Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	DET-090	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKLAHOMA COUNTY DETENTION CENTER	201 N SHARTEL OKLAHOMA CITY, OK 73102

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P 000	INITIAL COMMENTS: On July 26, 2023, Oklahoma State Department of Health staff conducted an unannounced investigation(s): D-2022-030, D-2022-036, D-2023-004 D-2023-008, D-2023-010, D-2023-011 D-2023-012, D-2023-013 SIJ-2022-150 C-2022-140, C-2022-141, C-2022-142 C-2022-144, C-2022-145, C-2022-146 C-2023-004, C-2023-008, C-2023-009 C-2023-014, C-2023-019, C-2023-029 C-2023-036, C-2023-038, C-2023-044 C-2023-045, C-2023-049, C-2023-051 C-2023-058, C-2023-064, C-2023-068 C-2023-069 The census at the time of the inspection was 1519, and the rated capacity is 2890. Based on the violations cited below the facility is not in substantial compliance. The following deficient practice(s) was identified:	P 000		
P5202	310:670-5-2(3) Detention Facilities-Hourly Sight Checks The facility administrator shall develop and implement written policies and procedures for the safety, security and control of staff, inmates and visitors. Policies and procedures shall address at least the following: ... . (3) There shall be at least one (1) visual sight check every hour which shall include all areas of each cell, and such sight checks shall be documented.	P5202		

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P5202	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct and document at least one (1) visual sight check every hour. Finding(s): 1) Review of the 8 Adam log book dated 04/21/23 through 04/22/23, revealed six (6) hourly sight checks were not documented as required. In addition, video review with staff B and H, of the outside of 8 Adam, cell #33, for these dates confirmed sight checks were not conducted by staff from 4:44 p.m., until 8:40 p.m. Staff B and H acknowledged staff assigned to inmate housing pod 8 Adam did not conduct all sight checks. 2) Review of the 6 Charlie log book dated 04/20/23 through 04/21/23, revealed nine (9) hourly sight checks were not documented as required. Four (4) of the nine (9), sight checks were documented as being missed. In addition, video review with staff B and H, of the outside of 6 Charlie, cell #5, confirmed sight checks were not being conducted by staff, ranging from one (1) hour to two (2) hours in length. Staff B and H acknowledged staff assigned to inmate housing pod 6 Charlie did not conduct all sight checks. 3) Review of the Men's Holding log book dated 04/07/23 through 04/08/23, revealed not all thirty (30) minute sight checks were documented as being conducted, ranging from thirty (30) minutes to one (1) hour in length. Video review of the	P5202	Pursuant to Title 74, Section 193(B)(1), the Department provides the following proposals for solution: There shall be at least one (1) visual sight check every hour which shall include all areas of each cell, and such sight checks shall be documented. 1) Conduct staff interviews to assess why the policy was not followed. 2) Ensure the policy reflects the current expected practice and revise as needed. 3) If the policy is revised or if the assessment determines staff knowledge of the policy is incomplete, conduct training of staff on the policy. 4) Review and adopt further corrective actions as needed based on observations and interviews.	

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P5202	Continued From page 2 Men's Holding Tank #2, with staff B and E, revealed thirty (30) minute sight checks were not being conducted by staff. Video review shows inmate #1 collapsed on the cell floor at 1:54 a.m. and remained in the same position until 6:42 a.m., when staff entered the cell and physically checked on him. Staff B and H acknowledged staff assigned to Booking/Mens's Holding cell, did not conduct the required thirty (30) minute sight checks. 4) Review of Internal Investigation Report "Established Timeline" for inmate #1 and video review, with staff B and D, revealed no sight checks were conducted by staff between the hours of 11:15 a.m. and 5:06 p.m., when a food tray was delivered to the cell. A medication pass was documented at 5:22 p.m., and the next sight check was not documented at 8:44 p.m. Staff B and D both acknowledged sight checks where not conducted. 5) When requested the facility failed to provide 2 Baker Log book for the dates of 01/28/23 through 01/30/23 for review.	P5202		
P5230	310:670-5-2(27)(B) Detention Facilities-Notify Serious Injury The facility administrator shall develop and implement written policies and procedures for the safety, security and control of staff, inmates and visitors. Policies and procedures shall address at least the following: ... . (27) The Department shall be notified no later than the next working day if any of the following incidents occur:	P5230		

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P5230	Continued From page 3 (B) Serious injury to staff or inmate defined as life threatening or requiring transfer to outside medical facility; This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to notify the Oklahoma State Department of Health of an injury of inmates who required a transfer to outside medical facility. Finding(s): 1) Review of the "Oklahoma County Jail Tracker", dated 07/07/23, with staff B, revealed the facility failed to notify the Oklahoma State Department of Health of inmate #9, who sustained an injury and required transfer to an outside medical facility on 06/25/23 and 06/27/23. 2) Review of the "Post ER/Hospitalization/Off-Site Consultation Assessment" on 07/25/23 at 11:14 a.m., with staff E and F, revealed the facility failed to notify the Oklahoma State Department of Health of inmate #10, who sustained an injury and required transfer to an outside medical facility on 07/07/23.	P5230	Pursuant to Title 74, Section 193(B)(1), the Department provides the following proposals for solution: The Department shall be notified no later than the next working day if any of the following incidents occur: ... . (B) Serious injury to staff or inmate defined as life threatening or requiring transfer to outside medical facility; 1) Conduct staff interviews to assess why the policy was not followed. 2) Ensure the policy reflects the current expected practice and revise as needed. 3) If the policy is revised or if the assessment determines staff knowledge of the policy is incomplete, conduct training of staff on the policy. 4) Review and adopt further corrective actions as needed based on observations and interviews. 5) Conduct periodic monitoring of the correction for compliance, conduct further training and/or review, revise the policy and adopt further corrective actions as needed.	

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P5621	Continued From page 4	P5621		
P5621	310:670-5-6(19) Detention Facilities-Eliminate Pests/Control The administrator shall develop and implement policies and procedures for the safety and maintenance of sanitation throughout the facility. These shall include at least the following: ... . (19) Any condition conducive to harboring or breeding insects, rodents or other vermin shall be eliminated immediately. Licensed pest control professionals shall be contracted to perform pest control on a scheduled basis specified in the facility policy and procedure.	P5621		
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a facility free of pests. Finding(s): 1) On 07/25/23, while accompanied by Staff B and C, the following areas were visited, housing pods 2 Adam, 2 Baker, 2 Charlie and 10 Adam. Sixty-four (64) inmates voiced complaints of bed bugs, cockroaches and mice infestation in their cell, on their person, in clothing and bedding. Several of the inmates displayed for the facility staff and inspectors, both dead and live bed bugs, roaches and a mouse. A. At 11:30 a.m., dead bed bug was observed smashed on the wall, located in housing pod 2		Pursuant to Title 74, Section 193(B)(1), the Department provides the following proposals for solution: The administrator shall develop and implement policies and procedures for the safety and maintenance of sanitation throughout the facility. These shall include at least the following: (19) Any condition conducive to harboring or breeding insects, rodents or other vermin shall be eliminated immediately. Licensed pest control professionals shall be contracted to perform pest control on a scheduled basis specified in the facility policy and procedure. 1) Conduct staff interviews to assess why	

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P5621	Continued From page 5 Adam cell #24. B. At 11:40 a.m., a live bug was displayed by inmate, assigned to housing pod 2 Baker cell #19. C. At 11:44 a.m., observed smashed bed bugs on toilet tissue and in corner of the bunk bed, located in housing pod 2 Baker cell #50 D. At 11:47 a.m., ten (10) inmates, complained of bed bug bites, assigned to housing pod 2 Baker cells #1, #6, #19 and #40. E. At 12:01 p.m., observed live and dead cockroaches, located in housing pod 2 Charlie cells #8, #13, #16, #34, #35, #39, #41, #42, #43 and #47. F. At 12:04 p.m., four (4) inmates, displayed bug bites on their shoulders, legs, feet and arms, assigned to housing pod 2 Charlie cells # 39, #47 and #48. G. At 12:15 p.m., observed a mouse lying motionless on the floor located between cells #38 and #39, in housing pod 2 Charlie. Inmate #24, assigned to cell #38, reported he had trapped and smashed the mouse during the night, placing it out of the cell with trash pick up that morning. H. At 12:17 p.m., observed over eighty (80) live cockroaches located on the shower wall located on the first floor of housing pod 2 Charlie. I. At 12:30 p.m., observed dead bed bugs in a used styrofoam food container, located in housing pod 10 Adam cells #16, #17, #20 and #39. J. At 12:43 p.m., observed a dead bed bug under	P5621	the policy was not followed. 2) Ensure the policy reflects the current expected practice and revise as needed. 3) Conduct staff interviews to assess knowledge of the policy and the practice for pest control extermination. 4) If the policy is revised or if the assessment determines staff knowledge of the policy is incomplete, conduct training of jail staff on the policy.	

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P5621	Continued From page 6 the mattress of the bunk bed, located in housing pod 10 Adam cell #28 K. At 12:44 p.m., a dead bed bug was displayed by inmates, assigned to housing pod 10 Adam cell #32. 2) Medical staff E and F reported of the inmates that sign up for sick call, to be seen by medical, approximately forty (40) percent are for bug bites.	P5621		
P5801	310:670-5-8(2) Detention Facilities-Observtion MED/PSY Risk "Adequate medical care shall be provided in a facility. The administrator shall develop and implement written policies and procedures for complete emergency medical and health care services. Policies and procedures shall include at least the following: ... . (2) Intake screening shall be performed on all inmates immediately upon admission to the facility and before being placed in the general population or housing area. An inmate whose screening indicates a significant medical or psychiatric problem, or who may be a suicide risk, shall be observed frequently by the staff consistent with the facility's policy and the identified need until the appropriate medical evaluation has been completed. After medical evaluation , these inmates may be assigned to housing consistent with the medical evaluation.	P5801		

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P5801	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to frequently observe those inmates whose screening indicates a significant medical or psychiatric problem, or may be a suicide risk. Findings(s): 1) Review of the 13 David log book, dated 12/21/22 through 12/22/22, revealed sight checks were not documented every fifteen (15) minutes. Eleven (11) fifteen minute sight checks were not documented as required. Video review of the outside of 13 David, cell #5, with staff B and H, revealed sight checks were not being conducted by staff from 4:30 p.m. until 9:09 p.m., when staff were observed conducting a medication pass and opening the door of cell #5. Review of Internal Investigation Report, revealed, when inmate #2 did not respond to staff during medication pass, it was documented as a refusal for medication. Staff later conducted a welfare check at 9:44 p.m. and found inmate #2 unresponsive in his cell. Inmates assigned to housing pod 13 David, require fifteen minute sight checks. Staff B and H acknowledged staff assigned to inmate housing pod 13 David did not conduct all the required sight checks.	P5801	Pursuant to Title 74, Section 193(B)(1), the Department provides the following proposals for solution: Intake screening shall be performed on all inmates immediately upon admission to the facility and before being placed in the general population or housing area. An inmate whose screening indicates a significant medical or psychiatric problem, or who may be a suicide risk, shall be observed frequently by the staff consistent with the facility's policy and the identified need until the appropriate medical evaluation has been completed. After medical evaluation , these inmates may be assigned to housing consistent with the medical evaluation. 1) Conduct staff interviews to assess why the policy was not followed. 2) Ensure the policy reflects the current expected practice and revise as needed. 3) If the policy is revised or if the assessment determines staff knowledge of the policy is incomplete, conduct training of staff on the policy. 4) Review and adopt further corrective actions as needed based on observations and interviews. 5) Conduct periodic monitoring of the correction for compliance, conduct further training and/or review, revise the policy and	

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P5801	Continued From page 8	P5801	adopt further corrective actions as needed.	