

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

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

**Dates of Visit:** June 2, 3, and 4, 2008

**Oversight Reviewer:** Ellen Harwell, Anthony Kibble, and  
Harold Jergenson, Oversight Specialists

**Focus of Visit:** Unannounced Visit 2008

**Date:** January 21, 2009

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### **Introduction**

The Office of Juvenile System Oversight (OJSO) conducted an unannounced visit to the Oklahoma Youth Center (OYC)/Norman Adolescent Center (NAC) on June 2, 3, and 4, 2008. The purpose of the visit was to assess compliance with established responsibilities and facility policies and procedures. The OYC/NAC was licensed by the Oklahoma Department of Human Services (OKDHS) Office of Child Care Services (OCCS) as a Residential Child Care Facility for thirty-eight residents at the OYC and twenty-three residents at the NAC. The census the day the oversight began was thirty residents at the OYC and eleven residents at the NAC. The OYC was contracted with the OKDHS for acute and residential care. The OYC and the NAC were in the process of merging at the time of the oversight visit. The merged facility will be called Children's Recovery Center of Oklahoma.

### **Interviews Conducted**

- Entry conference with administrative staff
- Exit conference with administrative staff
- Six direct care staff members
- Nine residents

### **Documents Reviewed**

- Five personnel files
- Eight patient files
- Contracts between the OYC and the OKDHS for acute and residential care

- OKDHS division OCCS license dated November 1, 2001, for the OYC
- OKDHS division OCCS license dated August 3, 2006, for the NAC
- Oklahoma State Department of Health Food Inspection report dated April 12, 2008
- Grievance file for calendar year 2008

## **Areas Toured**

- Entire facility

## **Findings**

### Resident Interviews

The OJSO interviewed nine residents in the custody of the OKDHS. Seven of the nine residents reported previous mental health treatment, two of which had previously received treatment at the OYC. Seven of the nine residents were familiar with the grievance process. One resident did not respond to the question, and one resident reported not being familiar with the process. No residents reported being forced to take medications. All residents reported having an individualized treatment plan and having participated in the development of the plan. None of the residents interviewed reported being physically assaulted by staff or peers. There were no reports of sexual activity between staff and residents. One resident reported having witnessed two female residents kiss a male resident.

### Staff Interviews

Six staff members were interviewed. When asked about their three most important responsibilities, all staff members responded that their number one priority was safety. Additional responses were structure, creating a positive environment, and ensuring that the needs of residents were met. Responses varied regarding the communication between staff members and administration. Several staff members were aware the facility was restructuring and acknowledged the transition influenced their opinions.

### Resident File Review

Eight resident files were reviewed. In four of the eight files, the OJSO noted the following:

#### File 1

- A restraint hold form dated June 2, 2008, was not completely filled out. Several areas on the form were left blank, and the form did not document the notification to the physician.
- A restraint hold form dated May 19, 2008, did not document the time the physician had been notified.

## File 2

- Documentation by the physician on a restraint hold form dated April 17, 2008, noted in the assessment that the “Patient was sleeping during the exam.”

## File 3

- A treatment plan review dated May 28, 2008, was not signed by the youth or the guardian.
- A treatment plan review dated May 21, 2008, was not signed by the youth or the guardian.

## Personnel File Review

Five personnel files were reviewed. Three files did not document twenty-four clock hours of training for calendar year 2007.

## Grievance File Review

Two grievances had not been resolved by the due date established by the facility. One resolved grievance was not dated. A second resolved grievance was documented as resolved, but it did not have the signature of the youth or the staff member, and it was not dated.

## Caretaker Conduct Reviews

At the time of the oversight, the OYC and the NAC were operating as two separate licensed facilities. Caretaker Conduct Reviews (CCRs) were not being completed by either facility. As verified by the OKDHS Office of Client Advocacy (OCA), the OYC had an agreement with the OCA that permitted the facility to forego conducting CCRs. The NAC was not completing CCRs, and the facility did not have an agreement with the OCA to forego doing so. Since the two facilities had not fully merged and were operating with two different licenses, the NAC was not exempt from completing CCRs. Correspondence from the OCA to the OJSO documented that the NAC will be required to complete the overdue CCRs.

## Observational Tour

### Unit 1

- In 125A, graffiti was written on the bathroom walls.
- An evacuation plan was not posted.
- In 125A and 126A, dead bugs were noted in light fixtures.

### Unit 3

- In 349, spit wads were noted on the ceiling, trash was noted behind the TV, and orange peels were noted on the window sill.
- In 349, doors were missing from cabinets, and sharp objects were protruding from the cabinets.
- Four bedrooms were missing window treatments. The OJSO was informed that the treatments were available and were only temporarily

down. When asked to produce the window covers, staff members were unable to locate them.

- No evacuation plan was posted.

### **Area of Concern**

1. Although the facility identified due dates for grievances, two grievances reviewed did not meet these deadlines, and timeliness for two grievances reviewed could not be determined due to the resolution date not being documented.

### **Violations**

1. Trash, insects in light fixtures, graffiti, broken cabinets with sharp objects, and spit wads on the ceiling were noted by the OJSO. OKDHS Licensing Standards for Residential Child Care Facilities, OAC 340: 110-3-157, 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."
2. Window treatments were missing in four resident rooms. OKDHS Licensing Standards for Residential Child Care Facilities, OAC 340: 110-3-157, Physical facility and equipment, (k), Furnishings and décor, (2), states, "Every bedroom and bathroom window is equipped with window treatments for privacy."
3. Two treatment plans were not signed by the patient or the guardian. OKDHS Licensing Standards for Residential Child Care Facilities, OAC 340: 110-3-154, Social services, (b), Service planning, (2), Service plan review, (B), 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." OKDHS Licensing Standards for Residential Child Care Facilities, OAC 110-3-154, Social services, (b), Service planning, (2), Service plan review, (C), (v), states, the service plan review includes "the names, and signatures, with the date, of those participating in the review."
4. Evacuation plans were not posted. OKDHS Licensing Standards for Residential Child Care Facilities, OAC 340: 110-3-165, Construction and fire safety, (3), Administration, (B), Evacuation plan, states, "Evacuation plans are posted in prominent locations on all floors in each building."
5. Restraint forms were not fully completed. OKDHS contracts for acute and residential care, Part III, (7), state the following information will be included in a report for each restraint:
  - (a) the patient's name;
  - (b) the date and specific location of the incident and the date of the report;

- (c) a statement of the circumstances and actions leading to the use of restraints, including attempts at less restrictive methods of control;
  - (d) the specific type of restraint utilized (i.e., therapeutic hold, wrist cuffs, five point, etc.) If a drug(s) is used, the name of the medication(s), dosages(s) and rout of medication;
  - (e) the amount of time in physical or mechanical restraints (indicate the time the youth was placed in and time taken out of restraints);
  - (f) any injuries incurred;
  - (g) the name of the physician ordering the restraint;
  - (h) the name of the patient's treating physician;
  - (i) the signature of the person completing the documentation.
6. The NAC had failed to respond to CCRs in a timely manner. OAC 340:2-3-37, Caretaker conduct review, (f), Time for completion of report, states, "The final written report is submitted to the advocate general within 30 calendar days from the date that OCA intake notified the administrator that an allegation is referred for CCR."

## **Summary**

During the facility tour, the OJSO noted that a medication room had been left unlocked with the door open and unattended. This event was observed by three oversight specialists and a staff member of the facility. The nurse on duty returned to the medication room within a few minutes of the OJSO discovering the incident. The OJSO informed administrative staff in the exit interview that the incident would be reported by the OJSO to the Oklahoma State Board of Nursing (Board). The OJSO has received correspondence from the Board acknowledging receipt of the Report of Nursing Practice Incident form submitted by the OJSO. Any further action resulting from this incident will be taken at the discretion of the Board.

Residents did not report safety concerns and reported an overall sense of safety. Most appeared to be engaged in treatment and were able to convey treatment goals to the OJSO. Staff members appeared concerned about the transition of the facility, but they also appeared focused on the needs of the residents and their safety.