Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on December 13, 2012. Report # LA12-22.

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.

As of June 30, 2012, we had identified 60 governmental and private facilities that met the requirements of NRS 218G: 20 governmental and 40 private facilities. In addition, 149 Nevada children were placed in 26 facilities in 13 different states as of June 30, 2012.

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, 2011, through June 30, 2012, we received 1,039 complaints from 34 facilities in Nevada. Twenty-six facilities reported that no complaints were filed during this time.

Purpose of Review

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. The report includes the results of our reviews of 6 children's facilities, unannounced site visits to 12 children's facilities, and a survey of 60 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, 2010. In addition, we discussed related issues and observed related processes during our visits.

Review of Governmental and Private Facilities for Children

December 2012

Summary

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the six facilities reviewed provide reasonable assurance that they adequately protect 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 12 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.

However, a lack of adequate supervision, including employee evaluations and training, may have contributed to numerous incidents regarding inappropriate staff behavior at Oasis On-Campus Treatment Homes, which could impact the safety and welfare of the children residing at the facility. These incidents, including inappropriate use of physical force and lack of supervision of the children by staff, were reported to Oasis's licensing agency, the Clark County Department of Family Services (DFS), in the past 2 years. Some of the reports were unsubstantiated by DFS and others were still being investigated. These reports and the subsequent DFS investigation resulted in an Oasis required action plan in June 2012.

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.

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 staff duties as mandatory reporters of suspected child abuse and neglect, to contraband searches, including documentation of searches. (page 6)

In addition, medication administration processes and procedures needed improvement at five of the six facilities. The medication administration process should include documentation of medications administered to youths, controls over prescribed medications, and the 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 four of the six facilities. Some youths' files were missing evidence of physicians' orders at two of the six facilities. At one facility, a youth's file indicated medication was administered on days that did not exist. In addition, medication files and records did not always contain evidence of independent review at three of the six facilities. (page 7)

Facilities Need to Improve Implementation of Medication Policies

During the 76th Session of the Nevada Legislature (2011), the Legislature passed Senate Bill 246. Effective January 1, 2012, this bill requires children's facilities to adopt policies to document medication administered and medication errors, and establish processes to minimize and address errors. (page 7)

Don Goforth Resource Center had not developed any policies or procedures related to medication administration at the time of our review. Senate Bill 246 requires all public and private institutions to which a court commits a child to adopt a policy covering several facets of medication administration. Furthermore, it requires each institution to ensure each employee who will administer medication receives a copy of and understands the policy. (page 7)

During our reviews of the six facilities included in this report, we determined that five facilities either had incomplete medication documentation or made errors during the administration of medications that went undetected until our review. Facilities could reduce the incidence of undetected errors by implementing a process, such as an independent review, to identify errors and improve the quality of medication administration processes. (page 8)

An independent review is a process to review medication administration records and identify potential errors, fraud, or abuse. For example, Desert Willow Treatment Center has assigned staff who are not routinely involved in the medication administration process to compare medication records with physician and pharmacy orders, and verify medication records are complete. The process has contributed to the facility identifying, documenting, and addressing errors. In addition, the facility has included this process in its policies and procedures. (page 8)

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