

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

Name and Location of Facility: Lawton Adventure Program
Lawton, Oklahoma

Date of Visit: December 26, 2007 and January 3, 2008

Oversight Reviewer: Dana S. Holden, Oversight Specialist

Subject: Second Biannual Visit for 2007

Date: February 14, 2008

Introduction

The Office of Juvenile System Oversight (OJSO) conducted a routine, unannounced visit to the Lawton Adventure Program on December 26, 2007, and returned on January 3, 2008, to complete the visit. The Office of Juvenile Affairs (OJA) contracts with Southwestern Oklahoma State University for the operation of the program, which serves OJA-custody males. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The program is licensed for sixteen residents by the Division of Child Care of the Department of Human Services (DHS). On the day of the visit, the census was fifteen.

Interviews Conducted

- Entry interview and an exit conference with the Program Administrator
- Four residents
- One Residential Juvenile Specialist

Documentation Reviewed

- Case records on four residents
- Personnel files of three direct care staff members
- Most current inspection reports by the DHS Division of Child Care, the Office of the State Fire Marshal, and the Oklahoma State Department of Health

Areas Toured

- Two residential buildings (main house and the annex)

Findings

Resident Interviews

The OJSO interviewed four residents. The interview questions pertained to the residents' perceptions of safety, program services, resident rights, discipline practices, and other residential program issues. The OJSO noted:

- All four residents stated they felt safe.
- Three residents rated the quality of the food as good.
- All four stated they got enough to eat.
- All reported receiving appropriate amounts of recreation time and activities.
- Three reported that the house and the annex were cold.
- All four stated that the staff used space heaters to heat the house and the annex.
- Two reported that staff used their personal cell phones while on duty to make personal phone calls.

Staff Interviews

One direct care staff member was interviewed. The interview questions pertained to the staff member's perception of program services, resident rights, discipline policies, and other residential program issues. The staff member confirmed that portable space heaters were used to heat the house and the annex. No other issues of concern were identified from the staff interview.

File Reviews

The OSJO reviewed the files on four residents. The files were well-organized, and the materials were easy to locate. No issues of concern were noted from the resident files reviewed.

The personnel files of three direct care staff members were reviewed. The files were well-organized, and the materials were easy to locate. The OJSO noted:

- One staff file had one of the three required references.
- One staff file did not contain a current job performance evaluation.
- All three staff files were missing copies of the employees' driver's licenses.
- One staff file did not contain documentation of current cardiopulmonary resuscitation (CPR) certification.
- One staff file did not contain documentation of current first aid certification.

No other areas of concern were noted from the staff files reviewed.

Observational Tour

The OJSO conducted a tour of the resident living areas, which were divided between two buildings: the main house and the annex. The OJSO noted:

The Main House

- The interior of the building was not well-lighted.
- The light fixture was hanging by the wires in the upstairs bedroom.
- Holes were observed in the closet wall of the small upstairs bedroom.
- The carpet throughout the building was stained and needed cleaning.
- The room temperature was cold in the large upstairs bedroom during the day.
- Portable space heaters were used to warm the large upstairs bedroom, presumably at night.
- Holes were observed in the north wall and in the cover on the fireplace in the large upstairs bedroom.
- Portable space heaters were being used to warm the living room.
- The floor of the kitchen had several broken tiles.
- The exhaust fan was hanging down from the ceiling by its wires in the downstairs bathroom.
- A large amount of graffiti was observed on the wall and door of the bathroom.

The Annex

- A large amount of trash was observed under the beds of the west bedroom.
- A portable space heater was being used to heat the west bedroom.
- Three long metal bars in the closet and one long metal bar under the bed were observed in the west bedroom.
- A large hole was observed in the ceiling above a bed in the west bedroom.
- Graffiti was observed on the closet wall in the east bedroom.
- A large amount of cable wire was running along the floor from the east door to the television.
- The exhaust fan in the bathroom did not have a cover, exposing the blades.

The OJSO conducted its first biannual visit to the Lawton Adventure Program on February 13, 2007. The facility had corrected the findings noted in that oversight report, with three exceptions:

- The interior of the main house was still not properly lighted.
- The carpet had not been cleaned or replaced.
- The main house and annex were not properly heated.

The OJSO reviewed the DHS Division of Child Care's inspection report, dated September 20, 2007. The violations cited were:

- Holes in upstairs closet (main house)
- Holes in the wall and closet (Annex)

The DHS licensing unit had given the facility until October 20, 2007, to make the necessary repairs. The OJSO noted that the problems still existed; however, the OJSO could not determine whether these were the same holes or whether new holes had been made in the walls.

The OJSO reviewed the Oklahoma State Department of Health's inspection report, dated July 20, 2007. No deficiencies were cited. The facility director reported that the health department inspector had informed the facility in the July 2007 visit that due to a policy change, the health department would only inspect the facility in the future when requested by the DHS licensing unit.

The OJSO reviewed the State Fire Marshal's report, dated January 22, 2007. No deficiencies were cited.

Areas of Concern

1. A large amount of graffiti was observed on the bathroom wall and door in the main house and on the closet wall in the east bedroom of the annex.
2. A long cable was strung from the door and across the floor of the dayroom in the annex.

Violations

1. One staff file did not contain the required number of employee references. DHS licensing standards, Section 153.1, Personnel, (o), Personnel records, (2), (D), in part, states, "The personnel record includes three references."
2. One staff file did not contain a current job performance evaluation. DHS licensing standards, Section 153.1, Personnel, (o), Personnel records, (2), (E), in part, states, "The personnel records includes annual performance evaluations and any reports and notes relating to the individual's employment with the facility."
3. Three staff files were missing copies of the employees' current driver's licenses. DHS licensing standards, Section 154.5, Transportation, (d) Transportation records, (1), states, "The facility maintains on file the name of each driver who transports residents and a copy of the valid driver's license for that person."
4. One staff file did not have documentation of current CPR certification and one did not contain documentation of first aid training. DHS licensing standards, Section 153.1, Personnel, (m), Staff Training, (3), Training for child care staff, (E), states, "Within 90 days of employment, all child care staff complete training in first aid and cardiopulmonary resuscitation (CPR) Child care staff maintain current training in CPR and first aid thereafter."
5. The interior of the main house was dim. Department of Human Services licensing standards, Section 157, Physical facility and equipment, (j), Sanitation and safety,

- (9), states, "All areas used by residents are well-lighted." The facility was cited for this violation during the previous OJSO oversight visit.
6. Holes were observed in the walls and the ceilings in both the main house and the annex. Department of Human Services licensing standards, Section 157, Physical facility and equipment, (j), Sanitation and safety, (7), states, "Floors, walls, ceilings, doors, and windows are maintained in good condition." The facility was cited for this violation during the previous OJSO oversight visit.
 7. The carpet throughout the main house had large stains and needed to be cleaned. Department of Human Services licensing standards, Section 163, Health regulations, (1), Building, (C), states, "Floors are cleanable and in good repair." In addition, Section 157, Physical facility and equipment, (j), Sanitation and safety, states, "All habitable . . . areas are maintained in a clean and sanitary condition. . . ." The facility was cited for this violation during the previous OJSO oversight visit.
 8. The facility was using portable space heaters to heat the main house and the annex. DHS licensing standards, Section 165, Construction and fire safety, 7, Interior. (C). states. "Use of open-face space heaters, unvented space heaters, and portable space heating devices is prohibited."
 9. The light fixture in the west upstairs bedroom and the exhaust fan in the downstairs bathroom of the main house were hanging down by the wires. In addition, the exhaust fan in the dayroom bathroom did not have a cover. DHS licensing standards, Section 163, Health regulations: Buildings, utilities, and grounds, (10), Electrical, in part, states, "The electrical distribution system is sized, installed, and maintained in a safe manner and in accordance with the Oklahoma Electrical Licensing Act."

Summary

The OJSO has concerns regarding the physical condition of the facility. The main house and the annex were being heated by portable space heaters, which could pose a fire hazard to the residents. Due to the amount and types of deficiencies noted in this report and previous oversight reports, the facility does not present as a safe environment for the residents. The OJSO was advised that attempts are being made to locate a new facility for the program. The OJSO conducted an exit conference with the Program Director and discussed all of the OJSO's findings.

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