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We have conducted a series of reviews of governmental and private facilities for children in the State of Nevada. These reviews were authorized by Assembly Bill 629, Section 6, of the 74th Session of the Nevada Legislature, 2007. The purpose of these reviews was to determine if the facilities protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care.

We wish to express our appreciation to the management and staff of the facilities for their assistance during the reviews.

Respectfully presented,

Paul V. Townsend, CPA
Legislative Auditor

December 1, 2008
Carson City, Nevada

STATE OF NEVADA
REVIEW OF GOVERNMENTAL AND PRIVATE FACILITIES FOR CHILDREN
DECEMBER 2008

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INTRODUCTION

This report includes the results of our work as required under Assembly Bill 629, Section 6, of the 74th Session of the Nevada Legislature. The report includes the results of our reviews of 13 children's facilities, unannounced site visits to 10 children's facilities, surveys of 43 children's facilities, and discussions with management and staff at Child Protective Services at the Washoe County Department of Social Services, Clark County Department of Family Services, and officials at the Division of Child and Family Services at the Nevada Department of Health and Human Services.

BACKGROUND

Assembly Bill 629 (AB 629) required the Legislative Auditor to conduct reviews, audits, and unannounced site visits of residential children's facilities. A copy of Section 6 of AB 629 is included in this report as Appendix A. This legislation was originally introduced in 2007 as Assembly Bill 305 on behalf of the Subcommittee to Oversee the Consultant to Study the Health, Safety, Welfare and Civil and Other Rights of Children in the Care of Certain Governmental Entities or Private Facilities.

Prior to the passage of AB 629, concerns about the health, safety, welfare and civil and other rights of children were raised following the U.S. Department of Justice investigation of a Nevada correctional facility in 2002. Subsequent to this investigation, a performance audit was proposed and money was set aside under AB 580, passed by the 73rd Legislature. In November 2005, the Legislative Commission selected the Nevada Institute for Children's Research and Policy (NICRP) to review policies, procedures, and protocols of 28 facilities. In addition, NICRP reviewed complaints filed subsequent to July 1, 2000, and conducted site visits and interviews at 28 facilities.

Number and Types of Facilities

AB 629 includes governmental and private facilities for children. Governmental facilities include any facility which is owned or operated by a governmental entity and which has physical custody of children pursuant to the order of a court. Private facilities include

any facility which is owned or operated by a person or entity which has physical custody of children pursuant to the order of a court.

We have identified a total of 57 governmental and private facilities which meet the requirements of AB 629: 23 governmental and 34 private facilities, 14 of which are out-of-state. Exhibit 1 lists the types of facilities located within Nevada and the total capacity of each type during calendar year 2007.

Exhibit 1

Summary of Nevada Facilities
Calendar Year 2007

		Population for CY 2007		Staffing Levels	
Facility Type	Number of Facilities	Maximum Capacity	Average Population	Full-time	Part-time
Correction and Detention Facilities	12	1,174	995	747	125
Resource Centers	3	95	45	44	18
Treatment Facilities	7	292	230	586	108
Child Welfare Facilities	2	178	141	131	43
Group Homes	6	95	90	82	5
Residential Centers	13	265	141	175	37
Total - Facilities Statewide	43	2,099	1,642	1,765	336

Source: Reviewer prepared from information provided by facilities.

We have categorized these types of facilities using the following guidelines:

- Correction facilities provide custody and care for youth in a secure, highly restrictive environment who would otherwise endanger themselves or others, be endangered by others, or run away. Correction facilities may include restrictive features, such as locked doors and barred windows.

- Detention facilities provide short-term care and supervision to youth in custody or detained by a juvenile justice authority. Detention facilities may include restricted features, such as locked doors and barred windows.

- Resource centers provide more than one type of service simultaneously. For example, a resource center may provide both treatment and detention services.

- Treatment facilities provide acute residential services for conditions that cannot be safely or effectively treated on an outpatient basis. Services are provided in a highly structured, highly supervised environment.

- Child welfare facilities provide emergency, overnight, and short-term services to youth who cannot remain safely in their home or their basic needs cannot be efficiently delivered in the home.

- Group homes provide safe, healthful group living environments in a normalized, developmentally supportive setting where residents can interact fully with the community. Group homes generally consist of detached homes housing 12 or fewer children.

- Residential centers provide a full range of therapeutic, educational, recreational, and support services. Residents are provided with opportunities to be progressively more involved in the surrounding community.

Grievances and Complaints

AB 629, Section 6, 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, 2007, through July 31, 2008, we received 1,709 complaints from 43 facilities. In Nevada, the most common type of complaint related to welfare. Exhibit 2 shows the number and type of complaints by type of facility. Appendix D, which begins on page 67, provides additional detail on complaints received from each facility.

Exhibit 2

Summary of Complaints From Nevada Facilities
July 1, 2007, through July 31, 2008

		Complaint Type					
Facility Type	Number of Facilities	Health	Safety	Welfare	Right(s)	Other	Totals
Correction and Detention Facilities	12	183	213	763	108	342	1,609
Resource Centers	3	2	4	6	1	2	15
Treatment Facilities	7	3	13	18	2	20	56
Child Welfare Facilities	2	0	8	1	0	0	9
Group Homes	6	1	5	4	0	7	17
Residential Centers	13	0	2	1	0	0	3
Facilities Statewide	**43**	**189**	**245**	**793**	**111**	**371**	**1,709**

Source: Reviewer prepared from complaints received.

The number and type of complaints received may be dependent on a number of factors, including the type of youth served, the type of facility, or the length of time spent at a facility. We used the following descriptions when analyzing the complaints and grievances received:

- Health – Anything related to a youth's physical health, such as nutrition, exercise, and medical care.
- Safety – Anything related to the physical safety of youth. This includes physical security and environment, protection from inappropriate comments or contact by staff or other youth, and staffing issues.
- Welfare – Anything related to the general well being of a youth. This includes education, wellness activities, and punishments or discipline.
- Rights – An earned privilege provided to a youth in the facility as a reasonable incentive to provide accountability, such as recreation time, telephone calls, and reading material.
- Other – Any other type of complaint or grievance, including those related to treatment. Treatment refers to the mental health and behavior treatment of youth. It includes access to counseling, treatment plans, and progress through a facility's program.

SCOPE, OBJECTIVE, AND METHODOLOGY

Reviews were conducted pursuant to the provisions of AB 629, Section 6, of the 74th Session of the Nevada Legislature. As reviews and not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in Government Auditing Standards issued by the Comptroller General of the United States, or in accordance with the Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

The purpose of our reviews was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care. These reviews included an examination of policies, procedures and complaints received for the period July 1, 2007, through the date of our visit to each facility. In addition, we discussed related issues and observed related processes during our visits, which were conducted from March 2008 through September 2008.

A detailed methodology of the work conducted can be found in Appendix G of this report, which begins on page 72.

RESULTS OF REVIEWS

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the facilities we reviewed provide reasonable assurance that they adequately protect the health, safety and welfare of youth at the facilities, and they respect the civil and other rights of youth in their care. In addition, during the 10 unannounced visits conducted, we did not note anything that would cause us to question the health, safety, welfare, or protection of rights of the children in the facilities.

During our reviews, we noted a common issue among the facilities. Facilities sometimes allow newly hired employees to have direct contact with youth prior to receiving the results of both state and federal background checks. Newly hired employees were fingerprinted for background checks at six of the seven facilities where we tested employee files for background checks. Background checks based on social security numbers were conducted at the seventh facility. However, at six of these facilities, new staff were allowed to have direct contact with youth prior to

facility management receiving all background check results. At some of these facilities, management stated the new staff were supervised and were not allowed to be alone with youth until the background checks were received.

We found it took from 2 to 15 weeks for facilities to receive the results of state and federal background checks. Two facilities reported it may take up to 4 months to receive the results of federal background checks. At one facility, management reported they cannot make applicants wait until background results are received because qualified applicants may not be willing to wait up to 2 months for an employment decision. In addition, having staff work in non-contact positions until the results of background checks are received may not be efficient.

We discussed this issue with staff at the Department of Public Safety, Records and Technology Division, Records Bureau (Bureau), facility management, and Division of Child and Family Services (DCFS) management. We determined that some facilities may be able to receive both state and federal background check results in about a week, at no additional cost, by having new employees fingerprinted at an agency that uses a scanner and electronically submits the fingerprints to the Bureau. However, some facilities may not be located close to an agency with a scanner. According to staff at the Bureau, some sheriff's offices have scanners, but some do not. Facilities may contact their local sheriff's office to find out if scanning and electronic submission are available.

Other practices that may be used by facilities include:

- ensuring new employees are supervised at all times when in contact with youth;
- requiring all applicants for positions to get a preliminary background check using a private firm to conduct a background check based on the employee's social security number; or
- assigning new employees to work in positions with no direct contact with youth until background checks are received.

However, each of these practices has drawbacks. While the results of background checks based on social security numbers are generally available sooner than conventional background checks, they may not detect if an employee used someone else's social security number. Smaller facilities may not have a sufficient

number of staff to provide constant supervision of new employees. In addition, facilities may not have the capability to assign new employees to positions with no direct youth contact.

Recommendations

1. Facilities should receive the results of all background checks prior to hiring new employees.

2. Facilities should work with the Department of Public Safety's Records and Technology Division, Records Bureau, to establish an efficient process to provide the results of background checks to those charged with approving potential employees as quickly as possible.

FACILITY OBSERVATIONS

While we observed nothing at the 13 facilities that caused us to question whether the facilities protect the health, safety, welfare, or rights of the residents, we found that many of the facilities had common weaknesses. These weaknesses included outdated or incomplete policies and procedures, less than optimal processes for complaints and grievances, a need to improve their medication documentation and delivery processes, and efforts to control access to contraband need to be strengthened.

Policies and Procedures Need Improvement

The most common observation at the 13 facilities we reviewed was that 11 facilities needed to develop, expand, or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated ranged from complaint processes, to substance abuse treatment, to records retention.

According to *Standards of Excellence* developed by the Child Welfare League of America (CWLA) and *Performance-based Standards* developed by the Council of Juvenile Correctional Administrators (CJCA), documented, up-to-date policies and procedures help ensure management and staff understand the facilities' processes. In addition, documented policies and procedures help ensure consistent services are provided to the youth residing at the facilities.

The CWLA is a coalition of private and public agencies serving vulnerable children and families. Its focus is on children and youth who may have experienced abuse, neglect, family disruption, or other factors that may have jeopardized their safety. The CJCA is a national non-profit organization dedicated to improving youth correctional systems and services. The CJCA aims to improve the practices and policies in local systems and increase the chances of success for delinquent youths.

Complaint Processes Not Adequate

The next most common observation related to the complaint and grievance (complaint) process. Some of the problems we found at the 13 facilities reviewed included:

- complaint forms were not readily available to youth at 9 of the 13 facilities;
- youth files did not contain evidence of a youth's acknowledgement of the right to file a complaint at 5 of 13 facilities;
- there were unclear, inconsistent, or deviations from complaint policies at 4 of 13 facilities;
- there were no locked complaint boxes at 4 of 13 facilities;
- complaints were not tracked for trends at 4 of 13 facilities; and
- information provided to youth at intake did not address the complaint process at 3 of 13 facilities.

According to *Standards of Excellence* developed by the CWLA and *Performance-based Standards* developed by the CJCA, all youth should have the right to file complaints and be assured their complaints will be addressed by an appropriate person at the facility without fear of retribution. Facilities should ensure residents are aware of their rights to file complaints. Tracking complaints for trends may help facilities better serve their clients and be proactive in addressing potential problems or behaviors before they become pervasive.

Medication Delivery and Documentation Needs Improvement

Documentation of medication administered to youth at 8 of 13 facilities needs improvement. Specifically, youth medical files did not contain clear documentation of dispensed prescribed

medication, medication discrepancies, or there was no evidence of a physician order for medication administered to a youth. In addition, we noted youth medical files were not reviewed by someone independent of the medication process at 4 facilities, and staff did not check for "cheeking" at 3 facilities. Cheeking is a method to conceal medication administered. Improvements to a facility's medication administration process may help ensure prescribed medication was administered to youth.

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

Efforts to Control Access to Contraband Could Be Strengthened

Common contraband findings included:

- a list of items considered contraband was not posted in 9 of 13 facilities;
- a list of items considered contraband was not developed or needed updating in 5 of 13 facilities; and
- youth were not searched for contraband or items considered contraband were found on campus at 4 of 13 facilities.

Contraband is any item that is not permitted in a facility. While items considered contraband may vary between facilities, common items include weapons, violent or sexually suggestive videos and movies, drugs, alcohol, and tobacco.

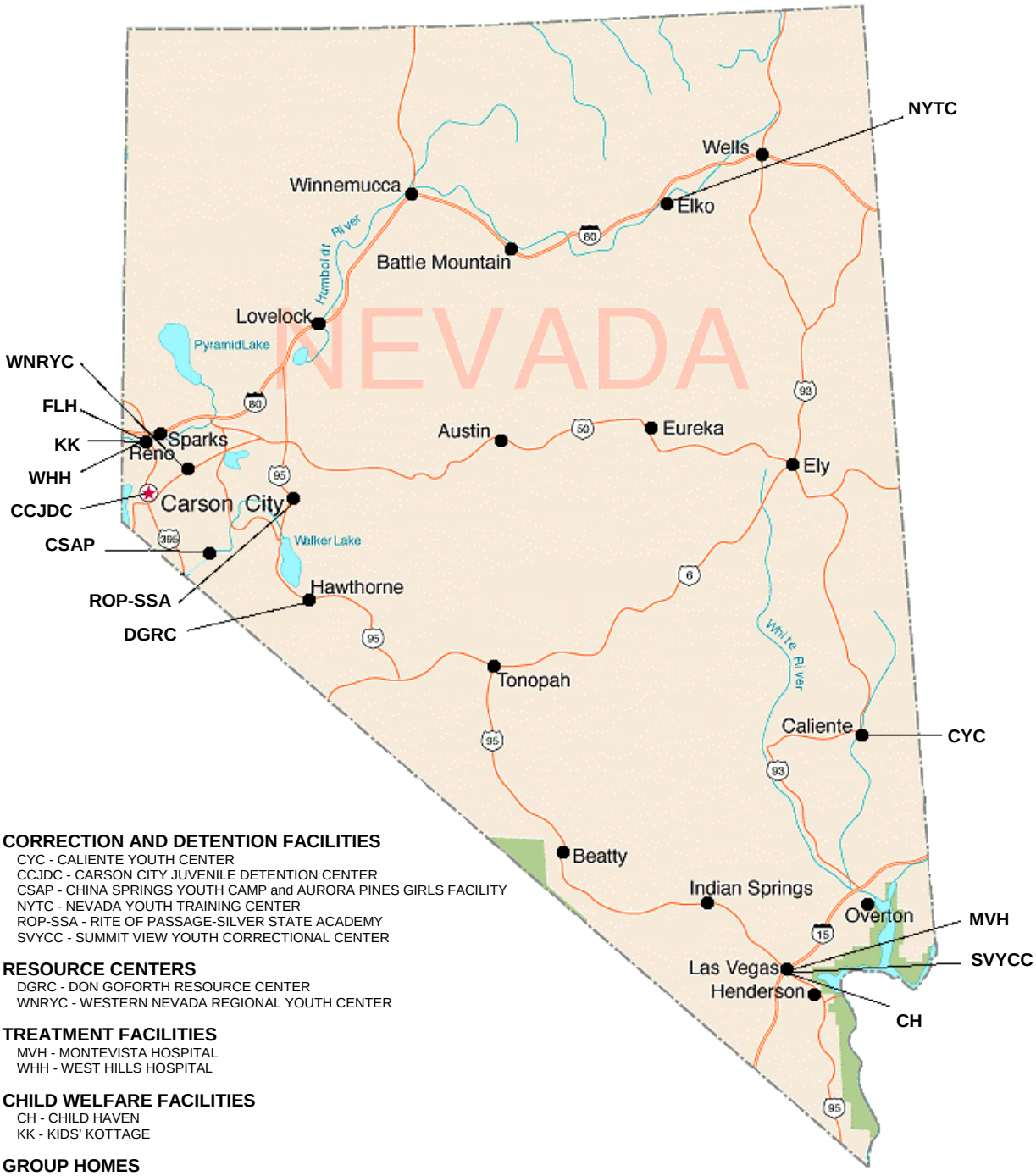
According to *Standards of Excellence* developed by the CWLA and *Performance-based Standards* developed by the CJCA, facilities should prevent the introduction of contraband and minimize access to contraband within the facility. Improvements to efforts to limit access to contraband at facilities may reduce the likelihood that unauthorized items enter a facility.

REPORTS ON INDIVIDUAL FACILITY REVIEWS

This section includes the results of reviews at each of the 13 facilities. Exhibit 3 lists the facilities and shows their locations. These results were provided to each facility and a written response was requested. A summary of each facility's response is included after each applicable issue.

Exhibit 3

Map of Facilities Reviewed



CORRECTION AND DETENTION FACILITIES
- CYC - CALIENTE YOUTH CENTER
- CCJDC - CARSON CITY JUVENILE DETENTION CENTER
- CSAP - CHINA SPRINGS YOUTH CAMP and AURORA PINES GIRLS FACILITY
- NYTC - NEVADA YOUTH TRAINING CENTER
- ROP-SSA - RITE OF PASSAGE-SILVER STATE ACADEMY
- SVYCC - SUMMIT VIEW YOUTH CORRECTIONAL CENTER

RESOURCE CENTERS
- DGRC - DON GOFORTH RESOURCE CENTER
- WNRYC - WESTERN NEVADA REGIONAL YOUTH CENTER

TREATMENT FACILITIES
- MVH - MONTEVISTA HOSPITAL
- WHH - WEST HILLS HOSPITAL

CHILD WELFARE FACILITIES
- CH - CHILD HAVEN
- KK - KIDS' KOTTAGE

GROUP HOMES
- FLH - FAMILY LEARNING HOMES

Source: Reviewer prepared.

Caliente Youth Center

Background Information

Caliente Youth Center (CYC) is a state-funded correctional facility. The facility is located in Caliente, Nevada, and houses male and female youth between the ages of 12 and 18. The purpose of CYC is to promote positive value change and skills development for delinquent youths through a structured, balanced, team-centered approach to service provision.

CYC is a staff-secured facility with a maximum capacity of 140 youth. During calendar year 2007, daily population averaged 92 youth with an average length of stay of 6 months. During the month of our review, August 2008, the average population was 118 youth.

CYC is funded by the Nevada Division of Child and Family Services. During calendar year 2007, the facility had 88 full-time employees. CYC reported 569 complaints to us for the period of July 1, 2007, to July 31, 2008. Of these, we classified 281 as welfare, 82 as health, 76 as safety, 22 as rights, and 108 as other.

Purpose of the Review

The purpose of our review was to determine if Caliente Youth Center adequately protects the health, safety, and welfare of the children in CYC and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies, procedures, and complaints for the period July 1, 2007, to June 30, 2008. In addition, we discussed related issues and observed related processes during our visit in August 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at CYC provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility and respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, CYC needs to improve its medication process, strengthen intake procedures, strengthen

contraband controls, and develop and update policies and procedures.

Principal Observations

Medication Process

CYC needs to improve its medication process. During our review of medication files, we noted 7 of 25 files did not contain clear documentation of dispensed prescribed medication. Although policies require documentation of all medication administered, youth can refuse prescribed medication; however, this must be documented. Alternatively, medical staff may have forgotten to administer prescribed medication, which is considered a medical error. Policies require documentation of medical errors. The CYC medication administration form requires staff administering medication to initial the form after administering medication. The form also provides a menu to document medication refused or missed. It is unclear if prescribed medication was administered and not documented, refused, or not administered because this was not clearly documented in medication files.

In addition, medical files are not reviewed by someone independent of the medication process. Periodic independent reviews of medical files help identify potential errors, fraud or abuse. Without periodic reviews, errors, fraud or abuse could occur and go undetected.

Also, CYC needs to update its infirmary standing order form. A standing order form identifies physician approved over-the-counter medication the facility may administer to youth. The facility's infirmary standing order form has not been updated since May of 2006. Not updating this form on a regular basis could result in medication administered to youth that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Facility Response

Caliente Youth Center clarified all but one of the unclear medication documents related to discontinued medication. In addition, Caliente Youth Center has revised its documentation process to distinguish between medication not administered and medication discontinued. CYC also confirmed it will review 25%

of youth medical files quarterly. The facility's standing order form had been revised, but had not been signed by their physician.

Intake

CYC needs to strengthen its intake procedures. During intake, we noted inconsistencies in conducting searches. Specifically, at least one male youth and two female youth were unsupervised during a clothing change, while others were supervised. Unsupervised clothing changes increase opportunities for contraband to enter the facility. We also noticed at least three male youth were asked personal intake questions while in the presence of other youth. Questions discussed included gang affiliation, parent and sibling information, and suicidal interpretation and experience. Limiting a youth's privacy during questioning may also violate the Federal Health Insurance Portability and Accountability Act. Consistent intake procedures provide increased assurance privacy is respected.

Facility Response

Caliente Youth Center explained the intakes we observed was unusually busy and, therefore, not consistent with normal intake procedures. The facility explained their standard operating procedure of conducting searches and measures to ensure confidentiality. CYC will assess this situation to determine if there are alternative methods to provide increased confidentiality.

Contraband

CYC should strengthen contraband controls. Although items considered contraband are addressed in student handbooks, the list was not posted in the facility. A list of items considered contraband should be posted within the facility, visible to youth, staff and visitors. In addition, we noted unsecured fishhooks accessible to youth. Because fishhooks are considered contraband, they could have been used without authorization. Posting a list of items considered contraband and prompt, secure storage of items considered contraband reduces the likelihood that unauthorized items may enter the facility.

Facility Response

Caliente Youth Center has posted a list of contraband in the facility, visible to youth, staff and visitors. In addition, unsecured fishhooks were addressed with a supervisor.

Policies and Procedures

CYC should develop and update existing policies. Although CYC reevaluates youth periodically, we did not note policies specific to reevaluation of youth. In addition, we noted policies and procedures were not updated regularly. Policies and procedures were updated between 1999 and 2006. Without clearly documented, updated policies and procedures, management and staff may be unclear of the facility's processes.

Facility Response

Caliente Youth Center is revising its policies and procedures.

Other Items Noted

Other items noted during our review include: employees had direct contact with youth prior to the results of all background checks being received; 8 of 25 files reviewed did not include documentation of a youth's acknowledgement of a right to file a complaint; 6 of 25 files did not contain documentation of a youth's treatment plan, although electronic plans were available; and staff brought an age-inappropriate movie into the facility.

Facility Response

Caliente Youth Center confirmed all offers of employment are made with an employee's knowledge that employment is contingent on the receipt and approval of any criminal history. Management is researching another option to obtain background checks more timely. In addition, the facility has updated its youth files for evidence of a youth's right to file a complaint and treatment plans. When staff exchange movies amongst themselves, they have been instructed to secure the movies.

Carson City Juvenile Detention Center

Background Information

Carson City Juvenile Detention Center (CCJDC) is a locked, temporary holding facility for youth between the ages of 8 and 18 pending disposition of their cases in Juvenile Court. The purpose of the facility is to provide security to the community by housing youth that may be or have been involved in activities considered dangerous to the public. The facility also provides a safe and secure environment for youth while they are involved in the court process.

CCJDC comprises two wings to house male and female youths. During calendar year 2007, daily population averaged 18 youths with an average length of stay of 6 days. Although CCJDC has a maximum capacity of 24 beds, management indicated capacity was reduced to 22 beds effective April 1, 2008. Funding is provided by the county and CCJDC employs 15 full-time and 6 on-call employees. During the month of our review, April 2008, the average population was 16 youths.

CCJDC did not report any complaints for the period July 1, 2007, to February 29, 2008.

Purpose of the Review

The purpose of our review was to determine if CCJDC adequately protects the health, safety, and welfare of the children in CCJDC and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies and procedures for the period July 1, 2007, to February 29, 2008. In addition, we discussed related issues and observed related processes during our visit in April 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the Carson City Juvenile Detention Center provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, we made some suggestions to improve policies and processes. Specifically, policies and the Resident

Rights, Rules and Discipline document need to be updated, and all grievances should be tracked.

Principal Observations

Policies

CCJDC's policies do not clearly address the following areas: intake, contraband, civil rights, and social skills. Policies contain a section on admission procedures; however, CCJDC should consider revising this section to include forms completed by staff and youth during intake. Although policies mention contraband, items considered contraband are not clearly identified. CCJDC should also consider posting contraband information within the secure area visible to youth and visitors. Civil rights policies do not contain a reference to religion, sexual orientation, or corrective action taken against staff who discriminate. In addition, policies do not address social skills.

Facility Response

CCJDC will adjust their policies to accommodate these suggestions.

Complaint Process

The Resident Rights, Rules and Discipline document provided to youth during intake contains a small paragraph about the complaint process. However, the paragraph does not clearly describe the complaint process and may be difficult for youth to comprehend. CCJDC should consider incorporating some of the complaint section from its policy manual into the Resident Rights, Rules and Discipline document to help improve youths' understanding of their right to file complaints.

According to management, youths sometimes file complaints that they subsequently retract, so management destroys the information. CCJDC should record and track these complaints to identify potential trends, which may help CCJDC improve services provided to youths. Also, complaint forms are not readily available to youth and there is no locked complaint box to provide reasonable assurance management receives all complaints filed.

Facility Response

CCJDC is revising its complaint process. CCJDC also clarified all complaints received are filed; however, a youth may retract and destroy a complaint during the complaint process. Also, the availability of complaint forms and a locked complaint box are being considered.

Other Items Noted

Other items noted during our review included: CCJDC does not separately identify youth at risk to run away; and daily or weekly schedules are not posted within the facility, which may be especially important to new intakes.

Facility Response

CCJDC stated they have always separately identified youth at risk to run away; schedules are not posted for security reasons.

Additional Information

CCJDC terminated one employee during 2007 for use of unreasonable force on a minor. We reviewed CCJDC's documents related to this incident and discussed the incident and the actions taken with management. Based on our review, CCJDC management took appropriate and prompt action when notified of this incident.

Facility Response

CCJDC did not comment on this item.

China Springs Youth Camp and Aurora Pines Girls Facility

Background Information

China Springs Youth Camp and Aurora Pines Girls Facility (CSAP) is a staff-secured, residential treatment facility for mid-level juvenile offenders between ages 12 and 18, located in Minden, Nevada. The purpose of the camp is to provide structure and programs for resident youth to overcome delinquent and antisocial behaviors, promote health and resilience, and create a safe, comforting, challenging, and nurturing environment to facilitate a positive reintegration with family and the community.

China Springs Youth Camp and Aurora Pines Girls Facility are co-located on the same campus. China Springs houses male offenders and has a maximum capacity of 41 beds. During calendar year 2007, the daily population averaged 40 and the average length of stay was 134 days. Aurora Pines Girls Facility houses female offenders and has a maximum capacity of 24 beds. During calendar year 2007, the daily population averaged 19 and the average length of stay was 155 days.

Although CSAP has a maximum capacity of 65 beds, it was funded for 56 beds during the period of our review. Funding is provided by the State and 16 of Nevada's 17 counties. CSAP has 38 full-time employees and 1 part-time employee. During the month of our review, March 2008, the average population was 60: 40 at China Springs and 20 at Aurora Pines. CSAP reported 82 complaints to us for the period July 1, 2007, to February 29, 2008. Of these, we classified 14 as health, 5 as safety, 26 as welfare, 9 as rights, and 28 as other.

Purpose of the Review

The purpose of our review was to determine if CSAP adequately protects the health, safety, and welfare of the children in CSAP and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies, procedures and complaints for the period July 1, 2007, to February 29, 2008. In addition, we discussed related issues and observed related processes during our visit in March 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at China Springs Youth Camp and Aurora Pines Girls Facility provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. Although we did not find any significant issues, we noted two deficiencies.

Principal Observations

Right to File a Complaint

Youth files do not contain evidence of a youth's right to file a complaint. All the youths we spoke with were aware of their right to file a complaint, but documenting the youth is aware of this right would further strengthen CSAP's controls.

Facility Response

China Springs Youth Camp and Aurora Pines Girls Facility developed a "Notice of Client Rights" document.

Schedules Not Posted

Daily or weekly schedules are not posted within the facility. Posting schedules would provide additional structure for residents and would help new arrivals understand what to expect for their daily routine.

Facility Response

A copy of the weekly schedule has been posted in the dormitories of both the China Springs Youth Camp and the Aurora Pines Girls Facility.

Nevada Youth Training Center

Background Information

Nevada Youth Training Center (NYTC) is a state-funded correctional facility in Elko, Nevada. The facility houses male youth between the ages of 12 and 18. The purpose of NYTC is to provide a positive environment to change behavior, attitude, values, and thinking in order to return youth to the community.

NYTC is a staff-secured facility with a maximum capacity of 160 youth. During calendar year 2007, daily population averaged 148 youth with an average length of stay of 7 months. During the month of our review, September 2008, the average population was 110 youth.

NYTC is funded through the Nevada Division of Child and Family Services (DCFS). During calendar year 2007, the facility had 110 full-time employees. NYTC reported 155 complaints to us for the period July 1, 2007, to July 31, 2008. Of these, we classified 9 as health, 16 as safety, 94 as welfare, 5 as rights, and 31 as other.

Purpose of the Review

The purpose of our review was to determine if NYTC adequately protects the health, safety, and welfare of the children in NYTC and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies, procedures, and complaints for the period July 1, 2007, to July 31, 2008. In addition, we discussed related issues and observed related processes during our visit in September 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at NYTC provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility and respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, NYTC needs to strengthen its medication administration process, develop and consolidate existing policies and procedures, and strengthen contraband controls.

Principal Observations

Medication Administration Process

NYTC needs to strengthen its medication administration process. During our review, we noted 6 of 25 medication files did not contain clear documentation of whether prescribed medication was dispensed. Although policies require documentation of all medication administered, youth can refuse prescribed medication. This must be documented. Alternatively, medical staff may forget to administer prescribed medication, which is considered a medical error. Policies also require documentation of medical errors. Staff is required to initial the medication administration form after administering medication. The form also provides a menu to document medication refused or missed. There was no documentation in some medication files indicating if prescribed medication was administered, refused, or not administered.

In addition, we noted 1 of 25 files did not contain evidence of physician orders to administer medication. Although the medication was considered an over-the-counter medication, policies require all medication have some documentation of physician approval. Without evidence of physician approval, medications could be erroneously administered to youth.

Also, medical files are not reviewed by someone independent of the medical process. Periodic, independent reviews of medical files would help identify potential errors, fraud or abuse.

Facility Response

NYTC has revised its process of documenting and reviewing documentation of medication administered to youth. In addition, NYTC obtained a standing order form signed by both its doctors for over-the-counter medication administered and will review 10% of its youth medical files quarterly and annually.

Policies and Procedures

NYTC should develop and consolidate existing policies. Although NYTC provides each youth's parent(s) or legal guardian with a copy of the complaint process, we did not note complaint policies for parent(s) or legal guardian, visitors, or staff to follow. During our review, NYTC used various NYTC and state policies and

procedures. NYTC should continue to develop procedures unique to its facility, consistent with the Department of Justice's recommendation. To efficiently complete this process, DCFS should provide some guidance and develop a method for NYTC to submit procedures for DCFS review. Implementing a method for NYTC to submit procedures provides some assurance that DCFS is aware of the procedures adopted by one of its facilities.

Facility Response

NYTC is in the process of revising its policies and procedures. The Deputy Administrator of DCFS will approve the policies and procedures.

Control of Contraband

NYTC needs to strengthen contraband controls. During our review, we noted some items considered contraband are addressed in the student handbook. The handbook also states "…or any other item listed on the contraband list." To avoid any potential misinterpretation of items considered contraband, NTYC should incorporate other items listed on the contraband list into the handbook. In addition, NYTC's list of items considered contraband was not posted in the administrative building or in two of seven living cottages. Posting a list of items considered contraband within the facility, visible to youth, staff, and visitors, reduces the likelihood that unauthorized items may enter the facility.

Facility Response

A list of items considered contraband has been incorporated into the student handbook and is being incorporated into parent packets. In addition, lists of items considered contraband have been posted within the facility.

Other Items Noted

Other items noted during our review include: employees had direct contact with youth prior to the results of all background checks being received; although all youth are provided with a student handbook that addresses the complaint process, 16 of 25 files reviewed did not include evidence of the youth's acknowledgement of the right to file a complaint; NYTC's list of cases referred to Child Protective Services was incomplete; fire escape routes were not

posted in all of the youth living units; and first-aid kits were not always fully stocked.

Facility Response

NYTC recognized there is a one to four month delay in receiving FBI background check results, which is out of their control. NYTC does run a Nevada background check before new employees begin work. In addition, NYTC has filed youth acknowledgement forms concerning a youth's right to file a complaint in youth files; updated and reviewed its CPS log; posted fire escape routes; and stocked first-aid kits.

Rite of Passage-Silver State Academy

Background Information

Rite of Passage-Silver State Academy (ROP-SSA) is a private non-profit, staff-secured facility located in Yerington. ROP-SSA is licensed as a group home that provides treatment to at risk male youth between the ages 14 and 18. ROP-SSA's mission includes a program based on restorative justice principles, dedicated to providing the most efficient treatment program for youth, and assisting youth transition back into the community.

ROP-SSA comprises a campus type environment with a maximum capacity of 225 beds. During calendar year 2007, daily population averaged 196 youth with an average length of stay of 12 months. ROP-SSA employed an average of 146 employees: 136 full-time and 10 part-time employees, during calendar year 2007. During the month of our review, August 2008, the average population was 186 youth.

ROP-SSA reported receiving nine resident complaints from Nevada youth between July 1, 2007, and June 30, 2008. We determined that seven complaints were related to welfare, one was related to safety, and one was considered a right.

Facility Response

Paragraph 1 sentence 2 should read: ROP-Silver State Academy provides a cognitive academy peer oriented culture that offers several evidence based treatment programs to assist youth developing into positive members of the community.

In addition to the fact that Silver State Academy adheres to licensing regulations, it should be noted that Silver State Academy currently accepts youth from six states (Nevada, California, Michigan, Minnesota, Indiana, and Utah) and each state has youth care standards and regulations. Furthermore, CA, MI, MN, IN, and UT all conduct annual compliance reviews of the Silver State program.

Purpose of the Review

The purpose of our review was to determine if ROP-SSA adequately protects the health, safety, and welfare of children in ROP-SSA and whether the facility respects the civil and other rights of the children in its care. The review included an examination of policies, procedures and complaints for the period July 1, 2007, to June 30, 2008. In addition, we discussed related issues and observed related processes during our visit in August 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at ROP-SSA provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, ROP-SSA needs to strengthen its controls of medication and medication administration, improve its complaint and grievance process, develop and update existing policies, and strengthen controls over contraband items.

Facility Response

Based on the information provided below the last sentence deserves revision.

Principal Observations

Medication and Medication Administration

ROP-SSA needs to strengthen its controls of medication and medication administration. Specifically, we noted: copious amounts of prescribed medication of graduated youth; unlabeled prescribed medication; unclear documentation of medication administered; lack of cheeking procedures; and an outdated over-the-counter physician standing order form.

Facility Response

Due to inaccuracies, it needs revision.

During our review, we observed copious amounts of prescribed medication of graduated youth. Policies require graduated youths'

medication be transported with youth or removed by medical personnel. We also observed two large bottles of unlabeled prescribed medication. Storing prescribed medication for graduated youth and unlabeled prescribed medication increases the risk of unauthorized use or expired medications being dispensed to youth. Not disposing of prescribed medication and storing unlabeled prescribed medication increases the risk of potential fraud or abuse occurring and going undetected.

Facility Response

Due to a leave of the Medical Director the established procedure for expired/exited student prescription medication was not current at the time of the audit. Currently ROP Silver State Academy is appropriately up to date on all medication disposal procedures. The procedures include weekly inventory audits that include a witnessed and documented destruction of all medication that should not be on site.

During our review of medication files, 4 of 13 files did not contain clear documentation of dispensed prescribed medication. Although policies require documentation of all medication administered, youth can refuse prescribed medication; this must be documented. Alternatively, medical staff may have forgotten to administer prescribed medication which is considered a medical error. Policies require documentation of medical errors. ROP-SSA's medication administration form requires staff administering medication to initial the form after administering medication. The form also provides a menu to document medication refused or missed. Because this was not clearly documented in medication files, it is unclear if prescribed medication was administered and not documented, refused, or not administered. Periodic, independent reviews of medical records increase opportunities to identify unclear documentation and identify potential errors, fraud or abuse. Without periodic reviews, errors, fraud or abuse could occur and go undetected.

Facility Response

ROP agrees the medical files did not include clear documentation of all dispensed prescribed medication. The issue has been corrected through the revision of the medication administration form and staff training. In summary, the corrective action included modifying the

form to include a section for medication refusal. Due to the fact that students at Rite of Passage Silver State Academy have the right to refuse medication at anytime a signature line has been added to document when a student refuses any medication. Furthermore, a weekly review of five random medical files is now being conducted by the Medical Director and the Director of Student Services.

Medication policies address various techniques to check for "cheeking". "Cheeking" is a method to conceal medications. However, we observed only one of these techniques was consistently followed during administration of medication. Failure to apply all techniques increases the risk of medications being cheeked for unauthorized use at a later time.

Facility Response

ROP agrees with the language in this paragraph. There are adequate policies to address attempts to "cheek" medication. Despite the staff having the youth do a mouth sweep and visual inspection they did not have all youth "cough and blow" to complete the process as listed in policy. Since the audit the medical staff have been retrained on this policy.

We also noted the ROP-SSA over-the-counter physician standing order medication form has not been updated since August 1999. The standing order form identifies physician approved over-the-counter medication the facility may administer to youth. Not updating this form on a regular basis could result in medication administered to youth that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Facility Response

Since the audit the over the counter physician standing order form has been updated. No medications were removed but one for constipation was added. A yearly periodic review of the form will be conducted each January. The last sentence, "Not updating this form…" is not necessary and should not be included in the final report. It is one of many examples of what could result.

Complaint and Grievance Process

ROP-SSA needs to improve its complaint and grievance process. Complaint and grievance forms are not readily available to youth, youth must request forms from staff. Forms that are not readily available to youth may decrease a youth's willingness to express his complaint or grievance in writing. We noted locked boxes are not available for youth to place their complaint and grievance forms. Locked boxes provide reasonable assurance the integrity of an issue will be maintained. In addition, 3 of 13 files tested did not contain evidence of a youth's right to file a grievance. Signed acknowledgements of youths' rights to file grievances is a method of documenting a youth's understanding of his right to file a grievance. Although ROP-SSA tracks grievances, management indicated they do not track or analyze complaints filed. ROP-SSA considers a grievance to be a follow-up to an unresolved complaint. Improved complaint and grievance processes may increase ROP-SSA's ability to adequately serve youth.

Facility Response

ROP disagrees with the language in paragraph 1. There is an established grievance policy and procedure that meets the current requirements of all licensing regulations and placing agencies currently using Silver State Academy.

Currently, students may complete and submit (to any staff) a student statement form. The use of locked boxes is not currently part of the ROP policy and procedures nor any established licensing standard. Their absence should not be noted as a deficiency, perhaps listed as a recommendation?

Tracking of grievances is completed monthly. Perhaps this was not adequately explained during the August audit. All formal grievances are numbered and who the grievance is for is documented in a book kept in a locked file cabinet. Every month the grievances are tracked among the site Key Performance Indicators as founded, unfounded, and unresolved. The subject of each is discussed by the ROP executive committee on the second Tuesday of each month.

ROP agrees that some student files were missing a signed Student's Rights and Privileges form. The revised process to ensure this does not happen again includes the student's case manager reviewing the student's rights and privileges with the student on the first business day after the student arrives. The signed form is then passed on to the Director of Student Services for final review and filing.

Policies and Procedures

ROP-SSA should develop and update existing policies. During the period of our review, we did not note policies specific to the following: mental health and substance abuse treatment; re-evaluation of youth; pre-prescribed psychotropic medication; staff, visitor, and parent complaint and grievance process and resolution; and records retention. ROP-SSA has policies addressing physical training and athletics; however, the policies do not address other types of unstructured recreation. In addition, the policy addressing youth and attorney communication does not include a youth's right to confidential communication with an attorney.

In addition, we noted deviations from existing policies. Official complaint and grievance policies are not consistent with policies posted in youth living units. Official policies have an effective date of 2008 and do not specify complaint resolution timelines; whereas, posted policies are dated 2004 and define complaint resolution timelines. During discussions with staff, we noted complaint forms (problem solving forms) are not always used, which is inconsistent with official and posted policies. Inconsistent policies can create confusion and failure to follow the correct protocol. Without updated policies and procedures, management and staff may be unclear of the facility's processes.

Facility Response

ROP strongly disagrees with the language of paragraph 1. The ROP assessment process clearly indicates a full assessment is to be completed every six months. Several hours in the daily schedule (all referenced in the operations manual) include recreation programs including but not limited to – MPE, sports training, club activities, interscholastic activities.

ROP agrees that the policies posted in some living units observed during the audit were not consistent with those with an effective date of 2008. Since the August audit all policies posted in the living units have been updated and the operations manual has been reviewed completely for accuracy.

Contraband

ROP-SSA needs to strengthen controls over contraband items. Information provided by ROP-SSA described incidents of youth having contraband, including tobacco, prescription medication, and other drugs. Possession of these items is strictly prohibited by ROP-SSA literature. In addition, according to personnel policies, ROP-SSA is a tobacco-free facility, however, we observed staff chewing tobacco and tobacco products in staff areas. We also noted a video game with an "M" rating, which is considered appropriate only for persons 17 and older. The video game was in a locked closet; however, it may have been possible for youth to have access to it. Although some contraband items are outlined in literature and policies, ROP-SSA does not have a comprehensive list. Posting a list of items considered contraband within the facility, visible to youth, staff, and visitors, may reduce the likelihood of unauthorized items entering the facility.

Facility Response

ROP disagrees with some of the language in paragraph 1. The information provided by management during the audit described the numerous incidents where students and/or parents attempted to bring on campus contraband items including tobacco, drugs, and sexually suggestive material. The reason management was aware of such attempts was due to staff vigilance and strong policies. Due to the fact that Rite of Passage Silver State Academy is privately operated licensed group home searches of students are limited compared to those permitted in county or state facilities.

Silver State Academy will continue to work on preventing contraband from coming in from parents and following home visits. A comprehensive list of contraband has been completed and will be posted throughout the site. Also signs saying that Rite of Passage Silver State Academy is a tobacco free site will be posted.

It should be noted that the one video game with "M" rating was found locked in a closet in an area inaccessible to students. It was not "available to youth." Despite the fact that the game was owned by a staff member and provided to other staff in the evenings after the youth were asleep it was removed from campus.

Other Items Noted

Other items noted during our review included: employees have direct contact with youth prior to the results of all background checks being received; various construction materials were observed in a youth living unit; first aid kits were not always fully stocked; there was no filtering software on the internet in the youth library; and there were inconsistencies between management, staff and the youth handouts regarding youth's valuables.

Facility Response

ROP believes some of the language in this section should be revised. It is ROP policy and procedure to NOT allow unsupervised contact with youth by employees prior to the results of all background checks being received. New staff in training are assigned a "staff shadow" until a clear background check is received.

The "construction materials" observed in a living unit included wooden door trim and it was removed prior to the LCB auditors exit from the facility. Including it in the final report really is not appropriate.

ROP agrees the first aid kits did not have 100% of the listed materials the day the LCB conducted the audit. The contents of the kits are now audited monthly. It should be noted that the on site medical department was and still is fully stocked with all items that were missing.

Since the LCB audit ROP has purchased and installed content filtering software named "websense." It is software specifically developed for schools that filters the internet access of all computers on campus. Youth's valuables are being boxed and sent home upon admission into Silver State Academy.

Summit View Youth Correctional Center

Background Information

Summit View Youth Correctional Center (Summit View) is a state-funded facility in Las Vegas for male youth between the ages 14 and 18. The facility provides for the custody, control, care, and treatment of youth. The facility also assists youth reintegrate into society to live more responsible lives.

Summit View has two dormitory buildings with four units each. Maximum capacity is 96 beds. During calendar year 2007, daily population averaged 93 youth and the average length of stay was 9 months. Summit View employed an average of 65 full-time employees during calendar year 2007. During the month of our review, July 2008, the average population was 72 youth.

Summit View reported 388 grievances to us for the period July 1, 2007, through June 30, 2008. Of these, we classified 178 as welfare, 43 as safety, 26 as health, 22 as rights, and 119 as other.

Purpose of the Review

The purpose of our review was to determine if Summit View adequately protects the health, safety, and welfare of the children in Summit View and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies, procedures and complaints for the period July 1, 2007, to June 30, 2008. In addition, we discussed related issues and observed related processes during our visit in July 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Summit View provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, Summit View needs to improve its administration of medication, develop and update existing policies, make complaint forms readily available to youth, and post lists of contraband items.

Principal Observations

Administration of Medication

Although staff require youth to "sweep" their mouth after receiving medication, the process of administering medication needs to be strengthened. During administration of medication to youth, we noted some instances where youth could have concealed medication. For example, after a youth received medication from medical staff, the youth was distracted with his clothing and another staff prior to taking the medication. Another youth did not follow generally accepted procedures when medication was administered to him. Distractions and not following generally accepted procedures during administration of medication increases the risk that medication could be concealed and go undetected.

In addition, we noted Summit View's over-the-counter physician standing order medication form has not been updated since December 2006. The standing order form identifies physician approved over-the-counter medication the facility may administer to youth. Not updating this form on a regular basis could result in medication administered to youth that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Facility Response

Summit View has developed a procedure directing staff how they are to assist the nurse when medication is being administered. In addition, Summit View has revised its standing order form.

Policies and Procedures

Summit View should develop and update existing policies. During the period of our review, we did not note policies specific to the following: administration of medication, including methods to prevent youth from concealing medication; parent or visitor grievances; privileges; and records retention. In addition, we noted a deviation from the recreation and exercise program policy. Although policies state the status of these programs will be reported annually, this is not being followed. Also according to a facility policy, policies, procedures, and practices will be reviewed annually. However, based on our review of policies and discussion with management, this is not being completed. Without updated

policies and procedures, management and staff may be unclear of the facility's processes.

Facility Response

Summit View is in the process of reviewing and updating policies and procedures. In addition, policies will be updated annually.

Complaint Forms

Although complaint forms are available to youth, they must request forms from staff in their living units. The resident handbook states youth have the right to file a complaint and youth never have to request a complaint form from staff. However, during our observation we noted complaint forms were not always available to youth. Complaint forms that are not readily available to youth may decrease a youth's willingness to express their complaint in writing, which could result in a complaint going undocumented.

Facility Response

Summit View has made complaint forms readily available to youth.

Contraband

Lists of items considered contraband are not posted in the facility. Although contraband items are outlined in handbooks distributed to youth, lists are not posted within the facility, visible to youth, visitors and staff. Posting lists of contraband items reduces the likelihood that unauthorized items may enter the facility.

Facility Response

Summit View posted a list of items considered contraband in the facility, visible to youth, visitors and staff.

Other Items Noted

Other items noted during our review included: employees had direct contact with youth prior to the results of all background checks being received; security cameras did not record; fire escape routes and youth schedules were not posted; parents or guardians were not notified when youth were at risk to or attempt to run away.

Facility Response

Summit View confirmed there is a one to four month delay on receiving results of the FBI background checks; however, Summit View does run a Nevada background check before new employees start. In addition, a new security camera recording system is being installed; fire escape routes and youth schedules have been posted; a system has been developed to document runaway attempts, which requires parents or guardians be notified.

Don Goforth Resource Center

Background Information

Don Goforth Resource Center (DGRC) is a temporary holding facility for youth. The facility is located in Hawthorne, Nevada, and houses male and female youth between the ages of 8 and 17. The purpose of the facility is to provide a safe and secure resource center for the custody and care of youth awaiting court, delinquent youth, or youth awaiting placement to a court ordered facility.

DGRC is a staff-secured facility with a maximum capacity of 32 youth. During calendar year 2007, daily population averaged 15 youth with an average length of stay of 21 days. During the month of our review, August 2008, the average population was 14 youth.

DGRC is funded by billing a youth's county or entity of residence. During calendar year 2007, the facility had 28 employees: 12 full-time and 16 part-time staff. DGRC reported two complaints to us for the period of July 1, 2007, to June 30, 2008. We classified both of these as health.

Purpose of the Review

The purpose of our review was to determine if Don Goforth Resource Center adequately protects the health, safety, and welfare of the children in DGRC and whether the facility respects the civil and other rights of the children in its care. This review included an examination of rules, procedures and complaints for the period July 1, 2007, to June 30, 2008. In addition, we discussed related issues and observed related processes during our visit in August 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the rules, procedures, and processes in place at Don Goforth Resource Center provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, DGRC needs to develop facility policies and procedures, improve its medication process, strengthen its complaint process, formalize documentation of census records, and develop a list of items considered contraband.

Principal Observations

Policies and Procedures

DGRC needs to develop facility policies and procedures. Although DGRC has developed staff rules and general rules for youth, there are no formal facility policies and procedures. In addition to incorporating these rules into formal written policies, DGRC should also consider incorporating applicable Mineral County policies. Without clearly documented policies and procedures, management and staff may be unclear of the facility's processes. In addition, services provided to youth may be inconsistent.

Facility Response

Don Goforth is in the process of developing policies and procedures.

Medication Process

DGRC needs to improve its medication process. During our review of medication files, we noted a youth refused medication; however, this was not clearly documented in the youth's medication file. In addition, we noted a youth did not receive his prescribed medication because his medication ran out. This may have been avoided if staff had reviewed prescriptions and ordered medication a day earlier.

Furthermore, DGRC has not developed an over-the-counter physician standing order medication form. A standing order form identifies physician approved over-the-counter medication the facility may administer to youth. Without a standing order form, medication could be administered to youth that is not approved or recommended for use by the Federal Food and Drug Administration.

Also, medical files are not reviewed by someone independent of the medication process and medications are not secure. Periodic reviews of medical records help identify errors or potential fraud and abuse. During our review, we noted the medication cabinet lock was broken, providing easy access to prescription and non-prescription medication. Without periodic reviews and secure medications, errors, fraud, and abuse could occur and go undetected.

Facility Response

Don Goforth Resource Center has developed a new medication form to better track medication dispensed. In addition, all full-time staff received medication training and the facility is in the process of developing an over-the-counter physician standing order form. The facility stated all medication is secure at all times.

Complaint Process

DGRC needs to strengthen its complaint process. General rules provided to youth at intake do not address a youth's right to file a complaint and do not clearly describe the complaint process. Without a clearly documented process, a youth may be unaware of his right to file a complaint. In addition, complaint forms are not readily available to youth; youth must request forms from staff. Because youth must request complaint forms, this may decrease a youth's willingness to express his complaint in writing, which could result in a complaint going undocumented. Further, DGRC does not have a locked box for youth to place their complaint. A locked box provides reasonable assurance that the integrity of a complaint is maintained.

Facility Response

The facility is implementing a new complaint process.

Census

DGRC should formalize documentation of census records. During our observations, we noted the daily census was recorded on a dry erase board. While this may provide a quick synopsis of the population, a youth's name could accidently be erased. Based on our review of DGRC's official notes, this did occur. To provide a safe environment for youth and staff, youth should be counted periodically and compared to official records.

Facility Response

A booking computer will be used to help ensure a better and more permanent tracking of youth.

Contraband

A list of items considered contraband should be developed. General Rules, provided to youth at intake, state, "Nothing is allowed to come in or out of the center without prior approval from the Facility Supervisor." Without a clearly documented list of items considered contraband, there may be inconsistencies in items considered contraband. In addition, a list of items considered contraband should be posted within the facility, visible to youth, staff and visitors. Posting a list of items considered contraband reduces the likelihood that unauthorized items may enter the facility.

Facility Response

The facility stated it is more reasonable to indicate that any item or items not issued by the facility or not approved by a probation officer are considered contraband.

Other Items Noted

Other items noted during our review included: employees have direct contact with youth prior to the results of all background checks being received, although staff are observed until the results are received; security cameras do not record; itineraries are not filed with someone independent of a trip; and fire inspections are not routinely completed.

Facility Response

Don Goforth's security system is being fixed and fire inspections have been completed. The facility did not provide any comment on the following items: employees having direct contact with youth prior to the results of all background checks being received and itineraries not filed with someone independent of a trip.

Western Nevada Regional Youth Center

Background Information

Western Nevada Regional Youth Center (WNRYC) is a residential treatment facility and temporary holding facility for youth pending disposition of their case in juvenile court. The facility is located in Silver Springs, Nevada, and houses male and female youth between the ages of 8 and 18. The purpose of the facility is to address the treatment, counseling, and rights advocacy needs of youth and families, and protect the community from destructive behaviors of youth.

WNRYC comprises one structure with two distinct sections. The residential treatment section is staff-secured and has a maximum capacity of 31 beds. During calendar year 2007, daily population averaged 17 youth with an average length of stay of 66 days. The temporary holding section is secure and has a maximum capacity of eight beds. During calendar year 2007, daily population averaged 3 youth with an average length of stay of 3 days. During the month of our review, June 2008, the average populations were 15 youths in the residential treatment section and 3 in the temporary holding facility.

WNRYC is funded by five counties: Carson City, Churchill, Douglas, Lyon, and Storey. During our visit, the facility had 31 employees: 19 full-time, 2 part-time, and 10 on-call staff. WNRYC reported six complaints to us for the period of July 1, 2007, to May 31, 2008. Of these, we classified three as safety, one as welfare, one as a right, and one as other.

Purpose of the Review

The purpose of our review was to determine if WNRYC adequately protects the health, safety, and welfare of the children in WNRYC and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies, procedures, and complaints for the period July 1, 2007, to May 31, 2008. In addition, we discussed related issues and observed related processes during our visit in June 2008.

Results in Brief

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

at Western Nevada Regional Youth Center provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility and respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, prescribed medication administration, and abuse and neglect reporting processes need improvement, all assessments should be dated, fire escape routes should be posted, and a list of prohibited items should be posted within the facility.

Principal Observations

Administration of Medication

WNRYC's prescription medication process should be improved. According to policy, prescriptions are administered according to written medical professional orders. However, we noted an instance where medication dispensed by the pharmacy did not agree to the physician-ordered medication and was subsequently administered to a youth. The error may have been noted if WNRYC had verified the medication received from the pharmacy to the physician order. Verifying medication received from a pharmacy reduces the risk of errors and increases assurance that medication administered agrees with physician ordered medication.

Facility Response

WNRYC confirmed they will remain focused on quality assurance, safety, privacy, and efficiency.

Abuse and Neglect Report Process

WNRYC's abuse and neglect report process should be improved. According to policy, once a disclosure of abuse or neglect has been made, a report of suspected abuse or neglect will be completed. During our review of files, we noted disclosures of alleged abuse and neglect. However, documentation of which agencies WNRYC contacted was not always clear. WNRYC should develop a method to clearly identify agencies contacted. Clear documentation of agencies contacted increases assurances that WNRYC complied with mandatory child abuse and neglect reporting requirements.

Facility Response

WNRYC has revised its abuse and neglect forms to more clearly identify the agencies contacted.

Assessments

WNRYC's assessments should be dated once administered. According to policy, the date a mental health assessment is completed is documented by the staff administering the evaluation. However, we noted an undated mental health assessment. Dating completed assessments provides staff with additional information on youths' progress, which increases WNRYC's ability to adequately serve youth.

Facility Response

WNRYC is in the process of resolving this.

Other Items Noted

Other items noted during our review included: fire escape routes were not posted in the temporary holding section of the facility; a list of prohibited items was not posted within the facility, visible to all youth, staff, and visitors; and policies do not include a formal timeframe to resolve complaints. In addition, WNRYC should extend the length of time video surveillance tapes are kept to a timeframe consistent with the timeframe for resolving complaints.

Facility Response

Fire escape routes and a list of prohibited items have been posted. In addition, policies have been revised to include a formal timeframe to resolve complaints. Due to WNRYC's revised formal timeframe to resolve complaints, the length of time video surveillance tapes are kept does not need to be adjusted.

Montevista Hospital

Background Information

Montevista Hospital is a privately owned, locked psychiatric hospital that provides acute residential care to adults and youth. Acute residential care is considered short-term care to quickly stabilize the most serious symptoms and transition residents to less intensive levels of care. Montevista is located in Las Vegas and has a maximum capacity of 80 beds, 28 of which are dedicated to youth between the ages of 5 and 18.

The purpose of acute residential care is to provide 24-hour skilled nursing observation and care in a safe, controlled, structured environment, which is overseen by a psychiatrist. The hospital also provides highly coordinated treatment by a physician-led team of mental health professionals. The hospital is licensed by the State of Nevada and accredited by the Joint Commission on Accreditation of Healthcare Organizations.

During calendar year 2007, daily population averaged 22 youths and the average length of stay was 13 days. The hospital employed 154 full-time and 18 part-time employees during calendar year 2007. During the month of our review, April 2008, the average population was 25 youths. Montevista reported eight complaints to us for the period July 1, 2007, to March 31, 2008. Of these, we classified one as health, one as safety, one as rights, and five as other.

Purpose of the Review

The purpose of our review was to determine if Montevista Hospital adequately protects the health, safety, and welfare of the children in Montevista Hospital and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies, procedures and complaints for the period July 1, 2007, to February 29, 2008. In addition, we discussed related issues and observed related processes during our visit in April 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Montevista Hospital provide reasonable assurance that it

adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Montevista should consider making complaint forms more readily available to youth and ensuring staff check all youth for "cheeking" medications. Cheeking is a method used by youth to conceal medication.

Principal Observations

Complaint Forms

Although complaint forms were available to youth, youth had to request forms from staff. The resident handbook states residents have the right to file a written complaint for any reason. However, youth may be less likely to file a complaint since they have to request complaint forms from staff. To aid this process, complaint forms should be more readily available to youth.

Facility Reply

Montevista has made complaint forms readily available to youth in a high visibility location, which is traveled by all youth and parents when they enter or leave the facility.

Administration of Medication

Although Montevista Hospital requires staff to observe youth "sweeping" their mouths after receiving medication, we noted staff did not always observe youth to ensure youth did not cheek medication. Cheeking is a method used to conceal medication administered to a youth. Requiring youth to sweep their mouths helps reduce the risk of abuse and provides increased assurance that youth took medication prescribed.

Facility Reply

Montevista has reinforced with both staff and medication nurses the need to ensure a complete mouth sweep is completed after a youth takes medication.

West Hills Hospital

Background Information

West Hills Hospital is a privately funded, acute inpatient psychiatric hospital for youth between the ages of 3 and 17 located in Reno. Acute inpatient hospitalizations are short-term and occur only with a physician's order for conditions that cannot be safely or effectively treated on an outpatient basis. The purpose of acute care is to quickly stabilize youth to allow transition to a less intensive level of care.

West Hills Hospital comprises two wings: one for adolescents between the ages of 13 and 17 and another wing for children ages 3 to 12. During calendar year 2007, daily population averaged 10 youth with an average length of stay of 9 days. West Hills Hospital employed an average of 20 employees: 19 full-time and 1 part-time. During the month of our review, July 2008, the average population of youths was 8.

West Hills Hospital reported receiving one resident complaint between July 1, 2007, and May 31, 2008. We determined this complaint was related to a safety issue.

Purpose of the Review

The purpose of our review was to determine if West Hills Hospital adequately protects the health, safety, and welfare of children in West Hills Hospital and whether the facility respects the civil and other rights of the children in its care. The review included an examination of policies, procedures and complaints for the period July 1, 2007, to May 31, 2008. In addition, we discussed related issues and observed related processes during our visit in July 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at West Hills Hospital provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, West Hills Hospital needs to improve medication administration documentation, eliminate inconsistencies in its complaint process,

address youth supervision issues, and update policies and procedures.

Principal Observations

Medication Administration

West Hills needs to improve its medication administration documentation. During our review of medication files, we noted prescribed medication was not always administered to a youth. According to management, the youth refused to take prescribed medication on the dates in question. However, this was not documented in the youth's file or in a medication variation report. Documentation of medication refused by a youth may indicate an issue(s) not noted during intake. In addition, inadequate documentation of medication variances increases the potential for abuse of prescribed substances.

Facility Response

All licensed nursing staff were re-educated on medication variance documentation.

Complaint Process

West Hills needs to eliminate inconsistencies in its complaint process. Specifically, we noted inconsistencies between information given to youth at intake, formal policies and procedures, and the actual complaint process. Information provided to youth at intake indicates youth should address the Patient Advocate if they think their rights have been violated. Policies state staff receiving a complaint should notify the Patient Advocate who will document the complaint. However, we noted that youth actually request a complaint form from staff. In addition, information provided to youth at intake and facility policies do not specifically address a youth's right to file a complaint. Without a clearly documented, consistent complaint process, management, staff, and youth may be unsure or unaware of the process. This could result in undocumented complaints, complaints not addressed, or inconsistent services to youth, which may reduce the facility's ability to adequately serve youth.

Also, complaint forms are not readily available to youth. Complaint forms that are not readily available to youth may decrease a youth's

willingness to express his complaint in writing, which could result in a complaint going undocumented.

Facility Response

West Hills Hospital revised its complaint policy and process, re-educated staff on the process, and has made complaint forms readily available to all youth.

Youth Supervision

West Hills Hospital should ensure youth are adequately supervised at all times. Based on our review of facility incident reports, we noted two incidents which indicated inadequate supervision. One incident report described a youth who had wrapped a cord around her neck while in the group room. However, if the youth had been adequately supervised this may have been avoided. Another report described an elopement of a youth who had been identified as an elopement risk. Details provided in the report stated an insufficient staff to youth ratio was part of the cause. Adequate staff to youth ratios minimizes the risk that youth will be a danger to themselves and others.

Facility Response

Staff at West Hills Hospital received training on their responsibility to maintain a safe environment for youth and 15 minute checks on youth. In addition, staff have been equipped with walkie talkies to aid communication without having to leave youth unsupervised.

Policies and Procedures

West Hills Hospital should update its policies and procedures. During the period of our review, we did not note policies specific to the following: injuries, visitation, behavior, religion, and privileges. Without updated policies and procedures, management and staff may be unclear of the facility's mission and provide inconsistent services to youth.

Facility Response

West Hills Hospital is updating its policies and procedures.

Item of Concern

In 2008, West Hills Hospital terminated three employees as a result of inappropriate contact with residents. We reviewed supporting documentation and discussed these incidents with management. We determined that, as part of the hiring process, West Hills Hospital uses the services of a for-profit company to complete background checks on employees. The results of local, state, federal, and sex offender background checks were received for two of the three employees prior to hiring. Results for the third employee were not received until one business day after the employee was hired. We concluded that West Hills Hospital acted appropriately based on allegations against the employees.

Facility Reply

The (fingerprint) background check was received timely, with no criminal activity noted, prior to the employee being hired.

Child Haven

Background Information

Child Haven is a staff-secure, emergency shelter that provides temporary care and treatment for abused, neglected and abandoned children from infancy to age 18. Children residing at Child Haven are children who cannot safely remain with their families. The purpose of Child Haven is to protect children by providing a safe, nurturing, temporary care environment while children are separated from their families. Child Haven's purpose also includes building and supporting nurturing, stable families in collaboration with community providers.

Child Haven is located in Las Vegas, funded by Clark County, and operated by the Clark County Department of Family Services. During calendar year 2007, Child Haven employed an average of 91 full-time and 40 part-time employees. The daily population averaged 95 youth whose average length of stay was 14 days.

Effective January 1, 2008, Child Haven became licensed to care for 96 youth. Licensing caps Child Haven's maximum capacity and helps ensure the facility meets state-mandated safety requirements. Prior to being licensed, Child Haven did not have an established maximum capacity. During the month of our review, April 2008, the average population was 39 youths. Child Haven did not report any complaints to us for the period July 1, 2007 to April 30, 2008.

Purpose of the Review

The purpose of our review was to determine if Child Haven adequately protects the health, safety, and welfare of the children in Child Haven and whether the facility respects the civil and the other rights of the children in its care. This review included an examination of policies, procedures and management reports for the period July 1, 2007, to March 31, 2008. In addition, we discussed related issues and observed related processes during our visit in April 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Child Haven provide reasonable assurance that it adequately

protects the health, safety, and welfare of youth at the facility and respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, Child Haven needs to improve its complaint process, develop and update policies, consolidate youth files, and develop treatment plans for all youth.

Principal Observations

Complaint Process

According to management, youth are aware of their right to file a complaint; however, there is no documentation to support this. We reviewed the document discussed with youth during intake and noted this document does not specifically address a youth's right to file a complaint. In addition, management explained that if a youth wishes to file a complaint, he is provided with an incident report form by staff. Because youth must request a form, this may decrease a youth's willingness to express his complaint in writing, resulting in a complaint going undocumented. Also, because incident report forms are used to document complaints, there is no clear distinction between an incident reported by staff and a complaint reported by youth. Clearly documented complaints that are tracked and used to analyze trends may improve the facility's ability to better serve youth.

Facility Response

Child Haven has amended its complaint policy and process. The complaint process is currently discussed with youth during orientation. In addition, a copy of the policy is provided to youth.

Policies

Child Haven should develop and update policies. During the period of our review, we did not note policies specific to the following: youth/attorney calls and visits; staff, parent or guardian's right to file a complaint; control over kitchen utensils; re-evaluation of youth; mental health and substance abuse counseling and programming; and administration of psychotropic drugs at intake. In addition, current complaint policies state youth will not suffer retribution for filing a complaint after the complaint investigation has begun. Policies should state youth will not suffer retribution for filing a complaint at any time. Also, Child Haven should consider updating

its policies and procedures to include: supervision of youth after their return from running away; staff intervention during a crisis; and incorporating some of Clark County's applicable policies. Without updated policies and procedures, some staff may not be aware of the facility's policies and processes.

Facility Response

Child Haven is in the process of revising policies with an expected completion date of November 2008.

Youth Files

During fieldwork, we noted portions of youth files in two different places. One file contained medical information while the other contained general youth information. As a result, cottage staff may be unaware of critical medical information. Cottage staff has significantly more interaction with youth on a daily basis and should have easy access to critical information in the event of an emergency. Merging files or making two copies of the same file available to both medical and cottage staff provides a more complete picture of a youth and his medical and non-medical issues. Upon discussing this with management, management noted the issue of merging files had also been raised by other agencies.

Facility Response

Medical information is now included in cottage files.

Treatment Plans

Child Haven did not always document youth treatment plans. Specifically, we noted treatment plans had not been documented for one of five youths tested. According to management, treatment plans should be developed for each youth who remains in the facility more than 3 days and who is older than 5 years of age. Not documenting a youth's treatment plan could result in a youth's significant issue(s) going unidentified, which may decrease Child Haven's ability to adequately serve a youth.

Facility Response

Child Haven required staff to review Treatment Plan policies. In addition, Child Haven instituted a new process that requires plans be reviewed at least weekly.

Other Items Noted

Other items noted during our review included: deviations from established food menus were not always documented; a list of contraband items was not posted within the facility; cottage daily or weekly schedules were not posted; and the door to the clinic was not always locked.

Facility Response

Child Haven has revised its food menu documentation, posted lists of contraband and schedules, and is monitoring locking of the clinic door when staff vacates the clinic.

Kids' Kottage

Background Information

Kids' Kottage (KK) is a staff-secured, emergency child welfare facility in Reno. The facility is operated under contract by Adams and Associates for the Washoe County Department of Social Services. The purpose of the facility is to provide temporary care for neglected, abandoned and abused youth from birth to 18 years of age.

KK comprises three separate buildings to accommodate both male and female youth: KK One houses youth ages 6 to 12 years; KK Too houses infants and toddlers; and a modular home houses teenagers.

Although KK has a maximum capacity of 82 youth, the daily population averaged 46 youth with an average length of stay of 35 days during calendar year 2007. Kids' Kottage employs 40 full-time and 3 part-time employees. During the month of our review, April 2008, the average population was 48 youths. KK reported receiving five complaints between July 1, 2007, and February 29, 2008. We determined four of the complaints were related to safety and one was related to welfare.

Purpose of the Review

The purpose of our review was to determine if Kids' Kottage adequately protects the health, safety, and welfare of the children in Kids' Kottage and whether the facility respects the civil and other rights of the children in its care. This review included an examination of policies, procedures and complaints for the period July 1, 2007, to February 29, 2008. In addition, we discussed related issues and observed related processes during our visit in April 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Kids' Kottage provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, complaint and medication administration procedures need

improvement, and the list of items considered contraband should be updated and posted within the facility.

Principal Observations

Complaint Process

According to management, youth are aware of their right to file a complaint; however, there is no documentation of this. During intake, "Shelter Rules for Children" is discussed with youth and, if age appropriate, the youth's signature is obtained. However, Shelter Rules does not include information about a youth's right to file a complaint. In addition, KK should make complaint forms readily available to youth, provide a locked box to help ensure the integrity of complaints filed, and develop a policy clearly stating staff will not retaliate against youth for filing a complaint. Management should record and track these complaints to identify potential trends, which may help KK improve services provided youth. In addition, policies should address procedures for visitors or parents to file a complaint.

Facility Response

Kids' Kottage has amended its "Shelter Rules for Children" to include information about a youth's right to file a complaint; placed complaint forms and locked boxes in each of its three buildings; revised policies to prohibit staff from retaliating against youth for filing a complaint; and began tracking complaints monthly for trends. KK stated policies and procedures now address procedures for visitors or parents to file a complaint.

Administration of Medication

During our observations of the administration of medication and discussions with management, we noted staff did not observe youth to ensure they did not "cheek" medication. Cheeking is a method used to conceal medication. Requiring staff to observe youths "sweeping" their mouths after receiving medication reduces the risk of abuse and provides increased assurance that youth took the medication prescribed.

Facility Response

Kids' Kottage changed its procedures to ensure staff verifies youth did not cheek medications.

Contraband

The list of items considered contraband should be updated. "Shelter Rules for Children" addresses contraband, smoking, drugs, and alcohol; however, the list should be updated to include items such as weapons, knives, matches, R-rated movies, etc. In addition, a list of items considered contraband should be posted within the facility, visible to youth and visitors.

Facility Response

Kids' Kottage updated its list of contraband and posted the list in each of its buildings.

Other Items Notes

Kids' Kottage provides access to mental health and substance abuse professionals, and staff are continually trained to identify and address issues and challenges encountered by youth. In addition, youth are re-evaluated periodically. However, these processes are not addressed in KK's policies.

Facility Response

Kids' Kottage updated and developed policies and procedures specific to assessing mental health and substance abuse.

Item of Concern

In 2007, KK terminated an employee as a result of a complaint filed by a staff member on behalf of a resident alleging inappropriate contact. We discussed this incident with management of both KK and the Washoe County Department of Social Services. We determined that, as part of the hiring process, the employee against whom the complaint was filed was fingerprinted by the Washoe County Sheriff's Office and, based on a local background check performed by the Sheriff's Office, was issued a 90-day temporary permit card to work in the facility. The alleged incident occurred prior to either KK or the Department of Social Services being

notified of the results of the State and federal background checks. Although we concluded that KK acted appropriately based on the allegation against the employee, we have some concerns with employees having direct contact with youth prior to the results of all background checks being received.

Facility Response

New employees are required to attend mandatory training, undergo intense supervision, and regular evaluations. Because a minimum of two staff are required in each building, new staff are not alone with youth.

Kids' Kottage acknowledged the length of time to obtain federal background checks, 90 days. Although they are evaluating possible options to avoid new employees having direct contact with youth, they raised a concern about new employees. Specifically, new employees would seek employment elsewhere due to the length of time it takes to get background check results. This could result in an inability to hire and retain sufficient staff to meet the needs of youth served.

Family Learning Homes

Background Information

Family Learning Homes is a group of staff-secure, group homes that provides mental health treatment for youth between the ages of 5 and 18. Treatment services are provided in a home-like environment to meet the specific behavioral and emotional needs of youth. In addition, Family Learning Homes strives to meet the treatment and training needs of emotionally disturbed children with interventions which incorporate the youth's family, as well as independent living skills for adolescents.

Family Learning Homes comprises three family style homes to house male and female youth. Two homes house youth between the ages of 5 and 12 and the third home houses youth between the ages of 12 and 18. Maximum capacity is 15 youth. During calendar year 2007, daily population averaged 15 youth with an average length of stay of 234 days (7 ½ months).

Family Learning Homes is located in Reno, is funded by the State through the Division of Child and Family Services and is organizationally within Northern Nevada Child and Adolescent Services. During calendar year 2007, Family Learning Homes employed an average of 13 full-time employees and 1 part-time employee. During the month of our review, April 2008, the average population of youths was 14.

Family Learning Homes reported two resident complaints to us for the period July 1, 2007, to March 31, 2008. Of these, we classified one as a safety issue and the other as a rights issue.

Purpose of the Review

The purpose of our review was to determine if Family Learning Homes adequately protects the health, safety, and welfare of children in the homes and whether the facility adequately respects the civil and other rights of the children in its care. This review included an examination of policies, procedures and complaints for the period July 1, 2007, to March 31, 2008. In addition, we discussed related issues and observed related processes during our visit in April 2008.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the Family Learning Homes provide reasonable assurance that it adequately protects the health, safety, and welfare of youth at the facility, and it respects the civil and other rights of youth in its care. However, we noted some areas for improvement. Specifically, Family Learning Homes needs to update policies, improve its complaint process, and strengthen contraband procedures.

Principal Observations

Policies and Procedures

Family Learning Homes needs to update its policies and procedures. During the period of our review, we did not note policies specific to the following: youth and attorney calls and visits; controls over keys, tools, and kitchen utensils; re-evaluation of youth; and sanitation of shared toys. In addition, Family Learning Homes should consider strengthening its runaway policies. Current policies address protocol after a youth has run away; policies should also address protocol if a youth expresses a desire to run away. Without updated policies and procedures, management and staff may be unclear of the facility's mission and provide inconsistent services to youth.

Facility Response

Family Learning Homes stated they are updating policies and procedures with an estimated completion date of September 2008.

Complaint Process

Family Learning Homes' complaint process needs improvement. According to management, information distributed during intake includes the complaint procedure. However, the complaint procedure information distributed is not always current. According to this procedure, youth complaints can be raised and resolved through daily discussion at community meetings, but the issues discussed are not documented. While resolving issues through discussion is important, management may be unaware of similar issues raised by youth in different homes if issues are not documented. In addition, a youth may not be comfortable raising

an issue at a community meeting, so the issue may persist and remain unknown to staff and management. Clearly documented, tracked, and analyzed community meeting issues may improve the facility's ability to better serve youth. Unresolved community meeting issues are documented in complaint forms for further follow-up. While management indicated these forms are readily available, we did not observe this. Youths may be unwilling to express complaints in writing if complaint forms are not readily available.

Facility Response

Family Learning Homes is in the process of implementing the following: documents to track daily community meeting issues; a database to track issues monthly; complaint forms will be provided to youth; and monthly reviews of the complaint process.

Contraband

Contraband procedures used by the Family Learning Homes need to be strengthened. Specifically, items considered privileges, such as I-Pods and MP3 players, are not always searched for content, which may be considered contraband. For example, newer generations of these devices have video capabilities. If video content is not periodically reviewed by staff or management, inappropriate images could be brought into the Family Learning Homes. In addition, after returning from school or an off-campus activity, youth backpacks should be searched for items considered contraband, such as weapons, knives, etc. Without adequate contraband procedures, age-inappropriate items may circulate the campus and go undetected by management and staff.

Facility Response

Family Learning Homes is developing policies and procedures to monitor I-Pods, MP3 players and search backpacks for contraband.

Other Items Noted

Other items noted during our review included: fire escape routes were not posted in one of three homes; youth files did not always contain up-to-date information, such as allergies; medical files did not contain a picture of youth to aid administration of medication;

off-campus trips are not documented and filed with someone independent of the excursion; and doors to rooms that contain a single youth were not open during sleeping hours.

Facility Response

Fire escape routes have been posted; all medical information is required to be completed; staff were reminded that youth photos are required in medical files; a process has been developed to document off-campus excursions; and doors to rooms that contain single youth will remain closed to protect the safety of other youth.

Appendices

Appendix A

Assembly Bill 629, Section 6
2007

Sec. 6. 1. There is hereby appropriated from the State General Fund to the Legislative Fund created by NRS 218.085 the sum of $250,000 for the Legislative Auditor to employ or contract with an auditor to serve as the Child Welfare Specialist.

2. The Child Welfare Specialist shall:

(a) Conduct such performance audits of governmental facilities for children as assigned by the Legislative Auditor; and

(b) Inspect, review and survey other governmental and private facilities for children to determine whether such facilities adequately protect the health, safety and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care.

3. In performing its duties pursuant to this section, the Child Welfare Specialist shall:

(a) Receive and review copies of all guidelines used by governmental and private facilities for children concerning the health, safety, welfare, and civil and other rights of children;

(b) Receive and review copies of each complaint that is filed by any child or other person on behalf of a child who is under the care of a governmental or private facility for children concerning the health, safety, welfare, and civil and other rights of the child;

(c) Perform unannounced site visits and on-site inspections of governmental and private facilities for children;

(d) Review reports and other documents prepared by governmental and private facilities for children concerning the disposition of any complaint which was filed by a child or any other person on behalf of a child concerning the health, safety, welfare, and civil and other rights of the child;

(e) Review practices, policies and procedures of governmental and private facilities for children for filing and investigating complaints made by children under their care or by any other person on behalf of such children concerning the health, safety, welfare, and civil and other rights of the children;

(f) Receive, review and evaluate all information and reports from governmental and private facilities for children relating to a child who suffers a fatality or near fatality while under the care or custody of a governmental or private facility for children; and

(g) Perform such other duties as directed by the Legislative Auditor.

4. Each governmental and private facility for children shall:

(a) Cooperate fully with the Child Welfare Specialist;

(b) Allow the Child Welfare Specialist to enter the facility and any area within the facility with or without prior notice;

(c) Allow the Child Welfare Specialist to interview children and staff at the facility;

(d) Allow the Child Welfare Specialist to inspect, review and copy any records, reports and other documents relevant to the duties of the Child Welfare Specialist; and

(e) Forward to the Child Welfare Specialist copies of any complaint that is filed by a child under the care or custody of a governmental or private facility for children or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child.

Appendix A

Assembly Bill 629, Section 6
2007
(continued)

5. When conducting any performance audit pursuant to this section, the Child Welfare Specialist shall carry out his duties in accordance with the provisions of NRS 218.737 to 218.893, inclusive.
6. The Legislative Auditor and the Child Welfare Specialist shall keep or cause to be kept a complete file of copies of all reports of audits, examinations, investigations and all other reports or releases issued by him.
7. All working papers from an audit are confidential and may be destroyed by the Legislative Auditor or the Child Welfare Specialist 5 years after the report is issued, except that the Legislative Auditor or the Child Welfare Specialist:
(a) Shall release such working papers when subpoenaed by a court; and
(b) May make such working papers available for inspection by an authorized representative of any other governmental entity for a matter officially before him.
8. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2009, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 18, 2009, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 18, 2009.
9. As used in this section:
(a) “Governmental facility for children” means any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is owned or operated by a governmental entity and which has physical custody of children pursuant to the order of a court.
(b) “Near fatality” means an act that places a child in serious or critical condition as verified orally or in writing by a physician, a registered nurse or other licensed provider of health care. Such verification may be given in person or by telephone, mail, electronic mail or facsimile.
(c) “Private facility for children” means any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is owned or operated by a person or entity which has physical custody of children pursuant to the order of a court.

Appendix B

Glossary of Terms

Census	Periodic official documentation of a facility's population.
Cheeking	A method used to conceal medication administered to a youth.
Child Welfare Facility	Provides emergency, overnight, and short-term services to youth who cannot remain safely in their home or their basic needs cannot be efficiently delivered in the home.
Civil and Other Rights	This relates to a youth's civil rights, as well as his rights as a human being. It includes protection from discrimination, the right to file a grievance, replacement of missing personal items, and protection from racist comments.
Correction Facility	Provides custody and care for youth in a secure, highly restrictive environment who would otherwise endanger themselves or others, be endangered by others, or run away. Correction facilities may include restrictive features, such as locked doors and barred windows.
CPS	Child Protective Services in Washoe County is part of the Department of Social Services, in Clark County it is part of the Department of Family Services, and in other counties it is part of DCFS.
DCFS	The Nevada Division of Child and Family Services.
Detention Facility	Provides short-term care and supervision to youth in custody or detained by a juvenile justice authority. Detention facilities may include restricted features, such as locked doors and barred windows.
Group Homes	Provide safe, healthful group living environments in a normalized, developmentally supportive setting where residents can interact fully with the community. Used for children who will benefit from supervised living with access to community resources in a semi-structured environment. Generally consists of detached homes housing 12 or fewer children.
Health	Anything related to a youth's physical health, such as nutrition, exercise, and medical care.

Appendix B

Glossary of Terms
(continued)

HIPAA	Health Insurance Portability and Accountability Act. Requires certain personal information remain confidential.
Patient Advocate	A facility-designated patient representative.
Privileges	Items considered earned and not considered a right. Items considered privileges may include movies, recreation time, phone calls, and reading material.
Residential Center	Provide a full range of therapeutic, educational, recreational, and support services. Residents are provided with opportunities to be progressively more involved in the community.
Resource Center	A facility that provides more than one type of service simultaneously. For example, a facility that provides both treatment and detention services.
Safety	Anything related to the physical safety of youth. This includes physical security and environment, protection from inappropriate comments or contact by staff or another youth, and staffing issues.
Staff-Secure	Access out of the facility is limited by staff and not monitored by a secure system.
Standing Order Form	Physician approved order for over-the-counter medication a facility may administer to youth.
Sweeping	A method used to detect medication concealed in the mouth.
Treatment	This includes the mental health and behavior treatment of youth, not necessarily how a youth is treated on a daily basis. It comprises access to counseling, treatment plans, and progress through the program.
Treatment Facility	An acute residential facility for conditions that can not be safely or effectively treated on an outpatient basis. Services are provided in a highly structured, highly supervised environment.

Appendix B

Glossary of Terms
(continued)

Welfare	Anything related to the general well being of a youth. This includes education, wellness activities, and punishments or discipline.
Youth	The term youth is intended to describe children of all ages, including infants and adolescents.

Appendix C

Summary of Common Findings at Facilities Reviewed

Findings	Total
Policies	
Policies not developed or updated	11
Complaints and Grievances	
Forms not readily available to youth	9
Youth files did not contain evidence of youth's right to file a complaint or grievance	5
Unclear or inconsistent complaint process or deviations from policy	4
No locked box	4
Not tracked for trends	4
Information given to youth at intake does not address the complaint or grievance process	3
Contraband	
A list of items considered contraband was not posted	9
A list of items considered contraband was not developed or updated	5
Youth not searched for contraband or contraband items noted at facility	4
Medication Process	
Documentation of medication administered needs improvement	8
Out-of-date standing order form	4
Youth medical files not independently reviewed	4
Staff did not check for "cheeking" of medication	3
Medication not disposed of	1
Unlabeled prescribed medication	1
Employee Background Checks	
Employees have direct contact with youth prior to the results of all background checks being received	7
Fire Escape Routes	
Escape routes not posted	4
Video Surveillance Camera(s)	
Do not record	3
Other Significant Items	
Documentation of allegations of child abuse and neglect reporting needs improvement	2
Documentation of daily census needs improvement	1
Inadequate supervision of youth	1
Construction materials in youth living units	1
No internet filtering software on computers, which are accessible to youth	1

Source: Reviewer prepared from facility conclusions.

Note: This is not a comprehensive list of findings.

Appendix D

Nevada Facility Reported Complaints
July 1, 2007, to July 31, 2008

Table 1: Correction and Detention Facilities	Complaint Type					
Facilities	**Health**	**Safety**	**Welfare**	**Right(s)**	**Other**	**Totals**
Caliente Youth Center *	82	76	281	22	108	569
Carson City Juvenile Detention Center *	0	0	1	0	0	1
China Springs/Aurora Pines *	21	13	46	28	28	136
Clark County Juvenile Detention Center	21	37	62	5	21	146
Douglas County Juvenile Detention Center	0	0	0	0	0	0
Humboldt County Juvenile Detention Center	0	0	1	1	2	4
Nevada Youth Training Center *	9	16	94	5	31	155
Northeastern NV Juvenile Detention Center	0	1	2	1	0	4
Rite of Passage-Silver State Academy *	0	1	11	1	1	14
Spring Mountain Youth Camp	4	1	17	1	2	25
Summit View Youth Correctional Center *	32	45	192	29	102	400
Washoe County Juvenile Detention Center	14	23	56	15	47	155
Total - Correction and Detention Facilities	**183**	**213**	**763**	**108**	**342**	**1,609**

Table 2: Resource Centers	Complaint Type					
Facilities	**Health**	**Safety**	**Welfare**	**Right(s)**	**Other**	**Totals**
Don Goforth Resource Center *	2	0	0	0	0	2
McGee Center	0	1	1	0	0	2
Western Nevada Regional Youth Center *	0	3	5	1	2	11
Total - Resource Centers	**2**	**4**	**6**	**1**	**2**	**15**

Table 3: Treatment Facilities	Complaint Type					
Facilities	**Health**	**Safety**	**Welfare**	**Right(s)**	**Other**	**Totals**
Adolescent Treatment Center	0	1	5	1	1	8
Desert Willow Treatment Center	0	1	3	0	1	5
Eagle Valley Children's Home	0	0	0	0	0	0
Montevista Hospital *	3	1	1	0	7	12
Spring Mountain Treatment Center	0	0	0	0	0	0
West Hills Hospital *	0	1	0	0	0	1
Willow Springs Treatment Center	0	9	9	1	11	30
Total - Treatment Facilities	**3**	**13**	**18**	**2**	**20**	**56**

Table 4: Child Welfare Facilities	Complaint Type					
Facilities	**Health**	**Safety**	**Welfare**	**Right(s)**	**Other**	**Totals**
Child Haven *	0	0	0	0	0	0
Kids' Kottage *	0	8	1	0	0	9
Total - Child Welfare Facilities	**0**	**8**	**1**	**0**	**0**	**9**

Appendix D

Nevada Facility Reported Complaints
July 1, 2007, to July 31, 2008
(continued)

Table 5: Group Homes	Complaint Type					
Facilities	**Health**	**Safety**	**Welfare**	**Right(s)**	**Other**	**Totals**
Achievement Place West	0	0	0	0	0	0
Family Learning Homes *	1	5	0	0	7	13
Oasis Homes	0	0	0	0	0	0
Palmer House	0	0	0	0	0	0
Boys Town Nevada	0	0	0	0	0	0
Rite of Passage-Qualifying Houses	0	0	4	0	0	4
Total - Group Homes	**1**	**5**	**4**	**0**	**7**	**17**

Table 6: Residential Centers	Complaint Type					
Facilities	**Health**	**Safety**	**Welfare**	**Right(s)**	**Other**	**Totals**
Austin's House	0	2	1	0	0	3
Boys Town Nevada	0	0	0	0	0	0
Briarwood	0	0	0	0	0	0
City of Refuge	0	0	0	0	0	0
Fresh Start Services	0	0	0	0	0	0
Hand Up Homes for Youth	0	0	0	0	0	0
HELP of Southern Nevada	0	0	0	0	0	0
Spring Mountain Residential Center	0	0	0	0	0	0
Vitality Center-Actions of Elko	0	0	0	0	0	0
Vitality Center-Actions of Washoe County	0	0	0	0	0	0
WestCare-Emergency Shelter	0	0	0	0	0	0
WestCare-Young, FACES	0	0	0	0	0	0
WestCare-Harris Springs Ranch	0	0	0	0	0	0
Total - Residential Centers	**0**	**2**	**1**	**0**	**0**	**3**

Total - 43 Facilities Statewide	**189**	**245**	**793**	**111**	**371**	**1,709**

Health: Anything related to a youth's physical health, such as nutrition, exercise, and medical care.
Safety: Anything related to the physical safety of youth. This includes physical security and environment, protection from inappropriate comments or contact by staff or another youth, and staffing issues.
Welfare: Anything related to the general well being of a youth. This includes education, wellness activities, and punishments or discipline.
Right(s): An earned privilege provided to a youth in the facility as a reasonable incentive to provide accountability, such as recreation time, telephone calls, and reading material.
Other: Remaining complaints different from those specified which do not directly contribute to a youth's general well being, such as access to counseling, treatment plans, discrimination, and grievance process.

Source: Reviewer prepared from complaints received.

* Indicates the facility was reviewed.

Appendix E

Nevada Facility Information
Calendar Year 2007

Table 1: Correction and Detention Facilities	Background			Population for CY 2007		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Caliente Youth Center	State	Caliente	12 to 18	140	92	88	0
Carson City Juvenile Detention Center	Carson City	Carson City	8 to 18	24	18	15	0
China Springs/Aurora Pines	State/Counties	Minden	12 to 18	65	59	38	1
Clark County Juvenile Detention Center	Clark County	Las Vegas	8 to 18	192	202	168	100
Douglas County Juvenile Detention Center	Douglas County	Stateline	8 to 18	16	10	9	1
Humboldt County Juvenile Detention Center	Various Counties	Winnemucca	8 to 17	24	13	11	2
Nevada Youth Training Center	State	Elko	12 to 18	160	148	110	0
Northeastern NV Juvenile Detention Center	Various Counties	Elko	8 to 17	24	13	12	0
Rite of Passage-Silver State Academy	Private	Yerington	14 to 18	225	196	136	10
Spring Mountain Youth Camp	Clark County	Las Vegas	13 to 18	100	97	45	11
Summit View Youth Correctional Center	State	Las Vegas	14 to 18	96	93	65	0
Washoe County Juvenile Detention Center	Washoe County	Reno	8 to 18+	108	54	50	0
Total - 12 Correction and Detention Facilities				1,174	995	747	125

Table 2: Resource Centers	Background			Population for CY 2007		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Don Goforth Resource Center	Various Counties	Hawthorne	8 to 17	32	15	12	16
McGee Center	Washoe County	Reno	8 to 17	24	10	13	0
Western Nevada Regional Youth Center	Various Counties	Silver Springs	8 to 18	39	20	19	2
Total - 3 Resource Centers				95	45	44	18

Table 3: Treatment Facilities	Background			Population for CY 2007		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Adolescent Treatment Center	State	Reno	12 to 17	16	15	21	0
Desert Willow Treatment Center	State	Las Vegas	6 to 18	58	51	110	0
Eagle Valley Children's Home	Private	Carson City	All ages	18	2*	72	0
Montevista Hospital	Private	Las Vegas	5 to 18	28	22	154	18
Spring Mountain Treatment Center	Private	Las Vegas	12 to 18	66	58	110	20
West Hills Hospital	Private	Reno	3 to 17	30	10	19	1
Willow Springs Treatment Center	Private	Reno	5 to 17	76	72	100	69
Total - 7 Treatment Facilities				292	230	586	108

Table 4: Child Welfare Facilities	Background			Population for CY 2007		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Child Haven	Clark County	Las Vegas	0 to 18	96	95	91	40
Kids' Kottage	Washoe County	Reno	0 to 18	82	46	40	3
Total - 2 Child Welfare Facilities				178	141	131	43

Table 5: Group Homes	Background			Population for CY 2007		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Achievement Place West	State	Reno	12 to 17	5	4	3	0
Family Learning Homes	State	Reno	5 to 18	15	15	13	1
Oasis Homes	State	Las Vegas	6 to 17	27	27	40	2
Palmer House	State	Reno	12 to 17	6	4	3	0
Boys Town Nevada	Private	Las Vegas	10 to 18	28	26	17	0
Rite of Passage-Qualifying Houses	Private	Minden	13 to 18	14	14	6	2
Total - 6 Group Homes				95	90	82	5

Appendix E

Nevada Facility Information
Calendar Year 2007
(continued)

Table 6: Residential Centers	Background			Population for CY 2007		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Austin's House	Private	Minden	0 to 18	10	6	6	14
Boys Town Nevada	Private	Las Vegas	10 to 17	18	12	14	2
Briarwood	Private	Las Vegas	13 to 18	15	14	15	1
City of Refuge	Private	Minden	Various	8	2	2	8
Fresh Start Services	Private	Las Vegas	14 to 18	35	28	14	2
Hand Up Homes for Youth	Private	Las Vegas	12 to 18	12	7	12	2
HELP of Southern Nevada	Private	Las Vegas	16 to 21	62	20	12	2
Spring Mountain Residential Center	County	Las Vegas	13 to 18	12	9	6	2
Vitality Center-Actions of Elko	Private	Elko	12 to 17	13	1 *	35	1
Vitality Center-Actions of Washoe County	Private	Sun Valley	12 to 17	20	1 *	25	0
WestCare-Emergency Shelter	Private	Las Vegas	10 to 17	20	15	12	2
WestCare-Young, FACES	Private	Las Vegas	12 to 17	24	12	10	1
WestCare-Harris Springs Ranch	Private	Las Vegas	12 to 17	16	14	12	0
Total - 13 Residential Centers				265	141	175	37
Total - 43 Facilities Statewide				2,099	1,642	1,765	336

Source: Reviewer prepared from information provided by facilities.

* These facilities also provide services to clients over the age of 18.
The average population given is for the number of clients aged 18 and under.

Appendix F

Unannounced Nevada Facility Visits

Facility Name	Facility Type	Date of Visit
Summit View Youth Correctional Center	Correctional	April 17, 2008
McGee Center	Resource	July 11, 2008
WestCare-Young FACES	Residential	July 25, 2008
WestCare-Emergency Shelter	Residential	July 25, 2008
Boys Town Nevada	Residential	July 25, 2008
Spring Mountain Treatment Center	Treatment	August 22, 2008
WestCare-Harris Springs Ranch	Residential	August 22, 2008
Vitality Center-Actions of Elko	Residential	September 11, 2008
Northeastern Nevada Juvenile Detention Center	Detention	September 12, 2008
Humboldt County Juvenile Detention Center	Detention	September 12, 2008

Source: Reviewer prepared from unannounced facility visits.

Appendix G
Methodology

To gain an understanding of Assembly Bill 629, Section 6 (AB 629), we reviewed the Nevada Institute for Children's Research and Policy's report and the Federal Department of Justice investigation report, issued to the State of Nevada, on the Nevada Youth Training Center. In addition, we interviewed management of the Division of Child and Family Services and reviewed applicable state laws and regulations. We also reviewed other federal and state reports.

To identify facilities pursuant to the requirements of AB 629, we reviewed state accounting records for facilities funded directly by the State and the Substance Abuse Prevention and Treatment Agency's website for facilities indirectly funded by the State. In addition, we reviewed the Bureau of Licensure and Certification's website for facilities licensed by the State. We also included a search of the internet for other potential facilities. Next, we contacted each facility identified to confirm if it met the requirements of AB 629. For each facility confirmed, we obtained complaint or grievance policies and procedures and complaints filed by youth or other persons on behalf of a youth while in the care of a facility, since July 1, 2007. In addition, we requested specific facility information, such as funding source, staffing, and youth population. We also visited and toured some facilities prior to engaging in any fieldwork.

To establish criteria pursuant to AB 629, we attended the International Conference on Child and Family Maltreatment and reviewed *Performance-based Standards* developed by the Council of Juvenile Correctional Administrators, Child Welfare League of America's *Standards of Excellence for Residential Services and Health Care Services of Children in Out-of-Home Care*. In addition, we reviewed the Nevada Association of Juvenile Justice Administrators *Peer Review Manual*.

We determined criteria included issues related to the health, safety, welfare, civil and other rights of youth, as well as treatment and privileges. Health criteria included items related to a youth's physical health, such as nutrition, exercise, and medical care. Safety criteria related to the physical safety of youth. This included the physical security and environment, inappropriate comments or contact by staff or other youth, and

staffing issues. Welfare criteria related to the general well being of a youth. This included education, wellness activities, and punishments or discipline. Treatment criteria related to the mental health and behavior treatment of youth, not necessarily how a youth was treated on a daily basis. This included access to counseling, treatment plans, and progress through the program.

We distinguished between criteria considered a privilege and a civil and other rights criteria. Specifically, we determined privilege criteria included items considered earned, such as movies, recreational time, phone calls, and reading material. We determined civil and other rights criteria included a right as a human being, such as protection from discrimination and racist comments, the right to file a grievance, and replacement of missing personal items.

Next, we developed a database to analyze and track complaints filed with each facility. Our analysis included: classifying complaints according to complaint type (e.g. health, safety, welfare) and sub-type (e.g. nutrition, exercise or medical care); facility management review, follow-up, and response; external referral or investigation; and whether the complaint resulted in a fatality or near fatality. To aid this process, we developed a data entry sheet which we used as a guideline to code complaints received monthly. Complaints coded to our database were analyzed prior to beginning a facility review. In addition, we developed database queries to manipulate and present useful complaint information within this report.

Next, we developed a plan to review facilities. As a review and not an audit, our work was not conducted in accordance with generally accepted government auditing standards, as outlined in Governmental Auditing Standards issued by the Comptroller General of the United Stated, or in accordance with the Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

Reviews were conducted pursuant to the provisions of AB 629, to determine if facilities adequately protected the health, safety, and welfare of children in the facility and whether facilities respected the civil and other rights of children in their care. Reviews included a review of policies, procedures and complaints filed since July 1, 2007. In addition, we discussed related issues and observed related processes with

management, staff, and youth. Issues discussed included: the facility in general, such as reporting of child abuse and neglect, staffing, background checks, youth records, and contraband prevention; fatalities or near fatalities; the complaint and resolution process; health, including the administration of medication, medical emergencies, and health assessments; safety, such as census, maximum capacity, use of force and de-escalation, fire safety, and transportation of youth; welfare, such as education, behavior, visitation, and room confinement; treatment, such as intake screening, mental health and substance abuse treatment, crisis intervention and suicide and runaway prevention; civil and other rights, such as discrimination, safekeeping of personal items, and religion; and privileges, such as activities on and off campus. Observations included the security of the facility, the sufficiency of operating communication equipment, the security of youth records and personal items, administration of medication, youth sleeping areas, staff interaction, and visitation areas.

Reviews also included reviewing management information and a sample of files. Management information reviewed included: reports of child abuse and neglect, fatalities, or near fatalities; reports used to monitor program activities; and other studies, audit reports, internal reviews, or peer reviews. We judgmentally selected a sample of files to review, which included: personnel files for evidence of employee background checks; and youth files for evidence of a youth's right to file a complaint, medication administered, treatment plan, and emergency contacts.

Next, we judgmentally selected a sample of facilities for review. Our selection was based on our assessment of risk, type of facility, geographic location, and funding source. Our selection included at least one of each type of facility, such as correction and detention facilities, resource centers, treatment facilities, child welfare facilities, group homes, and residential centers. In addition, our selection considered a facility's location, such as northern, southern, or rural Nevada. Our selection also included whether the facility was funded by state, county, or private sources.

During the course of completing facility reviews, we performed some unannounced facility visits. Unannounced facility visits included discussions with management and a tour of the facility. Discussions included medication administration, the complaint process, nutrition, and education. Tours included all areas accessible to

youth. A list of unannounced Nevada facility visits is contained in Appendix F, which is on page 71.

Our work was conducted from July 2007 to October 2008 pursuant to the provisions of Assembly Bill 629, Section 6, of the 74th Nevada Legislative Session.

In accordance with NRS 218.218, we furnished each facility reviewed with a conclusion letter. We requested a written response from management at each facility. A copy of each facility's review conclusion and summaries of managements' responses begins on page 11.

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