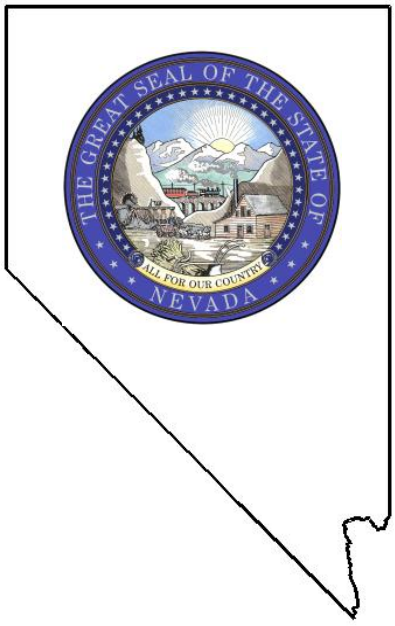
LA12-22

STATE OF NEVADA

Review of Governmental and Private Facilities for Children

December 2012



Legislative Auditor

Carson City, Nevada

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)

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

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Legislative Commission
Legislative Building
Carson City, Nevada

We have conducted a series of reviews of governmental and private facilities for children in the State of Nevada. These reviews were authorized by Nevada Revised Statutes 218G.570 through 218G.585. The purpose of these reviews 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 the reviews. We are available to discuss the report with any legislative committees, individual legislators, or other state and local officials.

Respectfully presented,

Paul V. Townsend, CPA
Legislative Auditor

November 29, 2012
Carson City, Nevada

STATE OF NEVADA
REVIEW OF GOVERNMENTAL AND PRIVATE FACILITIES FOR CHILDREN
DECEMBER 2012

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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 8), unannounced site visits to 12 children's facilities (page 61), and surveys of 60 children's facilities (pages 59-60).

BACKGROUND

Nevada Revised Statutes authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of residential children's facilities. Copies of NRS 218G.500 through 218G.535 and NRS 218G.570 through 218G.585 are 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 and 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.

As of June 30, 2012, we had identified a total of 60 governmental and private facilities that meet the requirements of NRS 218G: 20 governmental and 40 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, 2012.

Exhibit 1

Summary of Nevada Facilities
Year Ended June 30, 2012

Facility Type	Number of Facilities	Population		Staffing Levels	
		Maximum Capacity	Average Population	Average Full-time	Average Part-time
Correction and Detention Facilities	12	963	727	630	111
Resource Center	1	32	9	8	8
Child Welfare Facilities	4	187	82	84	39
Mental Health Treatment Facilities	6	280	203	335	94
Substance Abuse Treatment Facilities	5	84	47	63	11
Group Homes	17	243	186	180	42
Residential Centers	5	289	89	45	3
Foster Care Agencies	10	575	428	185	186
Total – Facilities Statewide	60	2,653	1,771	1,530	494

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 their homes.
- 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.
- Foster care agencies are nonprofit or for-profit corporations or sole proprietorships that assist an agency which provides child welfare services in the placement of children in foster care. Foster care agencies may operate multiple family foster homes, including specialized foster homes and group foster homes. Agencies often recruit and train foster parents, and place youths in either the foster parents' homes or in homes provided by the foster care agency. Foster parents are responsible for providing safe, healthful, and developmentally supportive environments where youths can interact fully with the community.

In addition to youths placed in facilities within the State of Nevada, an additional 149 youths were placed in out-of-state facilities by a county or the State as of June 30, 2012. Nevada youths were placed in 26 different facilities in 13 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, 2012. Exhibit 3 shows the number of youths placed in out-of-state facilities as of June 30 of the past 3 years.

Exhibit 2

Summary of Nevada Youths Placed in Out-of-State Facilities as of June 30, 2012

Placing Entity	Number of Youths Placed in Out-of-State Facilities	Number of Different States
Clark County Department of Juvenile Justice Services, Probation	61	12
Washoe County Department of Juvenile Services, Probation	29	5
Lyon County Juvenile Probation	7	3
5th Judicial District Court (Esmeralda, Mineral, and Nye Counties)	5	2
Elko County Juvenile Probation	2	1
9th Judicial District Court (Douglas County)	3	2
1st Judicial District Court (Carson City and Storey Counties)	7	3
State of Nevada Division of Child and Family Services	35	12
Total	**149**	

Source: Reviewer prepared from information provided by entities.

Exhibit 3

Summary of Nevada Youths Placed in Out-of-State Facilities As of June 30, 2010, 2011, and 2012

Placing Entity	As of June 30, 2010	As of June 30, 2011	As of June 30, 2012
Clark County Department of Juvenile Justice Services, Probation	56	87	61
Washoe County Department of Juvenile Services, Probation	11	19	29
Lyon County Juvenile Probation	10	2	7
5th Judicial District Court (Esmeralda, Mineral, and Nye Counties)	5	9	5
Elko County Juvenile Probation	3	1	2
9th Judicial District (Douglas County)	0	0	3
1st Judicial District Court (Carson City and Storey Counties)	1	3	7
Churchill County Juvenile Probation	2	0	0
State of Nevada Division of Child and Family Services	33	29	35
Total	**121**	**150**	**149**

Source: Reviewer prepared from information provided by entities.

Complaints

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, 2011, through June 30, 2012, we received 1,039 complaints from 34 facilities in Nevada. Twenty-six facilities in Nevada reported that no complaints were filed by youths during this time. In addition, we received complaint information from out-of-state facilities.

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, 2010. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from March 2012 through October 2012.

A detailed methodology of our work can be found in Appendix F of the report, which begins on page 61.

FACILITY OBSERVATIONS

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the 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 12 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.

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.

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

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 facility's 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 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 six facilities reviewed. Some youths' files were missing evidence of physicians' orders at two of 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.

Two of six facilities needed 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 ensure youths take only medications approved or recommended by the Federal Food and Drug Administration.

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

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 errors, and establish processes to minimize and address errors.

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 to a child receives a copy of and understands the policy.

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 reviews. 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.

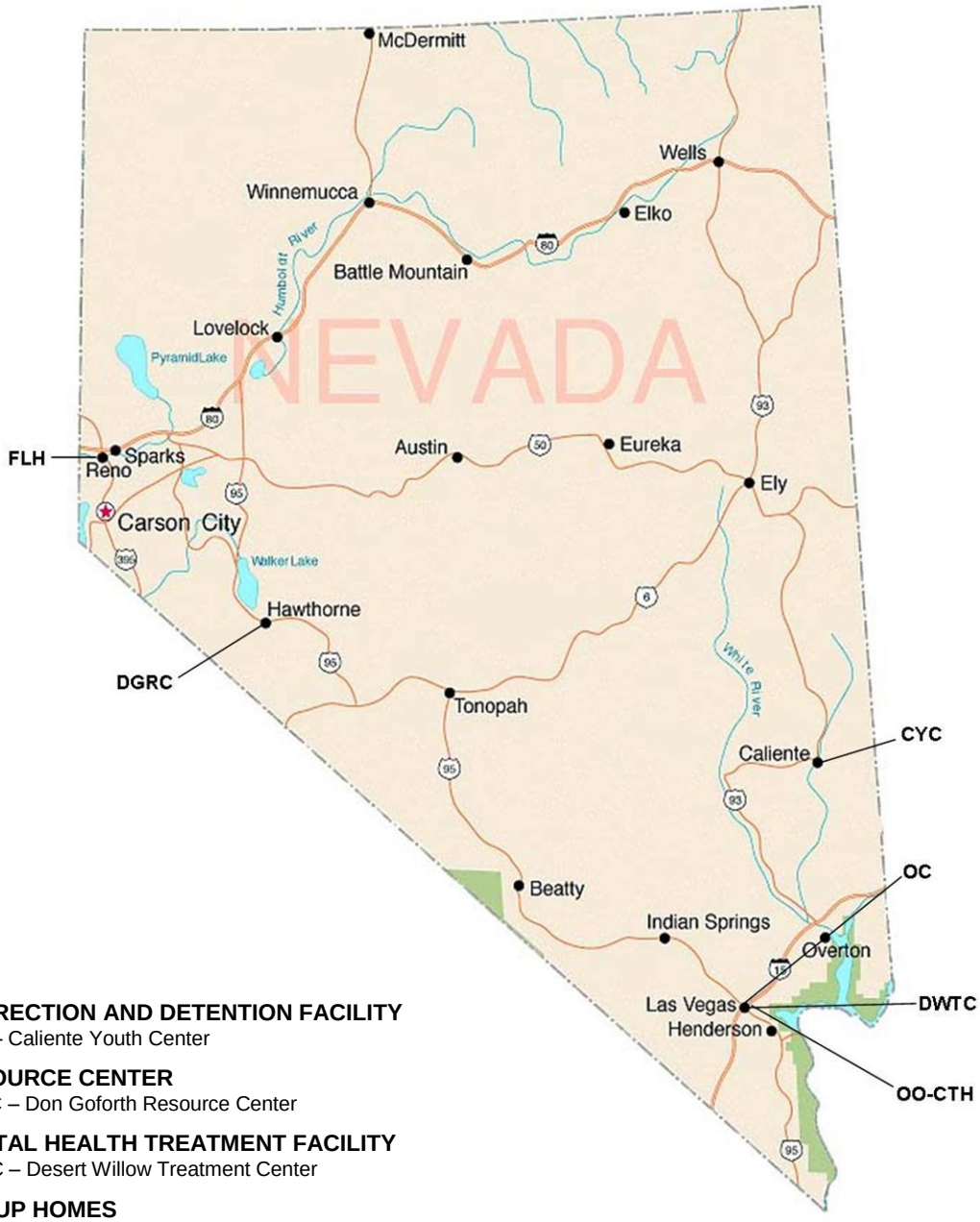
An independent review is a process to review medication administration records and identify potential errors, fraud, or abuse. For example, Desert Willow Treatment Center has assigned staff who are not routinely involved in the medication administration process to compare medication records with physician 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.

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.

Exhibit 4

Map of Facilities Reviewed



CORRECTION AND DETENTION FACILITY
CYC – Caliente Youth Center

RESOURCE CENTER
DGRC – Don Goforth Resource Center

MENTAL HEALTH TREATMENT FACILITY
DWTC – Desert Willow Treatment Center

GROUP HOMES
FLH – Family Learning Homes
OO-CTH – Oasis On-Campus Treatment Homes

FOSTER CARE AGENCY
OC – Olive Crest

Source: Reviewer prepared.

Caliente Youth Center

Background Information

The Caliente Youth Center (CYC) is a staff secured correctional facility located in Caliente. CYC is operated by the Nevada Department of Health and Human Services, Division of Child and Family Services.

During the year ended June 30, 2012, CYC:

- Had a maximum capacity of 140 youths.
- Provided services to youths from 12 through 18 years of age.
- Had an average daily population of 131 youths with an average length of stay of 8 months.
- Had 85 full-time staff.

CYC's mission is to promote positive value change to the youth served through a balanced, team centered, strength based approach.

Purpose of the Review

The purpose of our review was to determine if the Caliente Youth Center 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 processes for the period from July 2010 through the date of our visit in September 2012. We also discussed related issues and observed related processes during our visit.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the processes in place at Caliente Youth Center 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, CYC could make improvements to the quality of its policies and procedures and its medication management processes.

Caliente Youth Center (continued)

Principal Observations

Policies and Procedures

Some of CYC's policies and procedures need to be updated or changed.

- Policies addressing identity kits for youths do not include a list of allergies or medication a youth may be taking upon intake.
- Policies do not include a timeframe to develop a treatment plan. In addition, treatment plans were not always dated or signed.
- Policies do not address all of youths' rights. These rights include equal treatment regardless of gender, ethnicity, religion, disability, and sexual orientation. Although CYC's youth handbook, provided to youth at intake, addresses all youths' rights, policies do not include sexual orientation.

In addition, CYC should ensure staff understand all policies, procedures, and expectations to ensure youths' safety. CYC should also consider periodically reviewing policies and procedures.

Facility Response

CYC local policy 17.1 Juvenile Admission Procedures – Reception, Classification, and Transfers, has been revised to reflect that any medical conditions, allergies, and/or medications pertaining to a youth will be listed on the youth's "Facesheet" (information sheet).

CYC local policy 16.1 Individualized Programs – Programs, has been revised to reflect that a youth's initial treatment plan will be developed within 30 days of admission. The CYC Mental Health Counselors have been instructed to ensure that the dated and signed original is placed in the youth's master file. The Administrative Assistant I will track the receipt of the signed and dated treatment plans.

Caliente Youth Center (continued)

Facility Response (continued)

Equal treatment regardless of sexual orientation has been added to CYC local policy 13.2 Environmental and Programmatic Rights of Youth – Youth Rights.

All staff sign acknowledgements at hire that they have received, will read and comply with policies. It is the Division's understanding that there was some confusion regarding Suicide Alert and Suicide Watch. An All-Caliente staff email was forwarded to CYC staff on October 19, 2012. Additionally, the definitions of the two levels of supervision as stated in CYC policy 12.15 Suicide Recognition and Prevention have been posted on each cottage.

There are currently 113 CYC local policies. Current plans are to review nine policies monthly in order to begin a perpetual review so that each policy is reviewed annually. This will include a review by the Superintendent, Assistant Superintendent, the Head Group Supervisor and the Administrative Assistant II, in addition to any subject matter expert deemed appropriate. The Statewide Juvenile Justice Services policies are currently being reviewed by a Division policy review team.

Medication Administration Processes

CYC's medication administration processes were not always followed. For example, staff did not always observe medication given to youths to assure medication was taken, or timely document medication administered or refused as required by policy. In addition, staff removed medication from its secure and sealed container before confirming a youth's presence during the medication administration process.

In addition, CYC needs to strengthen its documentation of the disposal of prescribed non-controlled medication. Documentation should include the following: the number of pills for disposal; space for staff who prepare medication and documentation of the disposal to initial; space for another staff to initial after verifying

Caliente Youth Center (continued)

medication; and space for the pharmacist to verify the type and number of pills received.

Facility Response

Following the review, nursing staff were verbally instructed to follow the protocol for medication administration. The CYC Nursing Protocol Mouth Cheeks – Cheeking Prevention was also read and signed again by nursing staff. Nursing staff were randomly observed by the CYC Superintendent to ensure the correct protocol was being followed. Nursing staff were also instructed to ensure that Medication Refusal Forms and Medication Request Forms are kept in the medication boxes. Staff were also instructed to not remove a medication from the blister pack prior to ensuring that the youth receiving the medication is present.

All medications disposed of internally are documented with the name and number of pills, signatures of nursing staff destroying the medications, and a witness signature. A form has been developed for the return of medications to the pharmacy for credit that does include the date of return, the name on the prescription, the medication and dosage, the number of pills returned, initials of the CYC Nurse, CYC witness, and pharmacy representative to verify the number of pills, and the signatures of the CYC Nurse, CYC witness, and the pharmacy representative.

Other Issues

CYC did not post a list of youth's rights or the complaint process in cottages, visible to youths or visitors. In addition, we noted complaint forms were not readily available in two cottages; treatment plans were not always signed or dated; and sharp objects and cleaning materials were unsecured in an occupied cottage.

Facility Response

A copy of Youth Rights and the Youth Grievance Procedures has been posted on all cottages. These two items have been included on the Cottage

Caliente Youth Center (continued)

Facility Response (continued)

Inspection Form that the assigned Assistant Head Group Supervisor utilizes monthly to ensure that they remain posted, visible to youths and visitors. Grievance forms have also been added to the Cottage Inspection Form to ensure that all cottages provide youths unimpeded access to grievance forms.

Signed and dated treatment plans were addressed previously. As noted, the Mental Health Counselors will be responsible for ensuring that signed and dated treatment plans are accessible in the youths' master files. The staff member observed on the occupied cottage with the unsecured sharps items and cleaning supplies was verbally addressed.

Don Goforth Resource Center

Background Information

The Don Goforth Resource Center (Center) is a staff secured facility located in Hawthorne. The Center is operated by Mineral County and serves Mineral, Esmeralda, and Nye Counties.

During the year ended June 30, 2012, the Center:

- Had a maximum capacity of 32 youths.
- Provided services to youths from 8 through 17 years of age.
- Had an average daily population of nine youths with an average length of stay of 8 days.
- Had a total of 16 staff: 8 full-time and 8 part-time.

The Center's mission is to provide a safe and secure resource center for the custody and care of youth awaiting court, found to be delinquent, and/or awaiting placement in a court ordered facility. Resource centers provide more than one type of service. For example, a resource center may provide both treatment and detention services.

Purpose of the Review

The purpose of our review was to determine if the Don Goforth Resource Center 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 processes for the period from July 2010 through the date of our visit in August 2012. We also discussed related issues and observed related processes during our visit.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the processes in place at Don Goforth Resource Center 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, the Center does not have adequate policies and procedures documented to help ensure it protects the children in its care.

Don Goforth Resource Center (continued)

Principal Observations

Policies and Procedures

The Center does not have adequate policies and procedures. The Center does have a small booklet called staff rules that addresses some processes, but it does not address major operational areas, and the areas that are addressed are not sufficiently detailed. In addition, this booklet also includes youth rules and a description of the grading process for youths, but is not complete or sufficiently detailed to provide necessary information to youths.

- There are no medication administration or management policies or procedures. NRS 62B.240, effective January 1, 2012, requires all public and private institutions to which a juvenile court commits a child, including a facility for the detention of children, to adopt a policy covering documentation of physician's orders; administering, storing, handling, and disposing of medications; documenting the administration of medications and any errors; and minimizing and addressing errors. It also requires the institution ensure each employee who will administer medication to a child receives a copy of and understands the policy. The Center's staff rules booklet does not address medication administration or management.
- There are no policies regarding required staff training and documentation of the training. Two of the five personnel files reviewed did not contain evidence to support that the employees had received training.
- There are no policies informing staff of their duties as mandatory reporters of suspected child abuse and neglect or of the procedures to follow when reporting.
- There are no policies addressing identity kits for youths. As a result, identity kits did not contain consistent information and none of the five kits we reviewed were complete. For example, kits were missing photos of youths and lists of allergies and medications the youths were taking.
- There are no policies describing youths' rights. These rights include equal treatment regardless of gender, ethnicity, religion, disability, and sexual orientation. Furthermore, a list of youths' rights was not posted in the Center, and youths

Don Goforth Resource Center (continued)

are not provided with a list of their rights during intake at the facility.

- There are no policies addressing the complaint or grievance filing and resolution process for youths, visitors, parents, and staff. In addition, the Center did not post a description of the grievance process or make grievance forms readily available to youths. Further, there was no locked box available in which youths could put their grievances. Finally, a description of the grievance process was not given to youths at intake.
- There are no policies addressing documentation of injuries and searches, de-escalation, use of force or restraints, and medical or non-medical emergencies.
- There are no policies addressing visitation, school attendance, isolation and room confinement, the intake process, substance abuse services, suicide prevention, off-campus activities, or runaways.

Facility Response

The current policies identified as "Staff Rules" are being updated into a Policy and Procedure Manual and will address all the deficiency areas and concerns which you had brought to our attention. This new Policy and Procedure Manual is expected to be completed and introduced by November 1, 2012.

Medication Administration Processes

Although Center management stated independent reviews of medication records are done, there was no evidence of a review in either of the two youths' medication files we reviewed. In addition, the Center did not use an approved and dated over-the-counter medication standing order form. Medication used for external purposes was stored with medication taken internally. The Center's medication administration record form does not provide space to indicate if a youth has allergies and does not include a menu of acronyms to help document if a youth refused a medication, a dose was missed because a youth was not present, or any other reason why a medication was missed.

Don Goforth Resource Center (continued)

Facility Response

This will be addressed within the new Policy and Procedure Manual.

Background Checks

No background check had been obtained for one of the five employees whose files we reviewed. Although background checks were not required when the employee was hired, NRS 62B.270, effective October 1, 2011, requires all facilities to which a juvenile court commits a child, including a facility for the detention of children, obtain background information for each employee to determine whether the employee has been convicted of certain crimes. Mineral County Personnel policies also require pre-employment background checks of applicants and current employees as necessary, but does not mention the requirement to obtain background checks of Center employees at least once every 5 years pursuant to NRS 62B.270.

Facility Response

All employees with over 5 years working here at Don Goforth Resource Center have been re-fingerprinted including all staff of the Probation Department in accordance with NRS 62B.270.

Other Issues

The Center did not post a list of contraband in any area visible to youths or visitors, which may have contributed to the two movies with restrictive ratings and three video games with mature ratings found during our review.

Facility Response

A list of contraband is now posted outside of the facility, all rated "R" movies and "M" games have been removed from the facility property and are not allowed per policy. Also, a location for the youth grievance forms has been made accessible to the youth, along with a box to deposit their grievances into.

Desert Willow Treatment Center

Background Information

Desert Willow Treatment Center (Desert Willow) is a secured mental health treatment facility in Las Vegas. Desert Willow is licensed by the Nevada Division of Health, Bureau of Health Care Quality and Compliance, as a hospital and is operated by the Division of Child and Family Services.

During the year ended June 30, 2012, Desert Willow:

- Had a maximum capacity of 58 youths.
- Provided services to youths from 6 to 18 years of age.
- Had an average daily population of 38 youths with an average length of stay of 5 months.
- Had 110 full-time staff.

Desert Willow's mission is to provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community, and other providers to ensure that children and families of Nevada achieve their full human potential.

Desert Willow provides psychiatric care to the most severely emotionally disturbed youth. The services provided include: crisis intervention and stabilization; individual, family, and group therapies and behavior management; clinical case management; psychological evaluation and consultation; psychiatric evaluation and medication management; nursing care; recreational therapy; and special education through the Clark County School District.

Purpose of the Review

The purpose of our review was to determine if Desert Willow Treatment Center 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 from July 2010 through the date of our visit in July 2012. We also discussed related issues and observed related processes during our visit.

Desert Willow Treatment Center (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 Desert Willow Treatment Center 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. We would like to commend Desert Willow for improvements in its medication administration processes since our last review in 2009. Desert Willow's implementation of an independent review process contributed to the quality of the facility's medication documentation. However, Desert Willow could make improvements in the timeliness of obtaining background checks of employees and the clarity of policies and procedures.

Principal Observations

Background Checks

Two of the five employees whose files we reviewed were not fingerprinted for initial background checks timely. One of the employees was fingerprinted a year after his hire date. The other employee was fingerprinted 3½ years after fingerprint background checks became a requirement for all employees. NRS 449.123 requires employees be fingerprinted within 10 days of hire. This law was effective in November 1997. In addition, NRS 449.123(3) requires background checks be conducted at least every 5 years after the initial background check. One of the five employees' files indicated the employee's second background check was completed almost 4 months after the 5 year requirement.

Facility Response

Acknowledging the importance of background checks, all new employees of DCFS, that includes Desert Willow, are required to submit fingerprint cards for their initial background check by the close of business of their first day of employment. DCFS has created a monthly report of all employees subject to the provisions of NRS 449.123(3). This report is sent to all DCFS managers. In order to comply with the 5 year requirement, the DCFS Personnel Analysts then

Desert Willow Treatment Center (continued)

Facility Response (continued)

coordinate with the appropriate manager to notify any employee who is required to be re-fingerprinted within the next 2 months. The employee then receives the proper forms and completes the fingerprinting.

Policies and Procedures

Some of Desert Willow's policies and procedures need to be updated or clarified. For example:

- Policies prohibit leaving keys in storage room or cabinet locks, but do not address the security of keys to vehicles or other doors within the facility.
- The Consumer Complaint policy listed a facility contact person who is no longer at the facility.
- The Pharmacy Dispensing Procedures need to be revised. The procedures state pharmacy personnel from Southern Nevada Adult Mental Health Services will pick up all discharged patient medications or unused medications for return to the pharmacy. It also states all returned medications will be documented and reconciled. Although pharmacy staff pick up unused medications, they do not provide Desert Willow staff with documentation of the type and number of pills picked up for disposal. Desert Willow should revise its procedure to ensure its staff require the pharmacy staff to count and sign for any medications picked up. In addition, management needs to ensure all Desert Willow staff are aware of the procedure to be followed when disposing of unused medications.
- Desert Willow's policy on appropriate use of computers by staff and youths has not been approved.

Facility Response

Desert Willow's Computer Use Policy 6.13, delineating appropriate use of computers by staff and patients, was approved by the Leadership Executive Team on August 30, 2012. Desert Willow's Consumer Complaints Policy 2.45 was revised to replace all facility contact person names throughout

Desert Willow Treatment Center (continued)

Facility Response (continued)

the policy with employment position titles and was approved by the Leadership Executive Team on September 27, 2012. Desert Willow developed a Keys and Key Cards Policy 3.08 to be approved by the Leadership Executive Team on October 25, 2012, that addresses the security of keys to doors within the facility, as well as to the facility vehicle.

Desert Willow has requested for inclusion in the next DCFS fiscal budget the purchasing of a Pyxis MedStation system. The system automates the distribution, management, and control of medications. It provides innovative communication and workflow tools to enhance nursing and pharmacy's ability to work more efficiently and effectively in their efforts to deliver safe, high-quality patient care. In the interim, Desert Willow is implementing a pilot program regarding the return of medications to the pharmacy. The type of medication and the number of pills returned to the pharmacy are documented by the nurse and verified by pharmacy staff. The results of the pilot program are being reviewed and refined. The final procedures will be incorporated into a Desert Willow policy. Management will ensure through training and monitoring that all nursing staff is aware of and adhere to the new policy and procedures when returning and disposing of unused medications.

Other Issues

A list of contraband and prohibited items was not posted in one of Desert Willow's four units. Complaint forms were not readily available to youths in three of the four units. Staff stated paper is provided to youths when requested.

Desert Willow's procedures for requesting repairs to the facility need to be updated. In addition, Desert Willow should work with Division management to ensure requested repairs are made in a timely manner. Procedures state staff complete a maintenance request form when a repair is needed, and forward the form to the supervisor, who forwards the form to the Facility Supervisor.

Desert Willow Treatment Center (continued)

However, Desert Willow management told us requests are now made through e-mails. In addition, management told us that requested repairs are not made timely. During our visit to the facility, there were several holes in walls, some of which had been covered with plywood, but not adequately repaired.

Facility Response

Since the July 2012 review, Desert Willow has ensured that all units have posted the Contraband Items Not Permitted form. Desert Willow has also ensured that the Consumer Complaint forms are readily available to patients and in close proximity to the Consumer Complaint Box on each unit. To further ensure compliance, both forms have been added to the Unit Environmental Compliance Checklist (UECC) that is completed weekly by nursing staff. The revised UECC will be approved by the Leadership Executive Team on October 25, 2012.

Desert Willow has been consulting with DCFS management and working with DCFS maintenance staff to enhance procedures for requesting repairs and ensuring repairs are completed in a timely manner. Repair requests are currently submitted by email to DCFS maintenance and prioritized on a maintenance log. Desert Willow managers can obtain access to the maintenance log and assist in the prioritizing of repairs. DCFS maintenance is submitting returned emails upon completion of repair requests. With the support of DCFS management, the process and timeliness of requested repairs has improved.

Family Learning Homes

Background Information

The Family Learning Homes are staff secured, group foster homes in Reno. The Family Learning Homes are licensed by the Washoe County Department of Social Services as group foster homes and are operated by the Nevada Department of Health and Human Services, Division of Child and Family Services. During the month of our visit, April 2012, the Family Learning Homes consisted of four homes with an average daily population of 18 youths.

During the year ended June 30, 2012, the Family Learning Homes:

- Had a maximum capacity of 20 youths.
- Provided services to youths from 5 to 18 years of age.
- Had an average daily population of 18 youths with an average length of stay of 5 months.
- Had a total of 17 staff: 16 full-time and 1 part-time.

The Family Learning Homes' mission is to provide mental health treatment and rehabilitation services based on nationally recognized models built on core values and guiding principles of an individualized, client centered, strength-based system of care. The Family Learning Homes strive to reduce the use of seclusion and restraints, to protect the civil rights of all clients, to maintain a positive and safe treatment environment, and provide clients with opportunities to facilitate the process of recovery by developing skills commensurate with their physical, social, emotional, and behavioral development.

Purpose of the Review

The purpose of our review was to determine if the Family Learning Homes adequately protect 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 from July 2010 through the date of our visit in April 2012. We also discussed related issues and observed related processes during our visit.

Family Learning Homes (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 the Family Learning Homes 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, the Family Learning Homes could make improvements in medication management processes and the timeliness of background checks.

Principal Observations

Medication Administration Processes

Three of the five youths' medication files we reviewed contained either incomplete documentation or an error.

- Staff did not document the reason for a 6-day delay in administering a youth's medication. According to management, the delay was caused by the parent not bringing the medication to the facility timely; however, this was not documented in the youth's file. Family Learning Homes' policies do not require documentation of delays in the administration of medication. In addition, this youth's file did not contain a copy of the pharmacy's instructions for the medication.
- One medication administration record contained blank spaces, which could indicate the staff forgot to record the medication administered, the youth refused the medication, or the medication was not administered for some other reason.
- The third youth's file contained conflicting information. Staff completed a form indicating a dosage of medication was missed, but the youth's medication administration record contained documentation that the youth had received that dosage of medication.

Family Learning Homes can also improve medication administration processes by documenting a youth's known allergies on his or her over-the-counter standing order form. The facility uses a form approved by a physician for each youth. Adding a list of the youth's allergies to the form would help prevent adverse

Family Learning Homes (continued)

reactions to medications. We also noted that one youth's file contained inconsistent information about allergies on the medication administration records.

Finally, we noticed staff did not always wash their hands prior to handling youths' medications, even though policies require staff demonstrate clean techniques for administering medications.

Facility Response

The DCFS Children's Mental Health Medication Administration and Management Policy was approved by the Mental Health Commission in June 2012. Since this time, a statewide policy and procedure training has been developed and disseminated to all direct care employees. The training includes a written as well as a practice test to be completed by all direct care employees prior to September 30, 2012.

A Medication Administration and Review checklist for Supervisors and Managers has been developed. This checklist will assist supervisors and managers in reviewing medication administration, and ensuring errors are discovered and addressed quickly. Each Family Learning Homes supervisor is responsible to review the Medication Manual and Medication Administration Record (MAR) weekly. The manager will complete the Medication Review Checklist monthly. Errors or exceptions are noted on the Review Checklist as well as on the individual client MAR located in the client medical file.

A contract nurse provides an independent review of medication administration and management for all new clients at the time of admission, and for all current clients at least monthly. This review is documented on the MAR contained in each client medical file.

The statewide policy directs employees to document known allergies in red ink on the MAR and on medical records chart. This information will also be

Family Learning Homes (continued)

Facility Response (continued)

documented on the Identify Kids face sheet when the policy is complete. The Standing Order Form has been changed to include documentation of allergies. The medical records administrative assistant has been trained to review each client record to ensure the information is consistent on each document.

Family Learning Homes employees have been directed to document any delays in receiving medication in the client medical record, as well as on the MAR. The copy of the pharmacy instructions for each current client is kept in the Medication Manual. If a medication is discontinued, or at client discharge, the copy will be placed in the client's medical record.

In order to improve hygienic practices, employees are reminded at all employee meetings to wash his/her hands prior to administering medication. There is also a "wash your hands" sign posted on the locked medication cabinet. Medication trays were purchased and will be used for counting controlled substances and/or routine medications brought from home or another facility.

Background Checks

Family Learning Homes did not require all employees obtain background checks within the timeframes outlined in the Division of Child and Family Services' policies and within the timeframes required by Nevada Revised Statutes (NRS 424.031(4)). Division policies require new employees be fingerprinted within 5 working days of their date of appointment. One of the five personnel files we reviewed showed the employee was not fingerprinted until 17 working days after his appointment. Two of the five employees were not fingerprinted within 5 years of their initial background investigation, as required by NRS 424.031(4). According to Division personnel files, one was re-fingerprinted 4 months late and the other had not been re-fingerprinted at the time we reviewed her personnel file, which was 7 weeks past the 5-year anniversary of her initial background check.

Family Learning Homes (continued)

Facility Response

The Family Learning Homes Employee Orientation Policy has been changed to require all new employees to obtain his/her fingerprints on the first day of employment. The employee will not be allowed to work unless this is completed.

The Family Learning Homes Manager receives a monthly spreadsheet from the DCFS Personnel Officer indicating which employees are due for the 5 year renewal. The employee will be informed of the need to obtain the fingerprints 1 month in advance. The Family Learning Home Manager will be responsible to make sure the employee gets the fingerprints completed. Employees who do not do this within the 1 month time frame may be subject to disciplinary procedures.

Other Issues

One of the two state vehicles observed did not contain a fire extinguisher or first aid kit. Also, neither vehicle had a flashlight. These items are useful for minor emergencies. Family Learning Homes' policies state all vehicles must have a first aid kit and fire extinguisher.

A fire escape route was not posted in one of the four homes observed, and a list of prohibited items and contraband was not posted in one of the four homes. In addition, Family Learning Homes should update policies and procedures to document increased supervision of youths who have been identified as suicide risks until they are clinically cleared. Management stated youths at risk are supervised and observed until seen by a clinician, but this supervision is not documented.

Finally, Family Learning Homes should consider developing a policy to address the preparation of an identity kit for each youth. Having a complete identity kit at the facility may reduce the time needed to provide this information to first responders in case of an emergency. For example, a recent photograph, list of allergies, list of medications, and list of emergency contacts may all be useful

Family Learning Homes (continued)

information to provide to first responders immediately when reporting a runaway or during an emergency.

Facility Response

All state vehicles are equipped with a fire extinguisher, first aid kit, flashlight, registration and accident packets. All vehicles are checked monthly by the Clinical Program Manager for compliance. This monthly check is documented on the Family Learning Home Manager Review Checklist.

Fire escape routes and a contraband list are posted in each home. The Clinical Program Manager reviews compliance to this monthly and documents the review on the Family Learning Home Manager Review Checklist. The contraband list has been amended to add "no sexually explicit writing, poems, journals."

The Family Learning Homes High Risk Behavior Policy is being revised. Youth who are determined to be at risk to harm themselves or others, but are not admitted into an acute care facility because the risk is not determined to be acute, are supervised by the Treatment Home Provider employee. This may include line of sight supervision during awake hours and 15 minute checks while asleep in the bedroom. Written documentation will accompany this procedure. A copy of the revised policy and documentation procedure will be forwarded to the Legislative Counsel Bureau upon completion.

A Child Identity Policy and an identity kit are being developed and will be implemented. It will include a photo, physical identifiers, allergies, medications, emergency contacts, and other pertinent individualized identifiers/information. A copy will be forwarded to the Legislative Counsel Bureau upon completion.

Oasis On-Campus Treatment Homes

Background Information

The Oasis On-Campus Treatment Homes (Oasis) are group homes located in Las Vegas. Each Oasis treatment home is licensed by the Clark County Department of Family Services as a family specialized foster care home. Oasis is operated by the Nevada Department of Health and Human Services, Division of Child and Family Services. During the month of our visit, June 2012, Oasis consisted of five treatment homes; however, one home was closed.

During the year ended June 30, 2012, Oasis:

- Had a maximum capacity of 28 youths.
- Provided services to youths from 6 through 17 years of age.
- Had an average daily population of 18 youths with an average length of stay of 9 months.
- Had a total of 44 staff: 42 full-time and 2 part-time.

Oasis provides an intensive and structured treatment program for children and adolescents with severe emotional disturbances. Treatment homes are family-style residential homes. Services that are provided include: individual, family, and group therapies and behavior management; clinical case management; psychological and psychiatric assessment and evaluation; and parent training.

Purpose of the Review

The purpose of our review was to determine if Oasis On-Campus Treatment Homes adequately protect 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 from July 2010 through the date of our visit in June 2012. We also discussed related issues and observed related processes during our visit.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Oasis On-Campus Treatment Homes 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

Oasis On-Campus Treatment Homes (continued)

youths in its care. However, a lack of adequate supervision, including employee evaluations and training, may have contributed to numerous incidents regarding inappropriate staff behavior. Furthermore, Oasis could make improvements in its medication management processes, and the quality of its policies and procedures.

Principal Observations

Supervision of Personnel

Our review of 10 employee personnel files and other documents at Oasis and the Division of Child and Family Services found several issues that could impact the safety and welfare of the children residing at the facility. During the period of our review, numerous incidents were reported to Oasis's licensing agency, the Clark County Department of Family Services, concerning inappropriate staff behavior, including inappropriate use of physical force and lack of supervision of children by staff. Some of these reports were unsubstantiated by the licensing agency, and others were still being investigated. These reports and the subsequent investigations resulted in an Oasis required action plan in June 2012.

In addition, at the time of our review nearly 30% of Oasis positions were vacant, including two supervisory positions. These vacancies may have contributed to the number and types of incidents. Further, 9 of the 10 employees whose files we reviewed had not had timely performance evaluations. NRS 284.340 requires each agency conduct annual evaluations of each employee. Finally, not all employees had received training on new policies adopted by Oasis. Oasis had either developed or revised 25 policies and procedures within a month of our review. Management stated that all supervisors had been trained on these policies and procedures, and there are plans to train other staff, but it had not yet been done.

Facility Response

Oasis supervisors are in the process of completing evaluations for all staff. All evaluations will be current by the end of October 2012. In addition, Oasis has filled the Administrative Assistant position. This person will alert supervisors and the Clinical Program Manager II 45 days prior to an evaluation being due to

Oasis On-Campus Treatment Homes (continued)

Facility Response (continued)

ensure compliance with the DCFS Personnel Policy that evaluations be submitted 30 days prior to the due date.

Oasis continues to work from the corrective action plan developed in June. As a part of this action plan, managers and supervisors are having monthly staff meetings. New and revised policies are reviewed at each staff meeting. Oasis managers and staff will be completing a "train the trainer" course in early November to assist them in learning to train all Oasis staff. This course will include the development of an annual Oasis training plan for current and new staff.

Unfortunately, Oasis has had some barriers in completing the steps to ensure employees are adequately supervised and trained on new or revised policies. The most significant issue is hiring new staff, especially management and supervisor level staff. Another significant challenge is the time it takes from the point of identifying a potential employee to obtaining clearance from the Department of Family Services (DFS) Licensing, which has taken up to 2 months at times. Until an identified applicant receives provisional clearance from DFS Licensing, they may not work at Oasis. The following positions are currently vacant:

1. *The Clinical Program Manager (CPM) I position who oversees the entire Oasis program. A CPM I from Children's Clinical Services is currently reassigned part-time to help with oversight of the program. Interviews have not resulted in an applicant considered appropriate for this position.*
2. *The Mental Health Counselor III position had been filled. Unfortunately, the person identified for the position withdrew 2 days prior to the start date of September 11, 2012. A new round of interviews is in process.*

Oasis On-Campus Treatment Homes (continued)

Facility Response (continued)

3. *One Treatment Home Supervisor position remains vacant. An applicant was identified and the process for DFS Licensing Non-Primary Caretaker clearance initiated. Unfortunately, it was learned on October 3, 2012, that the applicant was not cleared by Licensing.*
4. *There remain five Treatment Home Provider positions vacant. Interviews have occurred and continue to occur. Barriers to filling these positions include a delay in the applicants providing necessary documentation required by DFS Licensing in a timely manner, lack of response by applicant references, and, at times, applicants themselves ceasing to respond to requests for additional information.*
5. *Mental Health Technicians also continue to be recruited for. At the time of this report, interviews were in progress to fill the two vacant part-time Technician positions.*

Medication Administration Processes

All 10 of the youth medication files we reviewed contained either incomplete documentation or a medication error.

- Medication administration records in 9 of the 10 files contained blank spaces for at least one medication for more than one day. Blank spaces on the records could mean staff forgot to administer the medication, the youth refused the medication, or staff administered the medication but did not record it on the form.
- Doctors' orders to start medication, change medication, or stop medication were either not followed timely or the changes were started early for 5 of the 10 youths whose files we reviewed.
- There were no doctors' orders in the files for one medication for 2 of the 10 youths.
- Allergy information was either not documented or not consistently documented in 8 of the 10 youths' files.

Oasis On-Campus Treatment Homes (continued)

In addition, staff did not perform a daily count of one youth's medication as required by policy. Seven pills were missing from the youth's prescription for a controlled substance. The prescription could not be refilled for another week, and the youth missed 7 days of the medication.

Oasis's over-the-counter medication standing order form was not dated and signed by a physician or nurse practitioner, as required by its policy. Furthermore, Oasis could improve its medication documentation by retaining pharmacy instructions in youths' files.

Oasis did not complete independent reviews of youths' medication files. Oasis's medication administration and management policy requires supervisors conduct weekly reviews of medication administration records to identify errors and to confirm the accuracy of data. It also requires managers to conduct monthly reviews to reconcile prescribers' orders with medications, medication administration records, and medication counts.

Facility Response

The DCFS Performance and Evaluation Unit (PEU) employees are assisting the Oasis program with medication management. All Oasis staff and supervisors have been trained on the Medication Management Policy and Procedure by a member of the PEU unit. This training has included classroom work, hands on training, and testing for competence for each staff member.

The PEU employees have been trained to complete medication reviews and have developed a form to be used for this purpose. The form is completed for each medication management independent review. The independent review includes inspecting and comparing to the policy the Medication Manual in each home, inspecting the Medication Administration Record (MAR) for each client, comparing the MAR to the Physicians' orders, the prescription bottles, and the Informed Consent; monitoring staff administering the medications, monitoring documentation of controlled substances, standing orders, and medication disposal. The independent review form is

Oasis On-Campus Treatment Homes (continued)

Facility Response (continued)

shared with Oasis management, staff, and supervisors at the weekly supervisor staff meeting.

The independent review form is also monitored by the Deputy Administrator. Supervisors have conducted individual trainings as needed or directed by the Clinical Program Manager II. Violations of the policy have resulted in significant response from management, communicating a commitment to hold Oasis staff accountable when policy and procedure are not followed.

Oasis had identified a nurse to assist with medication management reviews, training and oversight. Unfortunately, the nurse identified was unable to follow through with the commitment. DCFS is in the process of recruiting a part-time nurse through Avysion.

Policies and Procedures

Several of Oasis's policies and procedures need to be updated or changed.

- Oasis did not have a policy addressing identity kits. While Oasis does develop an identity kit for each youth, the kits do not consistently contain certain critical information, like photos, medications, and allergies.
- Oasis has not provided treatment home staff with adequate guidance related to nutrition. Oasis's policy states Oasis shall meet the daily nutritional needs according to the minimum United States Department of Agriculture (USDA) requirements of each child; however, it provides no other guidance to staff on determining what the USDA requirements are.
- Oasis's policy for medication disposal was inconsistent with the Division's policy and Oasis's practices. The facility's policy states medications should be taken to the pharmacy for disposal. However, the Division's policy states medications should be taken to the pharmacy or a local law

Oasis On-Campus Treatment Homes (continued)

enforcement agency for disposal. Oasis's staff told us all medications are taken to a local law enforcement agency.

- Oasis's physical examination policy is not consistent with the facility's practice. The policy requires each youth have a physical examination prior to the youth's admission. However, management stated physical examinations occur between 30 and 60 days after admission.
- Oasis's policies and procedures do not address conducting periodic censuses or head counts of residents.
- Oasis's policies and procedures do not address the use of video surveillance cameras, which were recently installed in each home.
- Oasis's policy on client searches is not consistent with the facility's practices and does not address documenting searches.

Facility Response

1. *A policy has been drafted addressing identity kits and is pending final approval.*
2. *Oasis does not have a nutritionist on staff. A part-time nutritionist position has been requested in the new budget or through Avysion via contract. In the meantime, the supervisors and Clinical Program Manager II continue to monitor menus and dining out, providing staff with feedback.*
3. *The policy for video surveillance has been drafted and is pending final approval.*
4. *The Admissions Policy has been revised and is being developed as a statewide policy to ensure consistency for all DCFS Children's Mental Health Residential Programs. The policy is in draft status and is currently under review before being submitted for final approval.*
5. *The new Admissions Policy reflects the current practice regarding physical examinations of youth entering the Oasis program. Oasis practice will be to initiate a full screening including physical wellness, vision, and dental between 30 and 60 days of admission.*
6. *Unfortunately, the policy for medication disposal for Oasis has changed several times, according to changes*

Oasis On-Campus Treatment Homes (continued)

Facility Response (continued)

made by Clark County DFS Licensing. Currently, two staff members take medication being disposed to the police station medication disposal area.

7. *Oasis is developing a policy regarding census and periodic head counts of residents, it is pending final approval.*
8. *Oasis is currently re-writing the client search policy.*
9. *DCFS continues to review and revise Oasis policies. As part of this process, it was also decided that, when appropriate, policies would be written to be consistent between Children's Mental Health Residential Programs statewide.*

Other Issues

During our visit to one of the homes, a set of keys was not adequately secured. Oasis's policy is to keep keys to vehicles, storage areas for medications and cleaning supplies, and the staff office in a secure location at all times. If keys are not in a secure location, they must be kept on the staff's person. In addition, several items considered contraband in Oasis's policies were observed in the homes, including unlabeled compact discs, a movie with a restricted rating, cigarette butts, and an unsecured I-pod.

Some of the homes were in need of repairs. For example, linoleum tiles had lifted from the subfloor and there was evidence of water damage to a wall in some bathrooms used by youths. We also found cleaning chemicals, such as glass and bathroom cleaners, were not always securely stored.

Facility Response

1. *Extensive repairs have been completed on all of the Oasis homes including painting, replacement/repair of floors, purchasing of new furniture, landscaping, and removal of the smoking area that was outside of homes 12E and 12W. The dirt areas outside these homes have since been paved, enhancing the appearance of the homes. A new designated smoking area has been*

Oasis On-Campus Treatment Homes (continued)

Facility Response (continued)

identified that is consistent with state policy and away from the homes. Additional kitchen cabinets had locks installed, allowing chemicals to be safely stored and locked under the sinks.

In addition to the Medication Reviews, the PEU unit is assisting Oasis with monthly checks of each home, using the "Home Review Checklist." This checklist includes a review of home cleanliness, sanitizing, contraband items, security of keys and chemicals, posting of notices, along with other policy requirements.

2. *Oasis has updated its contraband policy. Oasis will be obtaining MP3 players and portable DVD players so youth can listen to music and watch movies that are consistently monitored by Oasis staff. Each home will have an identified staff member who will be responsible for checking the MP3 players for any inappropriate music on a weekly basis. Youth are not allowed to bring in outside video games, music, movies, etc. into the home. If a family wishes to purchase a video game for the house, this will be considered pending approval by the home supervisor.*

Oasis continues to work on the corrective action plan developed in June. We will continue to send the LCB reviewers monthly updates of progress on each item in the plan.

Olive Crest

Background Information

Olive Crest is a private, not-for-profit foster care agency that provides specialized foster care, emergency shelter care, and sibling care to youths. Olive Crest's foster homes are licensed by the Clark County Department of Family Services and the Nevada Division of Child and Family Services. During the month of our visit, May 2012, Olive Crest operated 19 foster homes in Clark County and 1 in Nye County.

During the year ended June 30, 2012, Olive Crest:

- Had a maximum capacity of 43 youths.
- Provided services to youths from birth to 18 years of age.
- Had an average daily population of 27 youths with an average length of stay of 7 months.
- Had a total of 13 full-time staff.

Olive Crest's mission is to prevent child abuse, treat and educate at-risk children, and preserve the family one life at a time. In addition to its foster program, Olive Crest also operates a Family Resource Center, a Differential Response and Respite program, the Strong Families Family Preservation Program, and a Mental Health Program.

Purpose of the Review

The purpose of our review was to determine if Olive Crest 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 from July 2010 through the date of our visit in May 2012. We also discussed related issues and observed related processes during our visit.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Olive Crest 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,

Olive Crest (continued)

Olive Crest could make improvements in its medication management processes and facility policies and procedures.

Principal Observations

Medication Administration Processes

Olive Crest should improve its documentation of medication administered. Of the five youths' medication files we reviewed:

- Medication administration records for two youths contained blank spaces. Blank spaces could mean the foster parent forgot to administer the medication, the youth refused the medication, or the youth received the medication but the foster parent forgot to record it for that day.
- Neither the youths nor the foster parents signed the medication administration records in two youths' files. Olive Crest's medication administration record form contains a space for the parent and the youth to sign to attest to the accuracy of the medication administration record for the month.
- One youth's medication administration record was missing the name of the medication and the amount administered for the month.
- The medication administration record for the month of February 2011 for one youth indicated medication was administered to the youth on February 29th and 30th, days that did not exist.
- One youth's file contained two medication administration records for the same month for the same medications. Although both records showed the youth missed one medication for several days during the month, the number of days missed was different. In addition, the youth's file contained an incident report showing the youth missed medication for several weeks, but the dates were inconsistent with one of the records.
- One youth's medication administration records did not contain either the youth's or foster parent's initials for each day medication was administered. Instead, a check mark or "X" was entered in the space intended for initials. A second

Olive Crest (continued)

youth's medication log contained only the foster parent's initials and not the youth's initials.

- Two youth's files were missing pharmacy instructions, and one youth's file was missing doctor's orders for a prescription.
- Two youth's medication files were missing consents to administer medications.

Other errors were also noted in the youths' files. For example, documentation from the child welfare agency placing one youth indicated the youth was taking medication for attention deficit hyperactivity disorder. According to Olive Crest's management, the youth was not on any prescribed medication. There was no documentation to indicate Olive Crest received any medication or prescription information from the placing agency or ever administered the medication to the youth. However, there was no documentation to indicate Olive Crest followed up with the placing agency to determine whether the youth was or was not prescribed the medication.

We also found foster parents did not always have a photograph of youths in their medical files to assist in administering medications. In addition, foster parents did not always observe youths to ensure medication was not cheeked or hidden, instead of swallowed. Photographs help ensure the correct medication is administered to the correct youth. Observing youths swallow their medications and checking their mouths afterward helps ensure medication is taken as directed and not used for some other purpose.

At one foster home, medications were inappropriately stored in a garage that was not air conditioned when the temperature outside was over 100 degrees. For the medications stored in the garage, the storage conditions recommended by the manufacturer are room temperature and away from excess heat.

Olive Crest's policies and procedures for medication management and administration are not comprehensive and not adequately communicated to foster parents. For example, policies do not include maintaining physician orders and pharmacy instructions. In addition, not all policies are provided to foster parents. Finally, policies do not require an independent review of medication management files. Olive Crest's management stated independent

Olive Crest (continued)

review of medication records is done, but there was no evidence of this review in the youths' files.

Facility Response

Olive Crest has always taken a proactive approach to ensure that our staff and foster parents are trained regarding medication management and that policies are strong and up to date with current legislation. We have made efforts to equip our foster parents with information about medications and medication administration as well as their role in relation to psychiatric appointments for their foster children. Olive Crest has had in place a comprehensive medication administration manual for families that is fully revised on an annual basis, with additional policy changes communicated to families throughout the year. Olive Crest has documentation confirming foster parents receive the information through individual training and mandatory foster parent meetings (held 3-4 times per year).

It appears that your review of selected files indicated a need to modify some of our current medication administration and documentation policies and procedures. We also recognized an opportunity for increased reinforcement and oversight of foster parents to ensure a higher rate of compliance and implementation of the established policies in the individual foster homes.

Since the review, Olive Crest has revised some of the medication management policies in addition to enhancing the Quality Assurance process. In July, Olive Crest implemented the annual revision of the Medication Manual which clarified and strengthened existing policies that included: observation of the child taking medication, medication disposal, proper storage, and required documentation. These medication manuals are reviewed on an individual basis with the staff and foster parents. Foster parents sign a document indicating they have received the manual and understand the policy. Further, the new

Olive Crest (continued)

Facility Response (continued)

policies are being reviewed in the mandatory foster parent meeting scheduled in September.

Medication policies regarding proper storage have been revised to include storage temperature as this was documented as a concern in one of the homes. Follow up visits to the foster homes indicated that this was an isolated incident of improper storage, however as it is very serious, the policy has been changed and reviewed with foster parents (and staff). In order to ensure compliance with the revised policy, staff will use the monthly home checklist as an opportunity to observe proper storage during home visits. Policies regarding witnessing a child take a medication have also been strengthened to include language on observation and checking their mouths afterward to ensure the medication is taken as directed.

In addition to strengthening policies, Olive Crest has enhanced the Quality Assurance process to ensure that medication documentation errors are minimized. Olive Crest staff assigned to the homes will complete more thorough reviews of all medication paperwork received from foster parents. There is also a second level Quality Assurance review provided by the Program Coordinator on a monthly basis. Further, on a quarterly basis, management completes and documents reviews of medication documentation. Files will be selected on a random basis. Based on results, management will determine if more frequent higher level reviews are necessary for certain foster families.

Independent reviews are completed on youths' files. However, copies of the reviews are not included in the youth's file but are kept in a comprehensive supervision binder for each staff after they are reviewed. Olive Crest is considering including a copy of the reviews in the children's files as a quick reference. In addition, Olive Crest has a spreadsheet

Olive Crest (continued)

Facility Response (continued)

indicating which files were reviewed, when and by whom which also can be easily accessed.

Medication training continues to be given to all newly hired staff within 30 days of hire and then reviewed at a minimum on an annual basis. Foster Parents continue to participate in 2-hour Medication Administration training as part of their pre-licensing requirements. In addition, the Medication Manual is reviewed with them on an individual basis upon their first placement and then annually forward. As mentioned previously, foster parents and staff are also provided with information on policy changes throughout the year at mandatory meetings.

Olive Crest acknowledges that the files reviewed contained medication documentation errors and that was very concerning to us. However, we do want to note as the documentation requirements have changed over the years, some of the medication logs reviewed were from time periods prior to the regulations and policies changing and so may not accurately reflect what is occurring now.

Policies and Procedures

Olive Crest should develop and maintain a comprehensive set of policies and procedures. During our review, Olive Crest had three separate policy and procedure manuals, corporate policies and procedures, and an outdated booklet of state regulations and statutes. As a result, not all policies and procedures were complete, and some contained contradictory information.

- Olive Crest's policies and procedures do not address periodic post-employment fingerprint background checks or background checks for residents of foster homes over 18 years of age.
- There were no policies addressing the control and security of tools and keys, including kitchen knives and keys to medication safes.

Olive Crest (continued)

- The Dispute Resolution Policy and Complaint Procedure acknowledgement form does not address the use of the established complaint form, including the process to obtain and submit a complaint form.
- Procedures for disposal of unused or expired medications were not consistent and not clearly communicated to foster parents. During discussions with three foster parents, two provided different methods of disposal while one was not sure of the procedures. Olive Crest had two procedures describing the preferred method of disposal, but they were not consistent. Management stated one of the procedures was outdated.
- Medication procedures for the transfer of medications to and from respite foster parents are not consistent with Olive Crest's medication storage policy. The medication storage policy requires oral medication be stored separately from external medication. The respite medication policy requires all medications, oral and external, be placed together in a single bag.
- Olive Crest does not provide foster parents with nutritional guidelines.
- Olive Crest does not have a written policy addressing youths' internet access to help ensure appropriate use of computers.
- Policies and procedures do not include a comprehensive list of contraband or appropriate methods of searching for contraband, including documentation of searches.

Facility Response

Since the review, Olive Crest has reorganized policies to ensure that they are represented in a cohesive manner as we do have comprehensive policies for our foster care program, and we want that to be evident. We acknowledge that multiple policies within different areas could potentially cause confusion and impact the implementation of and compliance with actual policies.

In regards to the outdated booklet of state regulations and statutes mentioned in the review, it should be

Olive Crest (continued)

Facility Response (continued)

noted that this regulation book is a Clark County requirement and the regulations within the booklet are the governing procedures from which foster homes operate. This regulations booklet is still considered the reference for licensing unless an individual regulation has been changed. Then that change would be communicated to Olive Crest by the Department of Family Services (in relation to how they are going to implement and enforce) and then Olive Crest would make appropriate adjustments to policies and communicate to staff and foster families in meetings. Our understanding is that the expectation is we are to continue to distribute that booklet and utilize it until it is officially revised.

Olive Crest's revised policy on background checks is consistent with NRS 449.179 requirements. In addition, Olive Crest requires employees to be fingerprinted at least every 5 years following the initial background check. In August 2012, the Clark County Department of Family Services (DFS) communicated the implementation plan for re-fingerprinting of all foster parents and agency staff. As directed by our licensing body, Olive Crest foster parents will be completing the re-fingerprinting process as scheduled by their DFS licensing worker, and Olive Crest staff will be re-fingerprinted between August and October 2013 also as directed by DFS.

In relation to complaints/concerns, Olive Crest does have systems in place for youth and foster parents to express their concerns, however we have strengthened the policy based on the review. Olive Crest has taken the steps to ensure that foster parents and clients are aware of their avenues for submitting a grievance. In addition to the Complaint Procedure that is already in place (and is formally reviewed with the foster children at intake and annually), the Olive Crest Caseworker visits provide an opportunity for a child to share a concern in a safe manner, and the boxes at the office, the written format

Olive Crest (continued)

Facility Response (continued)

was more clearly identified. The Dispute Resolution policy now contains specific instructions on what form to utilize when filing a concern/grievance. During the mandatory foster parent meetings scheduled in September 2012, this policy and the grievance procedure are being reviewed with families. Further, it is continuously reinforced that foster children need to have an opportunity to share concerns and not be reprimanded for it. Olive Crest is reviewing expectations in this area reinforcing that foster children need to be able to contact their DFS caseworker or Olive Crest if requested. Olive Crest staff need to have time alone with the child at each home visit, and children can write their concern as well. Olive Crest is also reviewing with foster parents the steps Olive Crest takes if a concern from a foster child is brought to our attention.

Procedures for medication disposal have been updated to reflect the most current information. During the time of the review, the policy had just been changed, and even though it had been communicated to foster parents, some had apparently not fully understood and also had not put the updated information in their manuals. Further complicating the situation, conflicting information was given to Olive Crest and other agency providers on new medication disposal procedures from DFS. Proper disposal information has since been clarified and updated in the medication manuals. These were reviewed during the annual revision with staff and foster parents.

The Transfer of Medications for Respite policy was revised so it does not conflict with existing policy on external and internal storage.

The reviewers also identified several policies that they felt should be added to Olive Crest policies. Olive Crest actually has those policies in place for our group home programs, but they had not been included in our foster programs at this time. However,

Olive Crest (continued)

Facility Response (continued)

they could easily be transferred and we have made some of those adjustments. In relation to the recommendations around policies, Olive Crest has done the following:

- *Olive Crest has covered internet safety, social media, etc. in different meetings, but did acknowledge that there was no formal policy around internet usage for foster children. We have since developed a policy around internet access and appreciate that suggestion.*
- *Olive Crest has discussed food and nutrition with families as part of initial training, but has never enforced strict rules unless an issue has been identified in which case a family would be given a plan and more stringent guidelines. Olive Crest will make recommendations to foster parents around proper nutrition for children and youths and this will be provided in their foster parent handbook. Again if concerns arise pertaining to this area, plans of correction will be implemented and more restrictive guidelines will be imposed.*
- *Olive Crest policy on the storage of knives has been more clearly outlined. Since we only have foster homes and not shift staff, the keys are always maintained by the foster parents so there did not seem to be a need for a policy on keys like in our group homes. However, staff will make sure that families understand that keys need to be kept out of reach of the children and will confirm that this is occurring during home visits. This will be outlined in the handbook.*

Other Issues

Olive Crest should adopt a policy addressing identity kits for each youth in its care. The policy should include the information the kits should contain and the distribution of the kits. Having an identity kit at each home may reduce the time needed to provide this information to first responders in case of an emergency. For

Olive Crest (continued)

example, a recent photograph, list of allergies, list of medications, and list of emergency contacts may be useful information to provide to first responders immediately when reporting a runaway or during a medical emergency.

Of the four vehicles inspected, two did not have proof of insurance and one did not have registration documents in the vehicles. In addition, none of the four vehicles had a flashlight or fire extinguisher, and one did not contain a first-aid kit. One of the four homes visited did not have a fire escape route posted, and two had unsecured cleaning supplies. Unsecured knives were observed on the kitchen counter in one of the homes. Three of the four homes visited did not have a schedule of weekly activities, programs, and services posted in an area visible to the youths. In addition, two of the four homes had not posted a list of youths' rights, and none of the four homes had posted a list of contraband and prohibited items. Further, a description of the complaint process was not posted in any of the four homes visited, and complaint forms were not readily available for youths.

Information on allergies was incomplete or missing in three of the five youths' files we reviewed. In addition, one of the five youths' files did not contain an initial treatment plan. Olive Crest's policies require an initial treatment plan be completed within 30 days of placement.

Facility Response

In relation to Identity Kits, Olive Crest currently maintains a FACE sheet, which is similar to an Identity Kit, for all youths placed in care. FACE sheets are located in the front of client files at the Olive Crest office and will be added to the homes. As noted by the reviewers during the visit, the Olive Crest FACE sheets had all of the important information already included on it, with the exception of distinguishing features of youth placed in our foster homes. This has been added. Further, most files do have pictures of the youth, but it will now be more closely linked to the FACE sheets.

Some of the concerns noted in the LCB review are not currently required by foster care licensing

Olive Crest (continued)

Facility Response (continued)

regulations. However, Olive Crest does have established policies that are more restrictive than the current regulations so we have definitely taken the feedback into consideration.

Olive Crest believes that flashlights and first aid kits in every vehicle is a great safety standard and we will recommend utilizing these features to our foster families. Olive Crest already requires that vehicles are thoroughly inspected for safety upon licensure and will ensure that families understand the importance of maintaining appropriate documentation in their vehicles. It is an expectation that families maintain current insurance and registration and this is checked for on a regular basis. Families are required to submit proof of insurance so that Olive Crest always has the most current information on file. This is included in the handbook. Foster Families are required by Olive Crest to have their fire escape route posted on both floors. Upon inspection of all foster homes immediately following the review, this was verified with the exception of the one noted in the review (which has since been corrected). This was already included in their training as well as being reviewed at their licensing walk-through. It is in the handbook and we feel it has been addressed.

Olive Crest families are aware of the proper protocols for storing cleaning supplies and have been in compliance with county regulations. This is reinforced in the handbook. It should be noted that LCB home visits were conducted during the day while the youth were at school, thus giving the foster parents an opportunity to clean their homes and not have the cleaning supplies put away.

Olive Crest believes in the importance of having a routine and schedules in the home and has required all families to maintain a consistent schedule (could vary from day to day depending on activities and appointments) that is reviewed with the child upon

Olive Crest (continued)

Facility Response (continued)

intake and on a regular basis. This schedule should be accessible to them. Tips and guidelines for schedules and integrating a foster child into the home and family routine are also part of the handbook.

In relation to the findings around different documents being posted in the foster homes, it is important for us to note that while we think they are important items, we at Olive Crest are trying to find a balance for our families in ensuring the standards are met, while also respecting their home and the kids and trying to have some normalcy. House rules and routines are something you might see in a family home where there are not foster children, but personal rights, prohibited items, complaint processes are not. So we have established our policies and guidelines with this as a foundation, not requiring everything to be posted for people outside the family to see, but to be accessible, reviewed and followed by the family. It was reported by the reviewers that two of the homes did not have the foster child's rights posted. According to the regulation and the instructional memo from the Division of Child and Family Services dated August 8, 2011, only group homes of 7-15 children are required to post the foster child's rights. Olive Crest does not have any homes with 7 or more children. In 2011, Olive Crest provided all of the foster families with the foster child bill of rights at mandatory meetings and followed up with in-home meetings where it was confirmed they were reviewed with the child. Olive Crest advised foster parents that they needed to give a copy to the child and keep one accessible, but it was not necessarily a requirement to post.

For this specific review, we do think it is important to continue to acknowledge that there are some real differences between the living environments in family based, private foster homes and actual staffed facilities and that the policy expectations should be

Olive Crest (continued)

Facility Response (continued)

reflective of that. We appreciate your consideration of this when you are conducting your reviews and want to thank you for already making some adjustments to your process.

Appendices

Appendix A

Nevada Revised Statutes
218G.500 Through 218.535 and 218G.570 Through 218G.585

General Provisions

NRS 218G.500 Definitions. As used in NRS 218G.500 to 218G.585, inclusive, unless the context otherwise requires, the words and terms defined in NRS 218G.505 to 218G.535, inclusive, have the meanings ascribed to them in those sections.
(Added to NRS by 2007, 198; A 2009, 4)—(Substituted in revision for NRS 218.862)

NRS 218G.505 "Abuse or neglect of a child" defined. "Abuse or neglect of a child" has the meaning ascribed to it in NRS 432B.020.
(Added to NRS by 2007, 198)—(Substituted in revision for NRS 218.863)

NRS 218G.510 "Agency which provides child welfare services" defined. "Agency which provides child welfare services" has the meaning ascribed to it in NRS 432B.030.
(Added to NRS by 2007, 198)—(Substituted in revision for NRS 218.864)

NRS 218G.515 "Family foster home" defined. "Family foster home" has the meaning ascribed to it in NRS 424.013.
(Added to NRS by 2009, 2)

NRS 218G.520 "Governmental facility for children" defined.
1. "Governmental facility for children" means any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is owned or operated by a governmental entity and which has physical custody of children pursuant to the order of a court.
2. The term does not include any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is licensed as a family foster home or group foster home, except one which provides emergency shelter care or which is capable of handling children who require special care for physical, mental or emotional reasons.
(Added to NRS by 2009, 2)

NRS 218G.525 "Group foster home" defined. "Group foster home" has the meaning ascribed to it in NRS 424.015.
(Added to NRS by 2009, 2)

NRS 218G.530 "Near fatality" defined. "Near fatality" means an act that places a child in serious or critical condition as verified orally or in writing by a physician, a registered nurse or other licensed provider of health care. Such verification may be given in person or by telephone, mail, electronic mail or facsimile.
(Added to NRS by 2007, 198)—(Substituted in revision for NRS 218.865)

NRS 218G.535 "Private facility for children" defined.
1. "Private facility for children" means any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is owned or operated by a person and which has physical custody of children pursuant to the order of a court.
2. The term does not include any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is licensed as a family foster home or group foster home, except one which provides emergency shelter care or which is capable of handling children who require special care for physical, mental or emotional reasons. (Added to NRS by 2009, 2)

Appendix A

Nevada Revised Statutes
218G.500 Through 218.535 and 218G.570 Through 218G.585
(continued)

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)

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 homes 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.
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 restrictive features, such as locked doors and barred windows.
Federal Food and Drug Administration	Protects 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.
Foster Care Agency	A nonprofit or for-profit corporation or sole proprietorship that assists an agency which provides child welfare services in the placement of children in foster care. Foster care agencies may operate multiple family foster homes, including specialized foster homes and group foster homes. Agencies often recruit and train foster parents, and place youths in either the foster parents' homes or in homes provided by the foster care agency. Foster parents are responsible for providing safe, healthful, and developmentally supportive environments where youths can interact fully with the community.

Appendix B

Glossary of Terms
(continued)

Group Home	Provides a safe, healthful group living environment 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.
Identity Kit	Provides quick access to important information in case of emergency, such as a youth's full name, known aliases, a photograph, a list of allergies and medications, and a list of contacts.
Independent Review of Medication Files	A process to review medication administration records and identify potential errors, fraud, or abuse. Independent review includes assignment of 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.
Mandatory Reporter	Any person who, in his professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected.
Mental Health Treatment Facility	Provides mental health services to youths with serious emotional disturbances by providing acute psychiatric (short-term) and non-acute psychiatric programs. Mental health treatment facilities also provide services to behaviorally disordered youths. 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.
Non-Controlled Medication	Medication prescribed to treat medical conditions and does not generate abusive addictions.
Privileges	Items considered earned and not considered a right. Items considered privileges may include movies, recreation time, phone calls, and reading material.

Appendix B

Glossary of Terms
(continued)

Residential Center	Provides 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	Provides more than one type of service simultaneously. For example, a resource center may provide both treatment and detention services.
Safety	Anything related to the physical safety of youths. This includes physical security, environment, protection from inappropriate comments or contact by staff or another youth, and adequate staffing.
Specialized Foster Care	Comprehensive care and services provided to youths who require more intensive therapy or supervision due to serious physical, emotional, behavioral, or psychological conditions.
Staff-Secure	Access out of the facility is limited by staff and not monitored by a secure system.
Standing Order Form	Physician approved order for over-the-counter medication a facility may administer to youths.
Substance Abuse Treatment Facility	Provides 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.
Use of Force	Technique used to prevent a youth from harming himself or others, including restricting or reducing the youth's ability to move.
Welfare	Anything related to the general well-being of a youth. This includes education and punishments or discipline.
Youths	Children of all ages, including infants and adolescents.

Appendix C

Summary of Observations at Six Facilities Reviewed

Observations	Number of Facilities
Policies and Procedures	
Policies and procedures were not developed, not complete, or needed to be updated	6
Medication Administration Processes and Procedures	
Files contained incomplete or unclear documentation of dispensed prescribed medication	4
Medication files and records did not always contain evidence of independent review	3
Staff did not check for “cheeking” of medication	2
Over-the-counter standing order form needed to be developed or updated	2
Medication was not stored appropriately	2
Background Checks	
Initial fingerprint background checks were not always completed or not completed timely	3
Complaints and Grievances	
Complaint or grievance forms were not readily available to youths	4
Complaint or grievance process was not posted	3
Other Significant Items	
List of prohibited items and contraband was not posted	4
Cleaning chemicals, supplies, tools or other potentially dangerous items were not secured	3
Identity kits did not contain consistent information or were not complete	2
Youths’ living areas were in need of repairs	2

Source: Reviewer prepared from facility reviews.

Note: This is not a comprehensive list of observations.

Appendix D

Nevada Facility Information
Fiscal Year Ended June 30, 2012

Table 1: Correction and Detention Facilities	Background			Population for FY 2012		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Caliente Youth Center	State	Caliente	12 to 18	140	131	85	0
China Spring Youth Camp/Aurora Pines Girls Facility	State/Counties	Gardnerville	12 to 18	65	56	39	2
Clark County Juvenile Detention Center	Clark County	Las Vegas	8 to 18	192	130	190	50
Douglas County Juvenile Detention Center	Douglas County	Stateline	8 to 18	16	4	6	2
Jan Evans Juvenile Justice Center	Washoe County	Reno	8 to 17	108	40	43	27
Leighton Hall	Various Counties	Winnemucca	8 to 17	24	9	12	0
Murphy Bernardini Regional Detention Center	Carson City	Carson City	8 to 17	18	4	14	7
Nevada Youth Training Center	State	Elko	12 to 18	110	92	77	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	150	142	85	10
Spring Mountain Youth Camp	Clark County	Las Vegas	12 to 18	100	98	57	10
Teurman Hall	Churchill County	Fallon	12 to 18	16	12	11	3
Total - 12 Correction and Detention Facilities				**963**	**727**	**630**	**111**

Table 2: Resource Center	Background			Population for FY 2012		Staffing Levels	
Facility	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Don Goforth Resource Center	Various Counties	Hawthorne	8 to 17	32	9	8	8
Total - 1 Resource Center				**32**	**9**	**8**	**8**

Table 3: Child Welfare Facilities	Background			Population for FY 2012		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Carson Valley Children's Center	Private	Carson City	0 to 18	10	5	4	4
Child Haven	Clark County	Las Vegas	0 to 17	80	19	30	6
Kids' Kottages	Washoe County	Reno	0 to 18	82	47	40	27
WestCare-Emergency Shelter	Private	Las Vegas	10 to 17	15	11	10	2
Total - 4 Child Welfare Facilities				**187**	**82**	**84**	**39**

Table 4: Mental Health Treatment Facilities	Background			Population for FY 2012		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Adolescent Treatment Center	State	Sparks	12 to17	16	16	21	0
Desert Willow Treatment Center	State	Las Vegas	6 to 18	58	38	110	0
Montevista Hospital	Private	Las Vegas	5 to 17	34	25	18	22
Spring Mountain Treatment Center	Private	Las Vegas	5 to 17	28	21	24	1
West Hills Hospital	Private	Reno	3 to 17	28	5	22	5
Willow Springs Center	Private	Reno	5 to 18	116	98	140	66
Total - 6 Mental Health Treatment Facilities				**280**	**203**	**335**	**94**

Table 5: Substance Abuse Treatment Facilities	Background			Population for FY 2012		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Nevada Homes for Youth I	Private	Las Vegas	13 to 18	10	9	6	4
Nevada Homes for Youth II	Private	Las Vegas	13 to 18	10	9	6	4
Vitality Center-ACTIONS of Elko	Private	Elko	13 to 18	13	2	26	1
WestCare Nevada-Harris Springs Ranch	Private	Las Vegas	13 to 17	16	10	9	0
Western Nevada Regional Youth Center	State/Counties	Silver Springs	13 to 18	35	17	16	2
Total - 5 Substance Abuse Treatment Facilities				**84**	**47**	**63**	**11**

Appendix D

Nevada Facility Information
Fiscal Year Ended June 30, 2012
(continued)

Table 6: Group Homes	Background			Population for FY 2012		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Boys Town Nevada-Homes	Private	Las Vegas	10 to 18	30	27	20	3
Briarwood North [2]	Private	Sparks	11 to 20				
Casa de Vida	Private	Reno	12 to 25	8	3	1	11
Family Learning Homes	State	Reno	5 to 18	20	18	16	1
Golla Home	Private	Washoe Valley	6 to 18	6	3	2	0
Hand Up Homes for Youth, Inc.	Private	Reno	12 to 18	12	10	13	3
Hope Healthcare Services	Private	Reno	12 to 17	6	3	2	3
My Home, Inc.	Private	Reno	3 to 18	8	6	3	0
New Vista Group Homes	Private	Las Vegas	0 to 20	8	6	8	4
Oasis On-Campus Treatment Homes	State	Las Vegas	6 to 17	28	18	42	2
R House Community Treatment Home	Private	Reno	5 to 18	4	3	2	1
Rite of Passage-Qualifying Houses I	Private	Minden	14 to 17	16	12	8	0
Rite of Passage-Qualifying House II	Private	Minden	14 to 17	8	7	6	0
SAFY House	Private	Las Vegas	6 to 17	8	6	8	10
St. Jude's Ranch for Children	Private	Boulder City	0 to 21	66	50	38	2
The Reagan Home	Private	Reno	6 to 18	6	5	2	2
Transformations Therapy & Behavioral Consultation	Private	Sparks	13 to 18	9	9	9	0
Total - 17 Group Homes				**243**	**186**	**180**	**42**

Table 7: Residential Centers	Background			Population for FY 2012		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
DayBreak Equestiran Center I [2]	Private	Lund	12 to 18				
DayBreak Equestrian Center II [2]	Private	Baker	12 to 18				
HELP of Southern Nevada-Shannon West Homeless Youth Center	Private	Las Vegas	16 to 24	65	48	10	0
Horizon Academy	Private	Amargosa Valley	13 to 18	212	29	28	1
Spring Mountain Residential Center	Clark County	Las Vegas	12 to 18	12	12	7	2
Total - 5 Residential Centers				**289**	**89**	**45**	**3**

Table 8: Foster Care Agencies	Background			Population for FY 2012		Staffing Levels [1]	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Apple Grove Foster Care Agency	Private	Las Vegas	0 to 18	70	50	17	8
Eagle Quest of Nevada, Inc.	Private	Las Vegas	all ages	200	150	85	6
JC Family Services, LLC.	Private	Reno	8 to 18	17	16	4	1
Koinonia Foster Homes, Inc.	Private	Reno	3 to 18	56	30	5	2
London Family and Children's Services, Inc.	Private	Las Vegas	4 to 17	23	23	3	59
Maple Star Nevada	Private	Statewide	0 to 18	100	89	43	99
NOVA Housing for Hope, LLC.	Private	Sparks	0 to 19	30	15	5	2
Olive Crest	Private	Las Vegas	0 to 18	43	27	13	0
Sankofa Group, Inc.	Private	North Las Vegas	8 to 18	18	14	6	7
Unity Village Behavioral Health Center	Private	Las Vegas	0 to 18	18	14	4	2
Total - 10 Foster Care Agencies				**575**	**428**	**185**	**186**
Total - 60 Facilities Statewide				**2,653**	**1,771**	**1,530**	**494**

Source: Reviewer prepared from information provided by facilities.

[1] Staffing levels do not include foster parents.

[2] Facility closed during fiscal year ending June 30, 2012.

Appendix E

Unannounced Nevada Facility Visits

Facility Name	Facility Type	Date of Visit
Carson Valley Children's Center	Child Welfare	April 18, 2012
Rite of Passage–Qualifying House II	Group Home	April 18, 2012
Willow Springs Center	Mental Health Treatment	April 26, 2012
Hand Up Homes for Youth, Inc.	Group Home	April 26, 2012
Western Nevada Regional Youth Center	Substance Abuse Treatment	May 10, 2012
Apple Grove Foster Care Agency	Foster Care Agency	May 14, 2012
Spring Mountain Residential Center	Residential Center	July 27, 2012
Unity Village Behavioral Health Center	Foster Care Agency	July 27, 2012
HELP of Southern Nevada–Shannon West Homeless Youth Center	Residential Center	July 27, 2012
Teurman Hall	Detention Center	August 15, 2012
Boys Town Nevada–Homes	Group Home	September 14, 2012
Clark County Juvenile Detention Center	Detention Center	September 14, 2012

Source: Reviewer prepared from unannounced facility visits.

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 if it met the definitions included in NRS 218G.500 through 218G.535. 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, 2011.

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 youths. This included physical security, environment, inappropriate comments or contact by staff or other youths, and adequate staffing. Welfare criteria related to the general well-being of a youth. This included education and punishments or discipline.

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

We distinguished between privileges, and civil and other rights. Specifically, we determined privileges included items considered earned, such as movies, recreational time, phone calls, and reading material. We determined civil and other rights included rights as human beings, such as protection from discrimination and

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

We reviewed and tracked complaints filed by each facility to determine whether each facility submitted complaints monthly pursuant to NRS 218G.580. In addition, we calculated the number of complaints received.

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 S*tatements 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, 2010. 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 use of force and de-escalation, fire safety, and transportation of youth; welfare, such as education, 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 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, 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.

During one of our reviews, we examined youths' 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 notification of youths' 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.

In addition to facility reviews, we performed 12 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 background checks. Tours included all areas accessible to youths. A list of unannounced Nevada facility visits is contained in Appendix E, which is on page 61.

Our work was conducted from March 2012 through October 2012 pursuant to the provisions of NRS 218G.570 through 218G.585.

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 10.

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