

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

---

**Name and Location of Facility:** Norman Adolescent Center  
Norman, Oklahoma

**Dates of Visit:** November 1, 3, 7, and 8, 2006

**Oversight Reviewer:** Jenifer K. Cooks, Oversight Specialist

**Focus of Visit:** Oversight Visit and Complaint Investigation

**Date:** January 8, 2007

---

**General Information**

The Office of Juvenile System Oversight (OJSO) initiated unannounced visits on November 1, 3, 7, and 8, 2006, at the Norman Adolescent Center. This was the second oversight visit in the year 2006. The purposes of the visits were to assess the facility's compliance with established responsibilities and policy and procedures and to investigate complaint allegations the OJSO had received regarding the facility. The facility was licensed by the Division of Child Care of the Department of Human Services (DHS) for twenty-three beds, with eight of the beds reserved for female residents. On the first day of the OJSO visit, the census was twenty-one.

Persons Interviewed

- Six direct care staff members
- One teacher
  
- Two persons who were training to become substance abuse counselors

Materials Reviewed

- Files on seven residents
- Seven personnel files and training records
- Facility mission statement, philosophy, and guiding principles
- Fall schedule for residents (2006-2007)
- Agreement for educational services with the Department of Mental Health and Substance Abuse Services (DMHSAS)
- Office of the Oklahoma State Fire Marshal inspection report, dated February 3, 2006
- Notice of inspection by the Public Employee Occupational Safety and Health office, dated May 16, 2006

- Oklahoma State Department of Health inspection report, dated June 1, 2006
- Work orders for pest control, dated April 14 and May 12, 2006
- DHS Division of Child Care inspection report, dated March 29, 2006
- Facility policy and procedures
- Facility Corporate Compliance Plan (undated)
- Shift sign-in sheets for direct care staff members for August 6 through August 31, 2006, and September 2 through September 16, 2006
- Critical incident reports for the past two months
- Weekly Behavioral Report and Summary (Number One Reports)

## **Summary**

On December 7, 2006, the OJSO met with the facility's executive director and the program manager and the administrative staff of the DMHSAS. The areas of concern identified were:

1. Staff did not demonstrate knowledge of the policies governing the urine analysis screening process.
2. Staff were not able to ensure clients were in their rooms after "lights out." Staff were unclear to which rooms clients were assigned.
3. The evening and weekend schedule lacked structure and appropriate supervision.
4. Critical incident reports had not been forwarded to the DHS Office of Client Advocacy for investigation as policy requires.
5. Indications that medications had not been timely administered.
6. Staff did not demonstrate knowledge of the policies governing clients who return following discharge against counselor's advice (ACA).
7. Staff did not demonstrate knowledge of the policies governing the finding of contraband.
8. The OJSO observed staff lacking an understanding of the facility's Sanctuary Model.
9. Indications that program staff did not immediately respond to an alleged attempted suicide.
10. Indications of inadequate staffing during sleeping hours.

On December 10, 2006, the program director submitted an updated plan for development for the areas of concern noted above. The plan for development is attached. No further response is indicated at this time. Compliance to the noted areas of concern will be monitored at the next oversight visit.

JKC:js

