

STATE OF NEVADA

Performance Audit

Department of Health and Human Services
Division of Child and Family Services

Assessment and Safety of Child Placements

2022



Legislative Auditor
Carson City, Nevada

Audit Highlights



Highlights of performance audit report on the Division of Child and Family Services issued on May 4, 2022.

Legislative Auditor report # LA22-14.

Background

The Division of Child and Family Services' (Division) mission is to provide support and services to assist Nevada's children and families in reaching their full human potential. The Division provides or oversees a continuum of services to support children, parents, and caregivers. The continuum of services includes comprehensive case management, emergency shelter care, foster and relative care, group home care, respite care, residential treatment care, and independent living services.

When the Division identifies a child that is in need of protection due to abandonment or an unsafe home environment, the Division can remove the child from the home and place the child in licensed foster or unlicensed homes.

The Division is responsible for overseeing the home environment and care provided to children in state custody. The Division also provides supplemental payments to support additional needs regarding the care of children in licensed foster homes. Child welfare services are funded primarily by state and federal funds.

Purpose of Audit

The purpose of the audit was to determine if Division processes ensure foster care and other homes for children in state custody are adequate to ensure the safety and welfare of children. We also evaluated controls over certain payments supporting children and youth to ensure payments were accurate and appropriate. This audit included a review of the Division's activities for the 18-month period beginning July 1, 2020, through December 31, 2021. We also reviewed child and placement monitoring activities back to calendar year 2017.

Audit Recommendations

This audit report contains 10 recommendations to improve Division oversight of in-home providers who care for children in state custody. The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on August 1, 2022. In addition, the 6-month report on the status of audit recommendations is due on February 1, 2023.

Assessment and Safety of Child Placements

Division of Child and Family Services

Summary

While overall we found the Division generally complied with requirements associated with child placements, some improvements can be made. Health, safety, and regulatory standards were not always followed for some providers that care for children in state custody. Additionally, there was no evidence that some required background checks and provider assessments were completed, and some inspections and subsequent corrective action of foster homes were not adequately documented. We also found unlicensed homes are not subjected to the same standards of licensed foster homes, but additional measures can help ensure the welfare of children placed in these homes. Improved oversight of child placement providers will assist the Division in ensuring the safety and welfare of children in state custody.

Foster care payments were accurately and appropriately administered by the Division. We reviewed a representative sample of foster care and specialized payments and found payments were made to verified youth placements at licensed facilities. Additionally, specialized payments were supported by corresponding documentation in the Division's records. Accurate and justified foster care payments support the financial health of the Division, the State, and foster care providers.

Key Findings

Child placement providers did not always comply with health, safety, and regulatory standards. Of 30 homes inspected, 10 or 33% of homes had health and/or safety deficiencies, and 79% of foster placements had at least 1 foster care regulatory violation. (page 7)

Four foster providers assessed did not comply with medication management requirements established in regulation. Foster care providers are required to maintain records detailing provided medication and the date and time administered. Homes evaluated included children on antipsychotic and anti-seizure medications. (page 10)

After conducting reviews of Division files for 11 unlicensed placements selected for inspection, we found the Division did not have evidence required background checks and home assessments were completed for some providers. There was no evidence of home inspection documentation for 27% and no evidence of background checks for 45% of unlicensed placement providers reviewed. In addition, some emergency placements lacked required Division safety assessments, including Emergency Placement Checklists (29%) and Confirming Safe Environment assessments (57%). (page 11)

We also found that the Division did not always complete home inspection documentation and ensure that all residents of foster homes received required health assessments. Fifty-eight percent (14 of 24) of foster home inspection documentation was incomplete, including 2 missing inspection checklists, 7 checklists with inspection criteria not completed, and 10 inspection checklists with missing or incomplete corrective action plans. Of the 24 foster homes, 5 homes (21%) did not have a tuberculosis test completed timely for all the adults in the home, and 1 foster home resident did not have any tuberculosis test on file. (page 12)

The Division has not established a written agreement with unlicensed providers who oversee children in state custody, and home inspection procedures for unlicensed providers are brief or poorly defined. Additionally, the Division does not provide documentation regarding expected home health and safety standards to unlicensed providers. The Division, children in state custody, and providers are at increased exposure to preventable risk due to inadequate oversight of unlicensed placements. (page 13)

Foster care payments were accurately and appropriately administered by the Division. We randomly selected 50 fiscal year 2021 foster care payments of 4,068 total claims and found payments were accurately calculated, payment records in Unified Nevada Information Technology for Youth (UNITY) agreed to the state accounting system, and special payments were supported by medical documentation. (page 18)

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This report contains the findings, conclusions, and recommendations from our performance audit of the Department of Health and Human Services, Division of Child and Family Services, Assessment and Safety of Child Placements. This audit was conducted pursuant to the ongoing program of the Legislative Auditor as authorized by the Legislative Commission. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

This report includes 10 recommendations to improve Division oversight of in-home providers who care for children in state custody. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Daniel L. Crossman".

Daniel L. Crossman, CPA
Legislative Auditor

April 19, 2022
Carson City, Nevada

Assessment and Safety of Child Placements

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Introduction

Background

The Division of Child and Family Services' (Division) mission is to provide support and services to assist Nevada's children and families in reaching their full human potential. The Division is responsible for child welfare services; mental health services for children, adolescents, and their families; juvenile justice services; and services designed to support victims of abuse and neglect. In Nevada's 15 rural counties outside of Clark and Washoe, the Division is responsible for supervising and administering child protective and welfare services.

Budget and Staffing

Child welfare services are funded primarily by state and federal funds. In fiscal year 2021, the Division had revenues of \$23 million and expenditures of \$21 million supporting rural child welfare. Exhibit 1 shows fiscal year 2021 rural child welfare services' revenues and expenditures.

**Rural Child Welfare Services
Revenues and Expenditures
Fiscal Year 2021**

Exhibit 1

Revenues	Amounts
Federal Funds	\$ 9,245,703
Appropriations	7,948,526
County Assessments	4,077,148
Transfers from Other State Agencies	1,979,887
Other Revenue ⁽¹⁾	145,975
Gifts and Donations	4,150
Total Revenues	\$23,401,389
Expenditures	
Personnel	\$10,583,434
Program Costs	9,381,946
Operating & Travel	1,414,423
State Cost Allocations	164,313
Information Services	110,547
Purchasing Assessment	2,938
Total Expenditures	\$21,657,601
Difference	\$ 1,743,788
Less: Reversion to General Fund	(1,621,830)
Less: Budget Reduction to General Fund	(121,958)
Balance Forward to 2022	\$ -

Source: State accounting system.

⁽¹⁾ Other revenue includes adjustments and reimbursements.

As of June 30, 2021, the Division had 798 filled positions of 1,065 legislatively authorized positions. The Division's vacancy rate was 25%. The Division has rural child welfare offices in Carson City, Elko, Ely, Fallon, Fernley, Pahrump, Tonopah, Winnemucca, and Yerington.

Child Welfare Services

Child welfare agencies provide or oversee a continuum of services to support children, parents, and caregivers. The continuum of services includes comprehensive case management, emergency shelter care, foster and relative care, group home care, respite care, residential treatment care, and independent living services. Out-of-home placements provide short-term and long-term support for children to prepare them for reunification with birth parents or for adoption.

Child Removal Process

When the Division identifies a child that is in need of protection due to abandonment or an unsafe home environment, the Division can remove the child from the home, and the child can be placed in protective custody of the State. Statute prioritizes child out-of-home placements for children entering state custody in the following order: (1) in a hospital, if the child needs hospitalization; (2) with family or a person with a significant emotional and positive relationship with the child; (3) a licensed foster home; or (4) in any other licensed shelter that provides care to children.

Division Monitoring of Foster Homes

Children in state custody can be cared for in licensed foster homes, which are regulated by the Division's licensing personnel. The purpose of licensing is to guarantee basic safety standards within foster homes, to ensure continuous child safety, and to support permanency goals of children. These homes can be operated by nonrelatives or relatives of children. To become a foster home, a potential provider must submit an application and receive an in-depth evaluation of their household, including a home inspection, health and safety assessments, and background checks.

After becoming licensed, the home must maintain standards outlined in Nevada Revised Statutes (NRS) 424, Nevada Administrative Code (NAC) 424, and Division policy. Licensing personnel are responsible for ongoing monitoring of foster homes to ensure compliance with state law and licensing standards and to provide training, technical assistance, and support services. The Division monitors foster providers through annual home inspections, continuing background checks, and health assessments.

Division Monitoring of Unlicensed Homes

Children in state custody can also be placed with extended family or fictive kin in unlicensed placements. Fictive kin is a person who is not related by blood to a child but has a significant emotional and positive relationship with the child. Unlicensed relative and fictive kin placements are distinct from licensed foster care and in certain cases are prioritized over foster care when safe and

appropriate. Unlicensed homes cannot receive foster care payments and are not subject to the statutory and regulatory requirements for foster homes outlined in NRS and NAC 424.

When a child is placed in an unlicensed placement, the home must be inspected, and the adult residents must undergo background checks. If a child is being removed in an emergency situation, home and provider assessments are formally documented in an Emergency Placement Checklist and the Confirming Safe Environment assessment. Both unlicensed homes and licensed foster homes are required to be visited by caseworkers at least once every 2 months and assessed for safety. Exhibit 2 shows the total placements in which children in state custody reside by county and licensure status.

**Homes With Children in State Custody
By County and Licensure Status
As of June 14, 2021** **Exhibit 2**

County⁽¹⁾	Licensed Homes	Unlicensed Homes	Totals
Carson City	14	18	32
Churchill	6	5	11
Douglas	4	2	6
Elko	10	5	15
Eureka	1	0	1
Humboldt	4	5	9
Lander	1	1	2
Lyon	9	20	29
Mineral	2	3	5
Nye	10	29	39
Pershing	0	2	2
White Pine	4	1	5
Totals	65	91	156

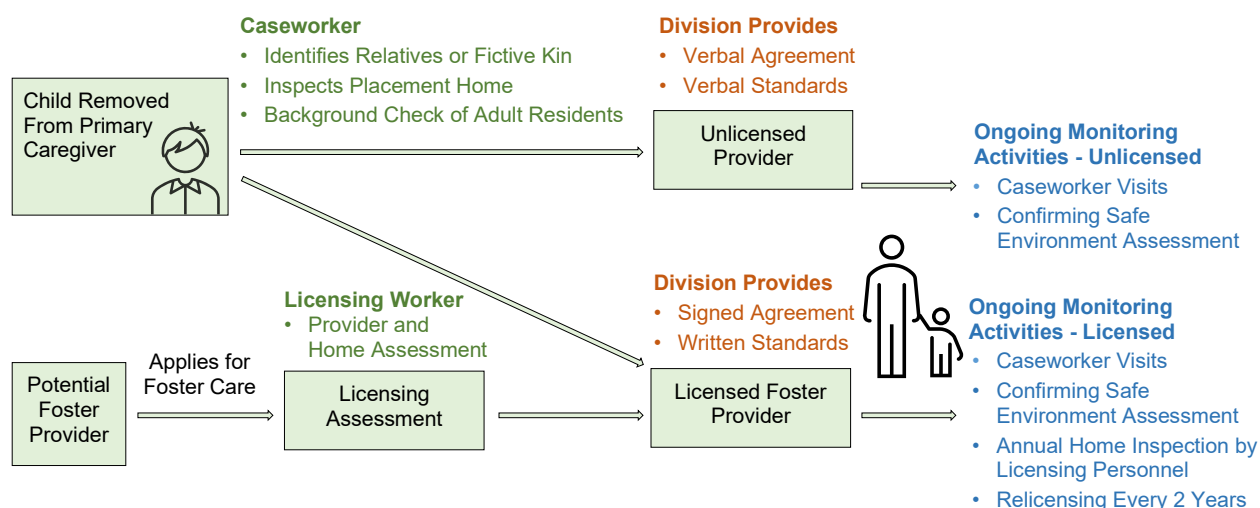
Source: Auditor prepared based on Division child placement records.

⁽¹⁾ Esmeralda, Lincoln, and Storey Counties are not listed because those did not have placements of children in state custody.

The Division’s current process for monitoring the safety of licensed and unlicensed child placements before and after child placement is outlined in Exhibit 3.

Process for Monitoring the Safety of Child Placements

Exhibit 3



Source: Auditor prepared based on Division policies and procedures.

Payments Supporting Child Out-of-Home Care

Foster providers receive payments for the services they render in caring for children in state custody. Advanced Foster Care and Specialized Foster Care receive enhanced payments to support specialized care of children with a severe emotional disturbance. Other specialty rates include supplemental payments for children with challenging medical or behavioral issues. Court Jurisdiction payments assist youth that have aged out of foster care and need financial support for the transition to independent living. Exhibit 4 shows fiscal year 2021 Division foster care payments by type.

Foster Care Payments by Type Fiscal Year 2021

Exhibit 4

Placement Type	Amount	Number of Claims	Percentage of Claims
Family Foster Care	\$1,230,903	2,523	62%
Court Jurisdiction	400,243	526	13%
Relative Foster Care	308,410	546	13%
Advanced Foster Care	254,893	287	7%
Specialized Foster Care	273,240	110	3%
Medically Fragile	20,331	75	2%
Special Rate	52	1	0%
Totals	\$2,488,072	4,068	100%

Source: Auditor prepared from Unified Nevada Information Technology for Youth (UNITY) data.

Scope and Objectives

The scope of our audit included a review of the Division's activities for the 18-month period beginning July 1, 2020, through December 31, 2021. We also reviewed child and placement monitoring activities back to calendar year 2017. Our audit objectives were to:

- Determine if Division processes ensure foster care and other homes for children in state custody are adequate to ensure the safety and welfare of children; and
- Evaluate controls over certain payments supporting children and youth to ensure payments are accurate and appropriate.

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission and was made pursuant to the provisions of NRS 218G.010 to 218G.350. The Legislative Auditor conducts audits as part of the Legislature's oversight responsibility for public programs. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

Enhanced Monitoring Can Help Ensure Safe Placements









While overall we found the Division generally complied with requirements associated with child placements, some improvements can be made. Health, safety, and regulatory standards were not always followed for some providers that care for children in state custody. Additionally, there was no evidence that some required background checks and provider assessments were completed, and some inspections and subsequent corrective action of foster homes were not adequately documented. We also found unlicensed homes are not subjected to the same standards of licensed foster homes, but additional measures can help ensure the welfare of children placed in these homes. Improved oversight of child placement providers will assist the Division in ensuring the safety and welfare of children in state custody.

Health and Safety Deficiencies of Child Placements

We found the majority of placements were sufficiently sanitary and safe; however, child placement providers did not always comply with health, safety, and regulatory standards. We inspected 30 licensed and unlicensed placements in all Division regions, including 24 licensed foster care and 6 unlicensed placements. Of those inspected, 10 or 33% of placements had health and/or safety deficiencies, and 19 or 79% of foster placements had at least 1 foster care regulatory violation. An example of a regulatory violation included providers not maintaining proper medical and other child records. In placements in which health and safety standards were not maintained, children were potentially exposed to conditions that put their health and safety at risk.

Health and safety deficiencies observed during auditor inspections are outlined in Exhibit 5.

Health and Safety Hazards Observed During Auditor Inspections of Select Placements **Exhibit 5**

	Chemical Hazard (2)		Hazardous Exterior Conditions (2)
	Egress Window Blocked (1)		Sharps Hazard (1)
	Safe Sleep Violation (1)		Fire Hazard (4)
	Tobacco Products Not Secured (1)		Electrical Hazard (1)

Source: Auditor prepared based on home inspections.

Note: Numbers within parentheses signify the numbers of placements identified with the indicated hazards. At certain placements, we identified more than one health and safety hazard.

We also identified one unlicensed placement with unsanitary and bleak living conditions, an additional placement with unsanitary conditions, and another with bleak living conditions. Examples of unsanitary conditions included a placement with an insect infestation, significantly dirty carpets, and inferior housekeeping conditions. In this same unlicensed placement, there were bleak living conditions in which the children in state custody did not have a bedroom or beds but instead slept on a couch even though the Division initially ensured the home had beds for the children. In this placement, there were sufficiently substandard conditions, and the Division promptly transferred the children to a different placement.

Unlicensed placements are not subject to the standards outlined in NRS and NAC 424 and do not receive assistance payments. Additionally, the Division does not provide unlicensed providers with written documentation regarding standards for living conditions at the time of placement. Without documented standards, unlicensed providers lack necessary guidance and may not meet Division health and safety expectations in the future.

Foster providers must adhere to standards outlined in statute and regulation, which ensure placements for children are safe and meet basic healthy living conditions. Foster providers are given and agree to follow written home health and safety standards. When placements do not follow these standards, children's health and safety is at risk.




Furthermore, the Division supports foster care providers by providing communication and training regarding health and safety standards, but they do not communicate common deficiencies identified through licensing or monitoring activities. Conversely, the Division does not regularly provide general communications to unlicensed providers, because they do not maintain a contact list that could be used for these purposes. Developing a contact list to inform and educate unlicensed providers and informing all providers of common issues or concerns can help ensure health, safety, and other standards are met and children are adequately cared for.

Foster Home Regulatory Violations

Of the 24 foster homes inspected, 19 or 79% had at least 1 regulatory violation. NAC 424 outlines requirements for health, safety, and proper management of foster homes. Medical records need to be maintained by the care provider to evidence the child received proper health care and also assist other providers if a child's placement changes. Additionally, requirements include maintaining an inventory of each child's clothing and belongings. This is important because it helps ensure a child's belongings stay with them and are not lost while they are in state custody. The foster care regulatory violations observed are defined in Exhibit 6.

Foster Care Regulatory Violations Observed During Auditor Inspections of Select Placements

Exhibit 6

	Child Medical Records Lacking (6)		Bedroom Window Screen Missing (1)
	No Child Clothing Inventory (18)		

Source: Auditor prepared based on home inspections.

Note: Numbers within parentheses signify the numbers of placements identified with the indicated violation. For certain placements, we identified more than one regulatory violation.

Deficient Medication Management Recordkeeping

Four foster providers assessed did not comply with medication management requirements established in regulation. Foster care providers are required to maintain records detailing provided medication and the date and time administered. Homes evaluated included children on antipsychotic and anti-seizure medications. Without completed medication administration records (MARs), there is no documentation verifying children receive medications timely. These records are important for confirming the right child got the right medication at the right dosage and frequency.

The Division stated it is unlikely its staff are always checking MARs during inspections or home visits due to the focus on other health and safety requirements. Furthermore, Division management stated it provides a MAR template to foster providers, but some providers might have trouble completing it due to its complexity. The Division is considering improving its MAR template, so it is easier to complete.

No Evidence Certain Health and Safety Assessments Completed

The Division did not have evidence that health and safety assessments were completed for some providers housing children in state custody. Additionally, some foster provider home inspection documentation was not completed according to policy. Important health and safety assessments were not completed timely, leaving children at a higher risk with providers lacking sufficient preliminary and continuing assessment.

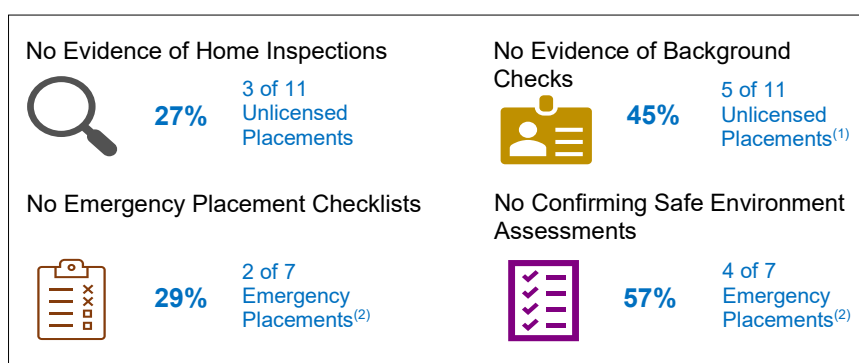
Unlicensed Placement Documentation Review

After conducting reviews of Division files for 11 unlicensed placements selected for inspection, we found the Division did not have evidence required background checks and home assessments were completed for some providers. Although some of these background checks may have been completed and not documented, evidence of certain required checks was not maintained.

Children in state custody should only be placed in an unlicensed placement once the care provider has passed a background check and a basic home safety inspection. In addition, when children are removed from their homes in emergency situations, policy requires Division staff to complete an Emergency Placement Checklist and Confirming Safe Environment assessment. These assessments document Division efforts to verify the safety of unlicensed placements. Children are exposed to higher risk in unlicensed placements when these required assessments are not completed. Exhibit 7 outlines the missing documentation we identified in our evaluation of unlicensed placements.

Auditor Evaluation of Unlicensed Placement Documentation

Exhibit 7



Source: Auditor results of documentation review of Division records.

⁽¹⁾ For 2 of 5, background checks were initiated, but there was no evidence results were received or reviewed.

⁽²⁾ Only 7 of 11 unlicensed placements reviewed occurred in emergency situations.

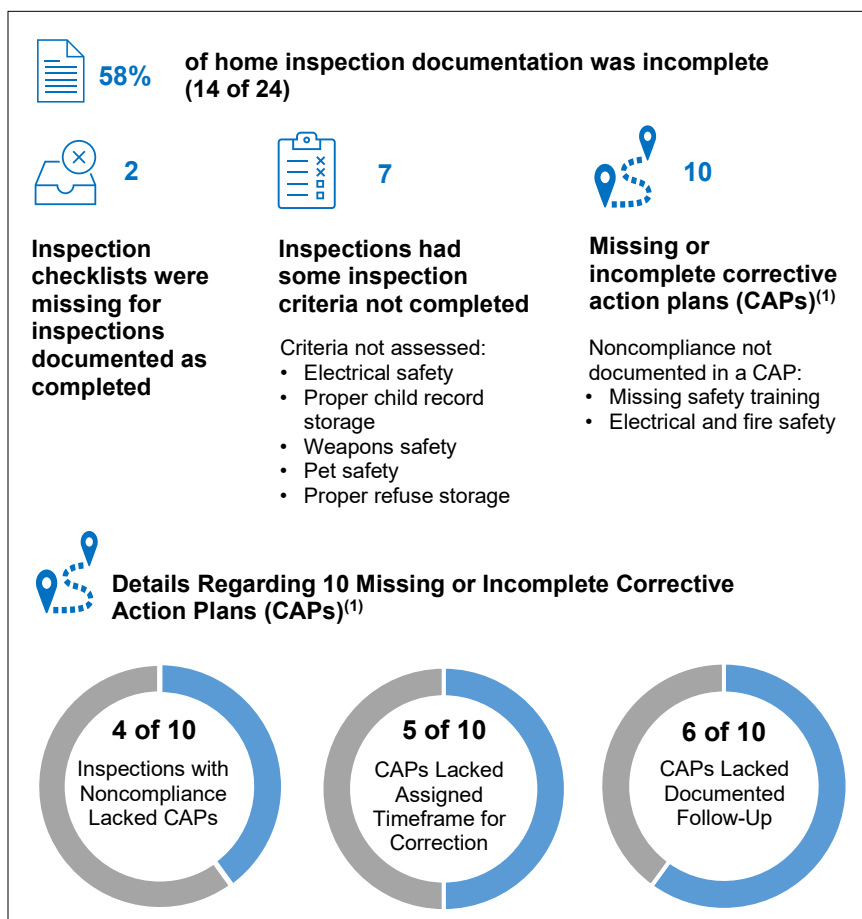
Foster Home Documentation Review

After conducting file reviews of 24 licensed foster homes, we found the Division did not always complete home inspection documentation and ensure that all residents of foster homes received required health assessments. When Division staff complete inspections of foster homes, they utilize a standardized checklist to verify regulatory standards are met. Home inspection paperwork also includes a section for the Division to document a corrective action plan, when necessary, to remedy certain deficiencies identified. Division policy requires corrective action plans to define the regulatory violation and actions to be taken to correct the violation, including a timeframe for corrective action. Division staff should monitor the corrective action process, and document measures taken by providers to correct the violation.

We evaluated foster home inspection checklists for completeness and for Division oversight of provider corrective action, when necessary. The results of our evaluation are in Exhibit 8.

Auditor Evaluation of Foster Home Inspection Documentation

Exhibit 8



Source: Auditor results of documentation review of Division records.

⁽¹⁾ Some CAPs lacked both an assigned timeframe and Division follow-up.

We also evaluated foster provider records for required tuberculosis testing. Of 24 foster homes, 5 homes (21%) did not have a tuberculosis test completed timely for all adults in the home, and 1 foster home resident did not have a tuberculosis test on file. Overdue tuberculosis screenings were on average over a year late.

Division files lacked documentation because monitoring and oversight controls were insufficient to ensure all activities were properly documented. Division management also stated that there were significant staff and supervisory shortages and telework challenges related to COVID-19 restrictions that impacted their licensing group during the period evaluated.

Finally, Division management stated that tuberculosis testing was difficult to schedule because of COVID-19 restrictions at medical offices during 2020.

Improving Unlicensed Placement Process

Improving the process by which the Division establishes and manages unlicensed providers would support both caretakers and children placed in these households. The Division has not established a written agreement with unlicensed providers who oversee children in state custody, and home inspection procedures for unlicensed providers are brief or poorly defined. Additionally, the Division does not provide documentation regarding expected home health and safety standards to unlicensed providers. The Division, children in state custody, and providers are at increased exposure to preventable risk due to inadequate oversight of unlicensed placements.

No Written Agreement for Unlicensed Providers

Unlicensed providers do not sign a written agreement with the Division that outlines responsibilities and expectations regarding the placement of children in a home. Instead, the Division relies on verbal descriptions of its expectations to unlicensed providers. In contrast, licensed foster care providers sign an agreement defining provider and Division responsibilities and authorizing the Division to make announced and unannounced home visits. Written agreements with unlicensed providers can help establish mutual understanding between the Division and providers regarding the responsibilities and rights of the parties when caring for a child in state custody. These agreements could also include the ability to inspect placements by the Division and its authorized representatives, when applicable.

Division management stated too much regimentation of the process governing unlicensed placements could lead to children being placed outside of familial and fictive kin placements. However, management also stated a concise unlicensed provider agreement would be reasonable.

Unlicensed Inspection Procedures Are Brief or Poorly Defined

The Division's initial unlicensed placement inspection procedures are brief, and continuing inspection procedures are poorly defined. For instance, the Emergency Placement Checklist includes brief inspection procedures but is not required to be completed after the initial placement. Additionally, there is no checklist used for continuing inspections of unlicensed placements, which can result in variation of how staff conduct monthly visits.

Monthly caseworker visits used to assess the continuing safety of unlicensed placements were also inconsistently documented in UNITY, Nevada's statewide automated child welfare information system. We reviewed 22 system case notes that documented unlicensed placement visits, including 2 for each unlicensed provider selected for inspection. We found case notes did not always specify a home inspection took place or certain activities like assessments of chemical and medicine storage or fire safety were completed.

Furthermore, four Division employees who perform monthly visits indicated procedures performed could vary. For instance, one of four employees interviewed did not inspect every room in the house during home visits. Consistent home inspection criteria and training can help ensure that home environments meet uniform safety and living standards.

Written Standards Not Shared With Unlicensed Providers

The Division does not provide documentation regarding expected home health and safety standards to unlicensed providers. Unlicensed health and safety standards are not published in statute, regulation, or policy. This contrasts with foster home providers that receive specific documentation that defines home health and safety standards published in statute, regulation, and policy.

Unlicensed providers, especially those without recent experience caring for children, may not be aware of safety and other standards that protect children. Thus, children could be at a higher risk of health and safety issues at unlicensed placements.

The Division could reduce the risk of harm to a child or provider in an unlicensed placement if proper agreements and standards are established.

Recommendations

1. Communicate to licensed and unlicensed providers applicable health, safety, and regulatory deficiencies identified in this audit report. Periodically inform licensed and unlicensed providers of common deficiencies identified in Division home inspections.
2. Generate a list that is routinely updated of all unlicensed providers that care for children in state custody and their contact information.
3. Enhance supervisory oversight to ensure staff routinely verify medication administration records are completed in accordance with Division policy and regulations.
4. Improve the medication administration template for ease of use and understandability.
5. Ensure supervisory oversight is performed and documented for unlicensed placements to ensure Emergency Placement Checklists, Confirming Safe Environment assessments, background checks, and home inspections are being completed timely.
6. Ensure documented supervisory review routinely takes place of a sample of foster home inspection paperwork to verify completeness and confirm corrective action plans are issued and resolved.
7. Comply with policy requiring tuberculosis testing be completed timely and documented.
8. Establish a written agreement with unlicensed placement providers regarding rights and responsibilities for care of children in state custody. Ensure the agreement acknowledges the Division or its authorized representatives may perform home inspections.
9. Create and implement an inspection checklist for unlicensed placements that is completed on a regular basis.

10. Develop and provide documented health and safety standards to unlicensed providers upon child placement.

Foster Care Payments Appropriately Administered

Foster care payments were accurately and appropriately administered by the Division. We reviewed a representative sample of foster care and specialized payments and found payments were made to verified youth placements at licensed facilities. Additionally, specialized payments were supported by corresponding documentation in the Division's records. Accurate and justified foster care payments support the financial health of the Division, the State, and foster care providers.

We selected a random sample of 50 fiscal year 2021 foster care payments of 4,068 total claims based on the percentage of total claims of different payment categories. Payment categories included Advanced Foster Care, Court Jurisdiction, Family and Relative Foster Care, Medically Fragile, Special Rate, and Specialized Foster Care. Our review found the Division calculated all payments accurately according to the established payment schedule. We then compared Division payment records from UNITY to state accounting records and found no discrepancies. All payments were also made to verified youth placements at licensed facilities. Lastly, we found Advanced Foster Care, Specialized Foster Care, Medically Fragile, and Special Rate payments were supported by medical documentation.

The Division has an automated payment disbursement system which accurately calculated payment rates and dispensed them appropriately to foster care providers. Additionally, there is a system of supervisory and quality assurance reviews that assisted in verifying the accuracy of payments. The Division helps support the financial health of foster care providers and the State when it administers accurate and justified foster care payments.

Appendix A

Audit Methodology

To gain an understanding of the Division of Child and Family Services (Division), we interviewed staff, reviewed statutes and regulations, and policies and procedures relevant to its operations. We also reviewed financial information, prior audit reports, budgets, legislative committee minutes, and other significant information such as user access and system programs utilized by the Division. In addition, we documented and evaluated internal controls related to Division oversight of placement providers of children in state custody and foster care payments.

Our audit included a review of the Division's internal controls significant to our audit objectives. Internal control is a process effected by an entity's management and other personnel that provides reasonable assurance the objectives of an entity will be achieved. Internal control comprises the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity. The scope of our work on controls related to Division oversight of child placements, provider health and safety assessments, and foster care payments, included the following:

- Exercise oversight responsibility; establish structure, responsibility, and authority; and evaluate performance and enforce accountability (Control Environment);
- Design control activities and design information system control activities (Control Activities);
- Use quality information (Information and Communication); and
- Perform monitoring activities (Monitoring).

Deficiencies and related recommendations to strengthen the Division's internal control systems are discussed in the body of the report. The design, implementation, and ongoing compliance with internal controls is the responsibility of agency management.

To determine if controls for monitoring placements for children in state custody were adequate, we received a list of homes in which children in state custody resided generated from Unified Nevada Information Technology for Youth (UNITY), Nevada's statewide automated child welfare information system. We assessed the accuracy and completeness of UNITY foster facility data by comparing UNITY records with Division physical records. To ensure the data was complete, we haphazardly selected foster home licensing files from the Carson City, Elko, and Pahrump regional Division offices. We verified there was a corresponding UNITY record for each physical file. We concluded the foster facility records were sufficiently reliable for our intended purposes.

We then selected a stratified random sample of 35 of 156 homes, including every Division district, for both licensed and unlicensed placements. We reviewed Division home inspection criteria including statutes, regulations, and policies and procedures. During home inspections, we noted deficiencies related to unsanitary conditions, personal health and safety hazards, bleak living conditions, and violations of foster care regulations. We discussed our results with Division management. Of 35 homes selected, only 30 homes could be inspected due to unlicensed placement providers that elected to not be inspected. Of homes inspected, 24 were licensed foster homes and 6 were unlicensed placements.

To determine if Division safety and health assessments of placement providers for children in state custody were performed, we obtained Division physical files. For licensed placement providers, we reviewed files for required licenses, background checks, tuberculosis testing results, and home inspections. We also verified that all residents 18 and older were documented in UNITY. For unlicensed providers, we reviewed UNITY and physical files for Emergency Placement Checklists, a Confirming Safe Environment assessment, law enforcement and other

background checks, home inspections, and supervisory review. We shared our results with Division management.

To evaluate the sufficiency of the Division's oversight of unlicensed placements, we reviewed Division statutes, regulations, and policies and procedures defining required Division oversight of unlicensed providers. We also held discussions with the Division regarding oversight activities.

To verify whether Division foster care payments were adequately administered, we requested a list of foster care payments recorded in UNITY during fiscal year 2021. To evaluate the reliability of UNITY foster care payment data, we discussed with the Division user access controls and additional IT controls. We tested controls to ensure they were operating as intended. Additionally, we conducted accuracy testing on the payment data. We concluded that foster care payment data was sufficiently reliable for our intended purpose.

We then identified the fiscal year 2021 payment data relating to Advanced Foster Care, Court Jurisdiction, Family and Relative Foster Care, Medically Fragile, Special Rate, and Specialized Foster Care and selected a stratified random sample of 50 of 4,068 payments. We reviewed the appropriateness of payments by gathering claim-related information in UNITY and comparing it to state accounting system records to verify the payment was accurate and appropriate. Additionally, we ensured payments were only provided for children in active placements with licensed providers, and payments had supporting documentation.

We used nonstatistical audit sampling for our audit work, which for these analyses was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgement, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provided sufficient, appropriate audit evidence to support the conclusions in our report. We did not project the exceptions to the population, because tests were not intended to be projected.

Our audit work was conducted from April 2021 to January 2022. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In accordance with NRS 218G.230, we furnished a copy of our preliminary report to the Administrator of the Division of Child and Family Services. On April 8, 2022, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report. That response is contained in Appendix B, which begins on page 23.

Contributors to this report included:

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Appendix B

Response from the Division of Child and Family Services

Steve Sisolak
Governor



Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF CHILD AND FAMILY SERVICES
Helping people. It's who we are and what we do.



Cindy Pitlock, DNP
Administrator

MEMORANDUM

April 18, 2022

TO: Daniel Crossman, Legislative Auditor

FROM: Cindy Pitlock, Administrator

SUBJECT: Division Response to the 2022 Performance Audit of the Department of Health and Human Services, Division of Child and Family Services, Assessment and Safety of Child Placements

INTRODUCTION

Thank you for the opportunity to respond to the 2022 Performance Audit findings. The Division of Child and Family Services (DCFS or Division) has begun work to address the findings in this audit related to safety and child placement.

Below are the Legislative Counsel Bureau audit recommendations and our responses. If you have additional questions, please do not hesitate to contact us.

Recommendation 1: Communicate to licensed and unlicensed providers applicable health, safety, and regulatory deficiencies identified in the audit report. Periodically inform licensed and unlicensed providers of common deficiencies identified in the Division home inspections.

Response: The Division accepts this recommendation.

The Division is in the process of developing a more structured and robust process for unlicensed homes that will include a more comprehensive home safety checklist modeled on the required licensing checklist, a handbook that provides important information on the Division and its process. Specialized training provided to the unlicensed homes through the Kinship Navigator program called "Caring for Our Own" will be required. A home inspection highlights form will be developed specifically for unlicensed homes, to provide direction on safety standards and grounds of the home (NAC 424.360).

Recommendation 2: Generate a list that is routinely updated of all unlicensed providers that care for children in state custody and their contact information.

Response: The Division accepts this recommendation.

The Division has started the process of working with BINTI which is a foster care licensing software and database, to capture the contact information of placements including unlicensed providers.

Recommendation 3: Enhance supervisory oversight to ensure staff routinely verify medication administration records are completed in accordance with Division policy and regulations.

Response: The Division accepts this recommendation.

The Division is currently working to create micro-session trainings to address critical issues such as medical record-keeping. This training would be required for both previously licensed and incoming new families to take within six months of the training being offered. To prepare families for this requirement, the Home Inspection Highlights Form that is provided at every new and relicensing visit will now show the expectation that families complete it within the six-month timeframe. As part of the 1:1 supervisory meeting completed with staff every week, this will become a standard conversation regarding their families' progress on maintaining these important records. This protocol will be added to the questions that are asked to every foster parent and documented in the file.

Recommendation 4: Improve the medication administration template for ease of use and understandability.

Response: The Division accepts this recommendation.

The Division is currently reviewing the medication management template to make it easier to read, understand and complete, with the goal of providing this to all licensed and unlicensed homes.

Recommendation 5: Ensure supervisory oversight is performed and documented for unlicensed placements to ensure Emergency Placement Checklists, Confirming Safe Environment assessments, background checks, and home inspections are being completed timely.

Response: The Division accepts this recommendation.

The Division is in the process of developing a standardized process for child protective services workers to submit the home safety checklist, background check request, and confirming safe environments present danger is entered into UNITY for their supervisor for review. These will be confirmed to have been completed by adding them to the case transfer checklist which is reviewed by the supervisors prior to the case moving to a permanency worker.

Recommendation 6: Ensure documented supervisory review routinely takes place of a sample of foster home inspection paperwork to verify completeness and confirm corrective action plans are issued and resolved.

Response: The Division accepts this recommendation.

The Division worked with BINTI developers to create "flags" within the system for any missing paperwork when a license is renewed, or the home is relicensed. This would catch any missed documentation.

Recommendation 7: Comply with policy requiring tuberculosis testing be completed timely and documented.

Response: The Division accepts this recommendation.

The Division and foster families struggled throughout the pandemic with being able to obtain the tuberculosis testing timely. The licensing workers will follow up with all licensed foster homes and make sure that the tuberculosis test results are in the file by the licensing renewal or will staff with the Licensing Supervisor on any delays or other impediments to meeting this requirement.

Recommendation 8: Establish a written agreement with unlicensed placement providers regarding rights and responsibilities for care of children in state custody. Ensure the agreement acknowledges the Division or its authorized representatives may perform home inspections.

Response: The Division accepts this recommendation.

The Division will create and provide information to unlicensed homes regarding the requirement to allow state workers to come to the home for the purposes of evaluating our licensing process.

Recommendation 9: Create and implement an inspection checklist for unlicensed placements that is completed on a regular basis.

Response: The Division accepts this recommendation.

The Division is in the process of developing a more structured and robust process for all unlicensed homes and a more comprehensive home safety checklist is being developed for permanency workers to use when doing home visits with the child and family. This form would be required to be completed every 6 months and placed into the file.

Recommendation 10: Develop and provide documented health and safety standards to unlicensed providers upon child placement.

Response: The Division accepts this recommendation.

The Division is working to create a more robust, standardized program for unlicensed care providers that more closely mimics some of the requirements asked of licensed homes. As part of this enhancement, we will create an unlicensed version of the home checklist currently used for licensed homes to be used by caseworkers and provided to unlicensed homes to be sure they understand the standards we are applying for the child's placement.

CONCLUSION

Once again, we thank the Legislative Counsel Bureau's Audit Team for their time and work on this audit which will benefit Nevada's families. We look forward to using the recommendations to improve our practice and processes to ensure the safety, well-being, and health of children in Rural Child Welfare. We look forward to being able to report positive improvements on these findings in the future.

The Division of Child and Family Services' Response to Audit Recommendations

<u>Recommendations</u>	<u>Accepted</u>	<u>Rejected</u>
1. Communicate to licensed and unlicensed providers applicable health, safety, and regulatory deficiencies identified in this audit report. Periodically inform licensed and unlicensed providers of common deficiencies identified in Division home inspections	<u>X</u>	<u> </u>
2. Generate a list that is routinely updated of all unlicensed providers that care for children in state custody and their contact information	<u>X</u>	<u> </u>
3. Enhance supervisory oversight to ensure staff routinely verify medication administration records are completed in accordance with Division policy and regulations	<u>X</u>	<u> </u>
4. Improve the medication administration template for ease of use and understandability	<u>X</u>	<u> </u>
5. Ensure supervisory oversight is performed and documented for unlicensed placements to ensure Emergency Placement Checklists, Confirming Safe Environment assessments, background checks, and home inspections are being completed timely	<u>X</u>	<u> </u>
6. Ensure documented supervisory review routinely takes place of a sample of foster home inspection paperwork to verify completeness and confirm corrective action plans are issued and resolved	<u>X</u>	<u> </u>
7. Comply with policy requiring tuberculosis testing be completed timely and documented	<u>X</u>	<u> </u>
8. Establish a written agreement with unlicensed placement providers regarding rights and responsibilities for care of children in state custody. Ensure the agreement acknowledges the Division or its authorized representatives may perform home inspections	<u>X</u>	<u> </u>
9. Create and implement an inspection checklist for unlicensed placements that is completed on a regular basis	<u>X</u>	<u> </u>
10. Develop and provide documented health and safety standards to unlicensed providers upon child placement	<u>X</u>	<u> </u>
TOTALS	<u>10</u>	<u> </u>