

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

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**Name of Facility:** Lawton Adventure Program  
**Date of Visit:** November 1, 2005  
**Oversight Reviewer:** Cliff A. Aldridge, Oversight Specialist  
**Purpose of Visit:** Second Unannounced Oversight Visit for 2005  
**Date:** February 24, 2006

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**General Information**

The Office of Juvenile System Oversight (OJSO) conducted a routine, unannounced visit to the Lawton Adventure Program (LAP) on November 1, 2005. The Office of Juvenile Affairs (OJA) contracts with the Southwestern Oklahoma State University for the operation of the program, which serves OJA-custody males. The program was licensed by the Division of Child Care of the Department of Human Services (DHS) for sixteen residents. On the day of the OJSO visit, the census was eleven.

Persons Interviewed

- Entry interview with the Administrative Assistant
- Subsequent entry briefing with the Social Worker II
- A sample of three residents
- Three direct care staff members
- An exit conference with the Social Worker II
- A subsequent telephone briefing with the Program Administrator

Documentation Reviewed

- Case records on two residents
- Personnel files of two direct care staff members
- DHS Division of Child Care's inspection report of October 13, 2005
- Office of the State Fire Marshal's inspection report of January 11, 2005
- Oklahoma State Department of Health's inspection report of August 23, 2005
- Facility organization chart
- Current resident census

## Areas Toured

- Two residential buildings
- Kitchen
- Classroom

## **Overview**

## Interviews

The three residents interviewed were asked questions regarding their quality of life, program services, their treatment plans, and the staff. Overall, the residents were favorable in their responses. The OJSO noted:

- All three reported receiving medical, dental, and vision services since being in the program.
- Each said they participated in their treatment planning and were able to describe their treatment goals.
- All three said they received individual and group counseling services.
- None indicated they were receiving family counseling; however, parental illness, resistance, and lack of transportation were reasons identified for lack of family counseling.

The OJSO also noted from the resident interviews:

- All three reported receiving only appropriate consequences for rule violations.
- Each named a number of staff members whom they believed cared about them and were willing to talk to them and wanted to help them.
- All three reported participating in a variety of recreational activities and adventure outings.

No issues of concern were identified from the resident interviews.

Three staff members representing all three shifts were interviewed relative to compliance with DHS Division of Child Care's licensing standards for residential child care facilities. They reported participation by the residents in a variety of meaningful recreational activities and other program services. The OJSO reviewer was told that two staff members had been injured during restraints:

- In one instance, a staff member sustained a dislocated shoulder. Reportedly, she stretched out her arm to catch a resident running past her.
- In the other instance, a staff member sprained an ankle during a restraint.

According to the interview responses, the residents were not injured during the restraints. The staff members described appropriate program and health services for the residents.

Some concern for the residents was expressed during the interviews:

- The house (physical plant) was cited as inadequate for the program.
- The number of residents on psychotropic medications.
- The behaviors of some residents were mentioned as being different and more difficult than residents in the past.

### Documentation Reviews

Two resident case records were reviewed for compliance with DHS residential facility licensing standards. Both of the files were current for the items reviewed.

The personnel and training files of two residential juvenile specialists were reviewed. Both of the personnel files documented training requirements and were current for the other items reviewed. No issues of concern were identified from the file reviews.

The DHS Division of Child Care's inspection report of October 13, 2005, cited a number of minor physical plant issues. Several of the items were noted as having been corrected during the DHS visit; one item was to be corrected within one week, and another was to be corrected within two weeks. The physical plant deficiencies listed in the DHS report were not identified during the OJSO tour on November 1, 2005. The Oklahoma State Department of Health's inspection report of August 23, 2005, cited only that a floor fan guard and blades were not clean. The floor fan was not in use at the time of the OJSO inspection.

### Facility Tour

On the day of the OJSO visit, the facility was clean; however, the OJSO reviewer noted unlevelled floors and creaking stairs and floors. Several tiles on the kitchen floor were damaged. During the visit, the OJSO was told that staff made repairs when they identified deficiencies or when they were identified by the DHS licensing representative or the OJSO reviewer, but that minor deficiencies were an ongoing problem in the current facility.

The urban location of the facility prohibits outside activities in the neighborhood until local offices or businesses close at 5:00 p.m. during the week. Indoor activities involving the residents have to be conducted in limited space in the main residence before the businesses close and during inclement weather. Early darkness during winter hours also makes outside recreation or adventure activities difficult for the LAP.

The current location and facility makes supervision of the residents difficult. The education program is situated a short distance from the residential facility and the sleeping accommodations are located in two separate building. The facility provides limited space for indoor activities, affords limited opportunities for adventure program activities, and requires moving the residents to a separate location for school.

The single classroom was a small room in the office suite that housed the administration. The classroom contained desks, books, computers, and other educational materials; however, the walls were bare and unappealing. A variety of educational materials could be used to decorate the walls to produce a more interesting environment to stimulate the learning process.

## **Conclusion**

On the day of the OJSO visit, the LAP appeared to be providing adequate residential care, appropriate treatment services, and a variety of program services. The staff and resident interactions appeared to be beneficial to the residents.

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