidence of substance use treatment being provided or referenced in clinical notes.

The Substance Use Education, Counseling & Screening Policy states youth are enrolled in the substance use program at OT RTC by Family Court, DCYF/Probation, parent/guardian, or by OT RTC. The OCA reviewed the curriculum used for the substance use program titled Anger and Substance Use Behavior Change Class. There are seven (7) classes in the curriculum and substance use is not addressed until class five (5). The curriculum states, "We are going to present and discuss some general information about what we know from the research on substance use/abuse." This program does not adequately address youths' substance use needs and/ or relapse prevention skills and tools to utilize in their daily lives.

Recommendation: The OCA recommends training staff to recognize symptoms of drug and alcohol use. OT RTC must create a policy and a protocol to identify steps taken by staff when youth appear under the influence. Youth must be medically cleared by a professional including but not limited to, nursing, EMS or a hospital when suspected of being under the influence. Documentation must include all follow up actions taken.

The OCA recommends OT RTC implement a comprehensive and in-depth substance use curriculum to better and adequately equip youth with knowledge and coping strategies to make healthier choices. Additionally, the OCA recommends specific substance use counseling and clinical work be fulfilled; including but not limited to the curriculum used by OT RTC be addressed and reflected in youth's clinical treatment.

Findings related to inappropriate behavior amongst youth: A recent DCYF investigation concluded a seventeen (17) year old resident rubbed his penis against the buttocks of a fourteen (14) year old resident at OT RTC. The seventeen (17) year old told the investigator other residents have done the same to him and that "everyone does that." The youth reported the residents rub against each other, slap each other on the butt and talk dirty all the time. The investigator interviewed a senior staff who described the incident as "not intentional sexual harassment" and said the residents often "horse around with each other." Mr. Sullivan's response to the allegation was, "It is not uncommon for

residents to rub against each other or slap each other's buttocks in an attempt to make other residents laugh. Mr. Sullivan reported staff address the incidents as they arise, however the residents continue to engage in "that sort of behavior." Mr. Sullivan further stated the victim youth "doesn't fit in with many of the other residents" and told the DCYF Investigator similar incidents have occurred between victim youth and his peers. Additionally, the youth admitted to rubbing his penis against the victim youth "as a joke." Mr. Sullivan later stated to a Licensing worker, "after reviewing the incident on camera it appeared to be an accident."

Staff often sanction youth for "horseplay" however statements provided by staff and Administration indicate this behavior is typical and occurs often. The "normalization" of these behaviors by administration places youth in potentially abusive and often uncomfortable situations.

The OCA reviewed IRs involving youth touching another resident, exposing themselves to other residents by opening their towel wrapped around their waist, opening the shower curtain while a youth is showering, and youth urinating in other youths' bedrooms.

Inappropriate behavior and/or touching amongst residents has been normalized by Administration and staff. The youths' behavior is described as a joke rather than a potentially traumatizing incident for the victim youth. The type of behavior described in IRs and the DCYF investigation is problematic and there is no documentation indicating it is being handled properly. All youth have the right to be protected from physical, and psychological harm including violence, abuse and neglect.

Recommendation: Inappropriate behavior and/or unwanted touching amongst youth must not be tolerated. All PREA violations must be appropriately reported immediately following a qualifying incident. Youth must be properly supervised to deter them from engaging in inappropriate behavior staff must quickly intervene if it happens. Youth must be given a clear expectation of acceptable behavior and appropriate consequences for the offending youth must be utilized. Support must be given to any youth who experiences inappropriate and/or unwanted contact with another youth and their clinician notified.

Many of the youth at OT RTC have significant trauma histories. While Administration has normalized this behavior, it is not appropriate for youth to be touching others in a residential treatment facility. Allowing and minimizing the inappropriate behaviors places youth in situations to be triggered and re-victimized.

Findings related to the management of youths' mental health: The Resident Safety & Suicide Prevention Policy states when a youth is expressing SI, a mental health status and risk assessment will be done by a qualified and immediately available professional. OT RTC could not provide a protocol used if there is a mental health emergency and there is no clinician available. Additionally, no suicide prevention training for staff was provided to the OCA.

IRs involving youth expressing SI contained no information regarding further assessment, intervention, or notification to a mental health provider, guardian, or assigned worker. Administration reported there may be follow-up regarding the SI statements in the youths' clinical session that week. Administration minimized the severity of the concerns noted in the IRs by explaining that staff are

aware of some youth who make SI comments on an ongoing basis and do not have actual intentions of harming themselves.

An IR indicated a youth was sanctioned for making SI statements and for self-harm and the IR does not state the suicide protocol was followed. Mr. Sullivan expressed agreement with the resident being sanctioned for his behavior and reiterated that staff know some youth are not actually suicidal and are just acting out. Sanctioning a youth for displaying self-harm or SI behavior is highly inappropriate and potentially places youth in dangerous situations.

The OCA reviewed a police report that contradicted the IR. The IR describes a hostile youth dismissive of police. The police report is labeled as a "Mental Health" response and describes the youth having a panic attack due to ongoing bullying. The youth was not combative with police and the police managed to de-escalate the youth.

The OCA reviewed documentation by youth's DCYF worker. This worker documented the youth's disclosure of bullying at OT RTC. The worker asked the youth's clinician at OT RTC, "What type of supervision they are providing for these youth and what type of intervention he and the staff are doing to ensure this stops. It is not okay for anyone. Bullying has a negative impact on the kids and we as the adults are mandated to find a way to stop it." The DCYF worker suggested OT RTC provide a counseling group about bullying for all residents. The OT RTC clinician's response was that Administration and staff are keeping their eyes on the youth, and they are supervising the other kids. Documentation completed by the DCYF worker one (1) month after the incident states the youth was still being bullied.

There is no additional information that OT RTC addressed the situation.

Recommendation: When a youth is expressing SI or there are concerns related to a youth's immediate mental health needs, the youth must be assessed by a mental health professional as soon as possible. Staff must take all statements made by youth seriously. Staff must consistently follow protocol to include having the youth assessed by a qualified individual and notifying all appropriate people.

To ensure the safety, dignity, and well-being of all youth, a clear, consistent, and trauma-informed response to bullying must be expected of all staff. The youth responsible for bullying others must be held accountable and appropriate and consistent consequences given. The victim must be offered clinical support with ongoing follow up. A safety plan must be created and followed to ensure the victim feels supported and safe in their environment.

Findings related to youth medical care: OT RTC is struggling to identify dentists who are accepting patients which makes it difficult to schedule dental services for the youth.

Recommendation: The OCA recommends that OT RTC works with DCYF to ensure youth are receiving dental services in a timely manner upon admission and throughout their time in the program.

After full review and completion of the site review including interviews with youth and staff, the OCA found OT RTC to operate with a punitive oversight and punishment-based system not in alignment

with the Lasallian Culture of Care. This is evidenced by youth walking the halls without purpose, hours of children sitting in chairs with little to no interaction with others, no individualized rewards to motivate youth, and significant loss of privileges with minimal documentation identifying the negative behaviors. No documentation was provided to the OCA to indicate any positive reinforcement, pro-social skill building, or trauma-informed care is occurring for the youth nor was this provided in any verbal conversations or feedback with youth, staff, or Administration. Youth reported many residents feel they had more freedom at the RI Training School than at OT RTC. The OCA finds there is minimal therapeutic work being done with the youth at OT RTC.

The OCA appreciates Ms. Dunlap and Mr. Sullivan's time spent accommodating the OCA's visits and additional requests for information.

The OCA requests follow up in a written response to the above recommendations by OT RTC within fifteen (15) days.

Respectfully submitted,

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