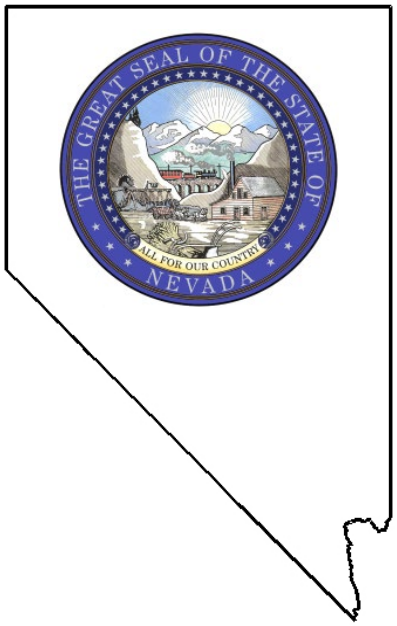
LA24-06

STATE OF NEVADA

Governmental and Private Facilities for Children – Inspections

December 2022



Legislative Auditor
Carson City, Nevada

Report Highlights

Highlights of Legislative Auditor report on the Governmental and Private Facilities for Children – Inspections issued on January 12, 2023.

Legislative Auditor Report # LA24-06.

Background

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

As of June 30, 2022, we had identified 57 governmental and private facilities that met the requirements of NRS 218G. In addition, 105 Nevada children were placed in 14 different out-of-state facilities across 6 different states as of June 30, 2022.

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, 2021, through June 30, 2022, we received 636 complaints from 30 facilities in Nevada. Twenty-seven Nevada facilities reported that no complaints were filed during this time.

Purpose

Inspections were conducted pursuant to the provisions of NRS 218G.570 through 218G.595. This report includes the results of our inspections of 19 children's facilities. As inspections are not audits, these activities were not conducted in accordance with generally accepted government auditing standards.

The purpose of our inspections was to determine if the facilities adequately 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.

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

Governmental and Private Facilities for Children – Inspections

December 2022

Summary

In 14 of 19 children's facilities inspected, we did not note significant issues that caused us to question the health, safety, welfare, or protection of the rights of the children. However, at the five facilities listed below we identified multiple issues that caused us to question whether the facility adequately protected the children in its care. Based on our observations, we contacted the facilities' licensing agencies and communicated our concerns.

Nevada Homes for Youth

We noted health, safety, welfare, and other issues at Nevada Homes for Youth. Health issues included: incomplete and inaccurate medication records, children self-administering medication, missing medication, contraband, child intoxication, and missing treatment plans. Safety issues included: unsecured chemicals, outdated first aid kit supplies, broken electrical outlets, a broken window, missing statutorily required personnel records, and face sheets were not readily available to staff. Welfare issues included: unsanitary living conditions, inappropriate age-related activities, and the complaint process was not posted. Other issues included: incomplete training records, incomplete and altered child records, and policies and procedures were weak. (page 4)

Never Give Up Youth Healing Center

We noted health, safety, welfare, and other issues at Never Give Up Youth Healing Center. Health issues included: incomplete and missing medication records, administration of medication without consent, and staff were unaware of children's treatment plans. Safety issues included: unsecured laundry supplies and chemicals, damaged property that posed safety hazards, missing statutorily required personnel records and training, missing documentation that an incident was reported in accordance with mandated reporting requirements or investigated internally in accordance with facility policy, and face sheets were not readily available to staff. Welfare issues included: unsanitary living conditions; beds missing pillowcases, sheets, and bed coverings; inappropriate age-related activities; and unsecured complaint boxes. Other issues included incomplete training records and policies and procedures were weak. (page 8)

3 Angels Care

We noted health, safety, welfare, and other issues at three of 3 Angels Care homes. Health issues included incomplete and missing medication records and a missed medication administration for a child. Safety issues included: unsecured tools, chemicals, and laundry supplies; an outside locking storage room being used as a place to sleep; children of opposite gender sharing a room; and lack of supervision. A welfare issue included the use of a storage room as a "quiet room." Other issues included incomplete personnel records and policies and procedures were weak. (page 12)

Advanced Foster Care Homes

We noted health, safety, welfare, and other issues at two homes licensed by the Advanced Foster Care program. Health issues included incomplete and missing medication records and incomplete and missing treatment plans. Safety issues included: unsecured tools, chemicals, and knives; fire escapes were not posted, and documentation of fire drills were missing; storage of medication was not readily available; and missing documentation to support a repeat background check for a foster parent. Welfare issues included: complaint forms not being readily available, the complaint process not being posted, no documentation that children were made aware of their right to file a complaint, and a complaint on behalf of a child was not forwarded to the Legislative Auditor. Other issues included missing and incomplete training records and policies and procedures were weak. (page 14)

Prison Rape Elimination Act (PREA)

In two of eight correction and detention facilities inspected, we noted issues that prompted us to question whether the facilities adequately implemented a PREA process in accordance with federal regulations. PREA standards require the facilities to use a screening tool to assess children for sexual victimization or abusiveness. Two facilities used a screening tool which did not assess for 10 of 11 items required by screening standards. (page 17)

STATE OF NEVADA

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We have conducted inspections of governmental and private facilities for children in the State of Nevada as authorized by Nevada Revised Statutes 218G.570 through 218G.595. The purpose of these inspections is to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care.

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

Respectfully submitted,

Daniel L. Crossman, CPA
Legislative Auditor

December 23, 2022
Carson City, Nevada

STATE OF NEVADA
GOVERNMENTAL AND PRIVATE FACILITIES
FOR CHILDREN – INSPECTIONS
DECEMBER 2022

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BACKGROUND

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

This report includes the results of our work as required by NRS 218G.570 through 218G.595. This report includes the results of inspections of 19 children's facilities.

A description of our methodology can be found in Appendix D, on page 30.

Number and Types of Facilities

For the fiscal year ended June 30, 2022, we identified a total of 57 facilities that met the requirements of NRS 218G. Exhibit 1 lists the types of facilities located within Nevada and the total capacity of each type for the fiscal year ended June 30, 2022.

Summary of Nevada Children's Facilities **Exhibit 1**
Fiscal Year Ended June 30, 2022

		Population		Staffing Levels	
Facility Type	**Number of Facilities**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
Child Care Institution	1	90	75	65	39
Correction and Detention Facilities	13	743	344	413	22
Facilities for Treatment of Abuse of Alcohol or Drugs	2	23	7	22	2
Foster Care Agencies	13	618	447	358	26
Foster Homes That Provide Specialized Care	13	62	45	43	20
Others	1	8	4	40	0
Psychiatric Hospitals	7	329	150	270	44
Psychiatric Residential Treatment Facilities	7	307	178	314	43
Totals – Facilities Statewide	**57**	**2,180**	**1,250**	**1,525**	**196**

Source: Auditor prepared from information provided by facilities.
Note: Appendix C on page 27 contains additional facility details.

In addition to children in facilities within the State of Nevada, an additional 105 children were located in out-of-state facilities as of June 30, 2022. Of the 105 children, 57 (54%) were placed during fiscal year 2022, and the other 48 (46%) were placed in prior years. Nevada children were placed in 14 different facilities across 6 different states.

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

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

Number of New Placements of Nevada Children in Out-of-State Facilities As of June 30, 2020, 2021, and 2022 **Exhibit 2**

Placing Entity	As of June 30, 2020	As of June 30, 2021	As of June 30, 2022
1st Judicial District Court (Carson City and Storey County)	4	5	1
2nd Judicial District Court (Washoe County)	6	10	8
3rd Judicial District Court (Lyon County)	0	2	1
4th Judicial District Court (Elko County)	0	0	1
5th Judicial District Court (Esmeralda and Nye Counties)	0	0	2
6th Judicial District Court (Humboldt County)	0	0	0
7th Judicial District Court (Eureka, Lincoln, and White Pine Counties)	1	1	1
8th Judicial District Court (Clark County)	25	27	10
9th Judicial District Court (Douglas County)	0	0	0
10th Judicial District Court (Churchill County)	1	0	1
11th Judicial District Court (Lander, Mineral, and Pershing Counties)	1	1	0
State of Nevada Division of Child and Family Services[1]	18	11	32
Totals	**56**	**57**	**57**

Source: Auditor prepared from information provided by the district courts and the State of Nevada.

[1] State of Nevada Division of Child and Family Services' placements include child welfare and juvenile justice children.

Exhibit 3 shows the total number of children and the entity that placed them in out-of-state facilities as of June 30, 2022.

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

Placing Entity	As of June 30, 2022
1st Judicial District Court (Carson City and Storey County)	5
2nd Judicial District Court (Washoe County)	10
3rd Judicial District Court (Lyon County)	3
4th Judicial District Court (Elko County)	1
5th Judicial District Court (Esmeralda and Nye Counties)	2
6th Judicial District Court (Humboldt County)	0
7th Judicial District Court (Eureka, Lincoln, and White Pine Counties)	1
8th Judicial District Court (Clark County)	14
9th Judicial District Court (Douglas County)	0
10th Judicial District Court (Churchill County)	1
11th Judicial District Court (Lander, Mineral, and Pershing Counties)	0
State of Nevada Division of Child and Family Services[(1)]	68
Total	**105**

Source: Auditor prepared from information provided by the district courts and the State of Nevada.

(1) State of Nevada Division of Child and Family Services' placements include child welfare and juvenile justice children.

SCOPE AND PURPOSE

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

The purpose of our inspections was to determine if the facilities adequately 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. Our work was conducted from January 2022 through November 2022.

INSPECTIONS OF FACILITIES

In 14 of 19 facilities inspected, we did not note significant issues that caused us to question the health, safety, welfare, or protection of the rights of the children. However, at five facilities, Nevada Homes for Youth, Never Give Up Youth Healing Center, 3 Angels Care, and two Advanced Foster Care (AFC) homes, we identified multiple issues that caused us to question whether management adequately protected the children in its care. Based on our observations, we contacted the licensing agencies and/or placement agencies for all five facilities. Information regarding our inspections and significant

issues noted at Nevada Homes for Youth, Never Give Up Youth Healing Center, 3 Angels Care, and Advanced Foster Care Homes are detailed below. Appendix B on page 26 of this report includes the facilities inspected, the facility types, and the dates of our work.

Nevada Homes for Youth

We inspected Nevada Homes for Youth in June 2022 and completed a secondary observation in August 2022. This was our third visit to the facility in the last 5 years. During our inspection and follow-up observation, we noted several issues that prompted us to question whether the facility adequately protected the children in its care.

Nevada Homes for Youth is considered a facility for the treatment of abuse of alcohol or drugs and is licensed by the Bureau of Health Care Quality and Compliance (HCQC), and contracted as a placement resource by Clark County Department of Family Services (DFS) and is required to comply with DFS licensing standards. The facility is also Substance Abuse Prevention and Treatment Agency (SAPTA) certified to provide substance abuse services.

Some significant issues observed included:

Health

- Medication records were incomplete, inaccurate, and required documentation was missing.

- Children were self-administering psychotropic and narcotic medications. During the initial inspection, staff were not trained in medication administration and could not physically handle the medications. They provided the medication to the children and observed them take the medication. During our follow-up observation, staff were subsequently trained in medication administration, but continued to allow children to self-administer medications.

- During the initial inspection and follow-up observation, medication counts reflected missing medication.

- During the initial inspection, two empty bottles of cough syrup that management was unaware of were located in a child's belongings. A review of child files yielded information that cough syrup, marijuana, and alcohol have been consumed by children in the home and confiscated on more than one occasion.

- Treatment plans could not be located during our initial inspection; and treatment plans were not completed timely during our follow-up observation.

Safety

- During the initial inspection and follow-up observation, chemicals and laundry supplies were unsecured.

- During the initial inspection and follow-up observation, first aid kit supplies were expired.

- During the initial inspection and follow-up observation, broken electrical outlets were observed.

- During the follow-up observation a broken window in a child's room was observed.

- During our follow-up observation, two personnel files were missing documentation that a Child Abuse and Neglect Screening (CANS) check was completed.

- During the initial inspection and follow-up observation, face sheets were not readily available to staff in the event of an emergency. Only management had access to face sheets.

Welfare

- During the initial inspection and follow-up observation, several areas of the homes were dirty. For example: bedrooms contained piles of clothing and trash, and the bathroom contained inappropriate drawings and obscene language written on the walls.

- During the initial inspection and follow-up observation, inappropriate age-related activities were observed including non-rated videogames and movies, and non-monitored use of electronics, which are prohibited by the facility as stated in intake documents.

- During the initial inspection and follow-up observation, the complaint process was not posted, and children were generally unaware of their right to file a complaint.

Other

- Training records were missing and incomplete.

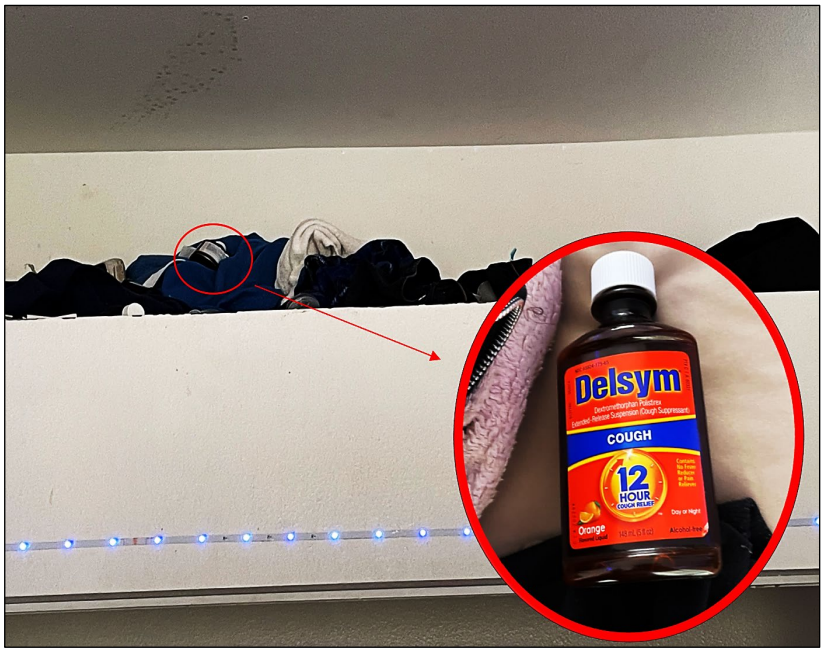
- Child records were incomplete and insufficient. For example, medication counts did not match medication administration records. Person Legally Responsible (PLR) consent documentation was missing or incomplete. After our inspection, three medication administration records were altered to reflect a different record of administration of medications during our follow-up observation.

- During the initial inspection and the follow-up observation, the facility did not provide a list of children placed at the facility or a staff roster.

- Policies and procedures were missing, weak, or not consistent with management's understanding and implementation of important practices. For example, policies stated that staff provide treatment services for the children despite the facility using a third-party provider to implement treatment services. The facility did not employ staff that provide treatment services.

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

Cough syrup found in a child's items in their bedroom during the initial inspection.



Based on our observations, we determined the care and living conditions at Nevada Homes for Youth did not meet certain minimum standards established in NRS 218G, NRS 424, NRS 432B, NRS 449; and outlined in Nevada Administrative Code (NAC) 424 and NAC 449. Specifically, management did not ensure the facility met the following minimum standards: medical care and medications, self-administration of medication, medication management, products intended only for adult use, treatment plans, securing chemicals, health services, electrical equipment, general sanitary requirements, grounds of home, living space and furnishings, care and treatment of children, complaints, identification kits, personnel and child records, and director responsibilities and duties.

Post-Inspection Information

Immediately following our visit to the home in June 2022, we contacted DFS and discussed our concerns. We also contacted HCQC and SAPTA to discuss our concerns. After our inspection, DFS, HCQC, and SAPTA completed follow-up contacts with the facility. HCQC and SAPTA documented deficiencies at the facility including: unreported critical incidents occurring in the home, insufficient policies and procedures, insufficient treatment services, insufficient training documentation and personnel records, and

concerns for the living conditions of the home. HCQC noted no deficiencies during their secondary follow-up contact with the facility. SAPTA placed the facility on corrective action and requested the facility submit a corrective action plan.

Upon contact, DFS determined the home was in suitable condition and reviewed three children's medication administration records, two of which they determined were filled out properly. DFS was unable to access and review personnel files. DFS does not license the facility, but does have a contract with the facility.

The facility has maintained their licensure through HCQC, has a provisional license by SAPTA, and continues to accept placements by DFS. We recommend the licensing agencies and placement agency enhance communication and coordinate their efforts to ensure proper oversight of the facility.

Never Give Up Youth Healing Center

We inspected Never Give Up Youth Healing Center in August 2022. This was our second visit to the facility in the last 5 years. During our inspection, we noted several issues that prompted us to question whether the facility adequately protected the children in its care. Never Give Up Youth Healing Center is considered a psychiatric residential treatment facility (PRTF) and is licensed by HCQC.

Some of the significant issues observed included:

Health

- Medication records were incomplete and required documentation was missing.
- A child's medication was started, discontinued, and doses were altered prior to obtaining consent from the PLR.
- Direct-care staff were unaware of the children's treatment plan goals.

Safety

- Laundry supplies and chemicals were unsecured at the time of inspection.

- Damaged property posed a safety hazard. For example: broken items included a door handle, tiles, fire alarm, bed and bedframes. Exposed items included: pipes in the bathrooms, wires of air conditioning units, and staples and nails on the exterior of a building. Review of a child's file indicated that some items noted as safety hazards during our inspection were used by the child in attempts to cause harm to themselves and others.

- Personnel files did not have documentation to support that a CANS check was completed. Personnel provide direct care to children at the facility.

- An employee was disciplined for an improper restraint, and there was no record that the employee received restraint training during their employment.

- Physician's orders authorizing 25 of 37 physical restraints of a child were missing.

- The child's file did not contain evidence that an allegation of child-on-child sexual abuse was reported to the appropriate authorities. Additionally, facility management could not provide documentation that the allegation was internally investigated, which is required by facility policy.

- Face sheets were not readily available to staff in the case of an emergency. Only management had access to face sheets.

Welfare

- Several areas of the facility were dirty and unkept. For example: children's dorms contained piles of clothing, including dirty and stained clothing; and a blood-stained pillow was located in one dorm. A bathroom toilet and urinal were clogged, and another urinal had feces in it.

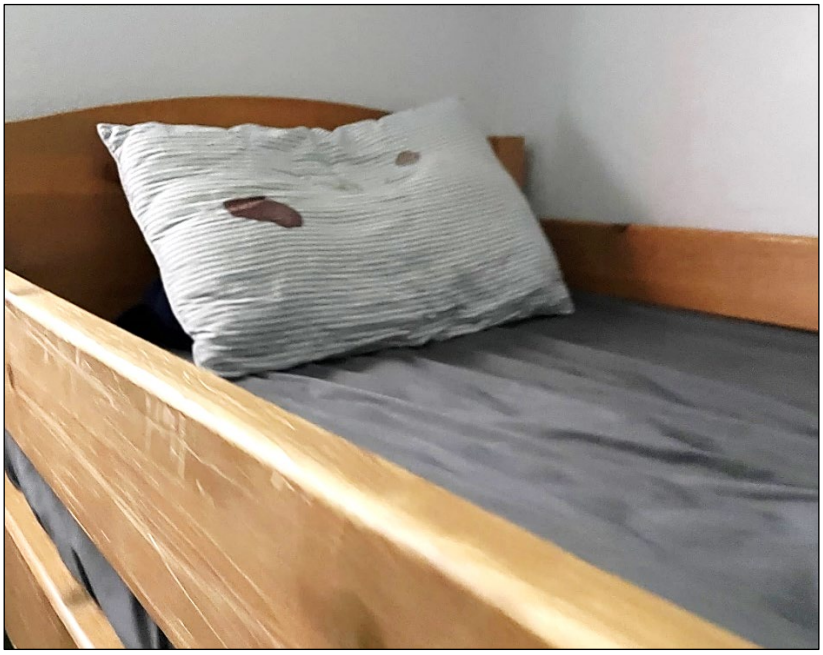
- Beds were missing pillowcases, sheets, and bed coverings.
- Inappropriate age-related activities were observed including a rated mature audience television show and a rated R movie.
- Secured complaint boxes were unlocked.

Other

- Training records were missing and incomplete.
- Policies and procedures were missing, weak, or not consistent with management's understanding and implementation of important practices. For example, treatment plan policy did not specify which staff are responsible for signing a treatment plan. As a result, one treatment plan reviewed did not have a signature from one staff member until three months after the development of the treatment plan.

The following pictures are examples of the living conditions at the facility:

Blood on a pillow of a vacant bed in a children's dorm.



Exposed pipes in a shower in the children's bathroom.

Based on our observations, we determined the care and living conditions at Never Give Up Youth Healing Center did not meet certain minimum standards established in NRS 432, NRS 433, NRS 433B, NRS 449; and outlined in NAC 449. Specifically, facility management did not ensure the following minimum standards: medical care and medications; treatment planning; laundry and linen services; housekeeping and sanitation; maintenance and availability of employee records; abuse or neglect substantiation records; bedrooms and bedding; resident activities; general rights; procedure for filing a grievance; training of direct care staff; and standards, qualifications, and other regulations.

Post-Inspection Information

Following our visits to the facility in August 2022, we contacted HCQC and discussed our concerns. HCQC typically inspects PRTFs every 6 years unless a complaint of the facility is received and investigated. HCQC completed three complaint investigations in the 2 months prior to our inspection and two complaint investigations after our inspection. Concerns noted at the facility by HCQC included: improper restraints, missing trainings for restraints, and an unsafe and unsanitary environment. HCQC imposed a financial sanction on the facility.

3 Angels Care

At three of four foster homes operated by 3 Angels Care that we visited in March 2022, we noted several issues that prompted us to question whether facility management adequately protected the children in its care. This was our fourth visit to the foster care agency in the last 5 years. 3 Angels Care is classified as a foster care agency by Washoe County Human Services Agency (WCHSA). All seven of 3 Angels Care foster homes are licensed separately by WCHSA.

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

Health

- Medication records were incomplete, and medications and medication records could not be produced.

- A child was not administered their daily scheduled medication at the time of our inspection.

Safety

- Tools, chemicals, and laundry supplies were unsecured.

- A vacant room intended for storage was used as a place to sleep without a proper bed or bedding. The door was equipped with a lock on the outside of the door inhibiting exit, which is inconsistent with standards established in NAC 424.370 and NAC 424.375. A child living in the home indicated that they could voluntarily sleep in the room.

- Two unrelated children of opposite gender were sharing a bedroom.

- Children were not receiving proper supervision.

Welfare

- Children voluntarily spent time in a vacant room intended for storage which is inconsistent with standards established in NAC 424.365. The room was described by the children and

staff to be a “quiet room” for children to sleep or spend time in alone.

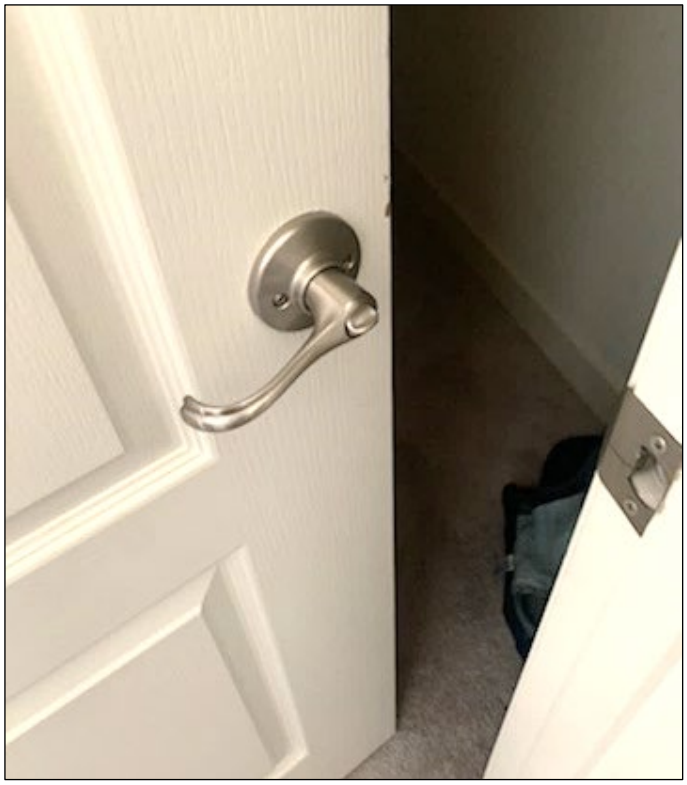
Other

- Personnel records were incomplete and outdated. Training records were missing.

- Policies and procedures were missing, weak, or not consistent with management’s understanding and implementation of important practices. For example, the medication administration policy did not clearly outline the process for medication refills and destruction.

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

A lock on the outside of a storage room used as a “quiet room” for children inhibiting exit, in violation of NAC 424.370.



Based on our inspections, we determined the care and living conditions at three of four 3 Angels Care homes did not meet certain minimum foster care standards established in NRS 424 and outlined in NAC 424. Specifically, agency management did not ensure its foster parents met the following minimum foster care standards: maintaining medical records, medication management, securing

tools and chemicals, living spaces and furnishings, sleeping accommodations, supervision, director responsibilities and duties, and training of direct care staff.

Post-Inspection Information

Immediately following our visits to the homes, we contacted WCHSA and discussed our concerns. WCHSA had originally authorized use of the vacant room for storage as a space for emergency placements to sleep, but later withdrew authorization. After WCHSA informed the foster home that the vacant room could not be used by children for sleeping accommodations, they have not received information that children are spending time or sleeping in the room. WCHSA reported they have never received information that a child has been locked in the room. WCHSA informed us that children are not using the vacant room for any purpose and the lock on the door is now no longer on the outside of the door.

WCHSA indicated they put corrective action plans in place for two of the homes, and a corrective action plan in place for the director of the agency. WCHSA conducted ongoing unannounced home visits, and WCHSA indicated the corrective action plans have been resolved as of November 2022.

Advanced Foster Care Homes

The Advanced Foster Care (AFC) Program is a program operated by DCFS to create and maintain foster homes that provide specialized care for children with a severe emotional disturbance. The program is intended to improve emotional, behavioral, and permanency outcomes for children in state custody. There were nine AFC homes licensed by DCFS as of June 30, 2022.

We inspected Home A in July 2022. At the time of our inspection, no children were placed in the home. However, the home was licensed to accept children in the future. Placements in foster homes can occur on short notice. We inspected Home I in July 2022. These were our first inspections of AFC homes. During our inspections of Home A and Home I, we noted several issues that prompted us to question whether the licensing agency ensured that the facilities adequately protected the children in their care. Home A and Home I are considered foster homes that provide specialized care and are licensed by DCFS.

Some of the significant issues observed included:

Health

- Medication records were incomplete and required documentation was missing.
- Treatment plans were incomplete and missing.

Safety

- Tools, chemicals, and knives were unsecured.
- Fire escape routes were not posted and there was no fire extinguisher in one home. Documentation of monthly fire drills was missing.
- Secured storage of medication was not readily available.
- A foster parent's file did not contain evidence to support they obtained their five-year repeat background check in accordance with statute.

Welfare

- Complaint forms were not readily available, and the complaint process was not posted.
- There was no documentation that children were made aware of their right to file a complaint.
- A serious complaint alleging physical discipline of a child was filed on behalf of a child that was not forwarded to the Legislative Auditor. More information regarding the complaint is included on page 20.

Other

- Training records were missing and incomplete.
- Policies and procedures were missing, weak, or not consistent with management's understanding and implementation of important practices. For example, policies

were missing for abuse and neglect reporting, complaints, background checks, and face sheets.

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

A hatchet on a side table in one of the homes.

Based on our observations, we determined the care and living conditions at the AFC homes did not meet certain minimum foster care standards established in NRS 218G, NRS 424, NRS 432, and NRS 432B; and outlined in NAC 424.

Specifically, agency management did not ensure its foster parents met the following minimum foster care standards: maintaining medical records; treatment plans; securing tools and chemicals, products intended only for adult use; plans for responding to disasters and other emergencies; medications; personnel records; complaints; duty of facilities to cooperate with inspections, reviews, and surveys; training of direct care staff; and director responsibilities and duties.

Post-Inspection Information

Following our inspection of the homes in July 2022, we contacted DCFS and discussed our concerns. DCFS did not renew one of the foster parent's licenses and is no longer placing children in the home.

Prior to our inspections, DCFS did not classify their AFC homes as foster homes that provide specialized care and was not following statutes for specialized foster care. After our inspections and discussions with DCFS, management consulted with their legal counsel who advised them that AFC homes are required to follow specialized foster care statutes. DCFS reported it is in the process of updating policies and procedures for their AFC program.

Prison Rape Elimination Act

We inspected eight correction and detention facilities between January and August 2022. In two of eight facilities, we noted issues that prompted us to question whether the facilities adequately implemented a Prison Rape Elimination Act (PREA) process in accordance with federal regulations.

Specifically, children were not properly assessed and screened for sexual victimization or abusiveness. PREA Juvenile Facility Standards, 28 CFR 115.341 requires the following information to be collected from residents within 72 hours of their arrival at the facility using an objective screening instrument:

- Prior sexual victimization or abusiveness;
- Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
- Current charges and offense history;
- Age;
- Level of emotional and cognitive development;
- Physical size and stature;

- Mental illness or mental disabilities;
- Intellectual or developmental disabilities;
- Physical disabilities;
- The resident's own perception of vulnerability; and
- Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

Both facilities used the Massachusetts Youth Screening Instrument (MAYSI-2) as their objective screening instrument. Only one question in the MAYSI-2 addresses prior sexual victimization. However, it does not encompass all forms of sexual victimization and does not assess for prior abusiveness. Ten of 11 items of PREA screening standards are not addressed through administration of the MAYSI-2.

Based on our inspection, we determined the two detention facilities did not meet certain minimum PREA federal regulation requirements established in 28 CFR 115. Specifically, facility management did not ensure its facility met the following minimum standards outlined in PREA Juvenile Facility Standards 115.341: Obtaining information from residents.

Post-Inspection Information

Following our visits to the facilities, we contacted the Statewide Juvenile PREA Coordinator employed by the Division of Child and Family Services and discussed our concerns. The State PREA Coordinator agreed the PREA standard was not met by the facilities. The State has developed a risk assessment to assess for sexual victimization or abusiveness. We recommend facility management at the two facilities discussed above obtain and implement the risk assessment developed by the State, or create their own assessment tool which meets PREA requirements.

Complaints

NRS 218G.585 requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their care or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child.

We received and reviewed 636 complaints from 30 facilities in Nevada, during the period from July 1, 2021, through June 30, 2022. Of the 636 complaints received, 309 (48.6%) were received from children placed in correction and detention facilities, and 282 (44.3%) were from psychiatric hospitals and PRTFs.

In general, the population of children at these facilities include children with high behavioral and mental health needs. Detention facilities, psychiatric hospitals, and PRTFs make up 27 of the 57 private and governmental facilities for children. We expect to review more complaints from these types of facilities due to their populations and the number of facilities.

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

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

- 1 of 13 correction and detention facilities;
- 2 of 2 facilities for the treatment of abuse of alcohol or drugs;
- 10 of 13 foster care agencies;
- 11 of 13 foster homes that provide specialized care;
- 1 of 7 psychiatric hospitals; and
- 2 of 7 PRTFs.

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

Based on inspections and discussions with facility management at some facilities, the complaint process is not well understood by management or clearly communicated to the children. For example, facility management did not understand that verbal complaints need to be documented and reported, or what is considered a health, safety, welfare, and civil and other rights issue. Additionally, children were not aware of the complaint process or how to file a complaint. The complaint process is essential to ensure a child's health, safety, welfare, and civil and other rights are adequately protected; and is statutorily required for governmental and private facilities who provide care to children.

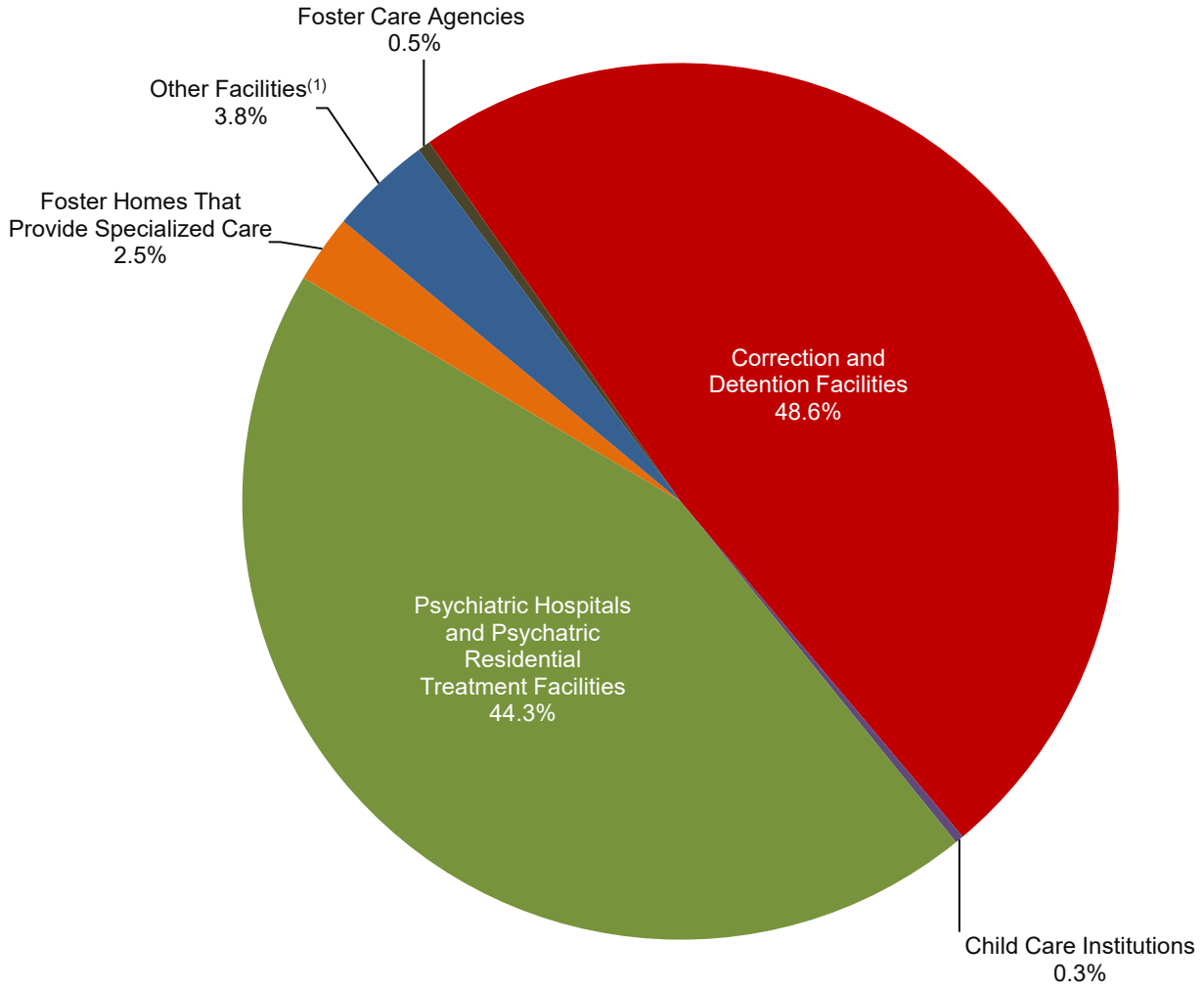
At 2 of 19 facilities inspected, we discovered evidence that facility management or the licensing agency were aware of incidents that posed a threat to a child's health, safety, welfare, and civil and other rights. However, a formal complaint was never reported to the Legislative Auditor. At one facility, the licensing agency was provided video evidence of a child being physically disciplined but did not forward the information to the Legislative Auditor. At the other facility, management was aware of an investigation of neglect of a child at their facility but did not forward the information to the Legislative Auditor.

However, NRS 218G.585 does not specifically define the complaint reporting process and only requires the facilities to forward complaints to the Legislative Auditor. Collection, documentation, review, and resolution of complaints vary at each facility. Facilities have different interpretations of what constitutes health, safety, welfare, and civil and other rights of a child. Some facilities resolve verbal complaints informally, instead of documenting the issue as a formal complaint, resulting in a lack of documentation.

Exhibit 4 summarizes complaints submitted by Nevada facilities to our office for the fiscal year ended June 30, 2022.

Summary of Complaints Submitted by Nevada Facilities
Fiscal Year Ended June 30, 2022

Exhibit 4



Source: Auditor prepared from complaints submitted by facilities.
(1) "Other Facilities" includes HELP of Southern Nevada's Shannon West Homeless Youth Center.

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

APPENDIX A

GLOSSARY

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

APPENDIX A

GLOSSARY (continued)

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

APPENDIX A

GLOSSARY (continued)

Foster Care Agency	A business entity that recruits and enters into contracts with foster homes to assist child welfare agencies and juvenile courts in the placement of children in foster homes. Foster care agencies may operate multiple family foster homes, including specialized foster homes and group foster homes. Foster care agencies train foster parents, and place children in either the foster parents' homes or in homes provided by the foster care agency. Foster parents are responsible for providing safe, nurturing, and supportive environments where children can continue daily activities that promote normalcy.
Health	Anything related to a child's physical health, including medical care and medication administration.
Nevada Division of Child and Family Services (DCFS)	Child welfare agency which provides child welfare services to all rural counties in Nevada.
Person Legally Responsible (PLR)	A person legally responsible for the psychiatric care of a child, which could be the child's parent(s), legal guardian, or other individual appointed by a court.
Prison Rape Elimination Act (PREA)	Prison Rape Elimination Act of 2003, including the U.S. Department of Justice National Standards to Prevent, Detect, and Respond to Prison Rape (28 CFR Part 115). The National Standards include guidance related to zero tolerance of sexual abuse and sexual harassment, supervision and monitoring, referrals of allegations for investigations, resident education, staff training, and obtaining information from residents.
Psychiatric Hospital	A hospital for the diagnosis, care, and treatment of mental illness which provides 24-hour care. Includes acute psychiatric (short-term) and non-acute psychiatric programs. Services are provided to meet the medical, psychological, social, and functional needs of the child in a safe and comfortable environment.

APPENDIX A

GLOSSARY (continued)

Psychiatric Residential Treatment Facility (PRTF)	A facility, other than a hospital, that provides a range of psychiatric services to treat residents under the age of 21 years on an inpatient basis under the direction of a physician. Services are provided to meet the medical, psychological, social, and functional needs of the child in a safe and comfortable environment.
Psychotropic Medication	A prescribed medication used to alter a child's thought process, mood, or behavior.
Safety	Anything related to the physical safety of children. This includes physical security, environment, and adequate staffing.
Specialized Foster Care	Provides full-time care and services for one to six children who require special care for physical, mental, or emotional issues.
Substance Abuse Prevention and Treatment Agency (SAPTA)	An agency within the Nevada Division of Public and Behavioral Health that plans, funds, and coordinates statewide substance abuse service delivery. A program that receives federal money for alcohol and drug abuse prevention and treatment services must be certified by SAPTA.
Washoe County Human Services Agency (WCHSA)	Child welfare agency which provides child welfare services in Washoe County.
Welfare	Anything related to the general well-being of a child. This includes education and punishments or discipline.

APPENDIX B

INSPECTIONS OF NEVADA CHILDREN'S FACILITIES

Facility Name	Facility Type	Type of Work	Date of Work
Summit View Youth Center	Correction Facility	Inspection	January 10, 2022 June 14, 2022
St. Jude's Ranch for Children	Foster Care Agency	Inspection	February 1, 2022 June 13, 2022
Jan Evans Juvenile Justice Center	Detention Facility	Inspection	March 1, 2022
3 Angels Care	Foster Care Agency	Inspection	March 16, 2022[1]
Douglas County Juvenile Detention Center	Detention Facility	Inspection	May 31, 2022
Reno Behavioral Healthcare Hospital, LLC	Psychiatric Hospital	Inspection	June 7, 2022[1]
Reno Behavioral Healthcare Hospital, LLC	Psychiatric Residential Treatment Facility	Inspection	June 7, 2022[1]
Child Haven	Child Care Institution	Inspection	June 14, 2022[1]
Clark County Juvenile Detention Center	Detention Facility	Inspection	June 15, 2022
Nevada Homes for Youth	Facility for the Treatment of Abuse of Alcohol or Drugs	Inspection Follow-Up Observation	June 16, 2022 August 25, 2022
R House Community Treatment Home	Foster Home That Provides Specialized Care	Inspection	June 29, 2022
Home A	Foster Home That Provides Specialized Care	Inspection	July 5, 2022
Home I	Foster Home That Provides Specialized Care	Inspection	July 25, 2022
Caliente Youth Center	Correction Facility	Inspection	July 26, 2022
Nevada Youth Training Center	Correction Facility	Inspection	July 27, 2022
Leighton Hall	Detention Facility	Inspection	July 28, 2022
Desert Winds Hospital	Psychiatric Residential Treatment Facility	Inspection	August 22, 2022
Spring Mountain Youth Camp	Correction Facility	Inspection	August 23, 2022
Never Give Up Youth Healing Center	Psychiatric Residential Treatment Facility	Inspection	August 24, 2022

Source: Auditor prepared from inspections completed.

[1] We conducted a survey or inspection of these facilities during fiscal year 2021 as well. See LA22-10, page 15.

APPENDIX C

NEVADA CHILDREN'S FACILITY INFORMATION
FISCAL YEAR ENDED JUNE 30, 2022

Correction and Detention Facilities	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Caliente Youth Center	Caliente	12 - 18	112	41	38	0
China Spring Youth Camp	Gardnerville	12 - 18	59	16	17	0
Clark County Juvenile Detention Center	Las Vegas	10 - 20	192	86	121	4
Douglas County Juvenile Detention Center	Stateline	10 - 17	16	2	6	3
Jan Evans Juvenile Justice Center	Reno	10 - 17	72	28	37	0
Leighton Hall	Winnemucca	10 - 18	6	1	10	4
Murphy Bernardini Juvenile Justice Center	Carson City	10 - 17	18	10	15	3
Nevada Youth Training Center	Elko	14 - 18	62	40	51	0
Northeastern Nevada Juvenile Detention Center	Elko	10 - 20	24	8	11	0
Spring Mountain Youth Camp	Las Vegas	12 - 18	100	54	49	1
Summit View Youth Center	Las Vegas	14 - 19	48	41	29	0
Teurman Hall	Fallon	11 - 17	16	8	13	4
Western Nevada Regional Youth Center	Silver Springs	12 - 18	18	9	16	3
Totals – 13 Correction and Detention Facilities			**743**	**344**	**413**	**22**

Child Care Institutions	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Child Haven	Las Vegas	0 - 18	90	75	65	39
Totals – 1 Child Care Institution			**90**	**75**	**65**	**39**

Psychiatric Hospitals	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
esert Parkway Behavioral Healthcare Hospital, LLC	Las Vegas	8 - 17	21	16	22	3
Desert Willow Treatment Center	Las Vegas	12 - 17	32	15	48	1
Desert Winds Hospital	Las Vegas	12 - 17	44	0	0	0
Reno Behavioral Healthcare Hospital, LLC	Reno	5 - 17	42	18	44	0
Seven Hills Hospital	Henderson	5 - 18	48	16	52	31
Spring Mountain Treatment Center	Las Vegas	5 - 17	26	12	15	0
Willow Springs Center	Reno	12 - 17	116	73	89	9
Totals – 7 Psychiatric Hospitals			**329**	**150**	**270**	**44**

APPENDIX C

NEVADA CHILDREN'S FACILITY INFORMATION
FISCAL YEAR ENDED JUNE 30, 2022 (continued)

Psychiatric Residential Treatment Facilities	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Desert Winds PRTF	Las Vegas	12 - 17	48	28	90	20
Never Give Up Youth Healing Center	Amargosa Valley	8 - 17	144	87	120	21
PRTF Enterprise	Reno	6 - 17	18	5	13	0
PRTF North	Sparks	12 - 17	16	8	21	0
PRTF Oasis	Las Vegas	6 - 17	12	5	14	0
Reno Behavioral Healthcare Hospital, LLC	Reno	12 - 17	21	15	11	0
Rite of Passage - Sierra Sage Treatment Center	Yerington	14 - 17	48	30	45	2
Totals – 7 Psychiatric Residential Treatment Facilities			**307**	**178**	**314**	**43**

Facilities for the Treatment of Abuse of Alcohol or Drugs	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Nevada Homes for Youth	Las Vegas	13 - 18	10	7	5	2
Vitality Unlimited - ACTIONS	Elko	14 - 18	13	0	17	0
Totals – 2 Facilities for the Treatment of Abuse of Alcohol or Drugs			**23**	**7**	**22**	**2**

Foster Homes That Provide Specialized Care	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
Austin's House	Carson City	0 - 18	10	8	3	7
Home A[(2)]	Yerington	0 - 18	2	1	1	0
Home B[(2)]	Pahrump	6 - 21	1	1	1	0
Home C[(2)]	Amargosa Valley	6 - 18	2	2	2	0
Home D[(2)]	Fallon	15 - 18	2	1	1	0
Home E[(2)]	Pahrump	0 - 18	3	3	2	0
Home F[(2)]	Pahrump	0 - 18	6	4	2	0
Home G[(2)]	Fernley	0 - 18	3	1	1	0
Home H[(2)]	Pahrump	3 - 18	4	3	2	0
Home I[(2)]	Ely	0 - 18	7	5	2	0
Kids' Kottages	Reno	0 - 18	15	12	19	10
Quest Counseling and Consulting, Inc.	Reno	14 - 18	6	3	5	3
R House Community Treatment Home	Reno	5 - 18	1	1	2	0
Totals – 13 Foster Homes That Provide Specialized Care			**62**	**45**	**43**	**20**

APPENDIX C

NEVADA CHILDREN'S FACILITY INFORMATION
FISCAL YEAR ENDED JUNE 30, 2022 (continued)

Other[1]	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
HELP of Southern Nevada's Shannon West Homeless Youth Center	Las Vegas	16 - 24	8	4	40	0
Totals – 1 Other			**8**	**4**	**40**	**0**

Foster Care Agencies	Background		Population		Staffing Levels	
	Location	Ages Served	Maximum Capacity	Average Population	Average Full-Time	Average Part-Time
3 Angels Care	Reno	6 - 18	20	19	14	1
180 Community Wellness Centers, LLC	North Las Vegas	4 - 18	12	8	5	2
Apple Grove Foster Care Agency	Las Vegas	2 - 18	25	8	16	0
Bamboo Sunrise, LLC	Henderson	0 - 18	73	60	54	11
Call to Compassion, LLC	Reno	0 - 18	7	7	7	2
Eagle Quest	Las Vegas	0 - 19	227	168	135	0
JC Lighthouse DBA	Reno	12 - 17	14	9	8	1
Koinonia Family Services	Reno	0 - 18	28	22	21	1
Mt. Olive Care	Reno	0 - 18	10	9	4	3
Olive Crest	Las Vegas	0 - 18	28	15	27	1
P6 Family Services, LLC	Sun Valley	6 - 18	18	15	15	1
St. Jude's Ranch for Children	Boulder City	0 - 18	61	22	17	2
Specialized Alternatives for Families and Youth of Nevada, Inc.	Las Vegas	0 - 18	95	85	35	1
Totals – 13 Foster Care Agencies			**618**	**447**	**358**	**26**
Totals – 57 Facilities Statewide			**2,180**	**1,250**	**1,525**	**196**

Facilities That Closed During Fiscal Year 2022 or No Longer Meet the Definition of a Facility Subject to Auditor Inspection in NRS 218G.535

Facility	Type of Facility	Location
Hand Up Homes	Foster Home That Provides Specialized Care	Reno
Home J [2]	Foster Home That Provides Specialized Care	Pahrump
Nevada Homes for Youth II	Facility for the Treatment of Abuse of Alcohol or Drugs	Las Vegas
Sierra Nevada Connections	Foster Care Agency	Reno
Tahoe House Family Services	Foster Home That Provides Specialized Care	Carson City
The Reagan Home	Foster Home That Provides Specialized Care	Reno
West Hills Behavioral Health Hospital	Psychiatric Hospital	Reno

Source: Auditor prepared from information provided by facilities.

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

[2] Homes A through J contain personal information in their facility name and have been coded alphabetically to provide anonymity.

APPENDIX D

METHODOLOGY

To identify facilities pursuant to the requirements of NRS we reviewed children's placement information submitted monthly by certain local governments. In addition, during examination of children's files, we noted the children's prior and subsequent placements. We also reviewed stories in the news media regarding children's facilities. Next, we contacted each facility identified to confirm it met the definitions included in NRS 218G.500 through 218G.535. For each facility confirmed, we obtained copies of complaints filed by a child or other persons on behalf of a child while in the care of a facility since July 1, 2021.

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

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

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

As inspections are not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States.

Inspections included discussions with management, a review of personnel and child files, and observations. Discussions with facility management included the following topics: medication administration, treatment plans, reporting of abuse or neglect, face sheets, the complaint process, background checks and training, and related policies and procedures. In addition, we judgmentally selected files to review which included: personnel files for evidence of background checks and required training; and child files

for evidence of children's acknowledgment of their right to file a complaint, medication administered, treatment plans, and face sheet information.

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

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

Our work was conducted from January 2022 through November 2022, pursuant to the provision of NRS 218G.570 through 218G.595.

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