

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

Name and Location of Facility: Oklahoma Youth Center
Norman, Oklahoma

Dates of Visit: June 28 and 30, 2006

Oversight Reviewers: Jenifer K. Cooks and Ellen Harwell, Oversight
Specialists

Purpose of Visit: First Biannual Visit in 2006

Date: November 28, 2006

General Information

The Office of Juvenile System Oversight (OJSO) initiated a routine, unannounced visit on June 28, 2006, to the Oklahoma Youth Center, and returned on June 30, 2006, to complete the visit. The purpose of the visit was to assess compliance with established responsibilities and facility policy and procedures. The facility was licensed for forty residents by the Division of Child Care of the Department of Human Services (DHS). The program was accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). On the day of the OJSO visit, the census was twenty-two.

Interviews Conducted

- Entry interview with the Director of Nursing
- Exit conference with the Medical Records director and the Director of Nursing
- Two direct care staff members
- Five residents

Documents Reviewed

- Files on five residents
- Four personnel files
- DHS Division of Child Care inspection report, dated April 4, 2006
- Oklahoma State Department of Health inspection report, dated January 6, 2006
- Office of the Oklahoma State Fire Marshal inspection report, dated May 24, 2006, and follow-up report, dated June 28, 2006
- JCAHO report, dated May 6, 2004

Areas Toured

- Three dormitories: Dorms I, II, and III
- Resident rooms
- Bathrooms
- Common areas
- Nourishment room

Overview

Interviews

Administrative staff members were attending training and were unavailable for interviews. The five residents on Dorm III were interviewed. The OJSO did not note any concerns from the resident interviews.

File Reviews

The files on five residents were reviewed. The OJSO noted:

- The signatures of the guardians were not documented on the initial treatment plans for two residents.
- The signatures of the residents and the guardians were not documented on four treatment plan reviews, nor did documentation indicate the reasons for the non-participation.
- Progress notes of individual therapy were not contained in the chart on one resident. The treatment plan developed for this resident included individual therapy.
- Progress notes of family therapy were not contained in the file on one resident. The treatment plan developed for this resident included family therapy.

The OJSO reviewed four personnel files. No issues of concern were noted.

Observational Tour

The OJSO conducted a tour of the areas utilized by the residents. The OJSO noted:

Dorm I

- Tub room, No. 100-4, and shower room, No. 100-5: Some of the lights did not work and dead bugs were observed in the light fixtures.
- Room 120: Graffiti was written on the ceiling and the blue sink stand in the bathroom.
- Room 121: The light above the door was not completely lighted and the baseboard/trim in the bathroom was loose from the wall.
- Room 125: Dead bugs were observed in the light fixture.

- Room 126: A hole in a wall of the bathroom exposed a nail.
- Nursing Room 134: Soft drinks were observed in the refrigerator designated for medicines.
- Room 141: Numerous dead bugs were observed in the light cover and the floor baseboard/trim was loose.
- Room 142: The room smelled of a strong unidentifiable odor and dead bugs were observed in the light cover.
- Room 143B: The door to the shower was left unlocked and a light above the shower did not work.
- Room 145: The baseboard in the corner by the toilet was loose from the wall.
- Room 146: The bathroom door and the door trim needed to be repaired.
- The dormitory was not well lighted and housekeeping was needed.

Dorm II

- Common Area: A purse belonging to a staff member was left on a table. The opening of the purse was unfastened, and a prescription bottle with various pills and a pair of scissors could be observed inside the purse. Upon entering the common area, the OJSO observed three residents had come into the area on their way to their rooms. Staff members were following the three residents but were not in constant supervision of them.
- Room 220: Window treatments were needed.
- Room 221 (unoccupied room): The light above the door did not work.
- Room 224: The curtains were not affixed securely.
- Room 223 (unoccupied room): The wood had splintered by the lock on the door, the plaster was loose above the entry door and by the bathroom door, the mattress was torn, and graffiti was written on the toilet seat.

Dorm III

- Room 343: The caulking around the bathroom sink needed to be repaired and the cover on the floor fan was missing.
- Room 344: Paint was peeling from the wall, the sheetrock on the wall was loose, and the smoke alarm was not securely affixed.
- Room 345: Window treatments were needed (only half of the window was covered).
- Room 347: Window treatments were needed.
- Room 348: Window treatments were needed.
- Room 349: A bulb was needed in the light fixture.
- Nutrition room: Salad dressing in an unlabeled carton and an unidentifiable substance in an uncovered container were observed in the refrigerator. Both containers were immediately disposed of when brought to the attention of staff.

Summary

On the day of the OJSO visit, maintenance and housekeeping concerns were noted regarding the three dormitories that were toured. Dormitory I had the most need for

immediate attention. In the exit conference, the OJSO was advised that the purse incident had been addressed with staff. The OJSO was provided a copy of an electronic message that had been sent to all staff regarding this issue.

Findings

1. The signatures of the residents and the guardians were not documented on four treatment plan reviews, nor did documentation indicate the reasons for the non-participation. Department of Human Services licensing standards, Section 154, Social services, (b), Service planning, (2), Service plan review, (B), and (C), (v), states, "The facility involves the resident and parents or custodian in the service plan review. If the parents or custodian do not participate in the service plan review, the reason for non-participation is documented in the service plan. The service plan review includes the names, and signatures, with the date, of those participating in the review."
2. Resident rooms were in need of maintenance and housekeeping, as indicated. Department of Human Services licensing standards, Section 163, Health regulations, (1), Building, (A) and (B), states "Exterior and interior surfaces are maintained in sound condition, free of holes, peeling paper, and paint. Windows and doors are in good repair, and free of broken glass or hazards." In addition, Section 157, Physical facility and equipment, (j), Sanitation and safety, states, "All habitable and non-habitable areas are maintained in a clean and sanitary condition, free of litter and hazards."
3. Food was left uncovered in a refrigerator. Department of Human Services licensing standards, Section 164, (4), Food service and sanitation requirements, (4), Food protection, states "Foods are covered and protected from contamination while being stored, prepared, displayed, or transported."
4. The windows in some of the resident rooms were not covered. Department of Human Services licensing standards, Section 157, Physical facility and equipment, (k), Furnishings and décor, (2), states, "Every bedroom and bathroom window is equipped with window treatments for privacy."

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