LA24-13

STATE OF NEVADA

Governmental and Private Facilities for Children – Inspections

January 2024

Legislative Auditor
Carson City, Nevada

Report Highlights

Highlights of Legislative Auditor report on the Governmental and Private Facilities for Children – Inspections issued on September 10, 2024.

Legislative Auditor Report # LA24-13.

Background

Nevada Revised Statutes (NRS) 218G.570 through 218G.595 authorize the Legislative Auditor to conduct audits of governmental facilities for children and inspections, reviews, and surveys of governmental and private facilities for children.

As of June 30, 2023, we had identified 53 governmental and private facilities that met the requirements of NRS 218G. In addition, 101 Nevada children were placed in 18 different out-of-state facilities across 10 different states as of June 30, 2023.

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, 2022, through June 30, 2023, we received 1,261 complaints from 34 facilities in Nevada. Nineteen Nevada facilities reported that no complaints were filed during this time.

Purpose

Inspections were conducted pursuant to the provisions of NRS 218G.570 through 218G.595. This report includes the results of our inspections of 29 children's facilities. As inspections are not audits, these activities were not conducted in accordance with generally accepted government auditing standards.

The purpose of our inspections was to determine if the facilities adequately protected the health, safety, and welfare of the children in the facilities, and whether the facilities respected the civil and other rights of the children in their care.

Inspections included discussions with management, a review of personnel and child files, and observations. Child and employee interviews occurred as applicable. Discussions with facility management included the following topics: medication administration, treatment plan process, abuse or neglect reporting, face sheet creation, complaint process, employee background checks and training, Prison Rape Elimination Act (PREA), and related policies and procedures as applicable. In addition, we judgmentally selected files to review which included: personnel files for evidence of employee background checks and required training; and child files for evidence of children's acknowledgment of their right to file a complaint, medication administered, treatment plans, and face sheet information as applicable.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Governmental and Private Facilities for Children – Inspections

January 2024

Summary

In 22 of 29 children's facilities inspected, we did not note significant issues that caused us to question the health, safety, welfare, or protection of the rights of the children. However, at the seven facilities listed below we identified multiple issues that caused us to question whether the facilities adequately protected the children in their care. Based on our observations, we contacted the facilities' licensing agencies and/or placement agencies and communicated our concerns.

Nevada Homes for Youth

We noted health, safety, welfare, and civil and other rights issues at Nevada Homes for Youth.

- Health issues included: children self-administering medication, missing medication, incomplete and missing medication records, and untimely and missing treatment plans.
- Safety issues included: missing statutorily required personnel records, a cracked windowpane and broken glass, damage to the facility, unsecured laundry supplies, face sheets were not readily available to employees, expired fire extinguishers, and missing fire drill records.
- Welfare issues included: substance use and contraband, lack of regular programming, unmonitored electronic use, inappropriate content, and unsanitary living conditions.
- Civil and other rights issues included: child rights and the complaint process were not posted, incomplete personnel records, incomplete child records, and policies and procedures were weak. (page 4)

Aurora Center for Healing

We noted health, safety, welfare, and civil and other rights issues at Aurora Center for Healing.

- Health issues included: incomplete and missing medication records and untimely treatment plans.
- Safety issues included: items that created strangulation and self-harm risks, unsecured utility storage, missing statutorily required personnel records, missing fire extinguishers, unsecured laundry supplies, and a cracked windowpane.
- Welfare issue included: inappropriate television content.
- Civil and other rights issues included: child rights and the complaint process were not posted, personnel discipline records for holds, and policies and procedures were weak. (page 12)

Advanced Foster Care Homes

We noted health, safety, and civil and other rights issues at four Advanced Foster Care Homes.

- Health issues included: incomplete and missing medication records, a medication error and medication error notification issues, untimely and missing treatment plans, and unsecured records.
- Safety issues included: missing statutorily required personnel records; debris that posed safety risks; missing fire drill records and fire escape routes were not posted; and expired first-aid kits.
- Civil and other rights issues included: child rights were not posted, incomplete personnel records, and policies and procedures were weak. (page 14)

HELP of Southern Nevada – Shannon West Homeless Youth Center

We noted health, safety, and civil and other rights issues at HELP of Southern Nevada – Shannon West Homeless Youth Center.

- Health issues included: children self-administering medication and incomplete and missing medication records.
- Safety issues included: lack of implementation of PREA standards, missing statutorily required personnel records, missing fire drill records, and expired first-aid kits.
- Civil and other rights issues included: child rights and the complaint process were not posted, incomplete personnel records, and policies and procedures were weak. (page 17)

For Possible Action by the Legislature

This report contains three recommendations the Legislature may want to consider that would help certain facilities improve the health, safety, welfare, and protection of the rights of the children in their care. (pages 25 and 26)

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We conducted inspections of governmental and private facilities for children in the State of Nevada as authorized by Nevada Revised Statutes 218G.570 through 218G.595. The purpose of these inspections is 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.

We wish to express our appreciation to the management and staff of the facilities for their assistance during inspections. We also appreciate the cooperation of the licensing agencies at the State and in Clark and Washoe Counties during our process. We are available to discuss the report with any legislative committees, individual legislators, or other state and local officials.

Respectfully submitted,

Daniel L. Crossman, CPA
Legislative Auditor

May 30, 2024
Carson City, Nevada

STATE OF NEVADA
GOVERNMENTAL AND PRIVATE FACILITIES
FOR CHILDREN – INSPECTIONS
JANUARY 2024

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BACKGROUND

Nevada Revised Statutes (NRS) authorize the Legislative Auditor to conduct audits of governmental facilities for children and inspections, reviews, and surveys of governmental and private facilities for children. Governmental facilities include any facility owned or operated by a governmental entity that has physical custody of children pursuant to the order of a court. Private facilities include any facility owned or operated by a person that has physical custody of children pursuant to the order of a court.

This report includes the results of our work as required by NRS 218G.570 through 218G.595. This report includes the results of inspections of 29 children's facilities. We have performed 277 inspections, reviews, and surveys of children's facilities since the implementation of Assembly Bill 629 of the 74th Session (2007), which authorized the Legislative Auditor to conduct this work.

A description of our methodology can be found in Appendix E, on page 38.

Number and Types of Facilities

For the fiscal year ended June 30, 2023, we identified a total of 53 facilities that met the requirements of NRS 218G.

Exhibit 1 on the following page lists the types of facilities located within Nevada and the total capacity of each facility type for the fiscal year ended June 30, 2023.

Summary of Nevada Children's Facilities Fiscal Year Ended June 30, 2023

Exhibit 1

Facility Type	Number of Facilities	Population: Maximum Capacity	Population: Average Population	Staffing Levels: Average Full-Time	Staffing Levels: Average Part-Time
Child Care Institutions	1	90	88	65	15
Correction and Detention Facilities	13	809	406	443	21
Facilities for Treatment of Abuse of Alcohol or Drugs	2	23	9	23	5
Foster Care Agencies	13	622	462	464	45
Foster Homes That Provide Specialized Care	8	55	43	38	20
Others	2	14	3	49	2
Psychiatric Hospitals	8	401	230	471	64
Psychiatric Residential Treatment Facilities	6	245	146	299	31
Totals – Facilities Statewide	**53**	**2,259**	**1,387**	**1,852**	**203**

Source: Auditor prepared from information provided by facilities.
Note: Appendix C on page 33 contains additional facility details.

During fiscal year 2024, the addition of facilities for intermediate care and skilled nursing facilities as private facilities in accordance with NRS 218G.535 occurred as a result of reviewing statutes and increased communication with licensing agencies. The facilities are not included in Appendix C on page 33 which lists children's facilities information for fiscal year ended June 30, 2023. However, we did inspect one facility for intermediate care and one skilled nursing facility during the calendar year, as documented in Appendix B on page 32.

In addition to children in facilities within the State of Nevada, an additional 101 children were located in out-of-state facilities as of June 30, 2023. Of the 101 children, 58 (57%) were placed during fiscal year 2023, and the other 43 (43%) were placed in prior years. Nevada children were placed in 18 different facilities across 10 different states.

In general, a child may be placed in an out-of-state facility if they have been denied placements in Nevada or if the State does not offer adequate services to meet their needs. Each placement of a child is unique with different criteria directing each placement including dual or specific diagnoses; highly sexualized or aggressive behaviors; and extreme medical, cognitive, or emotional needs that require specialized care for which in-state services are not available. Children are placed in out-of-state facilities by a district court or the State's Division of Child and Family Services (DCFS).

Exhibit 2 lists the number of children and the entity that placed them in out-of-state facilities during the past 3 fiscal years.

New Placements of Nevada Children in Out-of-State Facilities During Fiscal Years 2021, 2022, and 2023 **Exhibit 2**

Placing Entity	2021	2022	2023
1st Judicial District Court (Carson City and Storey County)	5	1	2
2nd Judicial District Court (Washoe County)	10	8	4
3rd Judicial District Court (Lyon County)	2	1	1
4th Judicial District Court (Elko County)	0	1	3
5th Judicial District Court (Esmeralda and Nye Counties)	0	2	3
6th Judicial District Court (Humboldt County)	0	0	0
7th Judicial District Court (Eureka, Lincoln, and White Pine Counties)	1	1	1
8th Judicial District Court (Clark County)	27	10	9
9th Judicial District Court (Douglas County)	0	0	2
10th Judicial District Court (Churchill County)	0	1	0
11th Judicial District Court (Lander, Mineral, and Pershing Counties)	1	0	0
State of Nevada Division of Child and Family Services[1]	11	32	33
Totals	**57**	**57**	**58**

Source: Auditor prepared from information provided by the district courts and the State of Nevada.
[1] State of Nevada Division of Child and Family Services' placements include child welfare and juvenile justice children.
Note: Columns of exhibit reflect children newly placed in out-of-state facilities during each fiscal year.

Exhibit 3 shows the total number of children in out-of-state facilities as of June 30, 2023.

Total Number of Nevada Children in Out-of-State Facilities **Exhibit 3**

Placing Entity	As of June 30, 2023
1st Judicial District Court (Carson City and Storey County)	3
2nd Judicial District Court (Washoe County)	5
3rd Judicial District Court (Lyon County)	2
4th Judicial District Court (Elko County)	3
5th Judicial District Court (Esmeralda and Nye Counties)	3
6th Judicial District Court (Humboldt County)	0
7th Judicial District Court (Eureka, Lincoln, and White Pine Counties)	1
8th Judicial District Court (Clark County)	12
9th Judicial District Court (Douglas County)	2
10th Judicial District Court (Churchill County)	0
11th Judicial District Court (Lander, Mineral, and Pershing Counties)	0
State of Nevada Division of Child and Family Services[1]	70
Total	**101**

Source: Auditor prepared from information provided by the district courts and the State of Nevada.
[1] State of Nevada Division of Child and Family Services' placements include child welfare and juvenile justice children.
Note: Exhibit reflects children placed in out-of-state facilities over the course of multiple years through June 30, 2023.

SCOPE AND PURPOSE

Inspections were conducted pursuant to the provisions of NRS 218G.570 through 218G.595.

The purpose of our inspections was to determine if the facilities adequately protected the health, safety, and welfare of the children in the facilities and whether the facilities respected the civil and other rights of the children in their care. Our work was conducted from January 2023 through January 2024.

INSPECTIONS OF FACILITIES

In 22 of 29 facilities inspected, we did not note significant issues that caused us to question the health, safety, welfare, or protection of the rights of the children. However, at seven facilities, Nevada Homes for Youth, Aurora Center for Healing, four Advanced Foster Care Homes, and HELP of Southern Nevada – Shannon West Homeless Youth Center, we identified multiple issues that caused us to question whether management and/or the licensing agency adequately protected the children in the facilities' care. Based on our observations, we contacted the licensing agencies and/or placement agencies for all seven facilities and discussed our concerns. Information regarding our inspections and significant issues noted at Nevada Homes for Youth, Aurora Center for Healing, Advanced Foster Care Homes, and HELP of Southern Nevada – Shannon West Homeless Youth Center are detailed below. Appendix B on page 32 of this report includes the facilities inspected, the facility types, and the dates of our work.

Nevada Homes for Youth

We inspected Nevada Homes for Youth in July 2023. This was our fourth visit to the facility in the last 5 years. We visited once in 2020, twice in 2022 to follow up on several concerns, and once in 2023. During our inspection, we noted several issues that prompted us to question whether the facility adequately protected the children in its care.

Nevada Homes for Youth is a facility for the treatment of abuse of alcohol or drugs and is located in Las Vegas. The facility is licensed by the Bureau of Health Care Quality and Compliance (HCQC),

contracted as a placement resource by Clark County Department of Family Services (DFS), and is contractually required to comply with foster home licensing standards.

Some of the significant issues observed and noted at the facility included:

Health

- Children were self-administering psychotropic medications in violation of Nevada Administrative Code (NAC) 449.144 and medication administration was not provided in accordance with NAC 424.560. We noted the same concerns in our 2022 visits.

- Medication counts reflected missing medication. Medication records were incomplete, inaccurate, and required documentation was missing including: Person Legally Responsible (PLR) consent documents for psychotropic medication, physician's orders, and medication administration records. We noted the same concerns in our 2022 visits.

- Treatment plans were not completed timely. We noted the same concerns in our 2022 visits. Updated treatment plans were missing. An undated treatment plan was backdated and provided to us at a later date. The treatment plan was dated for the day prior to the child being admitted to the facility. Assessment information was missing to ensure appropriate delivery of services and treatment planning.

Safety

- Three of three personnel files reviewed did not contain evidence of timely background checks and background check results were missing for one employee for over 2 years of their employment.

- Three of three personnel files reviewed did not contain evidence that child abuse and neglect screenings were completed. We noted the same concerns in our 2022 visits.

- In a 2022 visit, a broken window in a child's room was observed. During our 2023 inspection, broken glass was found in the windowsill of the same window. A windowpane at the front of the facility was cracked.

- Broken trim on a child's door exposed the nails. A child's door was missing a doorknob. There was standing water in the bathroom. Holes and damage were observed on walls and floors.

- Chemicals and laundry supplies were unsecured. We noted the same concerns in our 2022 visits.

- Face sheets were not readily available to employees in the event of an emergency in accordance with policy. Only management had access to face sheets. We noted the same concerns in our 2022 visits.

- Fire extinguishers were expired. Documentation of monthly fire drills was missing.

Welfare

- Children and an employee described multiple incidents of children bringing contraband into the facility, children abusing substances while placed at the facility, and children overdosing at the facility. The employee described contraband searches are only conducted monthly or every six weeks. Incident reports document multiple instances of children in possession of contraband, being under the influence of substances, and not being properly supervised.

- Management was unable to identify regular programming provided to children at the facility, only noting third-party treatment services which included counseling and juvenile probation services. When children described their typical day, they did not identify regular programming at the facility, only noting third-party treatment services which included counseling once a week or once every two weeks. Children reported enjoying the freedom they had at the facility compared to other placements at foster homes and emergency shelter homes. All children reported varying

curfews and daily routines at the facility. In general, a substance abuse facility should provide a higher level of care than a foster home or emergency shelter home.

- In May 2023, an incident occurred at the facility that resulted in a child receiving emergency services and being transferred to an acute care facility based on concerns of intoxication. HCQC was not notified of this incident until we notified them in June 2023. An inspection conducted by HCQC noted concerns with the facility not having or implementing policies regarding the use of alcohol or drugs and the safety and monitoring of children.

- Unmonitored electronic use and inappropriate age-related content were observed including mature-rated and Rated-R videogames and movies, which are prohibited by the facility as stated in intake documents. We noted the same concerns in our 2022 visits.

- Marijuana leaves were illustrated on a child's jacket. Because children are placed at the facility for substance use, it would be inappropriate for children to possess items depicting substances.

- Several areas of the facility were dirty and unkept. For example: the bathroom contained urine on bathroom stalls and inappropriate drawings, references to substance use, as well as gang-related and obscene language written on the walls. We noted the same concerns in our 2022 visits. One graffiti tag was previously observed in 2022. There was dirt on doors, food items and trash on the floors, clothing stacked in piles in bedrooms, graffiti on furniture, and rotten food on shelves.

- Trash was littered throughout the outdoor perimeter including cigarette butts and cigarette packages.

Civil and Other Rights

- Child rights were not posted. The complaint process was not posted and children were generally unaware of their right to file a complaint. We noted the same concerns in our 2022 visits.

- Start dates were not listed for employees and placement dates were not listed for children in records. On the date of our inspection, management incorrectly reported the census for children placed at the facility and provided incorrect child files to us. One such file was provided for a child that had been discharged three months prior to our visit.

- Training records were missing and incomplete for three of three employee files reviewed. We noted the same concerns in our 2022 visits.

- Policies and procedures were missing, weak, or not consistent with management's understanding and implementation of important practices. We noted the same concerns in our 2022 visits. Some policies contradicted each other. Management was generally unaware if policies documented procedures at the facility. For example, policies referred to the Substance Abuse Prevention and Treatment Agency (SAPTA) as an oversight agency despite the facility no longer being certified by SAPTA at the time of our inspection.

The pictures on the following pages are examples of the living conditions at the facility. See Appendix D on page 36 for additional pictures taken at the facility:

Rotten food and food wrappers in a child's room. Facility management reported that children are not allowed to have food in their rooms.

Standing water and broken tile in the bathroom.

Graffiti observed in the bathroom in 2022 and 2023.

2022 site visit observation.

2023 *site visit observation.*

Based on our observations, we determined the care and living conditions at Nevada Homes for Youth did not meet certain minimum standards established in NRS 424, NRS 432, NRS 432B; NRS 449; and outlined in NAC 424 and NAC 449. Specifically, management did not ensure the facility met the following minimum standards: self-administration of medication; medical care and medications; medication management; PLR consent; treatment plans; personnel records; construction and maintenance of facility; standing bodies of water; securing tools and chemicals, items intended only for adult use; safety from fire; fire drills; health services; general requirements for programs; notification to HCQC under certain circumstances; care and treatment of children; grounds of home; general sanitary requirements; living space and furnishings; child rights; complaints; child records; records of clients; and training of direct care staff.

Many of the issues we observed were noted in our 2022 visits and in 2022 visits by HCQC and SAPTA, but had not been adequately addressed by management. DFS did not note concerns in their 2022 visit. Following our first visit to the facility in 2022, HCQC completed an inspection and noted several concerns but later noted no concerns during their follow-up contact with the facility. During our 2022 visits, the facility was certified by SAPTA. SAPTA noted

several concerns with the facility after our visits in 2022 and placed the facility on a corrective action plan. As of December 2022, the facility is no longer SAPTA certified.

Post-Inspection Information

Following our visit to the facility in July 2023, we contacted HCQC and DFS and discussed our concerns.

- On September 1, 2023, management sent their 30-day notice to DFS reporting the closing of the facility with DFS.
- On September 8, 2023, HCQC reported that while management is retiring, the facility will remain open and licensed by HCQC, and new management will take over operations.
- On September 28, 2023, HCQC completed an inspection and noted concerns including: sanitation issues, dirty and unkept areas, graffiti on furniture and walls, garbage throughout the facility, missing fire drill records, an expired fire extinguisher, children self-administering medication in violation of statute, incomplete and inaccurate medication administration documents, missing documentation of children's substance abuse history, the complaint process was not posted, a complaint log was missing, and training records were missing for personnel. Facility management requested an extension for submitting a plan of correction to HCQC.
- On October 6, 2023, DFS confirmed there were still children placed in the facility, despite the 30-day timeframe from the notice having passed.
- In November 2023, facility management submitted a plan of correction to HCQC that was determined to be unacceptable by HCQC. HCQC requested an updated plan of correction from management.
- On December 5, 2023, HCQC issued a notice to management regarding the overdue plan of correction and reported they will continue to follow-up with management until an acceptable plan of correction is received or sanctions are implemented.
- On December 7, 2023, management reported there are no children placed at the facility due to renovations occurring, but the facility will begin accepting placements after the renovations are complete.

- On January 23, 2024, management submitted a plan of correction to HCQC that was accepted by HCQC.

Aurora Center for Healing

We inspected Aurora Center for Healing in April 2023. This was our first visit to the facility. During our inspection, we noted several issues that prompted us to question whether the facility adequately protected the children in its care. Aurora Center for Healing is a psychiatric residential treatment facility located in Hawthorne and is licensed by HCQC.

Some of the significant issues observed and noted at the facility included:

Health

- Medication records were incomplete, inaccurate, and required documentation was missing including: PLR consent documents for psychotropic medication, physician's orders, and medication administration records.
- Treatment plans were not completed timely or finalized in accordance with policy.

Safety

- Ligature risks for strangulation and items for self-harm were observed including: window blind cords, guitar strings, electronic device cords, extension cords, staples, binders with metal rings, and sharp rocks kept in the dorms; all within reach of the children. A prior inspection by HCQC identified similar potential items for self-harm and instances of strangulation risks.
- Storages areas with gas and utility lines were unsecured.
- Three fire extinguishers were missing in the dorms.
- Laundry supplies were unsecured.
- A windowpane was cracked which exposed glass shards that could be used for self-harm.

Welfare

- Inappropriate content was playing on the television and an employee reported that it was not an approved program for the children. The content contained a picture of a woman gagged and referenced a school shooting, suicide, a serial killer, and a child killing their family.

Civil and Other Rights

- In three of four dorms, child rights were not posted. The complaint process was not posted and there was no evidence children were made aware of their right to file a complaint. A child reported filing seven complaints that were never addressed.

- An employee was disciplined for failure to assist another employee in two restraints of children, despite not having received statutorily required training to implement restraints.

- Policies and procedures were missing, weak, or not consistent with management's understanding and implementation of important practices. For example, policy referenced the use of chemical restraint of children, but management denied using chemical restraint.

Based on our observations, we determined the care and living conditions at Aurora Center for Healing did not meet certain minimum standards established in NRS 432B, NRS 433, NRS 449, NRS 449A; and outlined in NAC 449. Specifically, management did not ensure the facility met the following minimum standards: medical care and medications; PLR consent; treatment plans; construction and maintenance of facility; housekeeping services; maintenance and availability of employee records; safety from fire; appropriate care of residents; and patient rights.

Post-Inspection Information

Following our visit to the facility in April 2023, we contacted HCQC and were informed staff had visited the facility every other month since April and were in the process of investigating multiple complaints. A ban on admissions was implemented May 25, 2023, by HCQC based on concerns documented during their inspections.

The ban was lifted September 1, 2023, after a sufficient plan of correction was provided by the facility. As of December 2023, DCFS reported they were not placing children at the facility.

Advanced Foster Care Homes

The Advanced Foster Care Program is a program operated by DCFS to create and maintain foster homes that provide specialized care for children with a severe emotional disturbance. The program is intended to improve emotional, behavioral, and permanency outcomes for children in State custody. There were five Advanced Foster Care Homes licensed by DCFS as of June 30, 2023.

We inspected Homes 1, 5, and 7 in March 2023, and Home 3 in September 2023. This was our second time visiting Advanced Foster Care Homes in the last 5 years. We have not previously visted Homes 1, 3, 5, and 7. During our inspections of Homes 1, 3, 5, and 7, we noted several issues that prompted us to question whether the licensing agency ensured that the homes adequately protected the children in their care. The homes are considered foster homes that provide specialized care, are located in various rural regions of the State, and are licensed by DCFS.

Some of the significant issues observed and noted at the homes included:

Health

- In two of four homes, medication records were incomplete and required documentation was missing including: PLR consent documents for psychotropic medication, physician's orders, and medication administration records. We noted the same concerns in our 2022 inspections.
- In one home, the foster parent was disciplined by DCFS for a medication administration error, despite not having received statutorily required initial medication administration training from the licensing agency.
- In two of four homes, the foster parents reported they do not contact a physician after a child refuses medication, which is a requirement of NAC 424.720(f).

- In two of four homes, updated treatment plans were missing. We noted the same concerns in our 2022 inspections.

- In two of four homes, child records were unsecured.

Safety

- In three of four foster parents' files reviewed, repeat background checks were not completed timely. We noted the same concerns in our 2022 inspections. One foster parent's background check was 11 months overdue, and another was more than a year overdue.

- Two of four foster parents' files reviewed did not contain evidence that child abuse and neglect screenings were completed annually.

- In two of four homes, debris, equipment, and materials were observed in the backyard that posed risks to the children's safety based on their age and development.

- In two of four homes, fire escape routes were not posted and in one home, documentation of monthly fire drills was missing. We noted the same concerns in our 2022 inspections.

- In one home, first-aid kit supplies were expired.

Civil and Other Rights

- In all four homes, child rights were not posted. In three of four homes, there was no documentation to support that children were made aware of their right to file a complaint. We noted the same concerns in our 2022 inspections.

- Training records were missing and incomplete for four of four foster parent files reviewed. We noted the same concerns in our 2022 inspections.

- Policies and procedures were missing, weak, or not consistent with the licensing agency or foster parents' understanding and implementation of important practices. We noted the same concerns in our 2022 inspections. There were no policies for abuse and neglect reporting or background checks. The

treatment plan policy did not adequately describe the treatment planning process or requirements for completion of treatment plans.

The following picture is an example of the living conditions at one of the homes:

Debris and other items in the backyard of a home that posed safety risks based on the children's ages and development.

Based on our observations, we determined the care and living conditions at the Advanced Foster Care Homes did not meet certain minimum foster care standards established in NRS 424, NRS 432, NRS 432B; and outlined in NAC 424. Specifically, the licensing agency did not ensure its foster parents met the following minimum foster care standards: maintaining medication records; medication management; medications; PLR consent; treatment plans; child records; personnel records; securing tools and chemicals, products intended only for adult use; grounds of home; plans for responding to disasters and other emergencies; fire drills; first-aid; child rights; complaints; and training of direct care staff.

Post-Inspection Information

Following our inspections of the homes in April 2023 and September 2023, we contacted DCFS and discussed our concerns. DCFS reported two of four homes were no longer licensed as specialized foster homes. However, one of the two homes became licensed as

a specialized foster home again in early 2024. To better assist foster parents in meeting specialized foster care standards DCFS has created a binder with literature and documents. Since our 2022 visits, DCFS created policies for complaints and developed and implemented agency treatment plans for children. Other policies noted as missing during our inspections have not yet been developed.

HELP of Southern Nevada – Shannon West Homeless Youth Center

We inspected HELP of Southern Nevada – Shannon West Homeless Youth Center (HELP) in March 2023. HELP is a homeless shelter for at-risk individuals, ages 16 through 24. The facility's maximum capacity is 150 individuals, with 8 beds available for placements of children ages 16 and 17. At the time of our inspection, one child was placed at the facility. For reporting purposes, we consider HELP as an "other" facility type.

HELP is located in Las Vegas and is not licensed by a state agency but has contracts with DFS and Clark County Department of Juvenile Justice Services (DJJS) to accept placements of children as an independent living placement, emergency shelter, and alternative living service. The contract the facility has with DJJS requires the facility to adhere to national, state, and local licensing regulations; standards for emergency shelter care; and Prison Rape Elimination Act (PREA) standards.

HELP is a community placement where a child resides independently from a caregiver. The facility provides emergency shelter to children experiencing or at-risk of homelessness. Children placed at the facility share common spaces with adults, are not supervised full-time, and cannot be prevented from leaving the facility.

This was our second visit to the facility in the last 5 years. During our inspection, we noted several issues that prompted us to question whether the facility adequately protected the children in its care in accordance with contracts the facility has with its placement agencies.

Some of the significant issues observed and noted at the facility included:

Health

- Children self-administered medications and medication administration was not provided in accordance with NAC 424.560.

- Medication records were incomplete and required documentation was missing including: PLR consent documents for psychotropic medication and medication administration records.

Safety

- The facility was not adhering to PREA standards and children shared common spaces with adults, including bathrooms. In September 2023, a complaint filed by a child noted interactions between an adult and the child in a common space. The adult touched the child's neck, thigh, and hair in two separate incidents.

- A child's file did not contain evidence that the child had been informed of the zero-tolerance policy, assessed for sexual victimization or abusiveness, or received comprehensive education on PREA. The facility is contractually required to adhere to PREA standards because of its contract with DJJS.

- A personnel file did not contain evidence that a child abuse and neglect screening was completed until 2 years after the employee's hire date.

- Documentation of monthly fire drills was missing.

- First-aid kit supplies were expired.

Civil and Other Rights

- Child rights were not posted. The complaint process was not posted and there was no documentation to support that a child was made aware of their right to file a complaint.

- Training records were missing and incomplete for an employee.

- Policies and procedures were missing, weak, or not consistent with management's understanding and implementation of important practices. For example, there was no employee training policy. The complaint policy did not address details of the complaint process including the use of complaint forms, complaint boxes, or timeframes for checking complaint boxes.

Based on our observations, we determined the care and living conditions at HELP did not meet certain minimum PREA and emergency shelter standards established in Title 28 of the Code of Federal Regulations (CFR) 115, NRS 424, NRS 432, NRS 432B; and outlined in NAC 424. Specifically, management did not ensure the facility met the following minimum standards: medication management; medications; PLR consent; PREA; personnel records; fire drills; first-aid; child rights; complaints; and training of direct care staff.

Post-Inspection Information

Following our visit to the facility in March 2023, we contacted the facility and placement agencies to communicate our concerns. Facility management reported several of our concerns noted had been resolved. DJJS is not enforcing PREA requirements at the facility and indicated they may revise contract language to remove PREA requirements upon the next contract renewal with the facility. DFS reported only placing three children at the facility since 2022 with the most recent child placed there in an independent living arrangement.

PRISON RAPE ELIMINATION ACT

We inspected three correction and detention facilities between January 2023 and May 2023. In two of three facilities, we noted issues that prompted us to question whether the facilities adequately implemented a PREA process in accordance with federal regulations. Specifically, children were not adequately assessed and screened for sexual victimization or abusiveness. Both facilities did not use an objective screening instrument to collect information on the 11 PREA screening topics. Additionally, policies did not require the use of an objective screening instrument.

PREA Juvenile Facility Standard, 28 CFR 115.341 requires the use of an objective screening instrument to collect the following information from children within 72 hours of their arrival at the facility:

- Prior sexual victimization or abusiveness;
- Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the child may therefore be vulnerable to sexual abuse;
- Current charges and offense history;
- Age;
- Level of emotional and cognitive development;
- Physical size and stature;
- Mental illness or mental disabilities;
- Intellectual or developmental disabilities;
- Physical disabilities;
- The child's own perception of vulnerability; and
- Any other specific information about individual children that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other children.

Based on our inspections, we determined the two detention facilities did not meet certain minimum PREA federal regulation requirements established in 28 CFR 115. Specifically, facility management did not ensure their facilities met the following minimum standard outlined in PREA Juvenile Facility Standards: Obtaining information from children.

Post-Inspection Information
The State's PREA coordinator has an objective screening instrument to assess for sexual victimization or abusiveness. We recommended facility management at the two facilities discussed above obtain and implement the screening instrument developed by the State or create their own screening instrument which meets PREA requirements.

COMPLAINTS

NRS 218G.585 requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their care or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. We received and reviewed 1,261 complaints from 34 facilities in Nevada during the period from July 1, 2022, through June 30, 2023. Of the 1,261 complaints received, 936 (74%) were received from children placed in correction and detention facilities, and 291 (23%) were from psychiatric hospitals and psychiatric residential treatment facilities.

In general, the population of children at these facilities include children with high behavioral and mental health needs. Correction and detention facilities, psychiatric hospitals, and psychiatric residential treatment facilities make up 27 of the 53 private and governmental facilities for children. We expect to review more complaints from these types of facilities due to their populations and the number of facilities.

We follow up with facilities when complaint information appears egregious with respect to a child's rights, if information received is incomplete, and to ensure complaint information is submitted to our office on a regular basis, as required by statute. In addition, we review complaint resolutions to ensure facility management resolved the issues identified. Complaint information is used as part of our risk assessment process for selecting facilities to inspect, review, and survey.

Nineteen facilities reported receiving zero complaints filed by children or on behalf of children for the fiscal year. Below are the facilities that reported receiving zero complaints, based on the type of facility:

- 1 of 13 correction and detention facilities;

- 2 of 2 facilities for the treatment of abuse of alcohol or drugs;
- 10 of 13 foster care agencies;
- 5 of 8 foster homes that provide specialized care;
- 1 of 2 other facilities.

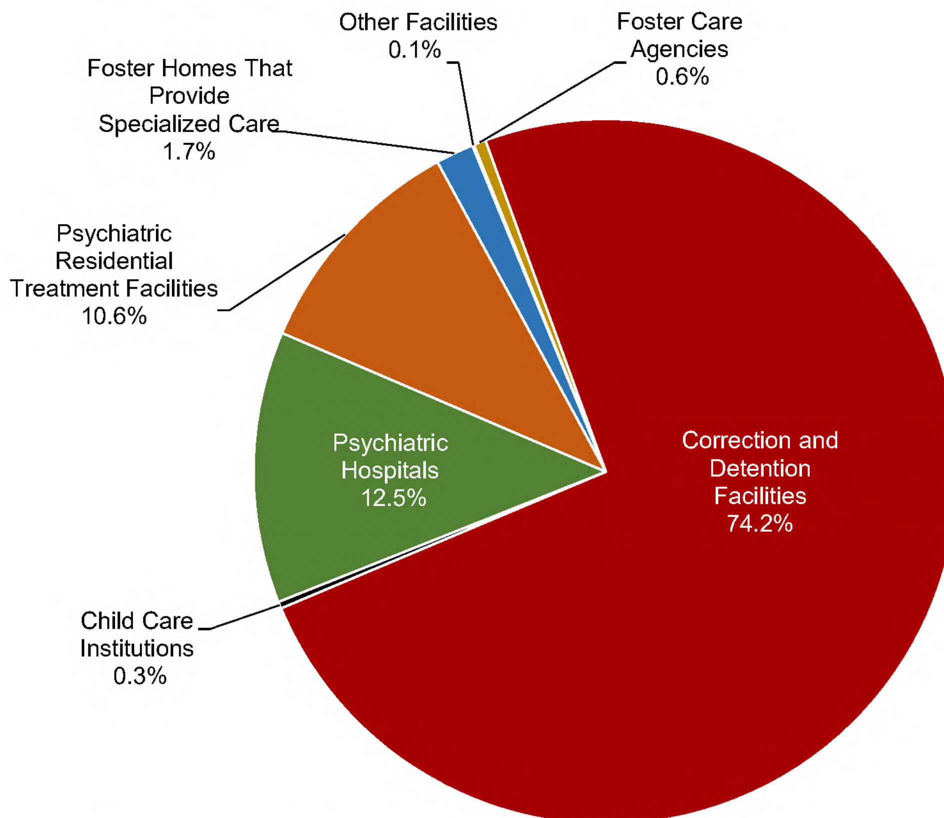
Some of the reasons facilities report that no complaints were filed include: the type of facility, the ages of the children, and the children's length of stay.

Based on inspections and discussions with facility management at some facilities, the complaint process is not well understood by management or clearly communicated to the children. For example, some facilities resolve verbal complaints informally instead of documenting the issue as a formal complaint, resulting in a lack of documentation. During fiscal year 2023, one facility was unable to locate documentation for complaints made in a 4-month period. The complaint process is essential to ensure a child's health, safety, welfare, and civil and other rights are adequately protected; and complaint reporting is statutorily required for governmental and private facilities who have physical custody of a children pursuant to the order of a court.

NRS 218G.585 does not specifically define the complaint reporting process and only requires the facilities to forward complaints to the Legislative Auditor. Collection, documentation, review, and resolution of complaints vary at each facility. Facilities have different interpretations of what constitutes health, safety, welfare, and civil and other rights of a child. In July 2023, we communicated our expectations for complaint reporting to the facilities, including the need for reporting both complaints and their resolutions. We also informed facilities that abuse and neglect allegations made against a facility or its employees while a child is placed at a facility are considered complaints, as they pertain to the child's health, safety, welfare, civil and other rights.

Exhibit 4 on the following page summarizes complaints submitted by Nevada facilities to our office for the fiscal year ended June 30, 2023.

Summary of Complaints Submitted by Nevada Facilities **Exhibit 4**
Fiscal Year Ended June 30, 2023



Source: Auditor prepared from complaints submitted by facilities.

(1) "Other Facilities" includes HELP of Southern Nevada - Shannon West Homeless Youth Center and Humboldt County Juvenile Services Transitional Living Center.

We also received and reviewed complaint information from Nevada children placed in out-of-state facilities. We follow up with out-of-state facilities when necessary, including complaint information that appears egregious with respect to a child's rights.

SOME LICENSED HEALTH FACILITIES' EMPLOYEES NOT REQUIRED TO HAVE CERTAIN TRAINING SPECIFIC TO CHILDREN

Statutes do not require most health facilities licensed by HCQC to ensure all employees who have direct contact with children are trained in certain areas specific to children's safety and welfare. The facility types include facilities for intermediate care, facilities for the treatment of abuse of alcohol or drugs, private psychiatric hospitals, private psychiatric residential treatment facilities, and skilled nursing facilities.

In contrast, statutes governing state-operated psychiatric hospitals and psychiatric residential treatment facilities require employees who have direct contact with children to have specific training. The training required by law for employees at child care facilities and institutions (NRS 432A.177), correction and detention facilities (NRS 63.190 and NRS 62B.250), specialized foster homes (NRS 424.0365), and state-operated psychiatric hospitals and psychiatric residential treatment facilities (NRS 433B.175), includes:

- Controlling the behavior of children;
- Using force and restraint on children;
- Rights of children in the facility;
- Suicide awareness and prevention;
- Administration of medication to children;
- Other matters affecting the health, welfare, safety, and civil and other rights of children in the facility; and
- Working with lesbian, gay, bisexual, transgender, and questioning children.

For fiscal year ended June 30, 2023, HCQC licensed two facilities for the treatment of abuse of alcohol or drugs, seven private psychiatric hospitals, and four private psychiatric residential treatment facilities that have physical custody of children pursuant to the order of a court. Additionally, there are private facilities recognized in fiscal year 2024 that are licensed by HCQC including facilities for intermediate care and skilled nursing facilities that have physical custody of children pursuant to the order of a court.

The requirements found in NRS and NAC are used by HCQC to license each of these types of facilities. However, license requirements addressed in the NRS and NAC do not require training specific to children. In our December 2018 Review of Governmental and Private Facilities for Children report (LA20-02), we noted these training requirements were not listed in NRS or NAC.

Recommendation

The Legislature may want to consider enacting legislation to require all facilities HCQC licenses, which have physical custody of children pursuant to a court order, to train employees who have direct contact with children on the specific topics statutorily required for other children's facilities. These facilities include facilities for intermediate care, facilities for the treatment of abuse of alcohol or drugs, private psychiatric hospitals, private psychiatric residential treatment facilities, and skilled nursing facilities that have physical custody of children pursuant to the order of a court.

CERTAIN LICENSED HEALTH FACILITIES NOT REQUIRED TO SCREEN EMPLOYEES FOR CHILD ABUSE OR NEGLECT

Statutes do not require health facilities licensed by HCQC to screen employees having direct contact with children for substantiations of child abuse or neglect. Specifically, these facilities are not required to submit employees' names to the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child (Central Registry) prior to an employee's hire. The submission of a name to the Central Registry and a check of the results of this submission is called a child abuse and neglect screening (CANS). While some of these facilities voluntarily performed CANS checks, updating the statutory requirements to include initial and recurring CANS checks would enhance protection of the children in these facilities.

Nine of 15 HCQC licensed health facilities we inspected in 2023 did not screen employees for substantiations of child abuse and neglect at the time of initial hire. The remaining six facilities voluntarily performed CANS checks of perspective employees before hire.

The facility types not required by state laws and regulations to perform CANS checks of employees include facilities for intermediate care, facilities for the treatment of abuse of alcohol or drugs, psychiatric hospitals, psychiatric residential treatment facilities, and skilled nursing facilities. In contrast, federal regulations and statutes governing childcare facilities (NRS 432A.170), correction and detention facilities (CFR 115.317), and specialized foster homes (NRS 424.033) requires a CANS check prior to an employee's hire or foster parent's licensure.

NRS 449.125 requires termination of an employee of a licensed health facility if information is received that the person has had a substantiated report of abuse or neglect made against them. However, statutes do not specify a method for obtaining this information.

Under state law, persons convicted of certain crimes, including child abuse or neglect, are prohibited from working at health care facilities. Criminal background checks detect these persons. However, a person with substantiations of child abuse or neglect may not have been convicted of a crime. A CANS check is needed to detect such persons.

Periodic Screening Also Not Required

In addition, only statutes governing child care institutions require periodic CANS checks of employees. This means only 1 of 53 governmental and private facilities for children subject to our review is required to perform this check periodically beyond initial licensure.

Of the 14 facilities we reviewed that are currently required to perform initial employment CANS checks, 11 performed periodic employee CANS checks despite there being no statutory requirement. Not requiring this periodic verification creates an opportunity for substantiations of abuse or neglect during an employee's tenure to go unnoticed by facilities.

HCQC Response

We contacted HCQC with our concerns regarding CANS checks not being statutorily required for employees at health facilities licensed by their bureau. HCQC recognized the issue and agreed that a potential solution would be to create statutory language to require CANS checks for health facility employees.

Recommendations

The Legislature may want to consider enacting legislation to require all facilities HCQC licenses, which have physical custody of children pursuant to a court order, to screen employees who have direct contact with children for substantiations of child abuse or neglect before hire. These facilities include facilities for intermediate care, facilities for the treatment of abuse of alcohol or drugs, psychiatric

hospitals, psychiatric residential treatment facilities, and skilled nursing facilities.

Additionally, the Legislature may want to consider enacting legislation to require all children's facilities that have physical custody of children pursuant to a court order to screen employees periodically for substantiations of child abuse or neglect.

APPENDIX A

GLOSSARY

Bureau of Health Care Quality and Compliance (HCQC)	An agency within the Nevada Division of Public and Behavioral Health that licenses and regulates health facilities in Nevada, including facilities for intermediate care, facilities for the treatment of abuse of alcohol or drugs, psychiatric hospitals, psychiatric residential treatment facilities, and skilled nursing facilities.
Child Abuse and Neglect Screening (CANS)	A review of the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child, which is a database for the collection of information on child abuse and neglect.
Children	Persons under the age of 18, including infants and adolescents.
Child Care Institution	Provides care and shelter during the day and night and provides developmental guidance to 16 or more children who do not routinely return to the homes of their parents or guardians.
Child Welfare Agency	In a county whose population is less than 100,000, the local office of the State's Division of Child and Family Services or, in a county whose population is 100,000 or more, the agency of the county which provides or arranges for necessary child welfare services.
Civil and Other Rights	This relates to a child's civil rights, as well as their rights as a human being. It includes protection from discrimination and harassment; the right to adequate food, shelter, clothing, and hygiene products; and the right to file a complaint.
Clark County Department of Family Services (DFS)	Child welfare agency which provides child welfare services in Clark County.
Clark County Department of Juvenile Justice Services (DJJS)	Juvenile justice agency which provides juvenile justice services in Clark County.

APPENDIX A

GLOSSARY

Complaint (Grievance)	A documented circumstance concerning the health, safety, welfare, and civil and other rights of a child. The complaint is filed by any child or other person on behalf of a child who is under the care of a governmental or private facility for children.
Consent	Authorization for the administration of psychotropic medications given by the person legally responsible for the psychiatric care of a child. Consent must include specific items as listed in NRS 432B.4687, such as the name of the child; the name of the person legally responsible; the name, purpose, and expected time frame for improvement for each medication; the dosage, times, and number of units at each administration of the medication; the duration of the course of treatment; and a description of the risks, side effects, interactions, and complications of the medication.
Correction Facility	A secure facility for children that have been adjudicated delinquent for an offense. Placement is generally long-term and a broad array of services are provided to promote successful transition of children back to their communities.
Detention Facility	A secure facility that has temporary custody of children who are subject to the jurisdiction of a court and require a restricted environment for their own or the community's protection pending legal action. Services are provided to support the child's physical, emotional, and social development.
Face Sheet (Identification Kit)	Provides quick access to important information in case of emergency, such as a child's full name, a photograph, a list of allergies and medications, and a list of contacts.
Facility for the Treatment of Abuse of Alcohol or Drugs	Any public or private establishment which provides residential treatment, including mental and physical restoration, of children with alcohol or other substance use disorders.

APPENDIX A

GLOSSARY

Facility for Intermediate Care	Provides 24-hour personal and medical supervision for children who do not have an illness, disease, injury, or other condition that would require the degree of care and treatment from a hospital or skilled nursing facility.
Foster Care Agency	A business entity that recruits and enters into contracts with foster homes to assist child welfare agencies and juvenile courts in the placement of children in foster homes. Foster care agencies may operate multiple family foster homes, including specialized foster homes and group foster homes. Foster care agencies train foster parents and develop policies and procedures for the homes. Foster parents are responsible for providing safe, nurturing, and supportive environments where children can continue daily activities that promote normalcy.
Foster Home That Provides Specialized Care	Provides full-time care and services for one to six children who require special care for physical, mental, or emotional issues.
Health	Anything related to a child's physical health, including medical care and medication administration.
Nevada Division of Child and Family Services (DCFS)	Child welfare agency which provides child welfare services to all rural counties in Nevada.
Person Legally Responsible (PLR)	A person legally responsible for the psychiatric care of a child, which could be the child's parent(s), legal guardian, or other individual appointed by a court.
Prison Rape Elimination Act (PREA)	Prison Rape Elimination Act of 2003, including the U.S. Department of Justice National Standards to Prevent, Detect, and Respond to Prison Rape (28 CFR Part 115). The National Standards include guidance related to zero tolerance of sexual abuse and sexual harassment, supervision and monitoring, referrals of allegations for investigations, resident education, employee training, and obtaining information from residents.

APPENDIX A

GLOSSARY

Psychiatric Hospital	A hospital for the diagnosis, care, and treatment of mental health which provides 24-hour care to children. Includes acute psychiatric (short-term) and non-acute psychiatric programs.
Psychiatric Residential Treatment Facility (PRTF)	A facility, other than a hospital, that provides a range of psychiatric services to treat residents under the age of 21 years on an inpatient basis under the direction of a physician.
Psychotropic Medication	A prescribed medication used to alter a child's thought process, mood, or behavior.
Safety	Anything related to the physical safety of a child. This includes physical security, environment, and adequate staffing.
Skilled Nursing Facility	Provides continuous skilled nursing and related care prescribed by a physician to children who are not in an acute episode of illness and whose primary needs are the availability of continuous care.
Substance Abuse Prevention and Treatment Agency (SAPTA)	An agency within the Nevada Division of Public and Behavioral Health that plans, funds, and coordinates statewide substance abuse service delivery. A program that receives federal money for alcohol and drug abuse prevention and treatment services must be certified by SAPTA.
Washoe County Human Services Agency (WCHSA)	Child welfare agency which provides child welfare services in Washoe County.
Welfare	Anything related to the general or emotional well-being of a child. This includes education, punishment, treatment of children, and environment issues that are not classified as safety issues.

APPENDIX B

INSPECTIONS OF NEVADA CHILDREN'S FACILITIES – 2023

Facility Name	Facility Type	Type of Work	Date of Work
Teurman Hall	Detention Facility	Inspection	January 18, 2023
Kids Kottages	Foster Home That Provides Specialized Care	Inspection	February 7, 2023
Vitality Unlimited – ACTIONS	Facility for the Treatment of Abuse of Alcohol or Drugs	Inspection	February 21, 2023
Northeastern Nevada Juvenile Detention Center	Detention Facility	Inspection	February 22, 2023
Rite of Passage – Sierra Sage Treatment Center	Psychiatric Residential Treatment Facility	Inspection	March 15, 2023
HELP of Southern Nevada – Shannon West Homeless Youth Center	Other Facility	Inspection	March 27, 2023
Desert Parkway Behavioral Healthcare Hospital, LLC	Psychiatric Hospital	Inspection	March 28, 2023
Seven Hills Hospital	Psychiatric Hospital	Inspection	March 29, 2023
Desert Willow Treatment Center	Psychiatric Hospital	Inspection	March 30, 2023
Home 7[(2)]	Foster Home That Provides Specialized Care	Inspection	March 31, 2023
Home 1[(2)]	Foster Home That Provides Specialized Care	Inspection	March 31, 2023
Home 5[(2)]	Foster Home That Provides Specialized Care	Inspection	March 31, 2023
180 Community Wellness Center	Foster Care Agency	Inspection	April 3, 2023
Eagle Quest	Foster Care Agency	Inspection	April 4, 2023
Apple Grove Foster Care Agency	Foster Care Agency	Inspection	April 5, 2023
PRTF Oasis	Psychiatric Residential Treatment Facility	Inspection	April 6, 2023
Aurora Center for Healing	Psychiatric Residential Treatment Facility	Inspection	April 25, 2023
China Spring Youth Camp	Correction Facility	Inspection	May 11, 2023
Willow Springs Center	Psychiatric Hospital	Inspection	May 25, 2023
PRTF North	Psychiatric Residential Treatment Facility	Inspection	June 6, 2023
Reno Behavioral Healthcare Hospital, LLC – Acute[(1)]	Psychiatric Hospital	Inspection	June 8, 2023
Reno Behavioral Healthcare Hospital, LLC – PRTF[(1)]	Psychiatric Residential Treatment Facility	Inspection	June 8, 2023
JC Family Services	Foster Care Agency	Inspection	June 28, 2023
Southern Hills Hospital and Medical Center	Psychiatric Hospital	Inspection	July 24, 2023
Olive Crest	Foster Care Agency	Inspection	July 25, 2023
Nevada Homes for Youth[(1)]	Facility for the Treatment of Abuse of Alcohol or Drugs	Inspection	July 26, 2023
Silver State Pediatric Skilled Nursing Facility	Skilled Nursing Facility	Inspection	July 27, 2023
Silver State Pediatric Behavioral Services	Facility for Intermediate Care	Inspection	July 27, 2023
Home 3[(2)]	Foster Home That Provides Specialized Care	Inspection	September 12, 2023

Source: Auditor prepared from inspections completed.

(1) We conducted an inspection of these facilities in 2022 as well. See LA24-06, page 26.

(2) For anonymity purposes we use numerical designations to identify specific homes. The numerical designations are updated each year as new homes are added or no longer operating as foster homes that provide specialized care. Due to this, the numerical designations may not match from year to year.

APPENDIX C

NEVADA CHILDREN'S FACILITIES INFORMATION
FISCAL YEAR ENDED JUNE 30, 2023

Child Care Institution	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Child Haven	Las Vegas	0 – 18	90	88	65	15
Totals – 1 Child Care Institution			**90**	**88**	**65**	**15**

Correction and Detention Facilities	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Caliente Youth Center	Caliente	12 – 20	140	45	35	0
China Spring Youth Camp	Gardnerville	12 – 18	59	12	32	1
Clark County Juvenile Detention Center	Las Vegas	8 – 18	192	134	114	4
Douglas County Juvenile Detention Center	Stateline	10 – 17	16	2	9	2
Jan Evans Juvenile Justice Center	Reno	8 – 18	108	30	45	2
Leighton Hall	Winnemucca	10 – 18	6	1	12	4
Murphy Bernardini Juvenile Justice Center	Carson City	10 – 17	18	12	16	1
Nevada Youth Training Center	Elko	14 – 18	64	43	45	0
Northeastern Nevada Juvenile Detention Center	Elko	10 – 20	24	10	10	0
Spring Mountain Youth Camp	Las Vegas	12 – 18	100	61	53	1
Summit View Youth Center	Las Vegas	14 – 20	48	35	43	0
Teurman Hall	Fallon	12 – 18	16	11	13	4
Western Nevada Regional Youth Center	Silver Springs	12 – 18	18	10	16	2
Totals – 13 Correction and Detention Facilities			**809**	**406**	**443**	**21**

Facilities for the Treatment of Abuse of Alcohol or Drugs	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Nevada Homes for Youth	Las Vegas	13 – 18	10	8	6	3
Vitality Unlimited – ACTIONS	Elko	13 – 18	13	1	17	2
Totals – 2 Facilities for the Treatment of Abuse of Alcohol or Drugs			**23**	**9**	**23**	**5**

APPENDIX C

NEVADA CHILDREN'S FACILITIES INFORMATION FISCAL YEAR ENDED JUNE 30, 2023 (continued)

Foster Care Agencies	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
3 Angels Care, LLC	Reno	6 – 18	22	20	13	4
180 Community Wellness Centers	North Las Vegas	0 – 18	8	6	8	4
Apple Grove Foster Care Agency	Las Vegas	0 – 18	28	13	22	3
Bamboo Sunrise, LLC	Henderson	0 – 18	84	74	87	13
Call to Compassion, LLC	Reno	0 – 18	7	6	4	0
Eagle Quest	Las Vegas	0 – 19	205	174	140	15
JC Family Services	Reno	3 – 18	8	8	3	2
Koinonia Family Services	Reno	0 – 18	21	16	20	2
Mt. Olive Care, LLC	Reno	0 – 18	10	8	5	0
Olive Crest	Las Vegas	0 – 18	25	19	36	0
P6 Family Services, LLC	Sun Valley	6 – 18	12	12	4	0
St. Jude's Ranch for Children	Boulder City	0 – 18	60	20	23	2
Specialized Alternatives for Families and Youth of Nevada, Inc.	Las Vegas	0 – 21	132	86	99	0
Totals – 13 Foster Care Agencies			**622**	**462**	**464**	**45**

Foster Homes That Provide Specialized Care	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Austin's House	Carson City	0 – 18	10	8	3	7
Home 1[(2)]	Pahrump	6 – 20	1	1	1	0
Home 3[(2)]	Fallon	12 – 18	2	1	1	0
Home 5[(2)]	Pahrump	1 – 18	6	5	1	1
Home 7[(2)]	Pahrump	2 – 18	4	2	2	0
Home 8[(2)]	Ely	5 – 18	1	1	2	0
Kids' Kottages	Reno	0 – 18	30	24	26	12
R House Community Treatment Home	Reno	5 – 18	1	1	2	0
Totals – 8 Foster Homes That Provide Specialized Care			**55**	**43**	**38**	**20**

Others[(1)]	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
HELP of Southern Nevada – Shannon West Homeless Youth Center	Las Vegas	16 – 24	8	2	43	0
Humboldt County Juvenile Services Transitional Living Center	Winnemucca	15 – 18	6	1	6	2
Totals – 2 Others			**14**	**3**	**49**	**2**

APPENDIX C

NEVADA CHILDREN'S FACILITIES INFORMATION FISCAL YEAR ENDED JUNE 30, 2023 (continued)

Psychiatric Hospitals	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Desert Parkway Behavioral Healthcare Hospital, LLC	Las Vegas	8 – 17	21	19	62	12
Desert Willow Treatment Center	Las Vegas	12 – 17	44	18	65	15
Desert Winds Hospital	Las Vegas	12 – 17	102	64	109	8
Reno Behavioral Healthcare Hospital, LLC	Reno	5 – 17	42	21	73	5
Seven Hills Hospital	Henderson	5 – 17	30	19	38	10
Southern Hills Hospital and Medical Center	Las Vegas	13 – 17	20	8	14	4
Spring Mountain Treatment Center	Las Vegas	5 – 17	26	12	15	0
Willow Springs Center	Reno	12 – 17	116	69	95	10
Totals – 8 Psychiatric Hospitals			**401**	**230**	**471**	**64**

Psychiatric Residential Treatment Facilities (PRTF)	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Aurora Center for Healing	Hawthorne	12 – 17	60	30	72	0
Desert Winds PRTF	Las Vegas	12 – 17	88	50	109	8
PRTF North	Sparks	12 – 17	16	10	15	8
PRTF Oasis	Las Vegas	6 – 17	12	5	28	3
Reno Behavioral Healthcare Hospital, LLC	Reno	12 – 17	21	15	21	4
Rite of Passage – Sierra Sage Treatment Center	Yerington	14 – 17	48	36	54	8
Totals – 6 Psychiatric Residential Treatment Facilities (PRTF)			**245**	**146**	**299**	**31**
Totals – 53 Facilities Statewide			**2,259**	**1,387**	**1,852**	**203**

Facilities That Closed During Fiscal Year 2023 or No Longer Meet the Definition of a Facility Subject to Legislative Auditor Inspection in NRS 218G.535

Facility	Type of Facility	Location
Home 2[(2)]	Foster Home That Provides Specialized Care	Amargosa Valley
Home 4[(2)]	Foster Home That Provides Specialized Care	Pahrump
Home 6[(2)]	Foster Home That Provides Specialized Care	Fernley
Never Give Up Youth Healing Center	Psychiatric Residential Treatment Facility	Amargosa Valley
PRTF Enterprise	Psychiatric Residential Treatment Facility	Reno
Quest Counseling and Consulting, Inc.	Foster Home That Provides Specialized Care	Reno

Source: Auditor prepared from information provided by facilities.

(1) Other facility types provide a full range of therapeutic, educational, recreational, and support services. Residents are provided with opportunities to be progressively more involved in the community.

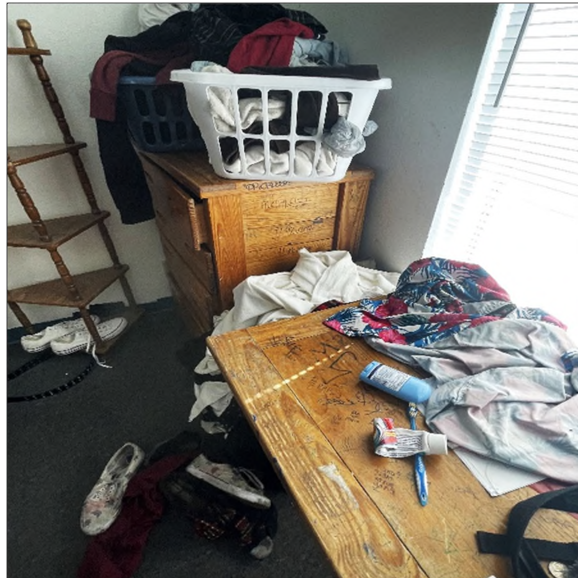
(2) For anonymity purposes we use numerical designations to identify specific homes. The numerical designations are updated each year as new homes are added or no longer operating as foster homes that provide specialized care. Due to this, the numerical designations may not match from year to year.

APPENDIX D

ADDITIONAL PHOTOGRAPHS OF LIVING CONDITIONS AT NEVADA HOMES FOR YOUTH (pages 4 – 12)

Child's door missing a doorknob.

Marijuana leaves on a child's jacket.



Piles of clothing in child's room.

Broken glass in a windowsill.

APPENDIX D

ADDITIONAL PHOTOGRAPHS OF LIVING CONDITIONS
AT NEVADA HOMES FOR YOUTH (continued)

Writing on a bathroom stall referencing drug paraphernalia.

Unsanitary conditions in the bathroom.

Damaged kitchen tile.

Empty cigarette packages on grounds of facility.

APPENDIX E

METHODOLOGY

To identify facilities pursuant to the requirements of Nevada Revised Statutes (NRS) we reviewed children's placement information submitted monthly by certain state and local governments. In addition, during examination of children's files, we noted the children's prior and subsequent placements. We also reviewed stories in the news media regarding children's facilities. Next, we contacted each facility identified to confirm it met the definitions included in NRS 218G.500 through 218G.535. For each facility confirmed, we obtained copies of complaints filed by a child or other persons on behalf of a child while in the care of a facility since July 1, 2022.

To establish criteria, we reviewed applicable state laws and federal regulations. We selected criteria that included issues related to the health, safety, welfare, civil and other rights of children, as well as their treatment. Health criteria included items related to a child's physical health, such as medical care and medication administration. Safety criteria related to the physical safety of a child, such as the environment and staffing. Welfare criteria related to the general or emotional well-being of a child, such as education, punishment, treatment of children, and environment issues that are not classified as safety issues. Civil and other rights included rights as human beings. Treatment criteria related to the mental health of a child, not necessarily how children were treated on a daily basis. This includes access to counseling, treatment plans, and progress through the program.

We received, reviewed, and tracked complaints filed by each facility to determine whether each facility submitted complaints monthly pursuant to NRS 218G.580. The nature and extent of each complaint received and facility management's consistency with statutory reporting requirements are considered in our assessment of risk and selection of facilities to inspect, review, and survey.

Next, we selected a judgmental sample to perform inspections of children's facilities. Our selection was partially based on our assessment of risk, the last time we visited, the size, and the type of facility.

As inspections are 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.

Inspections included discussions with management, a review of personnel and child files, and observations. Child and employee interviews occurred as applicable. Discussions with facility management included the following topics: medication administration, treatment plans, reporting of abuse or neglect, face sheets, the complaint process, background checks and training, Prison Rape Elimination Act, and related policies and

procedures as applicable. In addition, we judgmentally selected files to review which included: personnel files for evidence of background checks and required training; and child files for evidence of children's acknowledgment of their right to file a complaint, medication administered, treatment plans, and face sheet information as applicable.

As part of the onsite visit, we physically observed all areas accessible to children. We also observed areas for secure storage of records, medications, tools, and chemicals. As part of our observations, we ensured proper provision of food, clothing, supplies, and recreation activities for children. Other observations included ensuring important information, such as child rights and fire escape routes, were posted and visible to children.

We analyzed policies and procedures specific to the areas discussed with management, which included ensuring policies were consistent with management's understanding, statutes, and best practices. For example, we analyzed medication administration policies and procedures to ensure they addressed: documenting medication administered, including medication refused by children; maintaining physician's orders and consent to administer psychotropic medication; and processes for identifying, addressing, and minimizing errors. Our analysis also included ensuring policies and procedures addressed: verifying and documenting medication at intake and discharge; reordering prescribed medication; securing medication; and verifying and documenting medication for destruction.

Our work was conducted from January 2023 through January 2024, pursuant to the provisions of NRS 218G.570 through 218G.595.

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