Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on October 6, 2014. Report # LA14-21.

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, 2014, we had identified 63 governmental and private facilities that met the requirements of NRS 218G: 21 governmental and 42 private facilities. In addition, 105 Nevada children were placed in 25 facilities in 13 different states as of June 30, 2014.

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, 2013, through June 30, 2014, we received 833 complaints from 29 facilities in Nevada. Thirty-two facilities reported that no complaints were filed during this time, and two facilities did not provide us with complaint information.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. The report includes the results of our reviews of 4 children's facilities, unannounced site visits to 2 children's facilities, and a survey of 63 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, 2012, for three of the facilities, and since December 2013 for Rite of Passage-Red Rock Academy. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from January 2014 through September 2014.

Review of Governmental and Private Facilities for Children

October 2014

Summary

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

We concluded that the policies, procedures, and processes in place at the Rite of Passage-Red Rock Academy did not provide reasonable assurance that it adequately protects the health, safety, and welfare of the youths, and respects the civil and other rights of youths in its care. The facility is owned by the State and is located in Las Vegas on the campus of the former Summit View Youth Correctional Center. The Academy is operated through a contract between the Nevada Department of Health and Human Services, Division of Child and Family Services, and Rite of Passage, a private, not-for-profit organization. The Academy's policies and procedures need improvement, and management needs to take additional steps to ensure staff comply with all policies and procedures. For example, the Academy's noncompliance with requirements for administration of medications, noncompliance with requirements for staff-to-youth ratios, lack of control over tools and contraband, poor reporting of corrective room restrictions, and lack of notification of youth rights do not ensure the youths at the Academy are adequately protected.

We did not note anything that caused us to question the health, safety, welfare, or protection of rights of the children in the two facilities where we conducted unannounced site visits.

Facility Observations

Many of the facilities had common weaknesses. For example, policies and procedures needed to be developed or were outdated, medication administration processes and procedures needed to be strengthened, and facilities needed to improve background investigation processes and policies. (page 6)

All four facilities reviewed needed to develop or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated included: establishing identity kits for each youth served for use during an emergency; implementing the Prison Rape Elimination Act requirements; specifying the timeframe in which a treatment plan must be developed; and claryifying what types of actions constitute corrective room restriction and tracking the use of corrective room restrictions. (page 6)

Medication administration processes and procedures needed to be strengthened at all four facilities reviewed. Some youths' files were missing key documentation, such as physicians' orders, at two of the four facilities. In addition, at three facilities, some youths' medication administration records contained errors or blank spaces, such as documentation of an incorrect dosage of medication or documentation of medication administered to a youth on a day that didn't exist. At one facility, youths' files showed some youths did not receive their medication for up to 22 days after it was prescribed. Medication policies and procedures that needed improvement at three facilities included: verifying and documenting the amount of medication received by the facility; addressing the process and documentation of disposing of medications; and conducting independent reviews of medication files. (page 6)

All four facilities reviewed needed to improve their background investigation processes and policies. Policies at two facilities did not include an accurate list of the convictions which would preclude a person from working at the facilities. One facility obtained fingerprint background checks for all of its employees, but cited incorrect statutes as authority for the checks. This resulted in the background check results being compared to more lenient conviction standards than required. Finally, two facilities could improve their background investigation policies and procedures by including a requirement for all new employees to be subject to a search of the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child (CANS). Although neither facility is required to request information about employees from CANS, NRS 432.100 allows the Division of Child and Family Services to release information from CANS to employers if the employees have regular contact with children. (page 7)

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