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 Statues 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.

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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 admistration. 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 fingerpinted; 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 intial background check.

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