

STATE OF NEVADA

Review of Governmental and Private Facilities for Children

October 2011



Legislative Auditor
Carson City, Nevada

Review Highlights



Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on October 17, 2011. Report # LA12-08.

Background

Nevada Revised Statutes 218G.570 through 218G.585 authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of governmental and private facilities for children.

We identified 52 governmental and private facilities that meet the requirements of NRS 218G: 19 governmental and 33 private facilities. In addition, 150 Nevada children were placed in 22 facilities in 11 different states as of June 30, 2011.

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. During the period from July 1, 2010, through June 30, 2011, we received 1,253 complaints from 23 Nevada facilities. The remaining 29 facilities reported that no complaints were filed by youths throughout the year.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through NRS 218G.585. The report includes the results of our reviews of 6 children's facilities, unannounced site visits to 10 children's facilities, and surveys of 52 children's facilities. As reviews and not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

The purpose of our reviews was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care. These reviews included an examination of policies, procedures, processes, and complaints filed since July 1, 2009. In addition, we discussed related issues and observed related processes during our visits.

Review of Governmental and Private Facilities for Children

October 2011

Summary

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at five of the six facilities we reviewed provide reasonable assurance that they adequately protected the health, safety, and welfare of the youths at the facilities, and they respect the civil and other rights of youths in their care. In addition, during the 10 unannounced visits conducted, we did not note anything that caused us to question the health, safety, welfare, or protection of rights of the children in the facilities.

The policies, procedures, and processes in place at one facility, Eagle Quest of Nevada, Inc., did not provide reasonable assurance that it adequately protects the health and safety of the youths in its care. Eagle Quest is a foster care agency that recruits foster parents and places youths in the foster parents' homes or in homes provided by the agency. During the year ended June 30, 2010, the agency had an average of 38 homes. We visited five of Eagle Quest's foster homes.

Eagle Quest did not ensure foster parents maintained accurate documentation of medications prescribed or administered. In addition, it did not ensure foster homes were free of safety hazards or in a safe, healthful condition. We observed significant issues at one of Eagle Quest's higher level of care homes. As a result, we contacted Clark County's Department of Family Services, which began an investigation. The six foster children in the home were moved to other homes that evening. In addition, one youth's medication file contained three different medication logs for the same medication for the same month. Due to the lack of physician's prescriptions and orders, as well as transcription errors on the medication logs, we were unable to determine if the youth was overmedicated, undermedicated, or if the medication logs were erroneously completed.

Facility Observations

All six facilities reviewed needed to develop or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated ranged from youths' computer use and access to social networking sites to facilities' inventory and control of keys.

Medication administration processes and procedures need improvement at all six facilities. Youth medical files did not always contain complete or clear documentation of dispensed, prescribed medication at five of six facilities reviewed. This includes missing evidence of physicians' orders at four of six facilities and missing medication administration records at four of six facilities. In addition, youths did not always receive medications timely at three of six facilities. Three of six facilities need to develop or update their over-the-counter standing order forms. A standing order form identifies over-the-counter medications a facility may administer to youths.

Recent actions should help improve medication administration. In our Review of Governmental and Private Facilities for Children report issued in December 2010, we recommended all facilities strengthen medication management training. Based on the information provided by 50 facilities, 13 facilities' staff (26%) had participated in training between December 1, 2010, and June 30, 2011. In addition, the 2011 Legislature passed Senate Bill 246 to require children's facilities to adopt a policy concerning the administration and management of medications. The bill also requires facilities to ensure employees who administer medication receive a copy of and understand the policy.

Five of the six facilities reviewed need to improve their background check policies and processes. Two facilities did not obtain dispositions of cases against employees when background checks showed arrests with no dispositions. In one instance, facility management requested the employee provide dispositions for arrests; however, there was no evidence management received or reviewed the dispositions. As a result, the employee continued employment with a felony conviction for possession and trafficking of a controlled substance for 2 years after documentation of the arrest was received. Other weaknesses noted during reviews included a facility using background checks based on names and social security numbers rather than fingerprints, files not always containing evidence a caregiver was fingerprinted; and an employee not being fingerprinted until 16 months after her hire date.

In our Review of Governmental and Private Facilities for Children report issued in April 2010, we recommended the Legislature consider enacting legislation to strengthen employee background check requirements for all types of facilities that provide residential services to youths. During the 2011 Legislative Session, the Legislature passed Assembly Bill 536. This bill requires fingerprint criminal history checks of employees and residents over the age of 18 for all types of facilities and requires employees be supervised until the results of the background checks are received. This bill specifies the convictions that would require termination of employees and requires fingerprint criminal history checks of all employees be conducted at least every 5 years following the initial background check.

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We have conducted a series of reviews of governmental and private facilities for children in the State of Nevada. These reviews are authorized by Nevada Revised Statutes 218G.570 through 218G.585. The purpose of these reviews is to determine if the facilities protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care.

We wish to express our appreciation to the management and staff of the facilities for their assistance during the reviews. We are available to discuss the report with any legislative committees, individual legislators, or other state and local officials.

Respectfully presented,

A handwritten signature in black ink, appearing to read "Paul V. Townsend".

Paul V. Townsend, CPA
Legislative Auditor

October 3, 2011
Carson City, Nevada

STATE OF NEVADA
REVIEW OF GOVERNMENTAL AND PRIVATE FACILITIES FOR CHILDREN
OCTOBER 2011

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INTRODUCTION

This report includes the results of our work as required by Nevada Revised Statutes 218G.570 through 218G.585. The report includes the results of our reviews of 6 children's facilities (page 9), unannounced site visits to 10 children's facilities (page 78), and surveys of 52 children's facilities (pages 76 - 77).

BACKGROUND

Nevada Revised Statutes authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of residential children's facilities. A copy of NRS 218G.570 through 218G.585 is included in Appendix A of this report.

Number and Types of Facilities

Nevada Revised Statutes require reviews of both governmental and private facilities for children. Governmental facilities include facilities owned or operated by a governmental entity that have physical custody of children pursuant to the order of a court. Private facilities include any facility that is owned or operated by a person or entity and has physical custody of children pursuant to the order of a court.

We have identified 52 governmental and private facilities that meet the requirements of NRS 218G: 19 governmental and 33 private facilities. Exhibit 1 lists the types of facilities located within Nevada and the total capacity of each type during the year ended June 30, 2011.

Exhibit 1

**Summary of Nevada Facilities
Year Ended June 30, 2011**

Facility Type	Number of Facilities	Population		Staffing Levels	
		Maximum Capacity	Average Population	Average Full-time	Average Part-time
Correction and Detention Facilities	11	1,066	821	675	85
Resource Centers	2	64	32	26	15
Child Welfare Facilities	4	187	82	88	19
Mental Health Treatment Facilities	7	329	247	367	99
Substance Abuse Treatment Facilities	3	38	25	37	6
Group Homes	19	685	505	377	203
Residential Centers	6	326	101	67	10
Total – Facilities Statewide	52	2,695	1,813	1,637	437

Source: Reviewer prepared from information provided by facilities.

We have categorized these types of facilities using the following guidelines:

- Correction facilities provide custody and care for youths in a secure, highly restrictive environment who would otherwise endanger themselves or others, be endangered by others, or run away. Correction facilities may include restrictive features, such as locked doors and barred windows.
- Detention facilities provide short-term care and supervision to youths in custody or detained by a juvenile justice authority. Detention facilities may include restrictive features, such as locked doors and barred windows.
- Resource centers provide more than one type of service simultaneously. For example, a resource center may provide both substance abuse treatment and detention services.
- Child welfare facilities provide emergency, overnight, and short-term services to youths who cannot remain safely in their homes or their basic needs cannot be efficiently delivered in the home.
- Mental health treatment facilities provide mental health services to youths with serious emotional disturbances by providing acute psychiatric (short-term) and non-acute psychiatric programs. Mental health facilities also provide services to behaviorally disordered youths. Services include

a full range of therapeutic, educational, recreational, and support services provided by a professional interdisciplinary team in a highly supervised environment.

- Substance abuse treatment facilities provide intensive treatment to youths addicted to alcohol or other substances in a structured residential environment. Substance abuse treatment facilities focus on behavioral change and services to improve the quality of life of residents.
- Group homes provide safe, healthful group living environments in a normalized, developmentally supportive setting where residents can interact fully with the community. Group homes are used for children who will benefit from supervised living with access to community resources in a semi-structured environment. Group homes generally consist of detached homes housing 12 or fewer children.
- Residential centers provide a full range of therapeutic, educational, recreational, and support services. Residents are provided with opportunities to be progressively more involved in the surrounding community.

In addition to youths placed in facilities within the State of Nevada, an additional 150 youths were placed in out-of-state facilities by a county or the State as of June 30, 2011. Nevada youths were placed in 22 different facilities in 11 different states across the United States. In general, a youth may be placed in an out-of-state facility because the youth has failed at least two placements within the State, the youth has a combination of diagnoses that cannot be treated in Nevada, the youth has been adjudicated as a female sex offender, or the youth is sexually aggressive. Exhibit 2 lists the entities that placed youths in out-of-state facilities, the number of youths placed in out-of-state facilities, and the number of states where youths were placed as of June 30, 2011. Exhibit 3 shows the number of youths placed in out-of-state facilities during the past 2 ½ years.

Exhibit 2

**Summary of Nevada Youths Placed in Out-of-State Facilities
as of June 30, 2011**

Placing Entity	Number of Youths Placed in Out-of-State Facilities	Number of Different States
Clark County Department of Juvenile Justice Services, Probation	87	9
Washoe County Department of Juvenile Services, Probation	19	4
Lyon County Juvenile Probation	2	1
5 th Judicial District Court (Esmeralda, Mineral, and Nye Counties)	9	3
Elko County Juvenile Probation	1	1
1 st Judicial District Court (Carson City and Storey Counties)	3	2
State of Nevada Division of Child and Family Services	29	8
Total	150	

Source: Reviewer prepared from information provided by entities.

Exhibit 3

**Summary of Nevada Youths Placed in Out-of-State Facilities
From December 31, 2008, to June 30, 2011**

Placing Entity	As of December 31, 2008	As of June 30, 2010	As of June 30, 2011
Clark County Department of Juvenile Justice Services, Probation	71	56	87
Washoe County Department of Juvenile Services, Probation	23	11	19
Lyon County Juvenile Probation	5	10	2
5 th Judicial District Court (Esmeralda, Mineral, and Nye Counties)	4	5	9
Elko County Juvenile Probation	0	3	1
1 st Judicial District Court (Carson City and Storey Counties)	3	1	3
6 th Judicial District (Humboldt, Pershing, and Lander Counties)	2	0	0
7 th Judicial District (White Pine, Eureka, and Lincoln Counties)	1	0	0
Churchill County Juvenile Probation	0	2	0
State of Nevada Division of Child and Family Services	48	33	29
Total	157	121	150

Source: Reviewer prepared from information provided by entities.

Complaints and Grievances

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, or civil and other rights of the child.

During the period from July 1, 2010, through June 30, 2011, we received 1,253 complaints from 23 of 52 facilities in Nevada. The remaining 29 facilities in Nevada reported that no complaints were filed by youths throughout the year. In addition, we received complaint information from out-of-state facilities. The most common type of complaint from Nevada facilities was related to welfare. A welfare related complaint is one addressing the general well being of a youth. This includes issues related to education, wellness activities, and discipline.

SCOPE, PURPOSE, AND METHODOLOGY

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. As reviews and not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

The purpose of our reviews was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care. These reviews include an examination of policies, procedures, processes, and complaints filed since July 1, 2009. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from November 2010 through August 2011.

A detailed methodology of our work can be found in Appendix F of the report, which begins on page 79.

FACILITY OBSERVATIONS

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at five of six

facilities we reviewed provide reasonable assurance that they adequately protect the health, safety, and welfare of youths at the facilities, and they respect the civil and other rights of youths in their care. In addition, during the 10 unannounced visits conducted, we did not note anything that caused us to question the health, safety, welfare, or protection of the rights of the children in the facilities.

The policies, procedures, and processes in place at one facility, Eagle Quest of Nevada, Inc., do not provide reasonable assurance that it adequately protects the health and safety of the youths in its care. Eagle Quest is a foster care agency that recruits foster parents and places youths in the foster parents' homes or in homes provided by the agency. During the year ended June 30, 2010, the agency had an average of 38 homes. We visited five of Eagle Quest's foster homes.

Eagle Quest did not ensure foster parents maintained accurate documentation of medications prescribed or administered. In addition, it did not ensure foster homes were free of safety hazards or in a safe, healthful condition. We observed significant issues at one of Eagle Quest's higher level of care homes. As a result, we contacted Clark County's Department of Family Services, which began an investigation. The six foster children in the home were moved to other homes that evening. In addition, one youth's medication file contained three different medication logs for the same medication for the same month. Due to the lack of physician's prescriptions and orders, as well as transcription errors on the medication logs, we were unable to determine if the youth was overmedicated, undermedicated, or if the medication logs were erroneously completed.

Many of the facilities had common weaknesses. For example, policies and procedures needed to be developed or were outdated. In addition, medication administration processes and procedures needed to be strengthened and background check processes need improvement. Finally, facilities needed to ensure complaint or grievance forms and locked boxes in which youths can place their complaints are readily available to all youths.

Facilities Need to Develop or Update Policies and Procedures

All six facilities reviewed needed to develop or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated ranged from youths' computer use

and access to social networking sites to facilities' inventory and control of keys.

According to Standards of Excellence developed by the Child Welfare League of America (CWLA) and Performance-based Standards developed by the Council of Juvenile Correctional Administrators (CJCA), documented, up-to-date policies and procedures help ensure management and staff understand the facilities' processes. In addition, documented policies and procedures help ensure consistent services are provided to the youths residing at the facilities.

The CWLA is a coalition of private and public agencies serving vulnerable families. Its focus is on children and youths who may have experienced abuse, neglect, family disruption, or other factors that may have jeopardized their safety. The CJCA is a national non-profit organization dedicated to improving youth correctional systems and services. The CJCA aims to improve the practices and policies in local systems and increase the chances of success for delinquent youths.

Medication Administration Processes and Procedures Need to Be Strengthened

Medication administration processes and procedures need improvement at all six facilities. The medication administration process should include documentation of medications administered to youths, controls over prescribed medications, and a process used to ensure the accuracy of medication files and records. Youth medical files did not always contain complete or clear documentation of dispensed, prescribed medication at five of six facilities reviewed. This includes missing evidence of physicians' orders at four of six facilities and missing medication administration records at four of six facilities. In addition, youths did not always receive medications timely at three of six facilities.

Three of six facilities need to develop or update their over-the-counter standing order forms. A standing order form identifies over-the-counter medications a facility may administer to youths. This form helps to ensure youths take medications approved or recommended by the Federal Food and Drug Administration.

Standards of Excellence developed by the CWLA and standards developed by Nevada's Juvenile Justice Administrators provide guidelines to manage medications in accordance with federal and state laws.

Background Check Processes Need Improvement

Five of the six facilities reviewed need to improve their background check policies and processes. Two facilities did not obtain dispositions of cases against employees when background checks showed arrests with no dispositions. In one instance, facility management requested the employee provide dispositions for arrests; however, there was no evidence management received or reviewed the dispositions. As a result, the employee continued employment with a felony conviction for possession and trafficking of a controlled substance for 2 years after documentation of the arrest was received.

Other weaknesses noted during reviews included: one facility used background checks based on names and social security numbers rather than fingerprints; files did not always contain evidence a caregiver was fingerprinted at one facility; and an employee was not fingerprinted until 16 months after her hire date at one facility. In addition, one facility did not always obtain waivers from its licensing authority to hire persons with prior misdemeanor convictions.

Complaint Processes Need Improvement

Complaint and grievance processes need improvement. For example, complaint or grievance forms were not readily available to youths at four of six facilities. In addition, locked boxes where youths can file complaints or grievances were not always available at four of six facilities. Locked boxes provide assurance the integrity of the information on the complaints is maintained.

UPDATE ON PRIOR REVIEW RECOMMENDATIONS

In our Review of Governmental and Private Facilities for Children report issued in December 2010, we recommended all facilities strengthen medication management training. The recommendation suggested all facilities have key medication management staff participate in training conducted by an agency independent of the facility. We surveyed 52 facilities in June 2011 and requested information on medication management training provided to staff. Based on the information provided by 50 facilities, as of June 30, 2011, 13 facilities' staff (26%) had participated in training between December 1, 2010, and June 30, 2011. Of the 37 facilities that indicated staff had not participated in the recommended training (74%), 7 provided plans to participate in training during the next 6

months. One facility did not respond to our request for information, and one facility closed during the period between December 2010 and June 2011. In addition, the Legislature passed Senate Bill 246 to require children's facilities to adopt a policy concerning the administration and management of medications. The bill also requires facilities to ensure employees who administer medications receive a copy of and understand the policy. This bill is effective January 1, 2012.

In our Review of Governmental and Private Facilities for Children report issued in April 2010, we recommended the Legislature consider enacting legislation to strengthen employee background check requirements for all types of facilities that provide residential services to youths. During the 2011 Legislative Session, the Legislature passed Assembly Bill 536. This bill requires fingerprint criminal history checks of employees and residents over the age of 18 for all types of facilities and requires employees be supervised until the results of the background checks are received. This bill specifies the convictions that would require termination of employees. It also requires facilities to maintain the results of the checks for the employees' tenure and requires fingerprint criminal history checks of all employees be conducted at least every 5 years following the initial background check.

REPORTS ON INDIVIDUAL FACILITY REVIEWS

This section includes the results of reviews at each of the six facilities. Exhibit 4 lists the facilities and shows their locations. These results were provided to each facility and a written response was requested. A summary of each facility's response is included after each applicable issue.

Map of Facilities Reviewed



Source: Reviewer prepared.

Eagle Quest of Nevada, Inc.

Background Information

Eagle Quest of Nevada is a private, not-for-profit foster care agency and a therapeutic outdoor adventure program. This review focused on services provided by Eagle Quest's foster care agency (Agency). The Agency recruits foster parents and places youths in the foster parents' homes or in homes provided by the Agency. Homes are located within the Las Vegas and Pahrump areas of Nevada. During the year ended June 30, 2010, the Agency had an average of 38 foster homes operated by an average of 60 foster parents. Homes are foster parent secured and serve male and female youths from birth to 18 years of age. The Agency's mission is to provide opportunities for disadvantaged youths to achieve their goals and become healthy, productive citizens. The Agency's objective is to provide safe, secure, and structured foster homes to higher level of care youths. Higher level of care may include youths who: have multiple mental health diagnoses; have behavioral issues; have experienced abuse or neglect; have been adjudicated as juvenile sex offenders or have other legal issues; or are in sibling groups.

During the year ended June 30, 2011:

- The maximum capacity was 169 youths.
- The average daily population of youths was 136.
- The average length of stay was 3 months.
- The Agency had an average of 101 staff: 87 full-time and 14 part-time.
- Foster homes located in Clark County were licensed by the Clark County Department of Family Services (DFS).
- Foster homes located in Pahrump were licensed by the State of Nevada's Division of Child and Family Services (DCFS).

Purpose of the Review

The purpose of our review was to determine if Eagle Quest of Nevada (Agency) adequately protects the health, safety, and welfare of the children in the Agency and whether the Agency respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period July 1, 2009, to January 31, 2011. In addition, we discussed related issues and observed related processes during

Eagle Quest of Nevada, Inc. (continued)

our visit in March 2011. During our review, we also visited five of the Agency's foster homes.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the Agency do not provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the Agency and respects the civil and other rights of youths in its care. The Agency did not adequately protect the health and safety of the youths. The Agency did not ensure foster parents maintained accurate documentation of medications prescribed or administered. In addition, the Agency did not ensure foster homes providing higher levels of care were free of safety hazards or in a safe, healthful condition. We also noted other areas that need improvement. Specifically, the Agency needs to: develop, update, and comply with policies and procedures; strengthen its grievance process; and improve documentation of reporting abuse and neglect and conducting background checks.

Agency Response

Throughout the first week of March 2011, the Legislative Counsel Bureau conducted a review of our agency and foster homes. During this review, an array of concerns and areas of improvement were identified; many of which our agency accepts full accountability. Please note, there are a couple serious concerns noted in the LCB review that we feel are inaccurate/opinionated and we would like the opportunity to provide formal clarification for the record. Typically, an agency is able to provide a detailed response before the LCB review is shared with community partners; however, in our review the LCB report was sent prematurely failing to include Eagle Quest's response. Eagle Quest has learned a great deal from this review and we do feel as though we have become a better agency because of it. We found it highly concerning that the Legislative Counsel Bureau found our policies and procedures to be inadequate. The report indicated, "The policies, procedures and processes in place at the Agency do not provide reasonable assurance that it adequately protects the health, safety,

Eagle Quest of Nevada, Inc. (continued)

Agency Response (continued)

and welfare of youths at the agency". What is troubling about this allegation is that we have worked diligently with the State to ensure that our policies and procedures are in full compliance with Specialized Foster Care Contract mandates and have a signed letter from the State on formal letterhead documenting this prior to the LCB review. Throughout the remainder of the LCB review our agency has additional concerns that we would like to present. Some of the concerns indicated in the LCB review are not required by current licensing standards. As an agency, we want to fully comply with all County and State requirements; however, we feel as though if we are going to be held or scrutinized to different standards it would be desirable and less confusing if they became part of the State of Nevada Licensing Regulations for Foster Homes for Children (Chapter 424).

For those community partners who work with us on a daily basis I am confident that you are aware that we make every effort to keep our clientele safe. We are highly concerned about the well being of each and every one of our clients. On a daily basis we work with the Department of Family Services, Division of Child and Family Services and the Department of Juvenile Justice Services. Eagle Quest is frequently commended by the aforementioned agencies for acting quickly and efficiently in the event that any matter of concern arises. Eagle Quest is a highly responsive agency that is in fact concerned about the safety and well-being of every client that we work with. We operate family foster homes and family run group homes and want to maintain a family-style environment not a sterile, institutional one. We believe our clientele feel more comfortable in a home environment, not a facility environment.

Eagle Quest is eager to meet with all community partners to display and further discuss many of the positive changes that we have implemented over the past three months. Our audit compliance committee has met every single week since our LCB review and we have made an

Eagle Quest of Nevada, Inc. (continued)

Agency Response (continued)

unprecedented amount of progress to improve the quality of care and to ensure that program safety exceed industry standards. Ultimately, we are grateful for the LCB review, as it has been enlightening in many different ways. We look forward to hearing back from you so that we can ensure our community partners that safety and well-being is paramount for all clientele in Eagle Quest. Thank you for your time and consideration in regard to this matter.

Reviewer's Comment

A copy of the review conclusion letter was sent to Eagle Quest's licensing agencies, the Clark County Department of Family Services and the Nevada Division of Child and Family Services. These copies were sent at the same time the letter was sent to Eagle Quest because of our concerns for the health and safety of the children in the licensed foster homes. Eagle Quest was notified at the beginning of the review that outside agencies would be notified if the reviewers had concerns for the health or safety of the children.

Principal Observations

Significant Issues Observed at a Home

We observed significant issues at one of the Agency's higher level of care homes; the home was unsafe and unhealthy. As a result, we contacted Clark County's Department of Family Services, which began an investigation. The six foster children in the home were moved to other homes that evening.

Some of the significant issues observed included: an empty insulin syringe (without needle) on the floor of the home and an empty prescription medication bottle on a counter; unsecured flammable liquid, a hammer, sharp knives, and cleaning supplies; pans full of grease on the kitchen stove; overflowing garbage cans, both inside and outside the home; filthy bathroom sinks with standing dirty water used by foster youths; non-nutritious food throughout the home, including food remnants in and on the carpet, empty snack

Eagle Quest of Nevada, Inc. (continued)

food wrappers and soda cans that littered the floor; and piles of clothes throughout the home. Neither the foster youths nor the foster parents were home at the time we observed the home.

Based on our observations, we determined the Agency has not established minimum safety or health guidelines for foster parents. Minimum safety guidelines should include: a system to dispose of hazardous waste or toxic substances; keeping dangerous items, such as flammable liquids, hammers, sharp knives, and cleaning supplies secured and out of the reach of children; and home maintenance. Minimum health guidelines should include: general housekeeping, such as clean and sanitary cooking and food preparation surfaces; clean and sanitary bathrooms to enable youths to maintain their personal hygiene and appearance; food and snacks that meet the nutritional needs of youths; and organized, maintained living areas.

In addition, we determined the Agency has not established a process to monitor foster parents to help ensure safe living conditions for youths. Agency staff should visit, enter, and observe all areas of the homes. According to Agency management, staff are required to periodically visit youths in their foster home. However, based on Agency documentation and subsequent discussions with management and staff, visits may occur at other locations. When visits do occur in the youths' homes, Agency staff do not always enter or observe areas of the home other than an assigned meeting area.

In addition, the Agency has not established a process to ensure staff and supervisors manage and monitor Agency homes. According to the Agency, staff visit homes on a periodic basis. However, Agency staff had not visited this home for at least 6 weeks prior to our observation. Also, the staff's supervisor did not ensure staff conducted required visits.

Agency Response

In regard to the significant issues at one of our higher level of care homes, Eagle Quest has subsequently closed this home since the review due to a lack of overall cooperation from the foster family during the investigation process. It is important to note that the primary-caretaker was taken to the Emergency Room and admitted for a

Eagle Quest of Nevada, Inc. (continued)

Agency Response (continued)

serious medical condition earlier in the week whereupon the condition of the home quickly deteriorated to an unacceptable standard. Please note, only hours after the LCB review the Department of Family Services conducted a thorough inspection of the home and found that many of the deficiencies were already in compliance. DFS did not remove the children when they inspected the home; however, Eagle Quest chose to remove these children that same day, as the family was overwhelmed with the primary-caretaker being in the hospital. The Agency did not want to jeopardize any further safety issues for the clientele involved. The large sibling group was subsequently moved together to another Eagle Quest foster home to reside. Eagle Quest later learned that the foster home where the children were removed from was on a corrective action plan from DFS; however, we were never privy to this information due to confidentiality. In regard to not visiting the home for six-weeks, Eagle Quest did in fact have staff come to the home during that time period; however, the employee chose to render services in the community as opposed to within the home. We take accountability that the home environment was not properly monitored by the agency, but want to point out that the Eagle Quest Case Manager made multiple efforts to arrange visits; however, the foster family was unable to coordinate. It is important to note that this was an adoptive resource for the children removed from this home. Upon being questioned, it should be noted that the children were very happy in this home and referred to the caretakers as “mom” and “dad”. To this very day the DFS Case Manager desires for this previous foster family to be an adoptive resource to these children. The children would also like to return for permanency reasons.

Since the review the Agency has worked rigorously to ensure that a safety concern such as the one highlighted in the review will never happen again. A specialized committee was immediately established and has met consecutively each week since the review. This committee has developed numerous processes and

Eagle Quest of Nevada, Inc. (continued)

Agency Response (continued)

guidelines to ensure that all children in our care are safe at all times and that our foster parents maintain safe living conditions and are properly monitored by the agency. The aforementioned committee has created Standards of Excellence for our parents, which serve as our Foster Parent Agreement/Contract. These standards clearly address and enforce health, safety and supervision concerns above and beyond current Licensing regulations. In addition, Eagle Quest Case Managers are now mandated to facilitate a minimum of two in-home visits per month for each one of our licensed foster homes. These visits are thoroughly documented in writing via our newly developed "Monthly In-Home Safety Checklist" and our "Monthly Home-Visit Summary Form." Both of these documents are subsequently signed by a supervisor to ensure that management is properly monitoring for safety and that all required visits are taking place, thus further ensuring safety. The Standards of Excellence/Foster Parent Agreement serves as an incredibly valuable tool. One of its requirements mandate our foster parents to notify the agency in writing when one or more of the parents will be out of the foster home overnight i.e. in the instance of a hospital stay. This aids us in ensuring proper supervision and allows the agency to intervene proactively if a home is going to have a foster parent out of the home for one reason or another. In addition the Standards of Excellence/Foster Parent Agreement require that a foster parent notify the agency within twenty-four hours or less in the event that they are placed on a corrective action plan from DFS or DCFS. This allows the Agency to become aware of concerns and challenges a home may be experiencing that may not otherwise be available due to confidentiality reasons. From this valuable information, Eagle Quest can devise individual training and support to aid the parent with further skill development and obtaining full compliance. Since the review, Eagle Quest has also improved upon and further developed numerous policies and procedures including but not limited to medication management, mandatory reporting, and documenting and resolving client grievances. Eagle Quest feels

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strongly that we presently exceed industry and licensing standards for monitoring foster parents and keeping children safe at all times.

Medication Administration Process

The Agency's documentation of medications administered had significant weaknesses. Eight of ten medication files reviewed were missing important documentation. The other two files did not contain sufficient information to determine if the youths were prescribed medication.

Of the 10 files reviewed, 8 were missing one or more physicians' prescriptions or orders for medication administered to youths, changes in medications, or discontinuation of medications. In addition, one file did not contain evidence medication was purchased or administered to a youth as directed by a physician. Also, seven files were missing medication logs for up to 11 months.

Medication administration logs were not completely filled out. For example, some logs had blank spaces. Some logs were missing staff and youth initials, the time and dosage of medication, and the number of pills remaining. Blank spaces on a log could indicate a youth was administered medication and staff forgot to complete the form, the youth refused the medication, or the youth did not receive medication for some other reason.

In addition, we noted one file contained three different medication logs for the same medication for the same month. Due to the lack of physician's prescriptions and orders, as well as agency transcription errors, we were unable to determine if the youth was overmedicated, undermedicated, or if the medication logs were erroneously completed.

The Agency did not always account for medication. For example, the Agency did not always document the medications a youth was prescribed and taking at intake or the amount of medication a youth had at the time of intake. This may have occurred because the Agency has not established adequate policies to require such documentation.

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In addition, there was no documentation to support medication disposed, including the method used, and evidence of disposal. Although the Agency's medication policy does address medication disposal, foster parents were not aware of the policy and staff were unclear on the policy. This may have been caused by the Agency adopting the policy without informing or training foster parents and staff.

Furthermore, the Agency's medication administration logs do not have a menu. A menu is a list of acronyms used to identify specific actions, such as medications missed when a youth was on a home pass or refused medication. A menu would help foster parents document why medications were not administered.

Medication files and records did not contain evidence of independent review. Agency policy states medication logs will be reviewed to identify and evaluate medication errors. Without an independent review of medical files and records, errors, fraud, or abuse could occur and go undetected.

Medication Administration Procedures

The Agency's procedures for the administration of medication need improvement. The Agency did not have procedures requiring foster parents to observe youths while they complete mouth sweeps. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Cheeking is a method used to conceal medication. Failure to complete mouth sweeps increases the risk of medications being cheeked for unauthorized use at a later time. Improving medication administration procedures to require mouth sweeps may help reduce the risk of medication being abused.

In addition, medications are not always stored in a secure area. Although medication policies require medications be stored in a secure area that is not accessible to youths, we observed unsecured medications in a foster home. This may have occurred because the Agency did not adequately train foster parents on the importance of securing medication. Unsecured storage could result in unauthorized access to medications.

The Agency does not use an approved, dated over-the-counter medication standing order form. A standing order form identifies

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over-the-counter medications foster parents may administer to youths. Not having a dated and signed physician approved form could result in medication being administered to youths that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Agency Response

Since the review Eagle Quest has developed “Medication Standards of Excellence” and has made significant improvements to our Medication Management Policy. We also have a newly designed, innovative “Medication Log”, which includes coding to indicate the following: client refusal, medication contamination, medication error, medication given on home visit, at school etc. Eagle Quest’s Medication Logs now require three different signatures in addition to the foster parent and client signatures to ensure oversight, proper administration and improve file documentation. The medication log presently has mandatory signatures for the Eagle Quest Case Manager, which will be signed during routine home visits to ensure daily administration and proper documentation by the foster parent. There are also signatures required for an Eagle Quest Supervisor as well as our Clinical Director to ensure management that medications are being administered and documented exactly as prescribed. The medication log also has an area for the foster parent or staff to document side-effects of medication if any are observed. Eagle Quest requires foster parents to count each medication daily and enter it into the Med Count section of the Medication Log to prevent tampering and other potentially harmful medication concerns. In addition to the medication log, Eagle Quest also has a separate “Over the Counter Medication Log” to document non-prescription medication that may be given by the foster parent, so long as there is legal guardian consent. Consent for non-prescription medication is documented in Eagle Quest’s Intake Packet when a client is first admitted to the program. Eagle Quest requires written legal guardian consent whenever there is a change to a medication regiment or a new medication is prescribed.

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Agency Response (continued)

The newly developed Medication Standards of Excellence and the Medication Management Policy clearly indicate the approved methods of medication distribution i.e. surgical gloves, tweezers or medicine bottle cap. They also address proper locked storage of medications and techniques to prevent cheeking or slight of hand, such as sweeping of the mouth. Via the Medication Standards of Excellence and Policy and Procedure, Eagle Quest requires bio and natural families to fill out a "Client Release Form" when they take a child on pass. This Release Form details the correct medication to be given while on pass. Eagle Quest will provide a duplicate pill bottle detailing contents to a bio/natural parent when transporting medication on visit or pass. Since the review, Eagle Quest has now assigned a Quality Assurance team-member to collect all Foster Parent paperwork via use of a client specific checklist to ensure accuracy and completeness and that there is no missing documentation in client files whatsoever. With all of the above actions that Eagle Quest has taken since the review we are confident that we exceed all medication standards and regulations for foster and group homes.

Policies and Procedures

The Agency needs to develop, update, and comply with policies and procedures. Without clearly documented policies and procedures, management, staff, and foster parents may be unclear of the Agency's processes and provide inconsistent services to youths.

The Agency did not have policies specific to: the control and inventory of keys, tools, and kitchen utensils; religion; civil rights; controls to monitor youths' access and use of computers; records retention; periodic background checks following employment; and privileges, including the method to earn privileges, the method used to search for contraband, staff to youth ratios, and guidelines to monitor the appropriateness of movies. The Agency's lack of minimum guidelines may have contributed to staff conducting an

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inappropriate contraband search of a youth and contraband items observed in a home.

In addition, the Agency has not established minimum guidelines or protocols for foster parents, such as monitoring juvenile sex offenders and sanitary medication administration. Minimum guidelines for foster parents who accept juvenile sex offenders should address using video surveillance cameras, what to look for, and when to intervene. Once minimum guidelines are established, the Agency needs to train and monitor foster parents and homes to obtain reasonable assurance minimum guidelines and protocols are being followed.

Also, Agency policies and procedures that need to be updated include visitation and supervision, and crisis and non-emergency response. Visitation and supervision policies need to be updated to ensure the protection of all youths being served, including observations of the conditions of homes. For example, policies do not require Agency staff and management to document attempts to visit homes, enter homes as arranged, or document observations noted once inside the home. Further, Agency memos governing computer, network, and email use should be adopted and incorporated in policies.

The Agency did not require staff and foster parents to comply with training requirements in the statutes or its policies. NRS 424.0365 requires those who come in direct contact with children to receive use of force and restraint training within 30 days of employment and annually thereafter. Agency policy requires all primary and non-primary caregivers who have direct contact with youths to receive training within the first 30 days of employment. Agency management told us that not all staff and foster parents have received this training. Not having proper training increases the risk of potential injuries to youths and staff during a restraint or use of force.

Agency Response

Since the review Eagle Quest has taken extensive action to improve Agency policy and procedures. We have worked diligently over the last sixteen weeks to further develop and update Agency policies and processes. In addition to this we have also developed "Standards of

Eagle Quest of Nevada, Inc. (continued)

Agency Response (continued)

Excellence”, which serve as our Foster Parent Agreement/Contract, which hold parents to a level exceeding licensing standards and regulations. We have made significant updates and additions to policies/processes such as but not limited to: Medication Management, The Grievance Process, Mandatory Reporting, Home Accessibility, and Client Supervision. In addition to this, we have also held mandatory trainings since the LCB visit to review updated policies and procedures as well as our “Standards of Excellence” to ensure that our foster parents and team members were made well aware of and familiarized with company enhancements. We have also developed a “Youth handbook” detailing general program rules and items considered to be contraband while in the program. It should be noted that Eagle Quest foster and family run group homes are not facilities. In this spirit, we allow foster parents to develop an individualized environment and culture that is family driven and child friendly, so long as it adheres to Agency policies and procedures.

It is important to note that the LCB review documented, “The policies, procedures and processes in place at the Agency do not provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the agency”. What is troubling about this allegation is that we have worked diligently with the State to ensure that our policies and procedures are in full compliance with Specialized Foster Care Contract mandates and have a signed letter from the State on formal letterhead documenting this months prior to the LCB review. We respectfully request that the aforementioned quoted statement be retracted from this review due to the fact that our Policies and Procedures were in full compliance with State and County contract regulations at the time the review took place. Eagle Quest takes full accountability that at the time of the review we needed to improve the implementation of policies and procedures; however, required policies and

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Agency Response (continued)

procedures to ensure a client's safety and well-being were in place.

In regard to supervision and monitoring of sexual offenders we have cameras in these designated homes as well as clinical and medical oversight. Since the review, Eagle Quest has added video surveillance/monitoring as a requirement for this specific population into the Supervision Policy in our policies and procedures to further convey safety measures. We have also developed a "Chaperone Agreement" detailing increased supervision requirements to promote community safety while these clientele are on approved home visitations. In the eight years that we have served this population we have had zero incidents in the community and no additional victimization. Eagle Quest was recently praised by a local court Judge in front of County Commissioners detailing our outstanding effort and track record serving this unique population. Eagle Quest is willing to work with area experts to further improve our supervision and monitoring of these specified clientele.

Reviewers' Comment

We made numerous recommendations to the Agency to develop, expand, update, and follow policies and procedures. These policies and procedures encompassed nearly every area of our review: monitoring foster homes, administering medications, documenting medication administration, and ensuring foster parents have fingerprint background checks. Based on our comparison of the Agency's policies with best practices and standards developed by other entities, such as the Child Welfare League of America, we believe our conclusion that the Agency needs to improve its policies and procedures is reasonable.

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Grievance Process

The Agency needs to strengthen its grievance process. The Agency's grievance policy is not consistent with the actual grievance process or the Agency's intake packet discussed with youths during intake. For example, policy states grievances should be documented in writing and they will be reviewed within 48 hours. According to management and foster parents, grievances are expressed verbally and resolved immediately. The Agency's intake packet states grievances can be voiced or written. In addition, grievance policies do not clearly state management, staff, and foster parents will not retaliate against youths for filing a grievance.

Also, grievance forms were not readily available, and there were no grievance boxes available in any of the homes observed. Further, management should obtain a signed statement from youths indicating youths understand they have the right to file a grievance.

Agency Response

Since the review, Eagle Quest has entirely revamped its client grievance process. Every Eagle Quest Therapeutic Foster Home has been equipped with a locked grievance box and grievance forms for clients to fill out and sign. These grievances are collected on a bi-weekly basis by the client's Case Manager and reviewed by the Case Manager and Case Manager Supervisor. The Case Manager and Case Manager Supervisor then have 5 to 7 days to conduct a thorough investigation of the grievance and provide the client with an official Grievance Response. If the client is not satisfied with the result, they may choose to decline the response and file an appeal. If the client files an appeal, the Grievance and Grievance Response will then be reviewed by the Eagle Quest CEO, Board of Directors, and Director of Operations, where a final decision on the grievance will be made and a Grievance Appeal Response will be presented to the client. The status of the grievance process is tracked through the Grievance Log, which allows the client and management to know the current status of the grievance. The grievance process was incorporated into an official Client Grievance Policy, which was implemented into the Eagle Quest Policies

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Agency Response (continued)

and Procedures for Therapeutic Foster Parents. In April, 2011, Eagle Quest held a mandatory, formal training for Therapeutic Foster Parents to inform them of the revamped client grievance process.

Mandatory Reporting

The Agency needs to improve its mandatory reporting process. NRS 432B.220 requires those who know or have reasonable cause to believe that a child has been abused or neglected make a report within 24 hours to child welfare services or law enforcement. We noted three instances of youths' disclosures of allegations to foster parents; however, there was no evidence to support whether the allegations were reported. Agency policies do not identify foster parents or staff as mandatory reporters, indicate to whom suspected abuse or neglect should be reported, or provide information on documenting that a report was made.

Agency Response

Following the review, Eagle Quest took extensive measures to further educate both its employee base and its Therapeutic Foster Parents of their duties as a mandated reporter. In April 2011, two separate mandatory trainings were held for employees and Therapeutic Foster Parents where mandatory reporting was discussed in detail. Also, policies were added to the "Eagle Quest Policies and Procedures for Therapeutic Foster Parents" and the "Eagle Quest Employee Manual" that detailed the circumstances in which one must report suspicion of neglect or abuse to the proper authorities. These policies include under what condition they must report the suspected abuse or neglect, how soon they should report, the hotline information to report the suspicion, and that they should file an Incident Report with Eagle Quest stating that a report was made.

Background Checks

The Agency has not developed a process to ensure foster parent and caregiver personnel and contract files are complete. For example, files did not always contain evidence a caregiver was

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fingerprinted, as required by policy. In addition, the Agency's files did not include the date a contract foster parent began providing services. Furthermore, management was not aware of the actual date some foster parents began providing services. Without a process to ensure files are complete, the Agency may be unaware of an unlicensed caregiver or foster parent.

Agency Response

Since the review, Eagle Quest has developed a "Therapeutic Foster Parent and Caregiver File Checklist", which will be completed by the Eagle Quest Licensing Representative and stored in the respective caregiver's personnel or foster parent file. This form will indicate all necessary information regarding the individual's date of licensure, date of the foster parent and agency agreement/contract, date of policies and procedure review, date of FBI fingerprint and child abuse neglect check, the date of license closure (if applicable), etc. The purpose of this form is to ensure that foster parents and caregiver personnel are current with all licensing requirements and that they have completed the necessary documentation for licensure and agency approval. In addition, this form will ensure that Eagle Quest management is fully aware of the personnel and foster parents' licensing status. Since the review, Eagle Quest foster parents and caregiver personnel are in full compliance with the State of Nevada Licensing Regulations and we feel that our licensing procedures have greatly improved and exceed licensing standards of both the Department of Family Services and the Division of Child and Family Services.

Other Items

Other items noted during our review include: none of the three vehicles observed had a first aid kit or a fire extinguisher. In addition, items not posted in areas visible to youths, staff, and visitors included: a youth schedule in three of five homes; a list of prohibited items and contraband in five homes; and a description of the complaint process in five homes. We also reviewed 10 youth files and found: 1 did not contain a required rehabilitation mental

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health plan; 1 did not contain documentation to ensure the youth identified as at risk for suicide received increased supervision and observation until seen by a clinician; and 5 did not have information, or had incomplete information, about emergency contacts or allergies.

In addition, according to Agency management, the Agency does not require foster parents to follow an established nutritional protocol. Consistent with this statement, we observed a youth consume pie for breakfast and as an afternoon snack and observed non-nutritious foods in a home. Failure to follow nutritional protocols increases the risk of not meeting the nutritional needs of youth.

Further, youths are not provided with a handbook when they arrive at a home. A youth handbook should outline: the home's complaint process; home rules, including prohibited items and contraband; and youths' rights and privileges. A handbook may aid youths' transition to their stay at the homes.

Agency Response

In response to the review, all Eagle Quest vehicles used for transporting clients have been supplied with a fire extinguisher and first aid kit. To ensure all client files are complete, a Quality Assurance team member is now dedicated to perform monthly audits of all client files to ensure completeness and accuracy. A "Suicide Observation Form" has been developed to document when a client is at high risk for suicide, as well as to further ensure client safety. As Eagle Quest desires our foster homes to function as family environments and not as residential treatment centers or institutions, we do not require our foster parents to post the clients' daily schedules and prohibited contraband items in areas that would be visible to visitors. However, Eagle Quest now requires all foster parents to post a daily schedule in a discrete location that is accessible to the clientele in their home. Eagle Quest has also implemented grievance boxes in every foster home. These boxes are posted in discrete locations accessible to the clients in their home. The grievance forms are collected bi-weekly by the home's Case Manager when they conduct their required

Eagle Quest of Nevada, Inc. (continued)

Agency Response (continued)

home visits. Eagle Quest has developed a “Youth Handbook” and “Client Binder” addressing the prohibited contraband items, home rules, grievance process, no harm contract, youth rights and privileges, contact list, team member contact list (client profile), client notes, emergency information, medications, and allergies. Eagle Quest has implemented a nutritional guide, which includes the food pyramid, seven-day meal plan and information about each food group to address the lack of nutritional protocol.

Unlicensed Outdoor Program

During our review of the Agency, we determined Eagle Quest’s therapeutic outdoor adventure program, *Hero’s Journey*, was operating without a license. Because youths were participating in the program, we contacted the appropriate licensing agency, the Nevada Division of Child and Family Services (DCFS). According to Agency management, the program was licensed by the Clark County Department of Family Services. However, the program’s licensed address was not consistent with the actual location of the program. The license was issued to an address in Clark County; however, the program was located in a rural area of Nevada, north of Clark County. Based on the location of the program, it should have been licensed by DCFS. Because DCFS staff was not made aware of the program, they had not inspected or licensed the program to operate. Since our review, the Agency has discontinued this program.

Agency Response

The Hero’s Journey Program was formally closed due to financial constraints in April 2011. This was a very unique program with an unconventional approach that yielded incredibly successful results for some of the most challenging clientele in the community. Our community partners will fully vouch for the program’s effectiveness and to this day are requesting that Eagle Quest reopen it due to community demand. Eagle Quest made every effort to ensure that it’s outdoor program was properly licensed. The physical address of the program was in

Eagle Quest of Nevada, Inc. (continued)

Agency Response (continued)

fact in Clark County and was an emergency respite home in the event that clientele needed to be taken off the mountain location due to inclement weather. This physical address also was used for proper tracking and documentation in the Unity system. Both Clark County and DCFS were fully aware of the actual location of our camps in rural Nevada. In the review it states, "Because DCFS Staff was not made aware of the program, they had not inspected or licensed the program to operate." It is important to note that Eagle Quest worked on a daily basis with members of DCFS regarding the Hero's Journey outdoor program. DCFS youth Parole made weekly referrals to the program, as did State Win (Wraparound In Nevada) and other DCFS staff. Eagle Quest acknowledges that there may have been confusion at all levels on how to properly license the program due to it's uniqueness; however, we remain adamant that we were fully transparent and disclosed all program details to both State and County partners. Please note, in the event that we ever reopen the outdoor program we are more than willing to work hand in hand with DCFS to ensure proper State licensing. We respectfully request that the "Unlicensed Outdoor program" paragraph be retracted from this review due to inaccuracy and misleading information.

Reviewers' Comment

The review addressed licensing by DCFS, which was accomplished through its Bureau of Services for Child Care. The Bureau is responsible for licensing Outdoor Programs under NRS 432A.141.¹ Neither DCFS Youth Parole nor Wraparound in Nevada license outdoor youth programs.

NRS 432A.141 requires a license issued for an outdoor youth program be valid only for the area of operation described in the license. The home used

¹ Senate Bill 430 passed during the 2011 Legislative Session, transferred responsibility for licensing child care facilities, including outdoor programs, to the Health Division. The Bill was effective July 1, 2011.

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as an emergency respite home, located in Clark County, was not the primary location where youths in the program resided. DCFS is required to inspect the actual program location in order to license the program. According to Eagle Quest staff, the actual program location is north of Tonopah, which is not in Clark County. Since Eagle Quest did not provide a copy of a license from DCFS for this location or provide information regarding the type of license issued, and DCFS licensing staff were not aware of the program, we concluded it was not licensed as an outdoor program as required by NRS 432A.

Child Haven

Background Information

Child Haven provides emergency services and temporary protective placement to abused, neglected, and abandoned children who cannot remain safely with their families. Placement is provided to youths from birth to age 18 in a staff-secured environment. The purpose of emergency services is to provide a safe and nurturing environment for less than 24 hours while a more long-term placement is located. Placement includes locating a relative or licensed foster care provider that best suits the needs, safety, stability, and interests of the youth. If an appropriate placement is not located within 24 hours, youths are admitted to Child Haven's temporary placement. Temporary placement is only used when no other options are available while considering keeping sibling groups together or the medical needs of youths. Temporary care is provided on campus in a safe, nurturing, home-like setting. Child Haven's mission includes partnering with the community to protect youths by building safe, nurturing, and stable families.

During the year ended June 30, 2011:

- The maximum capacity was 80 youths.
- The average daily population of youths receiving emergency services and in temporary placement was 23.
- The average population of youths during the month of our visit, December 2010, was nine: eight receiving emergency services and one in temporary placement.
- Youths temporarily placed stayed for an average of 7 days.
- Child Haven was funded by Clark County.
- Child Haven was licensed as a child care facility by the state's Division of Child and Family Services.
- Child Haven had an average of 39 staff: 33 full-time and 6 part-time.

Purpose of the Review

The purpose of our review was to determine if Child Haven adequately protects the health, safety, and welfare of the children in the facility and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period July 1, 2009, to

Child Haven (continued)

October 31, 2010. In addition, we discussed related issues and observed related processes during our visit in December 2010.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Child Haven provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, Child Haven needs to develop and update policies and procedures and strengthen its complaint process.

Principal Observations

Policies and Procedures

Child Haven needs to develop and update facility policies and procedures. Without clearly documented policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths. During the period of our review, there were no policies specific to: staff to youth ratios for off-campus activities; securing tools and kitchen utensils; religion; a timeframe to resolve youths' complaints; handling staff, visitor, and parent complaints; and the complaint resolution process.

Policies and procedures do not clearly state that Child Haven has contracted for medical services. The contracted medical provider performs most medical services, including the administration and documentation of medication, medical intake screenings, and disposition of medications. In conjunction with clearly identifying contracted medical services, Child Haven needs to develop a quality assurance process to monitor the contractor. A quality assurance process should include: processes to identify potential fraud, abuse, or errors by contract management or staff; processes to ensure medication is administered accurately, including mouth sweeps or use of tongue blades; a review to verify forms include all elements necessary to ensure accurate documentation of medications administered; and sufficient processes and documentation of the disposal of expired or unused medications.

Child Haven (continued)

Child Haven's lack of oversight may have resulted in a youth not receiving his medication timely.

Also, some facility adopted procedures were not formally addressed in policies. For example, policies do not include counseling youths on the risks associated with running away when youths are identified as at risk for running away. In addition, policies do not refer to Clark County's computer use policies.

Further, policies and procedures need to be amended to consistently address Child Haven's initial mental health screening, as well as the form used to document the screening. Other needed amendments to policies and procedures include removing references to the on-campus school, which has been closed, and adding additional mandatory child abuse and neglect reporting requirements. Mandatory reporting policies address requirements to report abuse or neglect that could potentially occur while a youth is in the custody of Child Haven. However, policies do not address requirements to report allegations of abuse or neglect that may have occurred prior to youths receiving services from or being placed at Child Haven.

Facility Response

Review and revision of Child Haven Policies and Procedures has been scheduled. The workgroup has been identified and work sessions will begin in September of 2011. The scheduled completion date is November 2011. The following will be addressed in the rewrite:

- *Staff to youth ratios for off-campus activities,*
- *Tools and kitchen utensils,*
- *Religion,*
- *Timeframes to resolve youths' complaints,*
- *Staff, visitor, and parent complaints and resolution process,*
- *Contracted medical services quality assurance monitoring and review to include process to identify fraud and abuse, medication*

Child Haven (continued)

Facility Response (continued)

administration errors, and disposal of unused medication,

- *Counseling youth on the risks of running away,*
- *MHST (mental health screening) tool use,*
- *Reference to the on-campus school will be removed,*
- *Mandated reporting to include abuse or neglect occurring prior to the child entering the facility.*

Complaint Process

Child Haven needs to strengthen its complaint process. During the period reviewed, Child Haven provided a basic rights form to youths upon arrival at Child Haven. Although the form outlines basic rights and privileges youths are entitled to receive while at Child Haven, the form does not address a youth's right to file a complaint. This could result in youths not understanding their right to file a complaint if their basic rights or privileges are violated. Any revisions to the form should also be addressed in policies.

In addition, complaint forms were not readily available to youths. Youths may be unwilling to express a complaint in writing if forms are not readily available, which could result in a complaint going undocumented and unresolved. Also, there is no complaint box where youths may place their complaints. A complaint box provides reasonable assurance that the integrity of information is maintained.

Facility Response

In addition to addressing the complaint process in the revised Policies and Procedures, the Basic Youth Rights form was updated to include the youth's right to file a complaint. A "Youth Statement" form has been implemented for youths' complaints and is displayed for easy access by youth. The new forms were implemented on March 1, 2011, and work orders have been submitted for the installation of "complaint boxes" for the youth to use.

Child Haven (continued)

Other Items

Other items noted during our review included: one of the cottages did not include a first aid kit; a facility vehicle did not include a first aid kit; and cleaning chemicals were not always secured. In addition, 1 of 10 youth files reviewed did not contain evidence of an initial mental health screening. One of ten treatment plans and two basic rights forms were not signed by youths. Also, the following items were not posted in areas visible to youths, staff, and visitors: the youth schedule, a list of prohibited items and contraband, and a description of the complaint process.

Further, youths admitted to Child Haven are not provided with a youth handbook. A youth handbook should outline the facility's complaint process, facility rules, including prohibited items and contraband, and youths' rights and privileges. A youth handbook may aid youths transition to their stay at Child Haven.

Facility Response

First aid kits for campus buildings were all updated and new kits were purchased effective March 1, 2011. The county cars are not specific to the Child Haven facility. The DFS vehicle coordinator has been notified of the missing first aid kit in one of the cars.

Cleaning chemicals have been secured and storage was approved by DCFS Child Care Licensing Bureau as of January 2011.

There are circumstances where a mental health screening tool would not be appropriate, for example, the child's developmental delays prevent effective communication or the child is in current crisis and assessment is done by Family Clinical Services or Montevista assessment team. A new process has been implemented whereby the child's file will contain documentation regarding why the screening was not completed in these circumstances.

Child Haven's protocol is that if a child is unable or unwilling to sign one of these forms (treatment plan or youth rights form), the staff is to indicate why the child

Child Haven (continued)

Facility Response (continued)

could/would not sign. If that was not indicated on the forms in question, it is a matter of staff oversight. Supervisors have now been instructed to review and initial all forms to assure that they are complete.

Youth schedules, a list of contraband, and a description of the complaint process will be posted in both the Reception Center and Agassi Medical Respite Program no later than April first.

A youth handbook will be designed, printed, and implemented no later than July 1, 2011. The handbook will be given to each child upon entering the reception center. The handbook will include the facility's complaint process, facility rules, prohibited items and contraband and the youth's rights and privileges.

St. Jude's Ranch for Children

Background Information

St. Jude's Ranch for Children (SJRC) is a private, not-for-profit set of group homes. The facility is staff secured and serves male and female youths between birth and 21 years of age. The facility is located in Boulder City, Nevada. SJRC's mission is to serve all abused, abandoned, and neglected children and families by creating new chances and choices in a safe, homelike environment. SJRC provides: therapeutic residential treatment to youths, including sibling groups; transitional living for eligible youths over 16 years of age; and a pregnant and parenting teen program for at-risk mothers throughout their pregnancy.

During the year ended June 30, 2011:

- The maximum capacity was 66 youths.
- The average daily population was 43 youths.
- The average length of stay for youths was 14 months.
- The average population was 54 youths during the month of our visit, January 2011.
- The average number of staff was 45: 44 full-time and 1 part-time.
- SJRC homes were licensed by the Clark County Department of Family Services as foster homes, including specialized foster homes.

Purpose of the Review

The purpose of our review was to determine if St. Jude's Ranch for Children adequately protects the health, safety, and welfare of the children in SJRC and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period from July 1, 2009, to December 31, 2010. In addition, we discussed related issues and observed related processes during our visit in January 2011.

St. Jude's Ranch for Children (continued)

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at St. Jude's Ranch for Children provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, SJRC has significant medication documentation issues. We also noted other areas that need improvement. Specifically, SJRC needs to develop and update policies and procedures and strengthen its grievance process.

Principal Observations

Medication Administration Process

SJRC's documentation of medication administered had significant weaknesses. Specifically, 6 of 10 medication files reviewed were missing important documentation. Of the remaining four files, three were not missing documentation and one did not contain information indicating if the youth was supposed to receive medication.

Of the 10 files reviewed, 6 were missing one or more physicians' prescriptions or orders for medication administered to youths, changes in prescriptions, or discontinuation of medication. We also noted pharmacist orders were not always followed. For example, SJRC contacted its pharmacist to request direction following a medication error. However, SJRC did not administer the correct dosage as directed by the pharmacist to correct the original error. In addition, four files were missing medication administration logs for up to 2 ½ months.

Medication administration logs were not completely filled out. For example, we noted: blank spaces; missing staff signatures; and logs missing the time, month, and year medication was administered. Blank spaces on a log could indicate a youth was administered medication and staff forgot to complete the form, the youth refused the medication, or the youth did not receive medication for some other reason.

St. Jude's Ranch for Children (continued)

SJRC did not always account for medications. For example, documentation of medications a youth was prescribed and taking at intake did not include the dosage or the number of pills received. In addition, SJRC did not completely account for medications remaining following a physician's order to discontinue the medications. Specifically, medication administration logs indicated the number of pills remaining prior to a physician's order to discontinue. However, there was no documentation to support whether remaining medications were destroyed, reused, or stored for future use. This issue may have been caused by inadequate medication disposal policies and procedures.

Furthermore, SJRC needs to add a menu to its medication administration log. A menu is a list of acronyms used to identify specific actions, such as medications missed when a youth was on a home pass or refuses his medication. A menu would help SJRC staff document why medications were not administered.

Medication Administration Procedures

SJRC should develop procedures requiring staff to observe youths while they complete mouth sweeps. Although some staff did observe youths complete mouth sweeps, it is not required. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Cheeking is a method used to conceal medication and failure to complete a mouth sweep increases the risk of medication being cheeked for unauthorized use at a later time. Improving medication administration procedures to require mouth sweeps may help reduce the risk of medications being abused.

SJRC has a list of approved over-the-counter medications that may be administered to youths, however, the form is not dated or signed. Not having a dated and signed physician approved form could result in medication being administered to youths that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Documentation in two youths' files indicated the SJRC delayed administering prescribed medications. One youth received medication 5 days after it was prescribed and the other youth did not receive prescribed medication for 10 days. Delays in

St. Jude's Ranch for Children (continued)

administering prescribed medications could result in adverse effects.

Facility Response

SJRC is committed to providing quality services to children that ensures all their needs are being met to include medication administration. SJRC has current procedures in place and will enhance those procedures to ensure staff conduct mouth sweeps after medication is administered to youth. This policy revision will be approved and ratified by the SJRC Board of Directors within 60 days.

It is a policy of SJRC to ensure that all administration of medication be documented in a high quality and timely manner. It appears that your review of the selected files demonstrated that this is an area where there is great improvement needed. SJRC has created more in-depth medication administration training for staff in response to the findings. The training curriculum is very detailed regarding all areas of administration and documentation to include: understanding doctor's orders, documentation requirements, mouth sweeps, youth's rights regarding medication and other very important areas. This training will be required for all staff within 60 days and then must be reviewed on an annual basis.

In addition to the training, another important way in which to provide assurance that children are administered medication in a timely and correct manner is through supervisor oversight. On a daily basis it is the responsibility of all supervisors to ensure that medication documentation is being maintained up to date which includes the counting of medications and any errors. In addition, it is the responsibility of Residential Coordinators to ensure on a weekly basis that all requirements for medication administration are maintained. Random case reviews will be conducted to ensure there are quality services being offered to children and appropriate medication administration. The process for case reviews will be designed and implemented by July 1, 2011.

St. Jude's Ranch for Children (continued)

Facility Response (continued)

The medication log has also been revised to include a menu for documentation of errors. It is the policy of SJRC that all errors are documented in a timely manner and necessary staff will have additional training to address any areas of concern. In addition, SJRC has a well developed disciplinary process to address any employee's performance when there are repeated errors, and or any concern for improper administration. The revised menu will be in effect June 1, 2011.

A review of the approved over-the-counter medication was conducted by a physician on January 23, 2010. The physician signed and dated this list and the SJRC medication administration policy will be enhanced to ensure there is always a doctor's signature and date on the form. This over-the-counter medication list will be reviewed on a biennial basis and/or whenever necessary. In addition to having a current list of over-the-counter medication, SJRC staff will ensure that this list is accessible in each home for reference.

SJRC is committed to ensuring youth receive medication in a timely manner when prescribed. In some cases, the delay in administration of medication is due to the prior authorization process for Nevada State Medicaid. In one of the two cases cited the delay was due to the prior authorization process and questions regarding the type of psychotropic medication prescribed to the youth. Regardless of the reason, going forward SJRC staff will clearly document the circumstances for the delay in administering medication and will advocate where possible to expedite the process. This policy revision will be approved and ratified by the SJRC Board of Trustees within 60 days.

Policies and Procedures

SJRC needs to develop, update, and follow its policies and procedures. Without clearly documented policies and procedures, management and staff may be unclear about the facility's processes and provide inconsistent services to youths. SJRC did

St. Jude's Ranch for Children (continued)

not have policies specific to: control and inventory of keys, tools, and kitchen utensils; periodic background checks following employment, privileges youths can earn; and youth's access to websites other than social networking sites.

In addition, runaway procedures do not address protocols that should be used by staff to discourage youths from running away. Protocols employed include counseling the youth on the risks associated with running away, documenting when a youth runs away, and notifying other staff and management.

Furthermore, SJRC's contraband control processes should be added to its written policies. One home contained personal hygiene items with alcohol as one of the main ingredients, even though one of the youths in that home was identified as having substance abuse issues. Another home had a bottle of prescription medication that had not been stored and secured from access by youths. Prescription medication in a youth's possession could result in a potentially lethal situation.

SJRC should also comply with its social networking website policies. Policies state SJRC has the right to monitor youths' social network website accounts. However, a list of youths with approved access and their passwords was not readily available. In addition, staff was unclear of their monitoring responsibilities.

Facility Response

SJRC has extensive amounts of detailed, high quality policies and procedures to guide the work of staff providing services to children. SJRC is committed to on-going evaluation and improvement of those policies and accepts the recommendations for specific areas of development per the findings of this review. Specifically, policies will be strengthened in the areas of inventory of keys, tools and kitchen utensils; privileges youth can earn; and youth's access to websites other than social networking sites.

Specific to periodic background checks following employment, this item is currently in SJRC Human Resources policy, effective 5/1/2008. It is SJRC policy

St. Jude's Ranch for Children (continued)

Facility Response (continued)

that on an annual basis a criminal background is required for all staff.

Current runaway policies and procedures will be enhanced to address protocols to discourage youth from running away such as counseling the youth on the risks associated with running away. In addition, there will be further clarification on documentation and notification requirements when a youth threatens to run away or has run away.

SJRC will further develop the existing policy regarding contraband to detail procedures for regular checks to ensure no prohibited items are in the home and/or accessible to youth. These include items containing alcohol, such as personal hygiene products, medication (prescribed or over-the-counter), and other items that can be a risk to children and youth.

Furthermore, SJRC will add to the existing policy on youth access to social networking websites protocols that further detail how staff will monitor youths' accounts and the requirement that a list of youth passwords must be maintained.

All of the policy revisions referenced in this section will be approved and ratified by the SJRC Board of Trustees within 60 days.

Reviewers' Comment

Although SJRC's policies do require annual background checks of employees, the checks are based on social security numbers rather than on fingerprints. Background checks based on social security numbers may not be as accurate or complete as checks based on fingerprints.

St. Jude's Ranch for Children (continued)

Complaint Process

SJRC needs to strengthen its complaint process. During the period of our review, SJRC's complaint policy was not consistent with the actual complaint process. Although policy states a formal complaint can be submitted using a complaint form or by writing a letter, SJRC does not use or make complaint forms available to youths. Youths may be unwilling to express a complaint in writing if forms are not readily available, which could result in a complaint going undocumented and unresolved.

In addition, there is no complaint box in which youths may place their complaints. A complaint box provides reasonable assurance that the integrity of information is maintained. Also, management should obtain a signed statement from youths indicating youths understand they have the right to file complaints.

Facility Response

SJRC has a complaint policy detailed to ensure youths and staff have a means to address concerns when their care, treatment or services received are unsatisfactory. All youths and their families have the right to file a complaint at any time. SJRC has established a confidential 800 number available to all children, youths, families and staff in addition to a business card that youths can keep in their possession in the event they need to file a complaint. In addition, youths can access the SJRC website where there is a link for confidential reporting as well as completing a written complaint. The person responsible for responding to any complaint filed by children, youths, family members and/or staff is managed through the SJRC Director of Human Resources in conjunction with the Campus Director. In the event a complaint is filed an investigation will be initiated to determine appropriate steps necessary to remediate the situation.

Although prior to this review there were forms developed and in practice in accordance with the complaint policy, SJRC will implement complaint envelopes in all the homes and a complaint/comment box in the

St. Jude's Ranch for Children (continued)

Facility Response (continued)

administration building. This improved practice will be implemented within 30 days of this letter.

In addition, contained in the Youth Handbook, there is a section that explains the right of the youth to file a grievance/complaint. This is reviewed upon intake and then on a periodic basis. Whenever the youth handbook is reviewed the youth and staff will be required to sign their understanding of the policy and practice of SJRC related to filing a complaint.

Other Items

Other items noted during our review included: one of the vehicles observed did not include a first aid kit and the fire extinguisher was missing its pull pin seal; a log of visitors entering SJRC is not maintained; and the youth schedule and a list of prohibited items and contraband were not always posted in areas visible to youths, staff, and visitors.

Further, youths are not provided with a youth handbook when they arrive at SJRC. A youth handbook should outline: the facility's complaint process; facility rules, including prohibited items and contraband; and youths' rights and privileges. A youth handbook may aid youths transition to their stay at SJRC.

Facility Response

SJRC staff conducts on-going (daily, weekly and monthly) inspections of homes and vehicles for safety items such as first aid kits and in-tact fire extinguishers. There will be continued focus to ensure that all safety items are in-tact and random checks will be instituted by the SJRC Maintenance Supervisor, Campus Director and/or Director of Compliance to ensure first aid kits and fire extinguishers are present.

A log is maintained at the reception desk in the SJRC Administration building, as well as in each home, to track visitors to campus. Those logs will be collected on a monthly basis and maintained by SJRC staff for record-keeping basis.

St. Jude's Ranch for Children (continued)

Facility Response (continued)

In addition to the several mandatory documents to be posted in each home, a list of prohibited items and items that are considered contraband will also be posted. This will be added to the home inspection form for on-going review. Based on the therapeutic services provided to children, structure and consistency is an important component of the program. There is a standard schedule for the homes to use. The times for activities will be added based on the unique characteristics of the home and children. This form will be required to be posted in the homes where other required forms are maintained.

A Youth Handbook has been created and is being implemented so that youths understand their rights, privileges, the complaint process, lists of prohibited items, rules and information regarding the Model of Care used in the home and general questions about living in the SJRC home. The Youth Handbook will be issued at time of placement and the SJRC Case Manager will review basic rights and privileges as well as the complaint process. Subsequent sections of the Handbook will be reviewed with the youth by his foster parent. The youth and SJRC staff will be required to sign the Handbook. A Youth Handbook will always be accessible in each home for review.

Spring Mountain Treatment Center

Background Information

Spring Mountain Treatment Center (SMTC) is a private, for-profit, secured mental health treatment facility located in Las Vegas, Nevada. The facility serves male and female youths between the ages of 5 and 17. SMTC's mission is to provide healthcare that contributes to the medical, psychiatric, psychological, social, and spiritual well-being of the youths and community it serves. SMTC provides acute (short-term) and residential services to youths with severe emotional, psychiatric, behavioral, or substance abuse problems.

During the year ended June 30, 2011:

- The maximum capacity was 56 youths.
- The average daily population was 36.
- The average population during the month of our visit, March 2011, was 22.
- There was an average of 28 staff: 15 full-time and 13 part-time.
- SMTC was licensed by the Nevada Health Division, Bureau of Health Care Quality and Compliance, as a hospital.

Purpose of the Review

The purpose of our review was to determine if Spring Mountain Treatment Center adequately protects the health, safety, and welfare of the children in SMTC and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period July 1, 2009, to February 28, 2011. In addition, we discussed related issues and observed related processes during our visit in March 2011.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at SMTC provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects

Spring Mountain Treatment Center (continued)

the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, SMTC needs to improve its medication administration process, develop and update policies and procedures, and improve its background check process.

Principal Observations

Medication Administration Process

SMTC needs to improve its medication administration process. Medication administration records were not always completely filled out; 8 of 10 records contained blank spaces. Blank spaces on a record could indicate a youth was administered medication and staff forgot to complete the form, the youth refused the medication, or the youth did not receive medication for some other reason.

In addition, SMTC should add a menu to its medication administration record. A menu is a list of acronyms used to identify specific actions, such as medications missed when a youth refuses his medication. A menu may help eliminate some of the blank spaces noted.

Also, medication files and records do not contain evidence of independent review. Policies require SMTC's staff and management to review and reconcile medication administration records; however, there is no evidence to indicate these processes are being performed. Without documentation, management has no assurance records and files are reviewed and reconciled.

Facility Response

An acronym menu was developed and inserted on the Medication Administration Record. Regular audits of the medication administration and documentation process are conducted and the findings are reviewed in a structured committee forum. Licensed nursing staff were re-educated on medication variance documentation.

Policies and Procedures

SMTC needs to develop and update policies and procedures. Without clearly documented policies and procedures, management

Spring Mountain Treatment Center (continued)

and staff may be unclear of the facility's processes and provide inconsistent services to youths. SMTC did not have policies specific to exercise and privileges youths can earn. For example, SMTC's point system used by youths to earn privileges is addressed in youth handbooks; however, privileges are not addressed in policies and procedures.

In addition, SMTC needs to update medication disposal policies and procedures. Current policies instruct staff to not return open or contaminated medications to patient drawers. However, policies do not provide instructions on what to do with medications not returned to patient drawers. Policies do not address documentation of disposal of contaminated medication, the method used to destroy medication, or the number of witnesses needed to destroy medications. Further, policies do not address the disposal of non-controlled medications.

Facility Response

Spring Mountain Treatment Center is in the process of formally reviewing, revising, updating, and/or developing policies and procedures.

Background Checks

SMTC needs to improve its background check process. SMTC did not complete employee background checks consistent with statutes. NRS 449.179 requires fingerprint based background checks. However, all eight background checks we reviewed were completed using an employee's name and social security number. Social security based background checks may not be as reliable as fingerprint based background checks.

In addition, SMTC does not require fingerprint based background checks on a periodic basis for all employees after employment as required by the State. NRS 449.179 requires employees be fingerprinted at least every 5 years following employment.

Facility Response

Spring Mountain Treatment Center is in the process of implementing background checks consistent with NRS statutes requiring fingerprint based background checks.

Spring Mountain Treatment Center (continued)

Other Items

Other items noted during our review included: a list of prohibited items and contraband was not posted in areas visible to youths, staff, and visitors; complaint forms were not readily available to youths; and SMTC's patient rights and responsibilities form should be updated to address sexual orientation. In addition, patient observation forms were not completely filled out for 4 of 10 youths whose files we reviewed. Completion of these forms is required by SMTC's policies to ensure consistent surveillance of patients.

Facility Response

Contraband and prohibited items are posted in conspicuous locations. Complaint forms are easily accessible for the youth services program. Spring Mountain's "Rights" document was revised to address sexual orientation. Staff were re-educated on the appropriate method of completing and documenting Patient Observation Forms.

WestCare—Emergency Shelter

Background Information

WestCare—Emergency Shelter (WCES) is a private, not-for-profit, staff secure child welfare facility located in Las Vegas, Nevada. WCES serves male and female youths between the ages of 10 and 17. WCES's mission is to empower everyone with whom they come into contact to engage in a process of healing, growth and change benefiting themselves, their families, and communities. WCES carries out this mission by providing an immediate safe haven for runaway or homeless youths who are in need of crisis intervention or emergency placement. WCES also provides supervised adolescent detoxification services, including treatment options for early intervention to adolescent substance abuse problems.

During the year ended June 30, 2011:

- The maximum capacity was 15 youths.
- The average daily population of youths was 12.
- The average length of stay was 4 days.
- The average population during the month of our visit, May 2011, was 4 youths.
- There was an average of 14 staff: 12 full-time and 2 part-time.
- WCES was licensed by the State Health Division's Bureau of Health Care Quality and Compliance as a substance abuse treatment facility.

Purpose of the Review

The purpose of our review was to determine if WestCare—Emergency Shelter adequately protects the health, safety, and welfare of the children in WCES and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period July 1, 2009, to March 31, 2011. In addition, we discussed related issues and observed related processes during our visit in May 2011.

WestCare—Emergency Shelter (continued)

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at WestCare—Emergency Shelter provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, WCES needs to improve its medication administration process and procedures, develop and update policies and procedures, improve its mandatory reporting process, improve its background check process, and strengthen its supervision of youths.

Principal Observations

Medication Administration Process

WCES needs to improve its medication administration process. Specifically, 6 of 10 medication files reviewed were missing documentation or documentation was incomplete. For example, missing medication documentation included physicians' orders for medication administered to youths and medication administration records. Incomplete documentation included blank spaces on medication administration records and an unidentified over-the-counter medication administered to a youth. Blank spaces could indicate a youth was administered medication and staff forgot to complete the form, a youth refused the medication, or a youth did not receive medication for some other reason.

WCES needs to add a menu to its medication administration record. A menu is a list of acronyms used to identify specific actions, such as medications missed when a youth was on a home pass or refuses his medication. A menu may help eliminate documentation errors.

Medical files and records do not always contain evidence of an independent review and reviews completed were not always independent. Policies require a member of staff who is not routinely involved in the observation of client self-administration to independently review medication records. Without evidence of a review by someone independent of the medication administration process, errors, fraud, or abuse could occur and go undetected.

WestCare—Emergency Shelter (continued)

Medication Administration Procedures

WCES should require staff to observe youths while they complete mouth sweeps. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Cheeking is a method used to conceal medication and failure to complete a mouth sweep increases the risk of medications being cheeked for unauthorized use at a later time. Improving medication administration procedures to require mouth sweeps may help reduce the risk of medications being abused.

WCES does not use an approved, dated over-the-counter medication standing order form. A standing order form identifies over-the-counter medications staff may administer to youths. Not having a dated and signed physician approved form could result in medication being administered to youths that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Facility Response

The WestCare Medication Policy was revised to add the missing components. A copy of the original physician's orders for each prescription must be in the client file. If a copy does not accompany the client, staff will get a signed confidentiality release to call the pharmacy or prescribing physician to obtain a copy of the orders via fax or email.

Any medications that are discontinued, given for home visits or refused by the client will need to be documented on the medication log sheet at the required time and initialed by staff and the client verifying the reason. Follow-up is to be done in 24 hours with legal guardians or physicians for updated orders if they are not being followed. All spaces on the medication log are to be completed, according to the legend/menu of acronyms on the medication log.

All over-the-counter medications given must be documented on a separate log sheet noting date, time, and amount given with staff and client's initials. Over-the-counter medications may be provided for self

WestCare—Emergency Shelter (continued)

Facility Response (continued)

administration in accordance with WestCare's Protocol for Over-the-Counter Medications approved by medical staff, or with a physician's order.

Staff was trained on the policy additions noted above on June 28, 2011. The Director and other assigned designated staff (Case Manager and Lead Technician) will monitor to ensure on-going compliance on a daily basis.

The medication log sheet was revised to add a menu. All prescribed medications are counted every 8 hours and entered into a medication count log book. If any discrepancies are noted, the Director is notified to investigate and consult with the medical staff to correct the problem immediately. Medication log forms have a section that states "Audited by and Date audited" on each form. An independent review is conducted by the Director or appointed designee providing weekly random checks.

The WestCare Medication Policy was revised to include mouth sweep requirements. On June 28, 2011, all Crisis Stabilization staff were given a full report of observations and recommendations from the Legislative Counsel Bureau review. Each staff initialed understanding of all medication requirements and other needed changes to meet standards. For review, a copy of the checklist is attached with each staff's signature.

A WestCare Nevada Residential Programs "Protocol for Over-the-Counter Medications" was completed for medical staff to inform the staff of approvals given. The WestCare Physician/Family Nurse Practitioner will write an order stating the amount, frequency and duration of use of any over-the-counter medication use. A copy of this order is filed in the client file under the medical section. A medication log sheet is started informing staff of the medical order for the client to self-administer the medication at the appropriate times.

WestCare—Emergency Shelter (continued)

Policies and Procedures

WCES needs to develop and update policies and procedures. During the period of our review, there were no policies specific to exercise, recreation, social skills, and youths' access and use of computers.

In addition, policies and procedures that need to be updated include searches for contraband and prohibited items. For example, policies do not address the method used to complete a search of youths and their belongings for contraband. In addition, policies do not require documentation of completed searches. WCES should also consider updating its list of prohibited items and contraband to ensure the safety of staff and youths. Without clearly documented policies and procedures, management and staff may be unclear of processes and provide inconsistent services to youths.

Facility Response

WCES created two new policies: Nutrition, Childhood Obesity, Exercise/Recreation and Social Skills Policy, and Supervision of Youth during Computer Use Policy. WestCare's Client Search Policy was updated to include the steps staff should take when conducting searches. Staff will document that an initial search upon admission has been performed, as well as subsequent searches after outings, returns from visits, and readmissions.

WCES has added the following to its list of prohibited items and contraband: any sharp items, such as scissors, clippers, nail files, etc., and alcohol-based products.

Mandatory Reporting Requirements

WCES needs to improve its mandatory reporting process. NRS 432B.220 requires those who know or have reasonable cause to believe that a child has been abused or neglected make a report within 24 hours to child welfare services or law enforcement. We noted two instances of youths' disclosures of allegations to WCES staff; however, there was no evidence to support whether the allegations were reported. WCES's policies require staff to

WestCare—Emergency Shelter (continued)

complete an incident report and report allegations. However, staff did not complete incident reports for these two disclosures; therefore, documentation was inadequate to support that the allegations were reported.

Facility Response

Staff is mandated to report to Child Protective Services any and all allegations a youth makes according to NRS 432B.220. An event number is obtained as proof that the report was made. The information and report will be documented on the WestCare Incident Report.

Staff will also be required to submit verification reports when a child alleges abuse/neglect and states that it has been reported and investigated in the past. Staff will be expected to follow protocol and make the report to Child Protective Services or law enforcement confirming that a report was on file, obtain the event number, and submit it in the incident reporting system. If no report is on file, staff will make the report with the information given to them.

Background Checks

WCES needs to improve its practices related to fingerprint background checks. One of five employees whose files we reviewed was not fingerprinted timely. Specifically, the employee was not fingerprinted until 16 months after her hire date. In addition, the employee's personnel file was incomplete. For example, it contained evidence management requested the employee provide dispositions for arrests documented in the employee's background check results. However, there was no evidence management received or reviewed the dispositions. As a result, the employee continued employment with a felony conviction for possession and trafficking of a controlled substance for 2 years after documentation of the arrest was received.

Also, WCES's management did not comply with its hiring policies. Policies indicate WestCare complies with NRS 449.176 to NRS 449.188 and that management will determine if an employee is suitable for employment at WestCare. Based on our analysis of this employee's dispositions for arrests, the employee should have

WestCare—Emergency Shelter (continued)

been excluded from employment. In addition, the personnel file did not contain documentation from management to support the employee's suitability for continued employment. Management's failure to follow-up, obtain, verify, and review dispositions requested may have contributed to these oversights. The process to verify the disposition of a case when a background check does not show the outcome of the case was addressed previously with management during a review of WestCare's Harris Springs Ranch.

Facility Response

Based on the information discussed with the LCB staff regarding the May 2011 review, the following changes have been made:

- *As part of our pre-employment process, all candidates are directed to purchase their own fingerprint cards and obtain money orders so that the prints can be submitted to the Nevada Criminal History Repository and the Federal Bureau of Investigation. All candidates are told that employment is contingent upon passing several tests, including receiving an acceptable criminal history check.*
- *Candidates also review and sign the "Criminal History Statement". If they acknowledge they have done anything in violation of the 11 criminal convictions noted on the document, Human Resources discusses the situation with the candidate, his/her immediate supervisor, the Nevada Deputy Administrator and the Senior Vice President for Nevada. That group makes the decision as to whether or not the employee is suitable for employment.*
- *When completing new hire paperwork, WestCare submits the print cards, money orders and necessary forms to the Nevada Department of Public Safety.*
- *The forms submitted allow the results of the fingerprints to come to WestCare rather than the employee.*

WestCare—Emergency Shelter (continued)

Facility Response (continued)

- *Westcare also submits an “Employer Request for Child Abuse and Neglect Central Registry Information” to the Nevada Division of Child and Family Services. Results are usually obtained within 48 hours. If any record is found, the employment process is put on hold, and the candidate is directed to request a “Case Closure Summary” from Child Protective Services. Those results are reviewed as noted above. That management team makes the decision as to whether or not the employee is suitable for continued employment.*
- *When new hire information is entered into our automated Human Resources system, fingerprint renewal dates (5 years after initial fingerprinting) are plugged in. Reports are generated monthly and sent to Supervisors, requiring the employee to proceed through the fingerprinting process again.*
- *If the initial fingerprinting or the renewal result in any new arrests, the results are reviewed as noted above. If any information is in violation of the 11 statements on the “Criminal History Report”, the employee is placed on unpaid Administrative Leave while being directed to obtain a written disposition which is then presented to Human Resources, and reviewed with the Supervisor, Deputy Administrator, and the Senior Vice President. That group makes the decision as to whether or not the employee is suitable for continued employment.*
- *Documentation of the criminal history review process, and the decision of whether or not a candidate or employee is suitable for employment are kept with the criminal history forms and reports in the Human Resources Department.*

Youth Supervision

WCES needs to strengthen its supervision of youths. During our review, we noted two instances of inadequate supervision. First,

WestCare—Emergency Shelter (continued)

we observed a staff member leaving youths unsupervised while he escorted another youth outside. In addition, WCES self reported to its licensing agency inappropriate behavior between youths that was a result of inadequate supervision of the youths. Inadequate supervision of youths could result in other inappropriate behaviors and unsafe situations.

Facility Response

A new Crisis Stabilization Unit daily visual verification of clients form was created. Staff will document 24 hours a day, every 30 minutes, the number of clients and their location at that moment. Staff reviewed their supervision policy on June 28, 2011. Staff will supervise the buildings, grounds, bedrooms/cabins, and recreation areas whenever clients are occupying these areas. No client is ever allowed to supervise another client. Youth clients may only go places accompanied by staff. Staff needs to be able to see the youth clients that they are supervising and be close enough to hear the youth.

Other Items

Other items noted during our review included: intake information was not updated for readmitted youths; initial treatment plans were not prepared for 5 of 10 youths whose files we reviewed; increased supervision of youths who are at risk of harming themselves was not always documented; and a facility vehicle had an empty fire extinguisher.

In addition, youths are not provided with a youth handbook when they arrive at the facility. Based on our observations and discussions with management, a handbook is available for youths to use in the staff office, which is not always readily available to youths. A readily available youth handbook may aid a youth's transition to his stay at WCES.

Facility Response

Staff acknowledged and signed off on June 28, 2011, the following:

WestCare—Emergency Shelter (continued)

Facility Response (continued)

- *I understand that a client's paperwork will need updating on every admission. Staff and client will review each form requiring signatures and initial with a new date at the bottom. New confidentiality releases will be added as needed.*
- *All Crisis Stabilization Unit clients will have a treatment plan in their file if they are in the program more than 72 hours. Detox clients will have a treatment plan in the file shortly after admission.*

Staff will document visual sight of a client at risk of harming themselves. A 15 minute visual chart will note where the client is at all times until a proper transfer can be made to psychological services. Upon admission, staff works with the client to complete a client "Personal Safety Plan" to assist staff in knowing how the client feels his needs can be met when he is depressed, angry or wanting to hurt himself or others. In this plan, the client states clearly how he wants staff to handle him. The original plan is placed in the client file and a copy is in a master binder for staff to access with ease when the need arises.

The CSU is not a treatment program. The program is crisis intervention, problem identification, mediation, referrals and recommendations. Each youth will have a case management plan. Adjustments will be made on our forms to say "Case Management Plan" as opposed to "Treatment Plan".

A new extinguisher was purchased and installed. The extinguishers are being inspected monthly by maintenance and then will be re-certified annually when they come due. The monthly inspection will reveal if the unit has been discharged and can then be replaced or recharged. They are signed off monthly during the life safety resources inspection. They are on the schedule with all of our other hand held extinguishers for the

WestCare—Emergency Shelter (continued)

Facility Response (continued)

annual recertification and they would be flagged on the month prior that they will be due.

Copies of the handbook are offered at the time of intake. Clients are also made aware that a copy of the handbook is available 24 hours in the staff office located in a bin by the entrance door. Two additional copies were made and are available in the common living areas in the unit. Staff added a weekly review of the handbook to the daily schedule and will do so more frequently as the population changes.

Rite of Passage—Silver State Academy

Background Information

Rite of Passage—Silver State Academy (ROP—SSA) is a private, not-for-profit, staff secure facility located in Yerington, Nevada. The facility serves male youths between the ages of 14 and 18 years. ROP—SSA's mission is to provide a structured, controlled, safe environment for medium to high at-risk youths. ROP—SSA uses evidence based interventions and strategies to decrease the probability of recidivism and return youths to law abiding behavior. ROP—SSA provides services to youths placed by juvenile courts, child welfare agencies, and private parties.

During the year ended June 30, 2011:

- The maximum capacity was 215 youths.
- The average daily population was 170 youths.
- The average length of stay was 11 months.
- The average number of staff was 132: 125 full-time and 7 part-time.
- ROP—SSA was licensed as a youth care facility by the Yerington Paiute Tribe and as a group home by the State of California.

Purpose of the Review

The purpose of this review was to determine if Rite of Passage—Silver State Academy adequately protects the health, safety, and welfare of the children in the ROP—SSA and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period July 1, 2009, to April 30, 2011. In addition, we discussed related issues and observed related processes during our visit in June 2011.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Rite of Passage—Silver State Academy provide reasonable assurance that it adequately protects the health, safety, and welfare of the youths at the facility and respects the civil and other rights of

Rite of Passage—Silver State Academy (continued)

the youths in its care. However, we noted some areas for improvement. Specifically, ROP—SSA needs to: improve its medication process and procedures; develop and update policies and procedures; improve its documentation of reporting abuse and neglect; improve its background check process; and strengthen its supervision of youths.

Principal Observations

Medication Administration Process

ROP—SSA needs to improve its medication administration process. Specifically, 9 of 10 medication files reviewed were missing documentation or documentation was incomplete. Missing medication documentation included physicians' orders to administer, change, or discontinue medications and medication administration records. Medication administration records are used to record medications administered to youths. Incomplete documentation included blank spaces on medication administration records. Blank spaces could indicate a youth was administered medication and staff forgot to complete the form, the youth refused the medication, or the youth did not receive medication for some other reason.

In addition, documentation indicates youths may have been administered more or less medication than the physician ordered. Transcription errors and inconsistencies on medication administration records resulted in unclear documentation of the amount of medication actually administered.

ROP—SSA needs to add a menu to its medication administration record. A menu is a list of acronyms used to identify specific actions, such as medications missed when a youth was on a home pass or refuses his medication. A menu may help eliminate documentation errors.

Medication Administration Procedures

ROP—SSA did not always administer prescribed medication timely to youths. For example, there were delays of up to 49 days in 4 of 10 files reviewed. Facility policy requires staff to obtain consent prior to administering prescribed medication to youths. However,

Rite of Passage—Silver State Academy (continued)

there was no evidence in one youth's file to document attempts to obtain consent until 49 days after a physician's order was written. Delays in administering prescribed medications could result in adverse effects.

Facility Response

Rite of Passage has added a menu to the medication records to ensure auditors are clear with what each acronym means. We believe this will help eliminate some of the errors noted. Also all staff, direct care and medical staff will go through an extensive training on medication administration and documentation. The training is scheduled for the week of September 26th. Rite of Passage—Silver State Academy is also bringing in a person to conduct an outside review and training in proper medication management documentation.

Rite of Passage has developed a form to ensure all contacts to the court and parents are documented. As stated in the report, Rite of Passage is required to get approval from the court and parent and this can be a long process, but Rite of Passage understands the need to document all attempts to contact parents even when parents do not respond.

Policies and Procedures

ROP—SSA needs to develop and update policies and procedures. Without clearly documented policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths. ROP—SSA did not have policies to control facility keys. In addition, policies should be updated to include the length of time to retain files for Nevada youths. Computer technology policies that address staff computer usage should be incorporated into facility policies, and a comprehensive list of contraband should be developed. Finally, ROP—SSA's 24 hour medical emergency plan and critical incident/crisis triage policies should explain the difference between close supervision and constant supervision.

Rite of Passage—Silver State Academy (continued)

Facility Response

Rite of Passage—Silver State Academy has completed a facility key policy. All staff have been trained in this policy. Rite of Passage has also updated its file retention policy to include Nevada. Rite of Passage was already following the Nevada requirement, but the words “Nevada Requirement” were added. Rite of Passage has a computer use policy but it was in a different section and it has been added to the facilities policy. A list of contraband is posted throughout the site but has been updated in the policy manual. Also changes to crisis triage with the distinction between close observation and constant supervision has been added.

Mandatory Reporting

ROP—SSA needs to improve its mandatory reporting process. NRS 432B.220 requires those who know or have reasonable cause to believe a child has been abused or neglected to make a report within 24 hours to child welfare services or law enforcement. We noted a youth disclosed allegations of abuse; however, there was no evidence to support whether the allegations were reported. In addition to a verbal incident report, facility policies require a written incident report to document allegations; however, there is no evidence a written incident report was completed.

Facility Response

The incident that was referred to in this section was a student reporting previous abuse that had happened several years prior. After talking to the staff it was clear that he followed up with the court documents to ensure that this had been investigated. He admits that he should have written a follow-up note about following through on the allegation. Rite of Passage currently trains all staff in mandatory reporting procedures and has added a training on documenting all follow-ups.

Background Checks

ROP—SSA needs to improve its background check process. For example, ROP—SSA did not obtain waivers from its licensing

Rite of Passage—Silver State Academy (continued)

agency for 2 of 10 employees whose files we reviewed. According to ROP—SSA's licensing agency, a misdemeanor or felony conviction would exclude an employee from employment. Although both employees had been convicted of a misdemeanor, ROP—SSA did not notify its licensing agency of the convictions or obtain waivers.

In addition, personnel files did not always contain evidence that ROP—SSA obtained the disposition of an employee's arrest when the background check did not show the outcome of the arrest. Positive background check results indicate a person was arrested, but do not always indicate if the person was convicted of a crime for which he was arrested. Unless ROP—SSA follows up with the appropriate criminal justice agencies, it has no assurance whether or not the arrest resulted in a conviction.

Also, ROP—SSA needs to develop a policy to require employees who transfer to ROP—SSA from other ROP facilities to be re-fingerprinted. According to management, it is a generally accepted practice to require employees who transfer to be re-fingerprinted. However, without a policy, this practice may not be consistently followed.

Facility Response

Both staff were employees who transferred in from our California facility and had completed the necessary background checks for California employment. For all transfers, Rite of Passage will complete the Nevada background check prior to starting work at Silver State Academy. Waivers have been requested for the other staff. The current waiver process is being reviewed with licensing. ROP has obtained copies of the disposition and will ensure that for all staff, and especially transfers, this information is included.

Supervision

ROP—SSA needs to strengthen its supervision of youths. During our review, we noted three instances of inadequate supervision. For example, during the breakfast hour, we observed staff to youth ratios of 2:48, 3:41, and 1:25. The Nevada Association of Juvenile

Rite of Passage—Silver State Academy (continued)

Justice Administrators' Standards for Juvenile Detention Facilities recommends staffing ratios on interactive shifts (daytime) be 1:6, but should not exceed 1:8. Although ROP—SSA is licensed as a group home, it serves medium to high at-risk youth. Inadequate supervision may have contributed to youth searching for inappropriate websites, youth using inappropriate language, and contraband type items noted on campus. Inadequate supervision of youths could result in other inappropriate behaviors and unsafe conditions.

Facility Response

On the date of the review the population on site at Silver State Academy fluctuated between 167 and 172 youths with students graduating the program on June 1st. On those days the staff assigned during the morning was 26 staff. This is well within the required staff to student ratios. Rite of Passage does recognize that staff stayed back with individual students to complete daily chores and to escort the students around site. Rite of Passage staff have been instructed to stay with the group and ensure ratios are kept in compliance with recommended standards.

Other Items

Other items noted during our review included: a fire escape route was not posted and a grievance box was not available in one of the living areas; cleaning supplies were not always appropriately stored; and two of five vehicles did not contain a first aid kit. In addition, youth files were not always securely stored to prevent unauthorized access. Also, ROP—SSA needs to update the handbook provided to youth to be consistent with the actual grievance process, including the grievance form, the timeframe to resolve grievances, and the grievance box.

Facility Response

The first aid kits were replaced prior to the end of the review. The dorm without the statement box was only being used because of renovations to another dorm. Fire escape routes have also been updated and posted in the dorm. The dorm is not currently in use but Rite of

Rite of Passage—Silver State Academy (continued)

Facility Response (continued)

Passage has installed a box and the fire escape routes in case the dorm is used again. Automatically locking doors will be installed where cleaning supplies are kept to ensure proper storage. The student handbook has been updated to reflect the changes in policies. Rite of Passage is also in the process of installing automatically locking doors on all rooms where student and employee files are kept. The expected completion date is September 20, 2011.

Appendices

Appendix A

Nevada Revised Statutes 218G.570 Through 218G.585

Facilities Having Physical Custody of Children

NRS 218G.570 Performance audits of governmental facilities for children. The Legislative Auditor, as directed by the Legislative Commission pursuant to NRS 218G.120, shall conduct performance audits of governmental facilities for children.

(Added to NRS by 2009, 3)

NRS 218G.575 Inspection, review and survey of governmental facilities for children and private facilities for children. The Legislative Auditor or the Legislative Auditor's designee shall inspect, review and survey governmental facilities for children and private facilities for children to determine whether such facilities adequately protect the health, safety and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care.

(Added to NRS by 2009, 3)

NRS 218G.580 Scope of inspection, review and survey. The Legislative Auditor or the Legislative Auditor's designee, in performing his or her duties pursuant to NRS 218G.575, shall:

1. Receive and review copies of all guidelines used by governmental facilities for children and private facilities for children concerning the health, safety, welfare, and civil and other rights of children;
2. Receive and review copies of each complaint that is filed by any child or other person on behalf of a child who is under the care of a governmental facility for children or private facility for children concerning the health, safety, welfare, and civil and other rights of the child;
3. Perform unannounced site visits and on-site inspections of governmental facilities for children and private facilities for children;
4. Review reports and other documents prepared by governmental facilities for children and private facilities for children concerning the disposition of any complaint which was filed by any child or other person on behalf of a child concerning the health, safety, welfare, and civil and other rights of the child;
5. Review the practices, policies and procedures of governmental facilities for children and private facilities for children for filing and investigating complaints made by children under their care or by any other person on behalf of such children concerning the health, safety, welfare, and civil and other rights of the children; and
6. Receive, review and evaluate all information and reports from a governmental facility for children or private facility for children relating to a child who suffers a fatality or near fatality while under the care or custody of the facility.

(Added to NRS by 2009, 3)

Appendix A

Nevada Revised Statutes 218G.570 Through 218G.585 (continued)

NRS 218G.585 Duty of facilities to cooperate with inspection, review and survey. Each governmental facility for children and private facility for children shall:

1. Cooperate fully with the Legislative Auditor or the Legislative Auditor's designee in the performance of his or her duties pursuant to NRS 218G.575 and 218G.580;

2. Allow the Legislative Auditor or designee to enter the facility and any area within the facility with or without prior notice;

3. Allow the Legislative Auditor or designee to interview children and staff at the facility;

4. Allow the Legislative Auditor or designee to inspect, review and copy any records, reports and other documents relevant to his or her duties; and

5. Forward to the Legislative Auditor or designee copies of any complaint that is filed by a child under the care or custody of a governmental facility for children or private facility for children or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child.

(Added to NRS by 2009, 3)

Appendix B

Glossary of Terms

Cheeking	A method used to conceal medication administered to a youth.
Child Welfare Facility	Provides emergency, overnight, and short-term services to youths who cannot remain safely in their home or their basic needs cannot be efficiently delivered in the home.
Civil and Other Rights	This relates to a youth's civil rights, as well as his rights as a human being. It includes protection from discrimination, the right to file a complaint, replacement of missing personal items, and protection from racist comments.
Correction Facility	Provides custody and care for youths in a secure, highly restrictive environment who would otherwise endanger themselves or others, be endangered by others, or run away. Correction facilities may include restrictive features, such as locked doors and barred windows.
CPS	Child Protective Services in Washoe County is part of the Department of Social Services, in Clark County it is part of the Department of Family Services, and in other counties it is part of DCFS.
DCFS	The Nevada Division of Child and Family Services.
Detention Facility	Provides short-term care and supervision to youths in custody or detained by a juvenile justice authority. Detention facilities may include restricted features, such as locked doors and barred windows.
Federal Food and Drug Administration	Federal Food and Drug Administration is a federal agency responsible for protecting public health by assuring the safety, efficacy, and security of medications. The agency is also responsible for determining if approved medications are no longer safe for administration to youths.
Group Homes	Provide safe, healthful group living environments in a normalized, developmentally supportive setting where residents can interact fully with the community. Used for children who will benefit from supervised living with access to community resources in a semi-structured environment. Generally consists of detached homes housing 12 or fewer children.

Appendix B
Glossary of Terms
(continued)

Higher Level of Care	Comprehensive care and services provided to youth who require more intensive therapy, supervision, tutoring, or education due to serious emotional, behavior, or psychological conditions.
Home Pass	A home pass is a privilege earned by a youth and approved by a facility. During an approved home pass, youth can visit with his parent(s) or guardian(s) for a specified length of time. In general, passes do not occur on a facility's campus.
Mandatory Reporter	A mandatory reporter includes any person in his professional or occupational capacity who knows or has reasonable cause to believe that a child has been abused or neglected.
Mental Health Facility	Mental health facilities provide mental health services to youths with serious emotional disturbances by providing acute psychiatric (short-term) and non-acute psychiatric programs. Mental health facilities also provide services to behaviorally disordered youth. Services provided include a full range of therapeutic, educational, recreational, and support services by a professional interdisciplinary team in a highly structured, highly supervised environment.
Privileges	Items considered earned and not considered a right. Items considered privileges may include movies, recreation time, phone calls, and reading material.
Residential Center	Provide a full range of therapeutic, educational, recreational, and support services. Residents are provided with opportunities to be progressively more involved in the community.
Resource Center	A facility that provides more than one type of service simultaneously. For example, a facility that provides both treatment and detention services.
Safety	Anything related to the physical safety of youths. This includes physical security and environment, protection from inappropriate comments, inappropriate contact by staff or another youth, and staffing issues.
Staff-Secure	Access out of the facility is limited by staff and not monitored by a secure system.

Appendix B
Glossary of Terms
(continued)

Standing Order Form	Physician approved order for over-the-counter medication a facility may administer to youths.
Substance Abuse Treatment Facility	Substance abuse treatment facilities provide intensive treatment to youths addicted to alcohol or other drug substances in a structured residential environment. Substance abuse facilities focus on behavioral change and services to improve the quality of life of residents.
Sweep	A method used to detect medication concealed in the mouth.
Therapeutic Outdoor Adventure Program	A wilderness based intervention and rehabilitation program designed to elicit change through high adventure physical activities, such as backpacking, hiking, and orienteering.
Use of Force	Use of force is a technique used to prevent a youth from harming themselves or others. Techniques include restricting or reducing the youth's ability to move.
Welfare	Anything related to the general well being of a youth. This includes education, wellness activities, and punishments or discipline.
Youth	The term youth is intended to describe children of all ages, including infants and adolescents.

Appendix C

Summary of Observations at Six Facilities Reviewed

Observations	Facilities
Policies and Procedures	
Policies and procedures were not developed, not complete, or needed to be updated	6
Medication Administration Process and Procedures	
Incomplete or unclear documentation of dispensed prescribed medication	5
Medication administration records need to be revised or updated	5
Medication files and records did not always contain evidence of independent review	3
Over-the-counter standing order form needs to be developed or updated	3
Youths did not always receive prescribed medications timely	3
Medication disposed was not always documented	2
Background Checks	
Caregiver file did not contain evidence caregiver was fingerprinted, files did not include the date a caregiver began providing services, or personnel file did not contain evidence management received or reviewed arrest dispositions	3
Policies and procedures did not address obtaining periodic background checks following employment	2
Mandatory Reporting	
No evidence one or more allegations of abuse or neglect were reported	3
Complaints and Grievances	
No locked box for youths to file complaints or grievances	4
Complaint or grievance forms were not readily available to youths	4
Other Significant Items	
Youths not provided with a youth handbook or handbook provided needs to be revised or updated	5
List of prohibited items and contraband was not posted	4
Facility vehicle(s) did not contain a fully stocked first aid kit	4
Supervision of youths needs improvement	2
Unsafe and unhealthy higher level of care home	1
Unlicensed outdoor youth program	1

Source: Reviewer prepared from facility conclusions.

Note: This is not a comprehensive list of observations.

Appendix D

Nevada Facility Information Fiscal Year Ended June 30, 2011

Table 1: Correction and Detention Facilities				Background		Population for FY 2011		Staffing Levels	
Facilities	Funded By	Location	Ages	Maximum Capacity	Average Population	Full-Time	Part-Time		
			Served						
Caliente Youth Center	State	Caliente	12 to 18	140	125	85	0		
China Spring Youth Camp/Aurora Pines Girls Facility	State/Counties	Gardnerville	12 to 18	65	55	34	2		
Clark County Juvenile Detention Center	Clark County	Las Vegas	8 to 18	192	173	175	50		
Douglas County Juvenile Detention Center	Douglas County	Stateline	8 to 18	16	8	6	2		
Jan Evans Juvenile Justice Center	Washoe County	Reno	8 to 17	108	45	48	0		
Leighton Hall	Various Counties	Winnemucca	8 to 17	24	8	12	3		
Murphy Bernardini Regional Detention Center	Carson City	Carson City	8 to 18	22	9	14	13		
Nevada Youth Training Center	State	Elko	13 to 20	160	119	116	0		
Northeastern Nevada Juvenile Center	Various Counties	Elko	8 to 17	24	9	11	0		
Rite of Passage-Silver State Academy	Private	Yerington	14 to 18	215	170	125	7		
Spring Mountain Youth Camp	Clark County	Las Vegas	12 to 18	100	100	49	8		
Total - 11 Correction and Detention Facilities				1,066	821	675	85		

Table 2: Resource Centers				Background		Population for FY 2011		Staffing Levels	
Facilities	Funded By	Location	Ages	Maximum Capacity	Average Population	Full-Time	Part-Time		
			Served						
Don Goforth Resource Center	Various Counties	Hawthorne	8 to 17	32	10	8	12		
Western Nevada Regional Youth Center	State/Counties	Silver Springs	13 to 18	32	22	18	3		
Total - 2 Resource Centers				64	32	26	15		

Table 3: Child Welfare Facilities				Background		Population for FY 2011		Staffing Levels	
Facilities	Funded By	Location	Ages	Maximum Capacity	Average Population	Full-Time	Part-Time		
			Served						
Carson Valley Children's Center	Private	Carson City	0 to 18	10	3	4	7		
Child Haven	Clark County	Las Vegas	0 to 18	80	23	33	6		
Kids' Cottages	Washoe County	Reno	0 to 18	82	44	39	4		
WestCare-Emergency Shelter	Private	Las Vegas	10 to 17	15	12	12	2		
Total - 4 Child Welfare Facilities				187	82	88	19		

Table 4: Mental Health Treatment Facilities				Background		Population for FY 2011		Staffing Levels	
Facilities	Funded By	Location	Ages	Maximum Capacity	Average Population	Full-Time	Part-Time		
			Served						
Adolescent Treatment Center	State	Sparks	12 to 17	16	15	21	0		
Desert Willow Treatment Center	State	Las Vegas	6 to 18	58	44	110	0		
Montevista Hospital	Private	Las Vegas	5 to 17	28	24	30	5		
Oasis On-Campus Treatment Homes	State	Las Vegas	6 to 17	27	22	40	2		
Spring Mountain Treatment Center	Private	Las Vegas	5 to 17	56	36	15	13		
West Hills Hospital	Private	Reno	3 to 17	28	13	23	19		
Willow Springs Center	Private	Reno	5 to 17	116	93	128	60		
Total - 7 Mental Health Treatment Facilities				329	247	367	99		

Table 5: Substance Abuse Treatment Facilities				Background		Population for FY 2011		Staffing Levels	
Facilities	Funded By	Location	Ages	Maximum Capacity	Average Population	Full-Time	Part-Time		
			Served						
Nevada Homes for Youth	Private	Las Vegas	13 to 18	10	9	4	6		
Vitality Center-ACTIONS of Elko	Private	Elko	12 to 17	13	2	23	0		
WestCare-Harris Springs Ranch	Private	Las Vegas	12 to 17	15	14	10	0		
Total - 3 Substance Abuse Treatment Facilities				38	25	37	6		

Appendix D
Nevada Facility Information
Fiscal Year Ended June 30, 2011
(continued)

Facilities	Background			Population for FY 2011		Staffing Levels	
	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Boys Town Nevada - Homes	Private	Las Vegas	10 to 17	30	25	15	0
Briarwood North	Private	Sparks	11 to 20	42	35	36	11
Briarwood South ⁽²⁾	Private	Las Vegas	13 to 20				
Casa de Vida	Private	Reno	12 to 25	15	6	5	5
City of Refuge ⁽⁴⁾	Private	Gardnerville	Various	8	1	2	7
Eagle Quest of Nevada, Inc.	Private	Las Vegas	0 to 18	169	136	87	14
Family Learning Homes	State	Reno	5 to 18	24	18	17	1
Golla Home	Private	Washoe Valley	6 to 18	6	3	2	0
Hand Up Homes for Youth	Private	Reno	12 to 18	12	12	12	6
London Family and Children's Services, Inc.	Private	Las Vegas	6 to 18	50	30	15	35
Maple Star Nevada	Private	Statewide	0 to 21	144	97	53	91
New Vista Group Homes	Private	Las Vegas	0 to 22	8	7	10	4
Olive Crest	Private	Las Vegas	0 to 17	57	46	56	3
R House Community Treatment Home	Private	Reno	6 to 18	7	6	2	2
Rite of Passage-Qualifying Houses	Private	Minden	14 to 18	16	11	4	2
SAFY	Private	Las Vegas	6 to 18	9	9	7	13
Sankofa Group, Inc.	Private	Las Vegas	8 to 18	18	16	8	4
St. Jude's Ranch for Children	Private	Boulder City	0 to 21	66	43	44	1
Unity Village Behavioral Health Center	Private	Las Vegas	0 to 18	4	4	2	4
Total - 19 Group Homes				685	505	377	203

Facilities	Background			Population for FY 2011		Staffing Levels	
	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
DayBreak Equestrian Center I	Private	Lund	12 to 18	18	17	16	3
DayBreak Equestrian Center II ⁽³⁾	Private	Baker	12 to 18	4	4	8	0
HELP of Southern Nevada-Shannon West Homeless Youth Center	Private	Las Vegas	16 to 24	64	45	13	0
Horizon Academy	Private	Amargosa Valley	13 to 18	228	25	23	4
Spring Mountain Residential Center	County	Las Vegas	12 to 18	12	10	7	3
White Pine Boys Ranch ⁽¹⁾	Private	Lund	12 to 18				
Total - 6 Residential Centers				326	101	67	10
Total - 52 Facilities Statewide				2,695	1,813	1,637	437

Source: Reviewer prepared from information provided by facilities.

⁽¹⁾ Closed during the fiscal year ending June 2011 (one facility).

⁽²⁾ Facility did not provide information; effective July 2011, the facility began operating as an Eagle Quest, Inc. home.

⁽³⁾ Facility opened in April 2011.

⁽⁴⁾ Facility is operated by volunteers.

Appendix E
Unannounced Nevada Facility Visits

Facility Name	Facility Type	Date of Visit
Willow Springs Center	Mental Health Treatment	November 30, 2010
WestCare—Emergency Shelter *	Child Welfare	December 16, 2010
Sankofa Group, Inc.	Group Home	December 17, 2010
Oasis On-Campus Treatment Homes	Mental Health Treatment	January 28, 2011
Nevada Homes for Youth	Substance Abuse	January 28, 2011
Specialized Alternatives for Families and Youth (SAFY)	Group Home	January 28, 2011
Horizon Academy	Residential Center	May 5-6, 2011
China Spring Youth Camp/Aurora Pines Girls Facility	Correction and Detention	May 25, 2011
Rite of Passage—Qualifying Houses	Group Home	May 25, 2011
City of Refuge	Group Home	May 25, 2011

Source: Reviewer prepared from unannounced facility visits.

- Indicates the facility was also reviewed.

Appendix F

Methodology

To identify facilities pursuant to the requirements of statutes, we reviewed state accounting records for facilities funded directly by the State and the Substance Abuse Prevention and Treatment Agency's website for facilities indirectly funded by the State. In addition, we reviewed the website of the Bureau of Health Care Quality and Compliance for facilities licensed by the State. We also included a search of the internet for other potential facilities and reviewed youth placement information submitted monthly by certain local governments. Next, we contacted each facility identified to confirm it met the requirements of statutes. For each facility confirmed, we obtained copies of complaints filed by youths or other persons on behalf of a youth while in the care of a facility, since July 1, 2009. In addition, we requested specific facility information, such as funding source, staffing, and youth population.

To establish criteria, we reviewed *Performance-based Standards* developed by the Council of Juvenile Correctional Administrators, Child Welfare League of America's *Standards of Excellence for Residential Services and Health Care Services for Children in Out-of-Home Care*. In addition, we reviewed the Nevada Association of Juvenile Justice Administrators *Peer Review Manual*.

We selected criteria that included issues related to the health, safety, welfare, civil and other rights of youths, as well as treatment and privileges. Health criteria included items related to a youth's physical health, such as nutrition, exercise, and medical care. Safety criteria related to the physical safety of youth. This included the physical security and environment, inappropriate comments or contact by staff or other youth, and staffing issues. Welfare criteria related to the general well-being of a youth. This included education, wellness activities, and punishments or discipline.

Treatment criteria related to the mental health and behavior treatment of youth, not necessarily how a youth was treated on a daily basis. This included access to counseling, treatment plans, and progress through the program.

We distinguished between criteria for privileges, and civil and other rights. Specifically, we determined privilege criteria included items considered earned, such as movies, recreational time, phone calls, and reading material. We determined civil and other rights criteria included a right as a human being, such as protection from

Appendix F

Methodology (continued)

discrimination and racist comments, the right to file a grievance, and replacement of missing personal items.

We developed a database to analyze and track complaints filed by each facility. We classified complaints according to complaint type (e.g. health, safety, welfare). Complaints were entered into a database and analyzed prior to beginning a facility review. In addition, we queried the database to present complaint information within this report.

Next, we developed a plan to review facilities. We judgmentally selected a sample of facilities for review. Our selection was partially based on our assessment of risk and the type of facility. As reviews and not audits, our work was not conducted in accordance with generally accepted government auditing standards, as outlined in *Governmental Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

Reviews were conducted pursuant to the provisions of NRS 218G to determine if facilities adequately protected the health, safety, and welfare of children in the facility and whether facilities respected the civil and other rights of children in their care. Reviews included a review of policies, procedures, processes, and complaints filed since July 1, 2009. In addition, we discussed related issues and observed related processes with management, staff, and youths.

Issues discussed included: the facility in general, such as reporting of child abuse and neglect, staffing, background checks, youth records, and contraband prevention; fatalities or near fatalities; the complaint and resolution process; health, including the administration of medication, medical emergencies, and health assessments; safety, such as census, maximum capacity, use of force and de-escalation, fire safety, and transportation of youth; welfare, such as education, behavior, visitation, and room confinement; treatment, such as intake screening, mental health and substance abuse treatment, and suicide and runaway prevention; civil and other rights, such as discrimination, safekeeping of personal items, and religion; and privileges, such as activities on-campus and off-campus. Observations included the

Appendix F

Methodology (continued)

security of the facility, the sufficiency of operating communication equipment, the security of youth records and personal items, administration of medication, youth sleeping areas, staff interaction, and visitation areas.

Reviews also included reviewing management information and a sample of files. Management information reviewed included: reports of child abuse and neglect, fatalities, or near fatalities; reports used to monitor program activities; and other studies, audit reports, internal reviews, or peer reviews. We judgmentally selected a sample of files to review, which included: personnel files for evidence of employee background checks and required training; and youth files for evidence of a youth's acknowledgement of his right to file a complaint, medication administered, treatment plan, and emergency contacts.

In addition to facility reviews, we performed 10 unannounced facility visits. Generally, unannounced facility visits included discussions with management and a tour of the facility. Discussions included medication administration, the complaint process, and education. Tours included all areas accessible to youths. A list of unannounced Nevada facility visits is contained in Appendix E, which is on page 78. During one of our reviews, we examined youth files for compliance with NRS 432B.607 through NRS 432B.6085. The law relates to emotionally disturbed youths ordered by a court to be treated at a mental health treatment facility and applies to youths in the custody of child welfare services placed in a locked facility on an emergency basis. The law establishes timeframes for placement and youth's rights. Our examination included determining if the facility complied with the following timelines: certification of an emergency admission; notification of youths' rights; and a plan of care. Our examination also included determining if youths were notified of their rights. Based on our testing, we did not note any significant issues. Further, we developed a letter and notified each Nevada facility of legislation enacted during the 2011 Legislative Session that may impact their operations.

Our work was conducted from November 2010 through August 2011 pursuant to the provisions of NRS 218G.570 through 218G.585.

Appendix F

Methodology (continued)

In accordance with NRS 218G.230, we furnished each facility reviewed with a conclusion letter. We requested a written response from management at each facility. A copy of each facility's review conclusion and summaries of managements' responses begins on page 11.

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