

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

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**NAME OF FACILITY:** Enid Adventure Program

**DATES OF VISITS:** March 24 and September 27, 2005

**OVERSIGHT REVIEWERS:** Cliff A. Aldridge, Oversight Specialist (March and September visits)  
Lou Truitt, Program Supervisor, National Resource Center for Youth Services, University of Oklahoma (March visit)

**PURPOSE OF VISIT:** Unannounced Visits for 2005

**DATE:** May 11, 2006

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**GENERAL INFORMATION**

The Office of Juvenile System Oversight (OJSO) conducted routine, unannounced visits to the Enid Adventure Program on March 24 and September 27, 2005. The purpose of the March visit was to assess compliance with established responsibilities and facility policy and procedures. The Office of Juvenile Affairs (OJA) contracts with the Southwestern Oklahoma State University (SWOSU) for the operation of the program, which serves OJA-custody males. On the day of the first visit, March 24, the census was nine residents; on the day of the second visit, September 27, the census was eight.

Subsequent to the oversight visit in March, the OJSO learned that the program was receiving additional administrative assistance from the other SWOSU adventure programs. Personnel changes were made, including both staff and administration, at the Enid Adventure Program. The new Program Administrator assumed responsibility for the program on June 17, 2005. Consequently, the OJSO deferred the preparation of the March oversight visit report until after the subsequent visit. Information from both visits is included in this report.

**VISIT ON MARCH 24, 2005**

Persons Interviewed

- Initial entry interview with the administrative assistant, the therapist, and a residential juvenile specialist
- Subsequent entry briefing with the Program Administrator
- Three residents

- Two direct care staff members
- Exit conference with the Program Administrator

### Documentation Reviewed

- Case records on three current residents
- Personnel files of two direct care staff members
- Inspection report, dated November 11, 2004, by the Division of Child Care of the Department of Human Services (DHS)
- Inspection report, dated March 16, 2005, by the Enid Fire Department
- Inspection report, dated January 25, 2005, by the Oklahoma State Department of Health
- DHS Residential Child Care Facility license

### Areas Toured

- Residential, dining, and food preparation areas of the facility
- Vacant Nash public school building
- Twenty digital photographs were taken of the residential property and the Nash school building

### **Overview**

#### Interviews

All three residents interviewed:

- had participated in the development of their treatment plans;
- reported receiving individual, group, and family counseling treatment services; and
- reported receiving appropriate medical, dental, and eye care according to their needs.

The two staff members interviewed:

- reported receiving appropriate training;
- demonstrated awareness of facility policies;
- described only appropriate consequences for rule violations by the residents; and
- listed a variety of recreational activities in which the residents participated.

#### Documentation Reviews

The case records on two residents and the personnel files of two direct care staff were reviewed for compliance with DHS licensing standards. All four of the files were current for the items reviewed.

The Oklahoma State Department of Health's inspection report of January 25, 2005, noted only that the hand washing sink was not supplied with soap. The DHS Division of Child Care's inspection report of November 11, 2004, cited batteries missing from smoke detectors in two bedrooms, uncovered food in the refrigerator, and numerous damages to the walls. The Program Administrator had issued a memorandum to the staff to correct the deficiencies.

### Facility Tour

The facility that housed the program was once a residential home. Although the facility was clean on the day of the visit, the building continued to show a good deal of wear. There was evidence of repairs to damage, such as holes in the walls or doors; however, there also appeared to be new damage that had not been repaired.

The Enid Adventure Program has been in the process of looking for a more desirable location for a number of years. The OJSO reviewer was advised that agreements had been reached for the facility to occupy the school building in Nash, Oklahoma, which had been vacated earlier due to school consolidation. Although considerable renovation was needed, it was expected that the entire program would relocate later in the year to the site in Nash.

### **VISIT ON SEPTEMBER 27, 2005**

#### Persons Interviewed

- Entry interview with the therapist and the Program Administrator
- Three residents
- Two direct care staff members
- Exit briefing with the Program Administrator, the therapist, a residential juvenile specialist, and the adventure specialist

#### Documentation Reviewed

- Case records on two current residents
- Personnel files of two direct care staff members
- Inspection report, dated April 22, 2005, by the DHS Division of Child Care
- Inspection report, dated July 1, 2005, by the DHS Division of Child Care
- Inspection report, dated July 7, 2005, by the Enid Fire Department
- Inspection report, dated September 12, 2005, by the Oklahoma State Department of Health
- DHS Residential Child Care Facility license
- Referral log prepared by the DHS Office of Client Advocacy

## Areas Toured

- Residential, dining, and food preparation areas of the facility
- Two classrooms in use at Nash, Oklahoma

## **Overview**

## Interviews

All three residents interviewed:

- reported receiving medical, dental, and eye doctor services; and
- had received eye glasses since placement in the program.

The residents' responses to interview questions regarding the staff, use of restraints, and safety revealed:

- All three residents interviewed reported feeling safe in the facility.
- All three had positive comments about the staff; although, one of them described having been restrained for noncompliance of rules. The resident stated that the staff member who had restrained him no longer worked in the facility.

All three residents reported having been restricted "on lockdown" because two staff members had allowed some of the residents to view and print pornography from the computer during the night shift. The OJSO reviewer was told that it had been reported and investigated. Lockdown was described as loss of many of the privileges they had previously enjoyed, such as sports and other adventure outings. The OJSO reviewer subsequently reviewed the DHS Office of Client Advocacy referral log and confirmed that the incident had been reported.

The Program Administrator advised in a follow-up conversation that he had immediately terminated the employees responsible. When asked about the lockdown, he said that nothing was locked down, that the term merely indicated a restriction of privileges.

One of the two staff members interviewed had worked at the facility for only a week; the other had worked at the facility for a month. The OJSO reviewer had been told that almost all of the staff had been replaced since the previous oversight visit in March. Both interviewees:

- described thorough orientation training;
- demonstrated familiarity with recreational activities for the residents; and
- reported the use of only appropriate consequences for rule violations.

## Documentation Reviews

The files on two residents and two personnel files of newly hired staff were reviewed. The resident files were complete for all of the items reviewed. There was documentation of orientation training for both of the new staff members. Both were still in orientation training at the time of the oversight visit. No concerns were identified from the file reviews.

The DHS Division of Child Care's inspection report of April 22, 2005, cited numerous physical plant deficiencies, such as a loose light fixture, various holes in walls, dirty clothing in a closet, splintered wood on a closet door, uncovered food in the refrigerator, and an exposed electrical outlet. The deficiencies cited in April were not observed during the September tour of the facility by the OJSO reviewer.

## Facility Tour

The Enid Adventure Program had not relocated to the Nash facility as previously planned. Considerable improvements to the existing physical plant were noted during the tour. The walls had been painted, and old minor defects noted in previous visits had been repaired. On the day of the OJSO visit, the facility was clean. Renovations to the school building at Nash had not yet begun, but the program had started an onsite educational program in the school property at Nash. The residents were transported to and from a wood frame building on the school property behind the main building. The exterior of the building was in need of paint, but the interiors of the two classrooms were well maintained and pleasantly decorated. No concerns were noted from the tour.

## **SUMMARY**

By contrast to previous visits, the physical plant showed considerable improvement in maintenance and in aesthetics. The OJSO reviewer had concerns with the use of the term "lockdown" to describe the suspension of privileges, following the staff-assisted access to Internet pornography by some of the residents. There was also a concern with the duration of the suspension of privileges. The incident became known on September 6, 2005, and the residents were still restricted from adventure and outside recreational activities on the day of the oversight visit on September 27, 2005. The OJSO reviewer encouraged administration to reconsider the disciplinary suspension and resume programmatic activities. In a subsequent telephone interview, the Program Administrator reported that the period of loss of privileges for the residents ended shortly after the oversight visit.

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