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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, and Assembly Bill 103 of the 75th Nevada Legislature, 2009. 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 audit.

Respectfully presented,

Paul V. Townsend, CPA
Legislative Auditor

March 30, 2010
Carson City, Nevada

STATE OF NEVADA
REVIEW OF GOVERNMENTAL AND PRIVATE FACILITIES FOR CHILDREN
2010

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State of Nevada

Review of Governmental and Private Facilities for Children

2010

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 and Assembly Bill 103 of the 75th Nevada Legislature. The report includes the results of our reviews of 13 children's facilities (page 17), unannounced site visits to 14 children's facilities (page 113), and surveys of 50 children's facilities (pages 111-112).

BACKGROUND

Assembly Bill 629 (AB 629), passed during the 2007 Legislative Session, 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. During the 2009 Legislative Session, Assembly Bill 103 (AB 103) was adopted to amend Chapter 218 of the Nevada Revised Statutes to authorize the Legislative Auditor to continue conducting reviews, audits, and unannounced site visits of residential children's facilities. A copy of Assembly Bill 103 is also included in Appendix A of this report.

Number and Types of Facilities

AB 629 and AB 103 include 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 50 governmental and private facilities which meet the requirements of AB 629 and AB 103: 22 governmental and 28 private facilities. Exhibit 1 lists the types of facilities located within Nevada and the total capacity of each type during calendar year 2008.

Exhibit 1

Summary of Nevada Facilities
Calendar Year 2008

		Population for CY 2008		Staffing Levels	
Facility Type	Number of Facilities	Maximum Capacity	Average Population	Full-time	Part-time
Correction and Detention Facilities	13	1,203	964	741	112
Resource Centers	2	72	37	27	15
Child Welfare Facilities	7	225	123	144	47
Mental Health Facilities	7	301	252	532	120
Substance Abuse Treatment Facilities	4	61	29	80	1
Group Homes	13	383	347	263	45
Residential Centers	4	113	59	34	5
Total - Facilities Statewide	**50**	**2,358**	**1,811**	**1,821**	**345**

Source: Reviewer prepared from information provided by facilities.

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

- Correction facilities provide custody and care for youths in a secure, highly restrictive environment who would otherwise endanger themselves or others, be endangered by others, or run away. Correction facilities may include restrictive features, such as locked doors and barred windows.
- Detention facilities provide short-term care and supervision to youths in custody or detained by a juvenile justice authority. Detention facilities may include restrictive features, such as locked doors and barred windows.
- Resource centers provide more than one type of service simultaneously. For example, a resource center may provide both treatment and detention services.
- Child welfare facilities provide emergency, overnight, and short-term services to youths who cannot remain safely in their home or their basic needs cannot be efficiently delivered in the home.
- Mental health facilities provide mental health services to youths with serious emotional disturbances by providing acute psychiatric (short-term) and non-acute psychiatric programs. Mental health facilities also provide services to behaviorally disordered youth. Services provided include a

full range of therapeutic, educational, recreational, and support services provided by a professional interdisciplinary team in a highly structured, highly supervised environment.

- Substance abuse treatment facilities provide intensive treatment to youths addicted to alcohol or other substances in a structured residential environment. Substance abuse treatment facilities focus on behavioral change and services to improve the quality of life of residents.
- Group homes provide safe, healthful group living environments in a normalized, developmentally supportive setting where residents can interact fully with the community. Group homes 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.

In addition to youths placed in facilities within the State of Nevada, we identified an additional 157 youths who were placed in out-of-state facilities by a county or the State as of December 31, 2008. Nevada youth were placed in 31 different facilities in 16 different states across the United States from Utah to Florida. In general, a youth may be placed in an out-of-state facility because: the youth has failed several placements within the State; the youth has a combination of diagnoses which cannot be treated in Nevada; the youth has been adjudicated as a female sex offender; or the youth is sexually aggressive. Exhibit 2 lists the entities that placed youths in an out-of-state facility, the number of youths placed in out-of-state facilities, and the number of states where youths were placed as of December 31, 2008.

Exhibit 2

Summary of Nevada Youth Placed in Out-of-State Facilities as of December 31, 2008

Placing Entity	Number of Youth Placed in Out-of-State Facilities as of December 31, 2008	Number of Different States
Clark County Department of Juvenile Justice Services, Probation	71	11
Washoe County Department of Juvenile Services, Probation	23	7
Lyon County Juvenile Probation	5	2
Nye and Esmeralda County Juvenile Probation Department	4	2
City of Carson City Juvenile Probation	3	2
6th Judicial District (Humboldt, Pershing, and Lander Counties)	2	2
7th Judicial Court (White Pine, Eureka, and Lincoln Counties)	1	1
State of Nevada Division of Child and Family Services	48	11
Total	**157**	

Source: Reviewer prepared from information provided by entities.

Complaints and Grievances

AB 629 and AB 103 require 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 August 1, 2008, through June 30, 2009, we received 960 complaints from 50 facilities. In Nevada, the most common type of complaint was related to welfare. A welfare-related complaint is one affecting the general well being of a youth. This includes issues related to education, wellness activities, and discipline.

SCOPE, OBJECTIVE, AND METHODOLOGY

Reviews were conducted pursuant to the provisions of AB 629, Section 6, of the 74th Session of the Nevada Legislature and AB 103 of the 75th 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, processes, and complaints filed since July 1, 2007. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from November 2008 to December 2009.

A detailed methodology of the work conducted can be found in Appendix F of this report, which begins on page 114.

BACKGROUND CHECK REQUIREMENTS NEED TO BE STRENGTHENED

All of the 13 facilities reviewed could improve their background check processes. Many of the facilities' processes for background checks do not ensure staff have appropriate backgrounds. Exhibit 3 describes some of the most common or serious weaknesses found at the facilities.

Exhibit 3

Background Check Observations by Facility

	Clark County Juvenile Detention	Douglas County Juvenile Detention	Northeastern NV Juvenile Detention	White Pine Boys Ranch	Adolescent Treatment Center	Desert Willow Treatment Center	Oasis On-Campus Treatment Homes	WestCare-Harris Springs Ranch	Carson Valley Children's Center	Briarwood South	TOTAL
Facility did not conduct periodic post-employment background checks.	X	X	X	X	X	X	X	X		X	9
Facility's policy did not address hiring employees with prior criminal histories.		X	X	X		X	X	X			6
At least one employee was not subject to a background check or the results of the checks were not received at the facility.						X	X	X			3
Facility's employee files did not contain the results of background checks.	X								X		2
Facility did not require employees to submit fingerprints for state or federal background checks. Background checks were based on social security number and name, not fingerprints, or only local background checks were conducted.	X		X								2

Source: Reviewer examination of facilities' policies, procedures, and files.

In addition, facilities do not always follow-up when the results of background checks are not received or the results show an arrest, but no conviction information. WestCare-Harris Springs Ranch had four employees with felony convictions; however, as a substance abuse treatment facility, it was not required by state law or its licensing agency to obtain background checks on all employees. While the facility's policies required employees be fingerprinted, the policies did not provide guidance on the types of convictions that would exclude an applicant from employment. In addition, the facility did not determine whether reported arrests resulted in criminal convictions.

Requirements for background checks vary between different types of facilities, depending on the type of license and the licensing agency. Six of the thirteen facilities reviewed (four correction and detention facilities and two substance abuse treatment facilities) were not required by state law or regulation to obtain background checks on all employees. Even though not required, all six did obtain background checks of newly hired employees. However, two facilities used background checks based on social security numbers and names instead of fingerprints or obtained only local background checks. Background checks not based on fingerprints and local background checks may not be as complete or accurate as state and federal background checks based on fingerprints.

Exhibit 4 lists the types of facilities included in our review, the statutory or regulatory requirements for background checks, a brief description of those requirements, and the licensing agencies. Exhibit 5 shows the types of licenses and licensing agencies, and provides examples of the facilities that are licensed.

Exhibit 4

Background Check Requirements by Facility Type

Type of Facility	Statutory or Regulatory Requirement	Description of Requirements	Licensing Agencies
Group Foster Home – Provides full-time care for 7-15 children	NRS 424.031	Requires licensing agency to obtain background check	• Nevada Department of Health and Human Services, DCFS • Clark County Department of Family Services • Washoe County Department of Social Services
	NRS 424.033	Requires applicant for license to submit fingerprints to licensing agency	
	NAC 424.280	Permits conditional employment with local background check pending federal background check results	
Child Care Facility or Institution – Provides care to 5 or more children, including emergency shelters and facilities providing services to children diagnosed as severely emotionally disturbed	NRS 432A.170; NRS 432A.175	Lists convictions which would exclude an employee from working at facility; requires fingerprints be submitted to Bureau; no timeframe in statute	Nevada Department of Health and Human Services, DCFS, Bureau of Services for Child Care
	NAC 432A.200	Requires fingerprints be taken within 3 working days after hiring and every 6 years thereafter	
Mental Health Treatment	NRS 449.179	Requires administrator of facility to ensure each employee has background check at least once every 5 years	Nevada Department of Health and Human Services, Health Division, Bureau of Health Care Quality and Compliance
	NRS 449.188	Lists convictions which would exclude an employee from working at facility	
Substance Abuse Treatment	NRS 449.173	Exempts treatment facilities from provisions related to background checks under NRS 449.176 to NRS 449.188	Nevada Department of Health and Human Services, Health Division, Bureau of Health Care Quality and Compliance (also certified by the Nevada Division of Mental Health and Developmental Services, Substance Abuse Prevention and Treatment Agency)
	NRS 641C	Board of Examiners for Alcohol, Drug and Gambling Counselors conducts background checks when licensing Counselors, Interns, and Detoxification Technicians	
Detention and Correction [1]	NRS 63 (applies only to facilities administered by the State) does not contain background check requirements	Facilities subject to the requirements of various oversight agencies (county or State)	None
Resource Center	None	None	None

[1] Does not include Rite of Passage's Silver State Academy, which is licensed by the State of California.

Source: Reviewer prepared from Nevada Revised Statutes and Nevada Administrative Code.

Exhibit 5

Licenses and Licensing Agencies

Facility Type	Licensing Agencies	Examples of Facilities
Group Foster Home	Nevada Department of Health and Human Services, DCFS	• Carson Valley Children's Center
	Clark County Department of Family Services	• Briarwood South • Oasis On-Campus Treatment Homes
	Washoe County Department of Social Services	• Family Learning Homes
Child Care Facility or Institution	Nevada Department of Health and Human Services, DCFS, Bureau of Services for Child Care	• Adolescent Treatment Center • Child Haven • Kids' Kottage • White Pine Boys Ranch
Mental Health Treatment	Nevada Department of Health and Human Services, Health Division, Bureau of Health Care Quality and Compliance	• Eagle Valley Children's Home • Desert Willow Treatment Center • Montevista Hospital • West Hills Hospital
Substance Abuse Treatment	Nevada Department of Health and Human Services, Health Division, Bureau of Health Care Quality and Compliance (also certified by the Nevada Department of Health and Human Services, Mental Health and Developmental Services, Substance Abuse Prevention and Treatment Agency)	• Vitality Center-ACTIONS of Elko • WestCare-Harris Springs Ranch
Detention and Correction	None	• Caliente Youth Center • China Spring Youth Camp and Aurora Pines Girls Facility • Clark County Juvenile Detention Center • Douglas County Juvenile Detention Center • Jan Evans Juvenile Justice Center • Murphy Bernardini Regional Juvenile Justice Center • Nevada Youth Training Center • Northeastern Nevada Juvenile Detention Center • Summit View Youth Correctional Center
Resource Center	None	• Don Goforth Resource Center
	None (certified by the Nevada Department of Health and Human Services, Mental Health and Developmental Services, Substance Abuse Prevention and Treatment Agency)	• Western Nevada Regional Youth Center

Source: Reviewer prepared from information provided by facilities.

Governmental correction and detention facilities and resource centers have no statutory or regulatory requirements to obtain background checks of employees. These types of facilities are subject only to the background check requirements imposed by those charged with governance, such as a county or state agency. In addition, drug and alcohol treatment facilities have no requirements to obtain background checks on all employees. Nevada statute specifically exempts drug and alcohol treatment facilities from background check requirements. However, licensed staff at these facilities must obtain background checks to be certified by the Board of Examiners for Alcohol, Drug and Gambling Counselors. The Board has established its own standards for types of convictions that would exclude an applicant from licensure.

Different types of facilities also have different timeframes for obtaining background checks and different requirements for periodic post-employment background checks. For example, employees of child care facilities must be fingerprinted within 3 days of being present at the facility and every 6 years thereafter. There are no statutory or regulatory requirements regarding the timeliness of obtaining background checks and no requirements for periodic post-employment background checks for group foster homes.

In order to ensure all youths in Nevada facilities are afforded equal protection, background check requirements should be consistent for all types of facilities that serve youths. We researched statutory and regulatory requirements for employee background checks for several other western states. While no one state had statutes that were comprehensive, several contained requirements that were either more specific or stronger than those in Nevada statutes.

- Idaho Administrative Code states individuals may not provide services until the criminal history and background check is complete for foster care, certified family homes, and licensed child care providers. However, it allows employees of certain providers to work prior to receipt of background check results if no disqualifying crimes are disclosed on the application.
- New Mexico Administrative Code requires employees of all child care facilities or programs be under direct physical supervision until they receive clearance. Applicants are required to submit fingerprint cards by the end of the day following commencement of services. Child care facilities or programs include

those that have primary custody of children for 24 hours or more per week, juvenile detention, and correction and treatment facilities.

- Arizona law requires all employees of the Department of Juvenile Corrections, any contract providers and their employees, those who are not paid and provide services directly to juveniles, personnel of children's behavioral health programs, residential care institution personnel, and sponsors receiving federal child care food program monies to obtain fingerprint background checks.

Recommendation

1. The Legislature may wish to consider enacting legislation to:
   - Require all facilities that provide residential services to children to obtain state and federal fingerprint background checks of all employees prior to allowing the employees to have unsupervised access to the children in those facilities.
   - Specify the offenses for which a conviction would exclude a person from obtaining employment at a facility.
   - Require facilities to maintain the results of the background check for each employee for as long as that person remains employed by the facility.
   - Require background checks be obtained periodically for persons remaining employed at a facility for a specified time.

FACILITY OBSERVATIONS

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 protected the health, safety, and welfare of the youths at the facilities, and they respect the civil and other rights of youths in their care. However, during our visit, we were unable to obtain assurance that Briarwood South adequately protects the health of the youth residing at the facility because of significant medication documentation and administration issues. Subsequent to our visit, Briarwood South revised its medication administration policies and procedures. In addition, during the 14 unannounced visits conducted, we did not note anything that caused us to question the health, safety, welfare, or protection of rights of the children in the facilities.

Many of the facilities had common weaknesses. These weaknesses included policies and procedures that had not been developed or were outdated, medication administration processes and procedures that needed to be strengthened, and complaint and mandatory reporting processes that needed improvement.

Develop or Update Policies and Procedures

The most common observation at the 13 facilities we reviewed was that all 13 facilities needed to develop or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated ranged from suicide risk to privileges.

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 youths 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.

Medication Administration Processes and Procedures Need to Be Strengthened

Medication administration processes and procedures need improvement at all 13 facilities. The medication administration process includes documentation of medications administered to youth, controls over prescribed medications, and the process used to ensure the accuracy of medication files and records. Specifically, youth medical files did not always contain complete or clear documentation of dispensed, prescribed medication at 10 of 13 facilities, there was no evidence of physicians' orders or pharmacy instructions at 4 of 13 facilities, and medication errors were not adequately documented at 3 of 13 facilities. In addition, we noted medical files and records were not reviewed by someone independent of the medication process at 10 of 13 facilities. Also, there were no controls over prescribed medications returned to a pharmacy, physician, or clinic, or unused prescribed medications at 3 of 13 facilities.

Medication administration procedures include procedures used to ensure youths take medications administered. Specifically, staff did not check for "cheeking" at 6 of 13 facilities. Cheeking is a method used to conceal medication administered. Medication administration procedures also include approved, non-prescription medications lists to ensure medications are not administered that are no longer approved or recommended by the Federal Food and Drug Administration. There were no over-the-counter standing order forms at 6 of 13 facilities. A standing order form identifies over-the-counter medications a facility may administer to youths.

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.

Complaint Processes Need Improvement

Complaint and grievance processes need improvement. For example, youth files did not contain evidence of a youth's acknowledgement of his right to file a complaint at 6 of the 13 facilities. In addition, the complaint process was not posted or visible to youths at five facilities, and there was no locked complaint

box at three of the facilities. Finally, information provided to youths at intake did not address the complaint process at 2 of the 13 facilities.

According to *Standards of Excellence* developed by the CWLA and *Performance-Based Standards* developed by the CJCA, all youths 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 right to file a complaint by requiring youths to sign a statement of their understanding of the complaint process. Facilities should also ensure the complaint process is clearly addressed in information distributed to youths at intake and post a description of the complaint process in a location visible to all youths. In addition, locked complaint boxes help ensure the integrity of the complaints made by the youths.

Mandatory Reporting Needs Improvement

During our reviews, we noted instances where youths disclosed an allegation of abuse or neglect. However, we did not find evidence the allegations were reported to child welfare services or law enforcement at 2 of 13 facilities. We also noted an allegation of abuse or neglect was not documented consistent with policy at a third facility.

NRS 432B.220 requires those who know or have reasonable cause to believe that a child has been abused or neglected make a report within 24 hours to child welfare services or law enforcement. Improvements to ensure compliance with mandatory reporting requirements may reduce the likelihood of a youth being returned to an unsafe environment.

UPDATE ON PRIOR FACILITY REVIEW – WEST HILLS HOSPITAL

We conducted a review of West Hills Hospital in July 2008 and reported our observations in our December 2008 report. One of the issues reported was that West Hills Hospital needed to improve its supervision of youths. Incident reports at the Hospital documented two incidents where youths may have been inadequately supervised. One report described a youth who wrapped a cord around her neck while in the group room. The other report

described an elopement of a youth who had been identified as an elopement risk.

In its response to our review, West Hills Hospital represented staff received training on their responsibility to maintain a safe environment for youths and perform 15 minute checks on youths. In addition, the Hospital said staff had been equipped with walkie talkies to aid communication without having to leave youths unsupervised.

In March 2009, the Bureau of Health Care Quality and Compliance (Bureau), of the Department of Health and Human Services' Health Division, conducted a review of the Hospital and released a statement of deficiencies. The statement included a finding which stated that, based on record review, staff interviews and observation, the facility failed to provide adequate staffing to meet patient needs for 2 of 10 patients and failed to provide agency staff with the training needed to provide safe patient care. The Bureau also reported that a patient who was supposed to have constant supervision because of suicidal tendencies was found hanging from a bathroom door with a noose made from a bed sheet. Although the patient was not successful in her suicide attempt, the Bureau found she was not adequately supervised.

In June 2009, the Bureau issued a notice to suspend the Hospital's license due to ongoing safety issues and suspended new admissions to the Hospital. Subsequent to the notice, an independent monitor was appointed to ensure patient safety. The Bureau has reinstated the Hospital's license and the Hospital currently has monitored accreditation.

In October 2009, we requested an explanation from the Hospital regarding the actions taken to improve patient safety. The Hospital replied that it has corrected the deficiencies identified by the Bureau. The Hospital stated that significant changes were made in staffing throughout the Hospital; training was substantially expanded; leadership changes were made; and risk management and oversight procedures were modified to improve effectiveness.

In November 2009, we conducted an unannounced visit to West Hills Hospital. The focus of our visit was to review the actions taken by the Hospital to correct deficiencies related to the supervision of the youths at the facility. We found the Hospital had made improvements regarding the training of staff related to supervision. However, while the Hospital had purchased walkie

talkies for the staff, management indicated they had not been used since March 2009 due to technical difficulties and privacy concerns. Management indicated the Hospital will obtain better walkie talkies to assist staff with supervision of youths. We made some verbal suggestions to facility management regarding cross training of staff when they change shifts. We will continue to monitor West Hills Hospital's progress toward improving the supervision of youths and other issues noted in our prior review.

REPORTS ON INDIVIDUAL FACILITY REVIEWS

This section includes the results of reviews at each of the 13 facilities. Exhibit 6 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 6

Map of Facilities Reviewed

CORRECTION AND DETENTION FACILITIES
- CLCJDC – CLARK COUNTY JUVENILE DETENTION CENTER
- DCJDC – DOUGLAS COUNTY JUVENILE DETENTION CENTER
- JEJJC – JAN EVANS JUVENILE JUSTICE CENTER
- NENJDC – NORTHEASTERN NEVADA JUVENILE DETENTION CENTER
- WPBR – WHITE PINE BOYS RANCH

MENTAL HEALTH TREATMENT FACILITIES
- ATC – ADOLESCENT TREATMENT CENTER
- DWTC – DESERT WILLOW TREATMENT CENTER
- OH – OASIS ON CAMPUS TREATMENT HOMES

SUBSTANCE ABUSE TREATMENT FACILITIES
- VCAE – VITALITY CENTER–ACTIONS OF ELKO
- WCHSR – WESTCARE–HARRIS SPRINGS RANCH

GROUP HOMES
- B – BRIARWOOD SOUTH
- EVCH – EAGLE VALLEY CHILDREN'S HOME

CHILD WELFARE FACILITIES
- CVCC – CARSON VALLEY CHILDREN'S CENTER

Source: Reviewer prepared.

Clark County Juvenile Detention Center

Background Information

Clark County Juvenile Detention Center (Clark JDC) is a temporary holding facility located in Las Vegas, Nevada. The facility houses male and female youths between the ages of 8 and 18. The purpose of Clark JDC is to provide for the temporary, secure, and safe custody of juveniles who are accused of conduct subject to the jurisdiction of the Court, and who require a restricted environment for their own or the community's protection while legal action is pending.

Clark JDC is a secured facility with a maximum capacity of 192 youths. Including youths released throughout the day, the daily population averaged 180 youths with an average length of stay of 17 days during calendar year 2008. During the month of our visit, February 2009, the average daily population was 193 youth.

Clark JDC is primarily funded by Clark County. During calendar year 2008, Clark JDC had 267 employees: 176 full-time and 91 part-time.

Purpose of the Review

The purpose of our review was to determine if Clark JDC adequately protects the health, safety, and welfare of the children in Clark JDC 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 processes for the period July 1, 2007, to February 12, 2009. In addition, we discussed related issues and observed related processes during our visit in February 2009. We also reviewed complaints for the period July 1, 2007 to December 31, 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 Clark JDC provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, Clark JDC needs to improve its medication administration process, strengthen

Clark County Juvenile Detention Center (continued)

its complaint process, develop and update policies and procedures, and improve its employee background check process.

Principal Observations

Medication Administration Process

Clark JDC needs to improve its medication administration process. Specifically, improvements are needed to eliminate inconsistencies between practice and policy by requiring staff to check for cheeking. In addition, a process should be implemented to independently review medical files and records.

Clark JDC's medical staff did not check for cheeking. Cheeking is a method used to conceal medication. Policy instructs medical staff to check each youth's mouth to ensure medication has not been cheeked or hidden under the tongue. During our observation, we noted medical staff required youths to lift their tongue; however, staff did not check for cheeking. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Not checking for cheeking increases the risk of medications being concealed for unauthorized use at a later time.

Clark JDC should independently review medication files and records. During our review of medication files and discussion with management, we noted medication files and records were not independently reviewed to identify potential errors, fraud, or abuse by staff or management. Without periodic reviews, errors, fraud, or abuse could occur and go undetected.

Facility Response

We are revising our Medication Administration Policy and are currently implementing practice to ensure that "cheeking" is not occurring when medication is administered. Nursing staff will visually check the youth's mouth and the juvenile will perform a mouth sweep to avoid the possibility of hiding medications.

We have secured resources to ensure HIPAA (Health Insurance Portability and Accountability Act) compliance and provide adequate quality assurance to maintain periodic reviews. The plan will consist of our Clinical

Clark County Juvenile Detention Center (continued)

Services Division reviewing and auditing medical records and medication files on a monthly basis. The Medical Services Administrator will begin this function on July 1, 2009.

Complaint Process

Clark JDC needs to strengthen its complaint process. Facility policy and manuals state youths shall be informed of the complaint procedure and the right to file a complaint, and youths will sign a receipt indicating orientation to the complaint process. However, the receipt did not address a youth's right to file a complaint or clearly describe the complaint procedure. We also noted the complaint process was not posted in each unit visible to youths. Without evidence a youth is aware of the right to file a complaint and a clearly posted complaint process, a youth may not be aware of the right to file a complaint. As a result, a complaint may go undocumented and unresolved.

Furthermore, we noted complaint forms were not readily available to youths in two of eight units. Policy and handbooks state residents will have full access to the complaint forms. If forms are not readily available, youths do not have full access to forms. A youth may not be willing to express a complaint in writing if a form is not readily available, resulting in a complaint going undocumented.

Facility Response

Each youth currently receives a CASE (Creating a Successful Environment) Handbook indicating the complaint process and explanation of detention rules at the time of intake. This process has been enhanced by posting in each unit (and both sides of unit) a wallboard in plain view for youths to re-visit information in addition to their personal booklets on the complaint process and their youth rights while in detention.

Detention management has reiterated to Unit Supervisors to continuously check to ensure that complaint forms are readily available for youths in a convenient location (located in front of complaint box).

Clark County Juvenile Detention Center (continued)

Complaint boxes are checked twice weekly and reviewed by the designated supervisor where, in turn, complaints are resolved. If a complaint is not resolved at this level, the detention manager is the next step of this formal process.

Policies and Procedures

Clark JDC should develop additional policies and procedures and update existing policies and procedures. During the period of our review, we did not note policies specific to the following: visitor and parent complaint and resolution process; and the protection of the right to participate in all programs without discrimination based on sexual orientation. Clark JDC has a pre-prescribed medications policy specific to pregnant females; however, the policy does not address youths in the general population who may be taking pre-prescribed medications upon intake. Without clearly documented, updated policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Facility Response

We conduct periodic reviews of our policies on a yearly basis and make revisions as needed outside of our yearly review. The plan for the recommendations will include implementing a visitor and parent complaint/resolution form, which will be placed in our main lobby area near the visitor sign-in booklet. These complaints will be addressed directly by the Detention Manager. This process will be implemented on July 1, 2009. The protection of the right to participate in all programs without discrimination based on sexual orientation has been implemented into the policies and procedures manual. This revision took place June 8, 2009.

Our current Medication Administration Policy has been expanded to more clearly provide and include those youths in the general population to continue pre-prescribed medications by insuring receipt of a physician's orders in a timely manner. The policy is currently under revision to mirror this current practice and will be completed by June 15, 2009.

Clark County Juvenile Detention Center (continued)

Background Checks

During our review of personnel files, we noted Clark JDC did not require employees to submit state or federal fingerprint background checks. Instead, Clark JDC used an employee's social security number to check federal, state, local, and other states' databases to complete background checks. Background checks based on an employee's social security number may be less accurate than checks based on fingerprints. In addition, there were no results on file for one employee. Since our review, management indicated Clark JDC began requiring electronic fingerprint background checks, which may result in more accurate and timely results.

Further, we noted background checks are not completed on a periodic basis for all staff after employment. Some facilities are required to conduct background checks every 6 years. Clark JDC should consider adopting a policy to require employee background checks periodically.

Facility Response

Effective March 7, 2009, the Department of Juvenile Justice implemented electronic fingerprint background checks on all new department employees. The Department is currently in the process of researching the feasibility of implementing periodic background check reviews for existing employees.

Other Items Noted

Other items noted during our review include: a daily schedule of activities and a list of prohibited items and contraband were not posted in each unit, visible to youths; first aid kits were not fully stocked or not available in each unit; and youths were observed watching music television, which is contrary to policy. Although we noted during our review that video surveillance cameras did not record and were not used for monitoring, management indicated their capital improvement project includes additional cameras and the ability to monitor and record activity.

Clark County Juvenile Detention Center (continued)

Facility Response

A daily list of scheduled activities and a listing of prohibited items has been posted in each unit (both sides) in plain view for youths to review. This was implemented in April 2009. First aid kits are in each unit and are fully stocked. This was completed in March 2009. A listing of first aid items is posted on the cover of the first aid kit and the kit is sealed for quality assurance measures. Nursing staff routinely check the first aid kits and seal to ensure proper supplies are maintained.

Unit Supervisors have been advised that unit staff are not to allow youth to watch music television as this is a direct violation of our current policies (completed in March 2009). Our capital improvement video surveillance project is to be completed by October 2009 as reported by our Senior Construction Project Manager with Clark County's Real Property Management Department.

Douglas County Juvenile Detention Center

Background Information

Douglas County Juvenile Detention Center (Douglas JDC) is a temporary holding facility for youth. The facility is located in Stateline, Nevada, and houses male and female youths between the ages of 8 and 18. The purpose of Douglas JDC is to provide for the temporary and safe custody of juveniles who are accused of conduct subject to the jurisdiction of the Court, who require a restricted environment for the protection of the community, and for the protection of the juvenile pending legal action.

Douglas JDC is a secured facility with a maximum capacity for 16 youths. During calendar year 2008, the daily population averaged 12 youths with an average length of stay of 10 days. During the month of our visit, January 2009, the average population was 10 youths.

Douglas JDC serves as a detention facility for several counties, including: Douglas, Nye, Lyon, Churchill, and Mineral counties. Douglas JDC's funding is primarily provided by county government. Additionally, contractual services are extended to the Bureau of Indian Affairs, Nevada Youth Parole Bureau, and Rite of Passage. During calendar year 2008, Douglas JDC employed an average of 10 employees: 9 full-time and 1 part-time.

Purpose of the Review

The purpose of our review was to determine if Douglas JDC adequately protects the health, safety, and welfare of the children in Douglas JDC 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 processes for the period July 1, 2007, to January 23, 2009. In addition, we discussed related issues and observed related processes during our visit in January 2009. We also reviewed complaints for the period July 1, 2007, to December 31, 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 Douglas JDC provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and

Douglas County Juvenile Detention Center (continued)

respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, Douglas JDC needs to improve its medication administration process, develop and update policies and procedures, and improve its process for screening of employees through criminal history background checks.

Principal Observations

Medication Administration Process

Douglas JDC needs to improve its medication administration process. During our review of youth files, we noted two of five files did not contain clear documentation of prescription medication youths were taking at intake. Therefore, it is unclear if youths received all of their pre-prescribed medication while at the facility. We also noted an instance when medication was not administered timely.

In addition, Douglas JDC does not have an established standing order form. A standing order form identifies physician-approved over-the-counter medications. According to management, the facility's contract nurse practitioner approved all over-the-counter medications; however, the facility does not have documentation to support this. Without a formal standing order form, medication could be administered to youths that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Douglas JDC should independently review medication files and records. During our review of medication files and discussion with management, we noted medication files are not independently reviewed to identify potential fraud or abuse by staff or management. Without periodic reviews, errors, fraud, or abuse could occur and go undetected.

Facility Response

Douglas JDC staff were given additional training and the Medication Administration Policy was revised regarding the receipt of prescription medications at intake, the standing order form and independent review of medication files.

Douglas County Juvenile Detention Center (continued)

Policies and Procedures

Douglas JDC should develop and update policies and procedures. During the period of our review, we did not find policies specific to social skills programs, equal treatment of youths regardless of sexual orientation, and privileges youths may receive. In addition, the facility should update the search section of its visitation policy to be consistent with search procedures youths undergo after a visit. Inconsistent search policies could result in contraband being brought into the facility. Without clearly documented, updated, and consistent policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Facility Response

Douglas JDC updated each of the policies and procedures listed in the reviewer's letter.

Background Checks

Employee background checks were not completed on a regular basis after employment. Some facilities are required to conduct background checks every 6 years. Douglas JDC should consider adopting a policy to require employee background checks periodically. Further, Douglas JDC has not established standards to determine whether to hire an employee with a criminal conviction.

Facility Response

Douglas JDC revised its policy for background checks. The policy now includes standards for the hiring of employees with criminal convictions. Management stated they are reviewing the frequency necessary for background checks and the fiscal impact with the intention of adding it to policy.

Other Items Noted

Other items noted during our review include: a list of contraband was not posted within the facility, visible to youths, staff, and

Douglas County Juvenile Detention Center (continued)

visitors; and an allegation of abuse or neglect was not documented consistent with policy.

Facility Response

A list of contraband items will be posted in the facility. Also, certain policies have been updated to include contraband information. The Mandated Child Abuse Reporting Policy has been reviewed with the facility supervisor who in turn has reviewed the procedure with all staff. All staff review this policy yearly.

Northeastern Nevada Juvenile Detention Center

Background Information

Northeastern Nevada Juvenile Detention Center (Northeastern) is a temporary holding facility for youths. The facility is located in Elko, Nevada, and houses male and female youths between the ages of 8 and 17. The purpose of Northeastern is to protect the community by securely housing youths who may have been involved in activities injurious to the public by providing a safe and secure facility to detain youths.

Northeastern is a secured facility with a maximum capacity for 24 youths. During calendar year 2008, the daily population averaged 10 youths with an average length of stay of 6 days. During the month of our visit, January 2009, the average population was seven youths.

Northeastern serves as a regional detention facility for Elko County and the neighboring counties of White Pine, Eureka, and Lincoln. Northeastern's funding is primarily provided by county government. Additionally, contractual services are extended to the Bureau of Indian Affairs and the Nevada Youth Parole Bureau. During calendar year 2008, Northeastern had 12 full-time staff.

Purpose of the Review

The purpose of our review was to determine if Northeastern adequately protects the health, safety, and welfare of the children in Northeastern 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 processes for the period July 1, 2007, to January 8, 2009. In addition, we discussed related issues and observed related processes during our visit in January 2009. We also reviewed complaints for the period July 1, 2007, to November 30, 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 Northeastern provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However,

Northeastern Nevada Juvenile Detention Center (continued)

we noted some areas for improvement. Specifically, Northeastern needs to develop and update policies and procedures, independently review medical files and records, and ensure youths awaiting booking are adequately supervised until a mental health assessment is complete.

Principal Observations

Policies and Procedures

Northeastern should develop and update existing policies and procedures. During the period of our review, we noted policies were not dated. In addition, we did not note policies specific to the following: staff, visitor, and parent complaint and resolution process; protection of the right to participate in programs without discrimination based on sexual orientation; and ensuring pre-prescribed medications are administered upon intake or anytime thereafter. Also, the complaint policy is not consistent with the actual facility process and Detention Rules and Rights (the youth handbook). Specifically, policies do not address the forms and complaint box used. Without clearly dated, documented, and updated policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Facility Response

We are working to revise those policies that were brought to our attention as being inadequate or outdated. Our policies will be dated as individual policy is updated.

Independent Review of Medication Files and Records

Northeastern should ensure medication files and records are reviewed by a person independent of the medication administration process. During our review of medication files and discussion with management, we noted medication files and records were not independently reviewed to identify potential errors, fraud or abuse. Without periodic reviews, errors, fraud, or abuse could occur and go undetected.

Northeastern Nevada Juvenile Detention Center (continued)

Facility Response

We have changed our policy to include an annual review of medication records. The review will include no less than 25% of those records in the preceding calendar year and there will be written documentation of the findings.

Booking Procedure

Northeastern should amend its booking procedures to ensure youths awaiting booking are adequately supervised until a mental health assessment has been completed. During our review of files, we noted staff provided a youth awaiting booking with a tray of food and a dinner fork. While in his booking cell, the youth used the dinner fork to make lacerations on his arm. Since a mental health assessment had not been completed, Northeastern was unaware if the youth was a suicide risk or if he had a history of self-mutilation.

Facility Response

The process for receiving intakes has been reviewed and the procedure and written policy have been changed to include better observation of those awaiting completion of the booking process. This procedure will include visual observation and assessment of any object given to a juvenile in the process.

Background Checks

During our review of personnel files, we noted it took up to 4 weeks to receive the results of local background checks. Because it took so long to receive the results, employees may have had direct contact with youth prior to the results being received. In addition, local background checks are less comprehensive than state or federal checks. Since our review, management has indicated background checks are being completed electronically, which may result in receiving the results more timely. We also noted background checks are not done on a periodic basis for all staff after employment. Further, Northeastern has not established a policy outlining the types of criminal convictions which would exclude a person from employment.

Northeastern Nevada Juvenile Detention Center (continued)

Facility Response

Since the review, we have changed our background procedure to include both state and federal checks. In working with our Sheriff's department, we have submitted prints on the electronic scan with good results. We have received reports on state prints in under a week. We have also completed a comprehensive state and federal background on all staff at the Detention Center. It will be policy to run these periodic checks no less than every 7 years.

Other Items Noted

Other items noted during our review include: a list of prohibited items and contraband was not posted in a location visible to youth; a description of the complaint process was not posted in a location visible to youth; and staff have not received training on use-of-force tactics in the last 3 years.

Facility Response

A list of contraband and prohibited items has been placed on the wall in each cell block and in the multi-purpose room. A document explaining the complaint process is now posted beside the complaint box in the multi-purpose room.

We have invested in a proven program "Handle with Care" and will be sending one of our Senior Shift Supervisors to be certified in the training. In the past, tactics training that is offered in the Elko area is designed for POST certified officers and does not adequately address the needs of officers working in a juvenile detention setting.

Jan Evans Juvenile Justice Center

Background Information

Jan Evans Juvenile Justice Center (JEJJC) is a temporary holding facility located in Reno, Nevada. The facility houses male and female youths between the ages of 8 and 18. The purpose of JEJJC is to protect the community by securely housing juveniles that may be or have been involved in activities injurious to the public. JEJJC also provides for the safe and secure detention of juveniles detained within the facility.

JEJJC is a secured facility with a maximum capacity of 108 youths. During calendar year 2008, the daily population averaged 57 youths with an average length of stay of 14 days. During the month of our visit, April 2009, the average daily population was 39 youths.

JEJJC is primarily funded by Washoe County. During calendar year 2008, JEJJC had 46 full-time employees.

Purpose of the Review

The purpose of our review was to determine if JEJJC adequately protects the health, safety, and welfare of the children in JEJJC 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 processes for the period July 1, 2007, to February 28, 2009. In addition, we discussed related issues and observed related processes during our visit in April 2009. We also reviewed complaints for the period July 1, 2007, to February 28, 2009.

Results in Brief

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

Jan Evans Juvenile Justice Center (continued)

Principal Observations

Medication Administration Process

JEJJC needs to improve its medication administration process. During our review of medication files, we noted 3 of 15 files contained medication documentation errors. Specifically, we noted two files did not contain complete documentation of prescribed medication administered to youths. A third file did not contain complete documentation of medication administered to a youth in error. Because medication files contained errors, it is unclear if prescribed medication was actually administered consistent with the prescriptions.

In addition, JEJJC should revise its medication administration form to be consistent with policies. Specifically, policies indicate youth initial the form after receiving medication. However, during a recent revision of the form, the section for youths to initial was removed. Inconsistencies can cause confusion, which could result in errors.

We also noted JEJJC does not have an established standing order form. A standing order form identifies physician-approved over-the-counter medications. According to medical staff, the facility's nurse practitioner approves all over-the-counter medications. Without a formal standing order form, medications could be administered to youths that are no longer approved or recommended for use by the Federal Food and Drug Administration.

Facility Response

Medical staff on duty, as well as the on-duty supervisor, count and prepare prescription medications together for the upcoming shift. If there is not a medical staff on duty, another detention staff member will provide additional oversight and confirmation of this process to ensure accuracy. In addition, staff count each youth's remaining medication daily and review medication documentation to identify potential errors made the prior day.

Juveniles are no longer required to initial medication sheets. In addition, the dispensing of over-the-counter medications has been changed. The standing order form

Jan Evans Juvenile Justice Center (continued)

is prepared by an advanced practitioner nurse in consultation with a physician.

Complaint Process

JEJJC needs to strengthen its complaint process. During our review, we noted JEJJC has not developed a form for youths to sign indicating they are aware of their right to file a complaint. Without a signed youth statement, JEJJC has no assurance youths are informed of their right to file a complaint.

In addition, we noted JEJJC does not maintain a log of complaints received and resolved. Maintaining a log of complaints would help management identify the types of complaints filed, which would facilitate trend analysis. It would also assist management in identifying common issues. We also noted a description of the complaint process was not posted in each pod, visible to youths.

Facility Response

Youths now sign off on an orientation quiz directly concerning the complaint process and the right to file a complaint. A description of the complaint process has been posted in each detention pod and in the school area. In addition, a log was created to track complaints and record outcomes.

Policies and Procedures

JEJJC should develop and update policies and procedures. During our review, we did not note policies specific to the following: visitor and parent complaint and resolution process; guidelines for staff to monitor and screen the appropriateness of television shows, radio, and video games; and equal opportunity for youth to participate in all programs and work assignments without discrimination based on sexual orientation. In addition, we noted policies and procedures have not been revised since 2006. Without clearly documented, updated policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Jan Evans Juvenile Justice Center (continued)

Facility Response

We are working on a posting to put in the lobby and visitors' area to explain rules, as well as a complaint process for visitors or parents. Television movie guidelines have been established. Policies have been amended to specify that all juveniles are assured equal opportunity to participate in all programs and work assignment without discrimination based on sexual orientation. In addition, we are in the process of reviewing and revising the policy and procedure manual.

Background Checks

Based on our review of personnel files, it took up to 9 weeks for JEJJC to receive state background check results and up to 12 weeks to receive Federal Bureau of Investigation results. Because of the length of time it took to receive background check results, employees may have had contact with youths prior to all results being received. Since our review, management has indicated background checks are being completed electronically, which may result in receiving the results more timely.

Facility Response

The background investigation standards include the completion of a background packet; an on-site NCIC check (National Crime Information Center); local, state, and federal fingerprint check; Child Protective Services check for cases involving child abuse or neglect; and a check of the Nevada Department of Motor Vehicles driving record. No Department employee or volunteer shall work with youth until all facets of the background check have been completed.

Other Items Noted

Other items noted during our review included: youths' schedules were not posted in locations visible to youths, five vehicles did not have fire extinguishers, and one of five vehicles did not have a first aid kit.

Jan Evans Juvenile Justice Center (continued)

Facility Response

We are working with Risk Management to ensure vehicles contain appropriate fire extinguishers and first aid kits. In addition, youths' schedules are posted in the central control area within the individual pods.

White Pine Boys Ranch

Background Information

White Pine Boys Ranch (WPBR) is a private, for-profit, residential facility that opened in December 2008. The facility is staff secured, serves male youth between the ages of 12 and 18, and is located in a rural area of Lund, Nevada. WPBR's mission is to offer a clinically intensive program in a working ranch environment to youth with emotional and behavioral issues. WPBR's objective is to provide residents with a goal-oriented, supportive, and therapeutic environment based on positive peer culture. The facility is licensed by the Department of Child and Family Services (DCFS) as a child care institution.

WPBR's maximum capacity is 32 youth. During WPBR's operating period, December 2008 through July 2009, daily population averaged 22 youths with an average length of stay of 7 months, and an average of 17 employees. During the month of our visit, September 2009, the average population was 32 youths.

Purpose of the Review

The purpose of our review was to determine if White Pine Boys Ranch adequately protects the health, safety, and welfare of the children in WPBR 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 processes for the period December 2008 through July 2009. In addition, we discussed related issues and observed related processes during our visit in September 2009.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at WPBR provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, WPBR needs to improve its medication administration process and procedures; develop and formally adopt facility policies and procedures; improve its complaint process; and strengthen its background check process and supervision of staff and youths.

White Pine Boys Ranch (continued)

Principal Observations

Medication Administration Process and Procedures

WPBR needs to improve its medication administration process and procedures. Specifically, the improvements needed include documenting physician orders, pharmacy instructions, and medications received from the pharmacy; ensuring medication management logs are complete; adding a menu or key to the medication management log; documenting medication errors; and independent review of medication files and records. In addition, WPBR needs to improve its medication administration processes. For example, mouth sweeps were not completed, the physician-approved standing order form was not dated, files do not contain youths' photos, and allergies were not always noted.

Medication Administration Process

WPBR's medication files were incomplete and inconsistent with policies. Policies direct staff to maintain a copy of physician's orders and pharmacy instructions. Although, WPBR did contact its pharmacy to obtain some of the missing documentation, six files for nine youth receiving prescription medications did not contain this documentation. In addition, physician's orders were not always followed. For example, WPBR administered prescribed medication to a youth over a 10-day period even though medication was supposed to be administered over a 5-day period.

Policies require complete documentation of medication administered to youth; however, medication management logs were not always completely filled out. For example, we noted blank spaces and missing youth and staff initials in six of the medication logs for the nine youths receiving medications. Blank spaces and missing initials on the log could indicate a youth was administered medication and staff forgot to complete the form, the youth refused the medication, or the youth did not receive medication for some other reason.

WPBR did not document medication received from the pharmacy. Since WPBR did not document medications received, we were unable to determine if WPBR verified medications received matched physician-ordered medications. Not documenting and

White Pine Boys Ranch (continued)

verifying medications received from the pharmacy increases the risk of potential errors, fraud, or abuse.

WPBR needs to add a menu to its medication management log, which is used to record medications administered to youth. A menu is a list of acronyms used to identify specific actions, such as medications missed when a youth was on a home pass or refused his medication. When medication errors like those listed above are not documented, it is not clear if a youth received his medications, which could be important information in case of a medical emergency.

WPBR does not adequately document medication errors. During our review of facility information, we noted WPBR formally notified DCFS of a medication error. However, there was no supporting medication error form. Without adequate documentation of errors, management has no assurance DCFS will be notified of errors.

WPBR should independently review medication files and records. During our review of medication files, we did not find evidence that medication files and records were independently reviewed. In addition, policies do not require reviews. Without policies and procedures to require independent reviews, errors, fraud, or abuse could occur and go undetected.

Medication Administration Procedures

WPBR should ensure that staff observes all youths completing mouth sweeps. Although management indicated and policies require staff observe youths to ensure medications aren't cheeked, staff did not require youths to complete mouth sweeps. Cheeking is a method used to conceal medication. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Mouth sweeps reduce the risk of medication being cheeked for unauthorized use at a later time.

WPBR's physician-approved over-the-counter medication standing order form is not dated. A standing order form identifies over-the-counter medications the facility may administer to youths. Not dating the approved form could cause confusion, resulting in medication being administered to youths that is no longer approved or recommended for use by the Federal Food and Drug Administration.

White Pine Boys Ranch (continued)

In addition, medication files did not contain photos of youths. Photos help identify and match each youth with his medication. We also noted 11 of 12 files did not indicate if a youth had allergies or not. Identifying allergies may reduce the risk of reactions to medications or food.

Facility Response

White Pine Boys Ranch has improved its medication administration and tracking processes by implementing the following:

- *Medication to be administered is verified with the medication record book.*
- *Youths are given medication to take and staff watch the youths take the medication. After medication is swallowed, the staff instruct the youths to blow, lift their tongue, and do a finger sweep of the mouth.*
- *Staff initial the log and has youths initial the log as well.*
- *Each youth's medical file contains all medical records the Ranch received, including, but not limited to, doctor notes, prescriptions, pharmacy notes, any hospital or emergency room visit, dental visits, etc.*
- *Medical logs have a current instruction grid noting different types of entries. Each log divider has a picture of the youth. The logs have a counting grid for the number of pills received, which counts down.*
- *WPBR has implemented a bimonthly audit of medication records. The Director of WPBR and DCFS receives an email of medication errors and the medication administered for the week.*
- *WPBR has a disposal form for all medication that is no longer to be taken by the youths. The form notes medication disposed, by whom, the date, and how the medication was disposed.*
- *Each youth will have a dated standing order for over-the-counter medication. If a youth does not*

White Pine Boys Ranch (continued)

have a standing order, over-the-counter medication may not be administered.

- *When staff take a youth to the doctor's office, they are required to have the doctor fill out the medication treatment form. They are also required to bring back all paper work from the doctor's office. All doctor's office and pharmaceutical records are to be kept in the youth's medical file.*
- *WPBR has added a list of allergies to the intake form. Allergies are also listed in the medical files.*

<u>Policies and Procedures</u>

WPBR needs to develop and formally adopt comprehensive facility policies and procedures. During the course of our review, we noted facility policies comprised: a clinical manual, employee materials, position descriptions, staff training materials, and protocols. In addition, we noted facility procedures which were not formally addressed in policies. Without comprehensive formal facility policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

During the period of our review, we did not note policies specific to: mental health and substance abuse; inventorying and safeguarding a youth's personal items; records retention; injury; facility and vehicle keys; the sufficiency of staff-to-youth ratios for off-campus activities; and documentation of suicide attempts or ideations.

In addition, facility policies need to be updated. The clinical manual addresses intake tasks, such as providing new youths with a resident handbook and orienting new residents; however, it does not address WPBR's intake form, youth supervision prior to completion of the form, timeframes to conduct and complete all assessments, and treatment plan development. The clinical manual refers to a disposal log for all destroyed medications. However, it does not address: the method used to destroy medications, including witnesses; timeframes; or additional required documentation. The clinical manual addresses medical emergencies, such as contacting a youth's parent, billing, etc. However, it does not address intervention, evacuation, emergency vehicles, or emergency medical and ranch contacts. De-escalation

White Pine Boys Ranch (continued)

and restraint procedures indicate restraint and seclusion may be used during an emergency; however, WPBR does not use restraints or seclusion. WPBR's clinical manual discusses transportation to medical appointments; however, it does not address supervision, use of seatbelts, insurance, licensing, or ranch work transportation. Current policies address the facility's hands-off philosophy; however, it does not identify emergency techniques that may be used.

Subsequent to our review, WPBR addressed the following items through position descriptions. However, these items also need to be incorporated into facility policies: no food in dorms; kitchen utensils; sanitation of the sick room; contraband searches; procedures to help prevent a youth from running away once a youth is identified as a runaway risk; access to treatment, school, and other facility activities without discrimination based on sexual orientation; and the process and contact numbers to report child abuse and neglect, including tracking the report.

While management proactively addressed some items that we brought to their attention during our review, the items need to be incorporated into facility policies. For example, WPBR implemented a catalog system to control, inventory, and secure tools and ranch equipment, and WPBR updated its list of prohibited items and contraband. However, these items have not been added to facility policies.

> <u>*Facility Response*</u>
>
> *WPBR has compiled a comprehensive policies and procedure manual which addresses all guidelines, including those areas listed in the review letter. The new manual was distributed to all employees with a signature requirement noting they have received it, read it, and agree to follow it.*

<u>Complaint Process</u>

WPBR needs to improve its complaint process. Although management did improve its process subsequent to our review, improvements are still needed. For example, complaint policies do not address: the resolution process, including resolution timeframes; assurance staff will not retaliate against youth for filing

White Pine Boys Ranch (continued)

a complaint; independent review of complaints; youth and attorney contact; and a complaint and resolution process for visitors and parents. In addition, the updated complaint process should be added to the handbook provided to youths at intake and a description of the complaint process should be posted in a location visible to youths, staff, and visitors. Also, management should obtain a signed statement from youth indicating youth understand they have the right to file a complaint.

Facility Response

WPBR has revised its complaint policy and posted the complaint process in the lodge and in each dorm. Youths are instructed that they are free at any time to fill out a complaint form and place it in the locked box. The box is checked each week. The youth is notified of action taken by WPBR regarding the complaint and the complaint response form is filled out by WPBR administration. Staff are instructed clearly that they may not react negatively toward any youth who has issued a complaint. WPBR will consider all complaints as serious and see that appropriate action is taken.

Background Checks

WPBR needs to strengthen its background check process. Management confirmed employees had direct contact with youths prior to DCFS issuing clearance memorandums. In addition, WPBR policies do not specifically address hiring employees with a prior criminal history. Without complete hiring policies and procedures, WPBR may use inconsistent information or criteria when making employment decisions.

In addition, we noted at least four employees were not fingerprinted within 3 working days after the date of hiring or presence in the facility, as required by NAC 432A.200. According to management, they misunderstood the time allowed for fingerprinting. In addition, management stated WPBR employees are now required to make an appointment with the local sheriff's office to be fingerprinted, which may add to the delay.

We also noted WPBR has not developed a process to ensure personnel files are complete. For example, clearance

White Pine Boys Ranch (continued)

memorandums issued to WPBR by its licensing agency, DCFS, were not always available or part of an employee's personnel file. In addition, personnel files did not always contain the date an employee was fingerprinted. Further, WPBR has not developed a process to ensure background checks will be completed on a periodic basis for all employees after employment.

Facility Response

No employee will continue to work for WPBR who has not been fingerprinted in the first 3 days of employment. WPBR mails the background clearance form and fingerprints to the State as soon as they are completed. It can take months before results return to WPBR. WPBR added to its employment application a section for self-reporting of prior criminal history.

All employee files are to be accurate and kept up to date. WPBR follows the DCFS regulations for background checks for employees. Employee files will contain TB test results, CPR and First Aid Cards, copies of drivers licenses, certificates of training, copies of background clearance letters, fingerprint cards, DCFS log form, and other material as needed by WPBR.

Supervision

WPBR needs to strengthen its supervision of staff and youths. During our review we noted instances of inadequate supervision of staff. For example, we observed the following which should have been addressed directly by management: inappropriate staff attire and vehicle decals; inappropriate and unprofessional language by staff; unsecured facility files; and lack of or incompleteness of incident reports. In addition, we observed the following which went uncorrected by staff: various types of contraband; unsupervised youths; food in dorms; and fence wire in a facility van. Not adequately supervising staff and holding them accountable could portray negative images of the facility. Subsequent to our review management developed a bi-monthly checklist to strengthen supervision.

In addition, we noted various situations which may have been avoided if youths were adequately supervised. For example, facility

White Pine Boys Ranch (continued)

information indicated youths participated in physical altercations and harmful behavior. There was no evidence incident reports were consistently written to document youths' actions. An incident report is a method used to document undesirable behavior and hold youths accountable for their actions. An incident report may not have been written because the process was not clearly documented in policies. Without a clearly documented incident reporting process, staff may not have been holding youths accountable for their actions. Subsequent to our review, management revised its incident report form.

Facility Response

WPBR requires supervision of youths at all times. WPBR has implemented mandatory training for all staff twice a month to increase staff effectiveness in supervising youths, effective communication and role modeling for youths, resolve staff concerns, bring about new ideas, and educate staff on procedural changes. WPBR has made it clear to all staff that they are only to use positive modeling. Negative language or responses are not effective in behavioral modification of youths.

Other Items Noted

Other items noted during our review include: a facility vehicle did not contain a fire extinguisher and the first aid kit was not fully stocked; facility first aid kits were not fully stocked; treatment plans were not always signed by youths; and not all staff were trained in CPR. In addition, the youths schedule and a list of prohibited items and contraband were not posted in areas visible to youths, staff, and visitors.

Facility Response

WPBR will keep a fire extinguisher and a fully stocked first aid kit either in each vehicle or on the person with the youths in the vehicle. Each youth will sign his treatment plan. If a youth refuses to sign, a note will be made that the youth refused to sign. Lists of contraband have been posted in the lodge and in the dorms. Employees are required to have CPR and first aid training within the first

White Pine Boys Ranch (continued)

90 days of being hired. WPBR will also post the youths' schedule in an area visible to all youths.

Adolescent Treatment Center

Background Information

Adolescent Treatment Center (ATC) is a mental health treatment facility that provides rehabilitative services and is located in Sparks, Nevada. The facility houses male and female youths between the ages of 12 and 17. ATC provides mental health treatment and rehabilitation services for the most emotionally disturbed and behaviorally disordered adolescents. Services include: psychiatric evaluation; individual, family, and group therapy; and emergency evaluation and stabilization.

ATC is a staff-secured facility with a maximum capacity for 16 youths. During calendar year 2008, the daily population averaged 16 youths with an average length of stay of 5 months. During the month of our visit, December 2008, the average population was 14 youths.

ATC 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 2008, the facility had 20 full-time employees.

Purpose of the Review

The purpose of our review was to determine if ATC adequately protects the health, safety, and welfare of the children in ATC 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 processes for the period July 1, 2007, to December 17, 2008. In addition, we discussed related issues and observed related processes during our visit in December 2008. We also reviewed complaints for the period July 1, 2007, to October 31, 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 ATC provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, ATC needs to improve

Adolescent Treatment Center (continued)

its medication administration process, develop and update policies and procedures, and revise the employee background check process.

Principal Observations

Medication Administration Process

ATC needs to improve its medication administration process. During our review of medication files, we noted 2 of 10 files did not contain clear documentation of whether prescribed medication was dispensed. Although policies require documentation of all medication administered, youths can refuse medication. This must also be documented. Alternatively, medical staff may have forgotten to administer prescribed medication, which is considered a medical error. Policies also require documentation of medical errors. ATC's medical administration record (form) requires staff administering medication to indicate medication administered. The record also provides a key or menu to document medication refused. Because medication files did not contain clear documentation, it is not known if prescribed medication was administered and not documented, refused, or not administered for these two files.

In addition, the actual documentation process for refused prescribed medication is consistent with policy; however, it is not consistent with the medication administration form menu. Although the medication form menu indicates "REF" will be used to indicate if a youth refused medication, policy instructs staff to initial, circle, and chart the reason for refusal. Any inconsistencies in the medication administration process can cause confusion and result in errors.

ATC should independently review medication files and records. During our review of medication files and discussions with management, we noted medication files were not independently reviewed to identify potential fraud or abuse by staff or management. Without periodic reviews, errors, fraud, or abuse could occur and go undetected.

Further, ATC's standing order form is not signed or dated. A standing order form identifies physician-approved over-the-counter medication the facility may administer to youths. Not dating or

Adolescent Treatment Center (continued)

updating this form on a regular basis and not having it signed by a physician could result in medication administered to youths that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Facility Response

ATC has established a regular independent review of the Medical Administration Record and client files. ATC has also added a daily review by the nursing supervisor or designee. In addition, the nursing supervisor has conducted a training review of medication administration and documentation policies and procedures with all nursing staff.

The menu key on the medication administration form has been updated, and is now consistent with policy in that medication refusal is coded with a circle and staff initials.

ATC has developed a new policy and procedure for initial standing orders. The forms are signed by the parent/guardian at admission, as well as the physician.

Policies and Procedures

ATC should develop and update existing policies and procedures. During the period of our review, we did not find policies specific to the following: education; exercise program; staff, visitor, and parent complaint and resolution process; and guidelines regarding the sufficiency of staff-to-youth ratios for off-campus activities. Without clearly documented, updated policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Facility Response

Policies and procedures have been developed to address these specific areas.

Background Checks

ATC employees may have had direct contact with youths prior to the results of all background checks being received. Based on our

Adolescent Treatment Center (continued)

review of personnel files, it took up to 27 weeks to receive state background check results and up to 31 weeks for Federal Bureau of Investigation results. ATC does not require potential employees to obtain fingerprints from an agency using electronic scanning and fingerprint transmission for background checks, which provides results in less time. Lastly, there is no evidence to support if background checks were completed every 6 years, as required for licensed child care facilities by NAC 432A.200.

Facility Response

*Employees do have contact with youths prior to receiving the background check; however this contact is **always** directly supervised. When employees are new, they are "shadowed" constantly by another staff. It should also be noted that, due to the type of clients and physical setting, direct care staff are never alone with a client.*

ATC is currently researching law enforcement agencies that provide electronic scanning and transmission of fingerprints. The cost of implementing this will be analyzed in accordance with State of Nevada budget procedures. As this is an issue that affects other DCFS facilities as well, a work group across the Division may be formed to address this issue.

ATC would not be eligible for licensing if it did not conduct the background checks every 6 years. However, the licensing agency follows the State of Nevada procedures for retention of records, which indicates that records may be discarded every 7 years.

ATC has added to its licensing policy: "Documents of completed and current investigations must be kept on file at the facility for all persons required to be investigated for the period of their presence at the facility."

Other Items Noted

Other items noted during our review include: the facility vehicle did not include a fire extinguisher, and the facility's daily/weekly schedule of youth activity, programs, and services was not posted.

Adolescent Treatment Center (continued)

Facility Response

ATC management contacted the State of Nevada Fire Marshall for input regarding fire extinguishers in vehicles. The Deputy Administrator did speak with some firefighters who advised that staff never attempt to put out a fire in a vehicle and that they be instructed to immediately get all children out of a vehicle and move them to a safe distance away in case of the outbreak of a large fire and the potential explosion of the gas tank.

Client daily schedules are outlined on the youths' point cards, which they keep on their person throughout the day. Daily schedules are posted in the staff area. In addition, weekly schedules have been posted in common areas for youths to view.

Desert Willow Treatment Center

Background Information

Desert Willow Treatment Center (DWTC) is a state psychiatric hospital located in Las Vegas, Nevada. DWTC provides mental health services to youths with serious emotional disturbances by providing acute psychiatric (short-term) and non-acute psychiatric programs. DWTC's mission is to provide quality, individualized mental health services in a safe and culturally sensitive environment. The facility's mission also includes collaborating with caregivers, the community, and other providers to ensure that children and families of Nevada achieve their full human potential.

DWTC is a secured facility with a maximum capacity for 58 youths. The facility houses male and female youths between the ages of 6 and 18. During calendar year 2008, the daily population averaged 51 youths with an average length of stay of 23 days for acute care and 150 days for non-acute care. During the month of our visit, March 2009, the average daily population was 56.

DWTC is funded by the State through the Division of Child and Family Services (DCFS) and is organizationally within Southern Nevada Child and Adolescent Services. During calendar year 2008, DWTC had 110 full-time staff.

Purpose of the Review

The purpose of our review was to determine if DWTC adequately protects the health, safety, and welfare of the children in DWTC 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 processes for the period July 1, 2007, to January 31, 2009. In addition, we discussed related issues and observed related processes during our visit in March 2009. We also reviewed complaints for the period July 1, 2007, to January 31, 2009.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at DWTC provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects

Desert Willow Treatment Center (continued)

the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, DWTC needs to improve its medication administration process and procedures, strengthen its complaint process, develop and update existing policies and procedures, and strengthen and develop policies and procedures to conduct and receive employee background checks.

Principal Observations

Medication Administration Process and Procedures

DWTC needs to improve its medication administration process and procedures. Specifically, DWTC needs to strengthen its control over medications. Improvements are also needed to strengthen DWTC's medication administration procedures.

Medication Administration Process

DWTC needs to improve its medication administration process by strengthening its control over medications. For example, DWTC needs to restrict access to its pharmacy floor stock room, verify medications received from the pharmacy, ensure medication removed from the pharmacy floor stock room is verified by a second nurse, and track medications returned to the pharmacy.

DWTC needs to restrict access to its pharmacy floor stock room to allow access only to DWTC nursing staff. During our review we noted staff from the Southern Nevada Adult Mental Health Services pharmacy had unrestricted access to DWTC's floor stock room to deliver, restock, and remove medications for disposal. Unrestricted access to DWTC's floor stock room by non-DWTC staff increases the risk of errors, fraud, or abuse, which could go undetected.

In addition, DWTC should verify medications received from the pharmacy. Information obtained from the pharmacy indicated medications were delivered to DWTC the night before our observation. However, during our observation of the medication administration process, some of the medications were not available to administer to youths. Since DWTC did not verify medications received from the pharmacy, we were unable to determine if DWTC actually received the medications. Not verifying medications received from the pharmacy increases the risk of potential errors, fraud, or abuse.

Desert Willow Treatment Center (continued)

DWTC also needs to ensure medication obtained from its floor stock room is verified by a second nurse. The pharmacy requires verification of medication removed from the facility's floor stock room by a second nurse. However, medications removed from the stock room were not verified by a second nurse in 5 of 12 instances reviewed. Not complying with procedures increases the risk of potential errors, fraud, or abuse by DWTC medical staff.

Finally, DWTC needs to track medications returned to the pharmacy. Medications returned to the pharmacy may include medications returned to DWTC by a youth following a home pass. Home pass medications returned to DWTC are returned to the pharmacy for disposal. While DWTC adequately stores medications for return to the pharmacy, it does not track the medications returned for disposal. Not tracking medications returned for disposal increases the risk of errors, fraud, or abuse.

Facility Response

Since the review, DWTC has worked to strengthen its controls over medications. We have revised medication and pharmacy policies, retrained nursing staff on these policies, and are developing heightened monitoring processes to ensure safe medication management for reducing the risk of potential error, fraud, or abuse.

We have written into policy and developed a process for restricting the access to allow only DWTC registered nurses in the central medication room that stores the after hours medication cart containing floor stock. Two nurses must document any medication removed from the cart in the sign-out log. Pharmacy personnel will be in the presence of nursing staff during medication delivery and pick up.

DWTC has also developed a process for verifying medication received from the pharmacy, as well as tracking medications returned to the pharmacy. All returned medications will be documented and reconciled.

Desert Willow Treatment Center (continued)

Medication Administration Procedures

DWTC needs to improve its medication administration procedures. For example, DWTC should ensure two forms of identification are checked before administering medications, mouth sweeps are completed, medication records are clear and consistent, and medical files and records are independently reviewed.

DWTC should ensure two forms of identification are checked before administering medication. Facility policy requires two forms of identification before administering medication. A youth's photo and his date of birth are considered two acceptable forms of identification. However, during our observation of medication administration, youths were not always asked their date of birth. Not complying with policy increases the risk of administering medication to the incorrect youth.

In addition, DWTC should ensure medical staff observes youths complete a mouth sweeps. Although management indicated staff observe youths to ensure medication isn't cheeked, medical staff required youths to open their mouth, but did not require youths to complete mouth sweeps. Cheeking is a method used to conceal medication. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Completing a mouth sweep reduces the risk of medications being cheeked for unauthorized use at a later time.

We also noted 4 of 10 youths' files contained medication documentation errors. Specifically, three of the files did not contain clear documentation of dispensed prescribed medication. Another file contained inconsistent medication information. Although policies require documentation of all medication administered, youths can refuse prescribed medication; however, this was not always documented. Alternatively, staff may have missed administering prescribed medication, which is considered a medication error. Because medication files contained errors, it is unclear if prescribed medication was administered and not documented, refused, or not administered.

Furthermore, DWTC should independently review medication files and records. During our review of medication files and discussion with management, we noted medication files were not independently reviewed to identify potential errors, fraud, or abuse

Desert Willow Treatment Center (continued)

by staff or management. Also, policies do not require reviews. Without policies and periodic independent reviews, errors, fraud, or abuse could occur and go undetected.

Facility Response

Since the review, DWTC has worked to improve its medication administration procedures. The hospital has in policy that two forms of identification are required to be checked before administering medication. The patient is identified as the correct patient by the use of a photo ID and date of birth. Nursing staff has been retrained on this policy, and nursing supervisors will be monitoring this procedure for compliance. To prevent cheeking of medication, we have put into policy that the nurse will sweep the mouth of a "suspect" patient by the use of a tongue blade, using it to look under the tongue and in both cheeks. Nursing staff was trained on this policy and nursing supervisors will be monitoring this procedure for compliance.

We have put into policy procedures specifying that each dose is documented by the date and time of administration and is initialed by the nurse after administering the medication. If a patient refuses medication, the time is circled, initialed by the nurse, and the reason for refusal is documented. These procedures are enforced by DWTC. The institution of nursing peer reviews will assist with documentation of compliance in this area. Furthermore, DWTC has written policy stating that a quarterly audit, completed by an independent party, will be performed on all medication management files and records, including pharmacy, to reasonably ensure that the program supports patient safety and identifies any potential error, fraud, or abuse.

Complaint Process

DWTC needs to strengthen its complaint process. Facility policies are inconsistent with information provided to a youth's parent or legal guardian at intake. DWTC's Patient Rights and Responsibilities information provided to a youth's parent or legal guardian addresses a youth's right to file a complaint. However,

Desert Willow Treatment Center (continued)

DWTC's Patient Rights policy does not address a youth's right to file a complaint. In addition, DWTC's Consumer Complaints Policy addresses the right to file a complaint. However, the right to file a complaint is not clearly stated on the consumer complaint information provided to a youth's parent or legal guardian. Inconsistencies can cause confusion and result in a complaint going undocumented. In addition, there is no signed statement by youths indicating they are aware of their right to file a complaint. Without a signed youth statement, youths may be unclear of their right to file a complaint.

Facility Response

Since the review, DWTC has strengthened its complaint process by enhancing consistencies across information provided to patients and their parents or legal guardians. Our Patient's Rights Policy now addresses a youth's right to file a complaint. Currently, the Consumer Complaint Information sheet provided to parents or legal guardians clearly specifies the right to file a complaint. In addition, the General Authorizations form presently includes an item acknowledging that family and patient have each been provided with the Consumer Complaint Information sheet, and it also contains a signed statement by youths indicating they are aware of their right to file a complaint.

Policies and Procedures

DWTC should develop additional policies and procedures and revise existing policies and procedures. During the period of the review, we did not find policies specific to control over kitchen utensils and equal opportunity to participate in all programs without discrimination based on sexual orientation. Although policies and procedures refer to the Nevada Disability Advocacy & Law Center, policies do not address access to other attorneys with whom a youth may choose to consult. Without clearly documented policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Facility Response

Since the review, DWTC has taken steps to develop and update policies and procedures. In particular, we have

Desert Willow Treatment Center (continued)

updated the Use of Occupational Kitchen Policy to specify controls over kitchen utensils. DWTC has also updated and revised the Non-Discrimination in Service Provision Policy to address equal opportunity to participate in all programs without discrimination based on sexual orientation. We have further revised the Patient's Rights Policy to include the patient's right to contact an advocacy and/or legal service organization.

Background Checks

DWTC should improve its practices related to employee background checks. Based on our review of personnel files, it took up to 7 weeks to receive state background check results and up to 8 weeks to receive Federal Bureau of Investigation results. In addition, one employee was not subject to a background check because the employee was hired prior to DCFS's requirements for background checks. Because of the length of time it took to receive results, employees may have had direct contact with youths prior to the results being received. DWTC should consider requiring potential employees be fingerprinted by an agency that electronically scans and submits fingerprints for background checks. Results from electronic submission of fingerprints may be received in less time.

During our review of personnel files, we noted DWTC does not have a system in place to follow up on the receipt of background check results. In addition, we noted background checks are not completed on a periodic basis for all staff after employment. Background checks are required every 6 years for employees of some types of children's facilities. Requiring periodic background checks would help DWTC ensure an employee has not been involved in criminal activity that may be incompatible with the facility's mission. Also policies do not address hiring employees with a prior criminal history. Without complete hiring policies and procedures, DWTC may be inconsistent when hiring employees with prior criminal convictions.

Facility Response

DWTC follows the background check process implemented by DCFS. Aware of the concerns surrounding background checks, the DCFS Administrator

Desert Willow Treatment Center (continued)

is orchestrating a workgroup to address requirements and necessary improvements in this area via expediting Federal Bureau of Investigation results prior to employees having direct contact with youths, using an agency that electronically scans and submits fingerprints for background checks, following up on the receipt of background check results, requiring periodic background checks, etc. DCFS personnel are currently working on improving procedures to update background checks for personnel classification changes, secure background checks for employees hired prior to DCFS's requirements, and explore vendors who can scan fingerprints. DWTC will improve its practices related to employee background checks and develop policies that address hiring employees with a prior criminal history upon Division approval.

Other Items Noted

Other items noted during our review included one of two facility vehicles did not have a first aid kit and another vehicle's fire extinguisher appeared old and had not been inspected.

Facility Response

All facility vehicles are currently operating with an up-to-date inspection, a fully charged fire extinguisher, and a first aid kit stocked with unexpired supplies. To ensure the safety and upkeep of our vehicles, a DCFS Monthly Vehicle Maintenance Log was developed.

Oasis On-Campus Treatment Homes

Background Information

Oasis On-Campus Treatment Homes (Oasis) are state-run group treatment homes located in Las Vegas, Nevada. Oasis provides treatment services in a highly structured home environment for severely emotionally disturbed youth. Oasis' mission is to serve youths who can not be served in their natural home or in a less restrictive facility. The facility's mission also includes returning youths to a less restrictive environment.

Oasis is a staff-secured facility with a maximum capacity for 27 youths. The facility houses male and female youths between the ages of 6 and 17. During calendar year 2008, the daily population averaged 26 youths with an average length of stay of 151 days. During the month of our visit, March 2009, the average daily population was 24.

Oasis is funded by the State through the Division of Child and Family Services (DCFS) and is organizationally within Southern Nevada Child and Adolescent Services. During calendar year 2008, Oasis had 39 employees: 37 full-time and 2 part-time.

Purpose of the Review

The purpose of our review was to determine if Oasis adequately protects the health, safety, and welfare of the children in Oasis 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 processes for the period July 1, 2007, to January 31, 2009. In addition, we discussed related issues and observed related processes during our visit in March 2009.

Results in Brief

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

Oasis On-Campus Treatment Homes (continued)

and strengthen and develop policies and procedures to conduct and receive background check results.

Principal Observations

Medication Administration Process and Procedures

Oasis needs to improve its medication administration process and procedures. Specifically, Oasis needs to strengthen its control over the pharmacy process. For example, Oasis should develop controls to track medication returned to the pharmacy. Improvements are also needed to strengthen Oasis' administration of medication procedures. For example, mouth sweeps were not completed, most medication records contained one or more documentation errors, medical files and records were not independently reviewed, a standing order form was not developed and approved by a physician, and Oasis staff did not ensure the identity of youth was verified by name before administering medication.

Medication Administration Process

Oasis should develop controls to track medication returned to the pharmacy or its physician for disposal. Returned medications comprise medications a youth did not take during a home pass and physician-prescribed medications that were subsequently changed. We noted Oasis returned medications for disposal; however, Oasis did not track medications returned, as required by policy. Not tracking medications for disposal increases the risk of potential errors, fraud, or abuse, which could go undetected.

Medication Administration Procedures

Oasis should expand procedures to require staff to observe youths complete mouth sweeps. Although management indicated staff observe youths to ensure medication isn't cheeked, Oasis staff required youths to open their mouths, but did not require youths to complete mouth sweeps. Cheeking is a method used to conceal medication. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Failure to complete a mouth sweep increases the risk of medications being cheeked for unauthorized use at a later time.

Oasis On-Campus Treatment Homes (continued)

During our review of medication files, we noted 8 of 11 files contained one or more medication documentation errors. Specifically, the files did not always contain: a written physician order for medication administered to youth; clear documentation of dispensed prescribed medication; consistent dosage information; and complete allergy information. Although policies require documentation of all medication administered, youths can refuse prescribed medication; however, this was not always documented. Alternatively, staff may have forgotten to administer prescribed medication, which should also be documented. Because physician orders, medication, dosages, and medication records were not clearly documented in medication files, it is unclear when and if prescribed medication was administered and not documented, refused, or not administered, or if youths received the correct medication. In addition, Oasis documented nine medication errors for the period July 1, 2007, to January 31, 2009.

Also, Oasis should independently review medication files and records. During our review of medication files and discussion with management, we noted medication files and records were not independently reviewed to identify errors, potential fraud, or abuse by staff or management. Also, policies did not require reviews. Without policies and periodic independent reviews, errors, fraud, or abuse could occur and go undetected.

Although Oasis policies address approved over-the-counter medications, Oasis does not have a physician-approved over-the-counter medication standing order form. A standing order form identifies over-the-counter medication the facility may administer to youths. Having a physician approved form helps ensure medication being administered to youths is approved or recommended for use by the Federal Food and Drug Administration.

Furthermore, Oasis needs to ensure youths are verified by name before administering medication. Facility policy requires verification of youths by name before administering medication. However, during our observation of medication administration, youths were not always asked their names. Not complying with the medication administration policy increases the risk of administering medication to the incorrect youth.

Oasis On-Campus Treatment Homes (continued)

Facility Response

Since the review, Oasis has worked to improve its controls over the medication administration process. We have written into policy that the physician or pharmacy staff will document the receipt of medication returned by staff by signing the Disposal of Medication Form. We have also revised policies addressing the acknowledgement of youth by name and ensuring a youth has not cheeked medication. Other policies which have been revised include: standing orders for over-the-counter medications, obtaining a receipt for all medication returned to the clinic or pharmacy, documenting medications administered to youths, and verification of prescriptions.

Oasis began independent reviews of medications and client files in April 2009. We have made maintaining accurate medical records and reducing medication errors a priority.

Complaint Process

Oasis needs to strengthen its complaint process. Oasis should update admission information to include parents' and guardians' right to file a complaint and the process to file a complaint. In addition, the Client's Rights and Responsibilities form, which indicates a youth's right to voice a complaint, was not signed by youths upon intake in 6 of 10 files reviewed. Without a signed youth statement, youths may be unclear of their right to file a complaint. Also, the youths' handbook, Rules and Guidelines, should be updated to address the complaint process. Furthermore, the complaint box is not easily accessible to youths. A complaint box provides reasonable assurance that the integrity of information is maintained. Without a secured area in each home for youths' complaints, a complaint may go undocumented or uninvestigated.

Facility Response

Oasis has strengthened its complaint process. Locked boxes were installed in all homes. Youths can anonymously express their complaints if not comfortable expressing to the staff in their home. Policy revision has

Oasis On-Campus Treatment Homes (continued)

taken into account that complaints may involve direct care staff or the supervisor in the youth's home. The management chain of command will be part of the collection and resolution of complaints, so youths are more at ease in filing a complaint.

Oasis has enhanced its process by consistently providing the information regarding the client complaint process at admission and throughout treatment. Management is doing audits, making sure youths sign the Client's Rights and Responsibilities form (not just the legal guardian). We are also reviewing the handbook to be sure the youth and family are given accurate information regarding the complaint process. In addition, we have expanded the complaint process to include staff complaints.

Policies and Procedures

Oasis should develop additional policies and procedures. We did not find policies specific to: daily exercise; recreation; school and education; behavior code; social skills; preventing a youth from running away once identified as a risk; a system of all privileges youth can earn; and a process to report, document, and assess all injuries. Also, policies and procedures should address civil and other rights to provide reasonable assurance all youths will be treated equally, including religious rights and activities. In addition, Oasis should develop policies and procedures to ensure pre-prescribed drugs are administered to youths upon intake or anytime thereafter, and control of keys. Without clearly documented policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Facility Response

Since the review, Oasis has taken steps to develop and update policies and procedures. Specifically, we have developed the following policies and procedures: recreation; education; fair treatment of children; staff problem resolution; appropriate staff communications/interactions; intake prescriptions; psychoeducational model of treatment, which includes behavioral code, social skills, and expectations; preventing elopement risk; incident/accident logs, which

Oasis On-Campus Treatment Homes (continued)

addresses a process to report, document and assess all injuries; and maintaining security of keys.

In addition, we have made revisions to the following policies: medications – supervising client ingestion of prescribed medications; medical supply inventory, which addresses standing orders; administration, evaluation, storage and disposal of medication; administration of medication; and runaways.

Background Checks

Oasis should strengthen and develop policies and procedures to conduct and receive background check results. An employee was promoted, but was not subject to a background check as required by policy. Policy requires a criminal background check for any change in employment status. In addition, two employees were hired prior to DCFS's implementation of requiring background checks. There was no evidence in Oasis's records that these employees have ever been subjected to background checks. Therefore, employees had direct contact with youth prior to the results being received.

We also noted background checks are not completed on a periodic basis for all staff after employment. Some facilities are required to obtain background checks of employees every 6 years. Also, policies do not specifically address hiring employees with a prior criminal history. Without complete hiring policies and procedures, Oasis may be unaware of an employee's involvement in criminal activity which may be incompatible with the facility's mission.

During our review, we noted Oasis employees had not been fingerprinted by its licensing agency, as required by law. State law instructs Oasis' licensing agency to complete background checks of employees. According to DCFS management, employees were not fingerprinted due to an oversight by its licensing agency. Since our review, employees have been fingerprinted as required by statute.

Facility Response

Oasis implements the background check process as outlined by DCFS. The DCFS Administrator is pulling together a Division-wide workgroup to address improving

Oasis On-Campus Treatment Homes (continued)

the background check process to include exploring how results may be expedited. Consistency across DCFS programs is critical. The specific concerns in your report regarding Oasis will be shared with this workgroup.

All DCFS staff who have had a change in status within DCFS on or after April 1, 2005, had not had a criminal background check within the prior 2 years, and had not had a background check per DCFS policy were required to submit new background checks. All background checks were completed by May 2009. (It should be noted that new employees are never left unattended with Oasis youths, and that a senior staff or home supervisor is always present prior to receiving complete results of background checks.)

Other Items Noted

Other items noted during our review include: a list of prohibited items and contraband was not posted in two of five homes; chemicals used for cleaning were not appropriately stored in one of five homes; the first aid kit was not fully stocked in one of five homes; the sharp knife drawer was not always locked in one of five homes; and Oasis does not maintain a record of food served to youths. Also, one facility vehicle did not have a first aid kit, while three of four vehicles did not have a first aid kit or fire extinguisher, which is inconsistent with facility policy.

Facility Response

Since the review, periodic and random "walk throughs" of all homes have been completed. A list of prohibited items and contraband is posted in all five homes. Management has addressed staff with a verbal reminder that all chemicals for cleaning are to be properly stored, and that the sharp knife drawer is to be locked at all times. We have developed a policy to address the protection of keys to the sharp knife drawer, medications, cleaning supplies, vans, staff offices, and confidential client data.

Oasis will develop a record of food served to youths by weekly menus for that month to be kept on file and will

Oasis On-Campus Treatment Homes (continued)

develop a policy. The first aid kit checks will be part of the periodic and random "walk throughs" done by management, to ensure they are fully stocked. First aid kits and fire extinguishers were delivered to the homes. DCFS has developed a monthly vehicle maintenance log, implemented by our maintenance department.

Vitality Center–ACTIONS of Elko

Background Information

Vitality Center–ACTIONS of Elko (ACTIONS) is a private, not-for-profit substance abuse treatment facility. The facility is staff-secured, serves both youths and adults, and is located in Elko, Nevada. The purpose of ACTIONS is to help improve the health and welfare of society by reducing the number of individuals dependent on alcohol and other drugs, as well as establishing and fostering linkages, services, and programs that improve the quality of life of the residents.

ACTIONS' maximum capacity is 13 youths and adults. During calendar year 2008, the daily population of youths averaged one youth and the average length of stay was 45 days. During the month of our visit, January 2009, the average population for youths was three youth.

ACTIONS' treatment components are certified by the Nevada Division of Mental Health and Developmental Services, Substance Abuse Prevention and Treatment Agency. In addition, ACTIONS' housing facilities are licensed by the Nevada Health Division's Bureau of Health Care Quality and Compliance. During calendar year 2008, the facility had 36 staff: 35 full-time employees and 1 part-time employee.

Purpose of the Review

The purpose of our review was to determine if ACTIONS adequately protects the health, safety, and welfare of the children in ACTIONS 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 processes for the period July 2007 to January 2009. In addition, we discussed related issues and observed related processes during our visit in January 2009. We also reviewed complaints for the period July 1, 2007, to November 30, 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 ACTIONS provide reasonable assurance that it adequately

Vitality Center–ACTIONS of Elko (continued)

protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, ACTIONS needs to improve its medication administration process, improve its complaint process, and develop and update policies and procedures.

Principal Observations

Medication Administration Process

ACTIONS needs to improve its medication administration process. During our review of medications files, we noted two of six files did not contain clear documentation of dispensed prescribed medication. ACTIONS has a Client Medications policy which requires staff and youths to initial the Medication Administration Record (MAR) after medication has been administered. Youths can refuse prescribed medication; however, policy dictates this must be documented on the MAR. The MAR also provides a menu to document whether the medication was refused, discontinued, missed because the facility was out of the medication, or the youth did not show up to take medication. Because documentation on the MAR was incomplete, it is unclear whether prescribed medication was administered and not documented, refused, or not administered.

In addition, we noted inconsistencies in ACTIONS' documentation of standing order forms. A standing order form identifies physician-approved over-the-counter medications. We noted three different standing order forms during our review; however, none of these were consistent with policy. The policy was last revised in 2008 and lists 15 items. The standing order form provided by medical staff lists 15 items, but had an effective date of 2004. The standing order form included in the intake information lists 18 items and does not have an effective date. The standing orders listed on the Client History and Physical Form lists 5 items and does not have an effective date. In addition, forms and policies do not specifically indicate physician approval. Without a consistent, physician-approved standing order form, medication could be administered to youths that is not approved or recommended for use by the Federal Food and Drug Administration.

Vitality Center–ACTIONS of Elko (continued)

We also noted medical staff did not ask youths to verify their date of birth during the medication administration process, as required by policy. Policy requires staff to ask youths to state their full name and date of birth and to compare this information to medical records. However, we noted during observations staff did not verify the youths' date of birth. Without completely verifying a youth's identification and comparing the information to medical records, youths may not receive the correct prescribed medication.

Facility Response

Vitality Center has taken the following corrective actions to address missing information on the MAR and staff verifications of client birth date: 1) All rehabilitation technicians are receiving additional training on completion of the MAR; and 2) Staffing changes and duties have been made to ensure proper completion of the MAR, including changing working hours and duties to provide additional time for training and supervision of technicians.

An update and redesign of the standing order form to correspond with current policy is underway. Once complete, the policy and standing order form will be reviewed and approved by the physician.

Complaint Process

ACTIONS needs to improve its complaint process. Specifically, the policy is not clear regarding documentation of complaints. Facility policy states complaints must be documented in writing, but does not specify a form. Management reported a blank piece of paper is used to document a complaint, while facility staff reported an Incident Report form is used to document a complaint. In addition, we noted the complaint process reviewed with youths and their parent(s) or guardian(s) at intake is outdated. Information reviewed during intake refers to a process that is no longer used by the facility. Without a clearly documented, consistent complaint process, management, staff, and youths may be unsure or unaware of the process. This could result in undocumented complaints or complaints not being addressed, which may reduce the facility's ability to adequately serve youths.

Vitality Center–ACTIONS of Elko (continued)

Facility Response

The complaint policy and procedure is being updated and will include a specific form for reporting complaints. A complaint tracking form is being designed in order to document the resolution of complaints. After the policy and procedure are updated, staff will be trained on the complaint process.

Policies and Procedures

ACTIONS should develop and update policies and procedures. We noted policies and procedures do not address: control of kitchen utensils and tools, including seasonal equipment; visitor and parent complaint and resolution; steps to be taken after a youth runs away; and privileges and off-campus activities. ACTIONS should also update its mandatory reporting of child abuse and neglect allegations policy. Without clearly documented, updated policies and procedures, staff and management may be unclear of the facility's processes.

Facility Response

Policies and procedures are being researched and written for: control of kitchen utensils and tools, including seasonal tools; visitor and parent/guardian complaint resolution; steps to be taken if a youth runs away; privileges; and off-site activities. The mandatory reporting of child abuse and neglect allegations policy is being reviewed and updated. Staff training will take place regarding these complaint policies and procedures.

Background Checks

ACTIONS's employees may have had direct contact with youth prior to the results of all background checks being received. Based on our review of personnel files, it took up to 26 weeks to receive state background check results and up to 28 weeks for Federal Bureau of Investigation results. In addition, we noted employee background checks were not always completed annually, as required by facility policy.

Vitality Center–ACTIONS of Elko (continued)

Facility Response

The background check process and all related policies and procedures are currently under management review. When management recommendations are complete, policies and procedures and related documents will be revised as needed.

Other Items Noted

Other items noted during our review include: a treatment plan was not developed in one of six youths files reviewed, according to management, staff responsible for completing the plan was terminated; one of two vehicles did not have a fully stocked first aid kit or fire extinguisher; and, although management noted items in the cleaning supplies closet contained no alcohol, we noted the cleaning supplies closet door was unlocked.

Facility Response

Staff training was conducted regarding timelines for ensuring complete clinical files, including treatment plans. The Program Coordinator is providing additional oversight regarding the completion of clinical files according to timelines specified by the Substance Abuse Prevention and Treatment Agency. First aid kits and fire extinguishers have been placed in vehicles used to transport clients. In addition, staff received training on the necessity of keeping all cleaning supplies kept in a locked closet when not in use.

WestCare–Harris Springs Ranch

Background Information

WestCare Nevada–Harris Springs Ranch (WestCare HSR) is a private, not-for-profit, substance abuse treatment facility. The facility is staff-secured and serves male youths between the ages of 13 and 17. WestCare HSR is located in the Spring Mountains National Recreation Area, about 45 minutes from Las Vegas. WestCare HSR's mission is to empower youths to engage in a process of healing, growth, and change to benefit themselves, their families, coworkers, and communities. WestCare HSR carries out its mission through a therapeutic setting that embraces the concept that behavioral change can occur through positive peer support and pressure in a highly structured environment.

WestCare HSR's maximum capacity is 16 youths. During calendar year 2008, the daily population averaged 16 youths with an average length of stay between 4 and 6 months. During the month of our visit, April 2009, the average population was 14 youths. WestCare HSR also provides residential substance abuse treatment to adult males.

WestCare HSR is funded by the State of Nevada's Substance Abuse Prevention and Treatment Agency, Clark County, the City of Las Vegas, and several other agencies. During calendar year 2009, the facility had 10 full-time employees.

Purpose of the Review

The purpose of the review was to determine if WestCare HSR adequately protects the health, safety, and welfare of the children in WestCare HSR 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 processes for the period July 1, 2007, to February 28, 2009. In addition, we discussed related issues and observed related processes during our visit in April 2009. We also reviewed complaints for the period from July 1, 2007, to February 28, 2009.

Results in Brief

Based on the results of the procedures performed, improvements to WestCare HSR's policies, procedures, and processes are needed

WestCare–Harris Springs Ranch (continued)

to provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. Specifically, WestCare HSR needs to improve its medication administration process; develop, update, and comply with policies; strengthen its complaint process; improve its practices related to fingerprint background checks; and comply with the mandatory reporting requirements of NRS 432B.

Principal Observations

Medication Administration Process

WestCare HSR needs to improve its medication administration process. For example, we noted: 17 of 26 files contained one or more medication documentation errors; training materials and the medication administration record form need to be updated; medical files and records should be independently reviewed; and WestCare HSR does not have an established standing order form.

During our review of youths' files, we noted 17 of 26 youths' files contained one or more medication documentation errors. Specifically, files did not always contain a written physician order for medication administered to youths and clear documentation of dispensed medication and unused prescribed medication. We also noted medications administered were not always consistent with medications prescribed. Although policies require documentation of all medication administered, youths can refuse prescribed medication; however, this was not always documented. Alternatively, staff may have missed administering prescribed medication, which is considered a medical error. Because physician orders, medication, dosages, and medication records were not always clearly documented in medication files, it is unclear when and if prescribed medication was administered and not documented; if medication was not administered; or if the youth refused the medication.

WestCare HSR needs to update training materials to be consistent with policy and our observations. Specifically, training materials instruct staff to prepare medications to give to youths. However, policy and our observations indicate youths self-administer medications while staff observe. Without accurate materials and

WestCare–Harris Springs Ranch (continued)

policies, inconsistencies can occur, which could result in medication administration errors.

WestCare HSR needs to update its medication administration record form used to record medications administered to youths. Although WestCare HSR did revise its form during the period of time covered by our review, we noted some critical elements were missing. The revised form did not include the following: the month and time medications were administered to youths; youths' allergies; the dose of medication administered; and a menu. A menu is a list of acronyms used to identify specific actions, such as medication missed when a youth was on a home pass or refused his medication. A comprehensive form helps prevent and document medication errors.

WestCare HSR should independently review medication files and records. During our review of medication files and discussions with staff and management, we noted medication files were not independently reviewed to identify potential errors, fraud, or abuse by staff or management. Also, policies do not require reviews. Without policies and periodic independent reviews, errors, fraud, or abuse could occur and go undetected.

WestCare HSR does not have an established standing order form. A standing order form identifies approved over-the-counter medication the facility may administer to youths. A standing order form helps prevent the administration of medications that are not approved or are no longer recommended for use by youths by the Federal Food and Drug Administration.

Youth allergy information was incomplete in 6 of 26 youths' files tested. Allergy information should be clearly indicated in medication files to avoid potentially dangerous situations. In addition, youth medication forms should include a photograph of the youth to assist new or part-time staff in administering medication.

WestCare–Harris Springs Ranch (continued)

Facility Response

Policies and procedures have been updated with staff training and monitoring audits to eliminate errors. The Medication Policy and Training materials have been updated to be consistent, stating that youths self administer while monitored by staff. We also added a section on how to document refusals and the need to contact a supervisor immediately in case of a refusal.

The medication administration form was updated to require a copy of the prescription as provided by either the physician or pharmacy to ensure there is no transcribing error. In addition, a menu to explain shorthand and a system to show dosage and allergies was added to the medication form, as well as a portion to attach a client picture to each sheet. Finally, a sheet was added for parents to document youth taking medications while on passes.

Independent review was instituted immediately. The reviews are completed weekly by staff that do not monitor medications and the results are forwarded to the campus director. The campus director also conducts a random review once a month on the files and records to ensure accuracy and that all medication administration forms are filled out properly, including notations about allergies. The independent review was also added to the Medication Policy.

An over-the-counter medications protocol has been developed by WestCare's Advanced Nurse Practitioner and approved by the supervising physician.

Policies and Procedures

WestCare HSR needs to develop, update, and comply with policies. During the period of our review, there were no policies specific to off-campus activities, including, but not limited to: ensuring a sufficient staff-to-youth ratio; ensuring staff is adequately trained to identify and handle emergency situations, such as heat stroke or dehydration; and conducting contraband searches following the activity. Policies also do not address procedures to help prevent a

WestCare–Harris Springs Ranch (continued)

youth from running away once the youth is identified as a runaway risk and safeguarding of tools and kitchen utensils, such as sharp cooking knives.

In addition, facility policies need to be updated to include some of WestCare's Corporate Compliance policies and expected practice. Facility policies did not contain the following, which are addressed in Corporate Compliance policies: control of all keys, including vehicle keys; parents' and visitors' right to file a complaint; and a mental health emergency care plan related to the supervision of youths on suicide precaution. In addition, treatment plan development timeframes were not contained in policies. Nevada regulations (NAC 458.246) require treatment plans be developed within 72 hours of intake. The absence of this requirement in WestCare's policies may have contributed to 17 of the 26 treatment plans we tested not being developed timely.

There were also inconsistencies between policies and our observations. For example, youths' razors were not returned to a locked cabinet, youth were not always supervised, and staff did not wear identification. Deviations from policies can cause confusion and result in inconsistent services being provided to youths.

Facility Response

An audit of all policy and procedures was completed following this review. The client supervision procedure was changed to include the appropriate staff-to-youth ratios and the need to complete searches on all clients upon returning to the facility. WestCare has an established procedure for responding to medical emergencies either on or off the property. All staff are required within the first 6 months of employment to become CPR/First Aid certified and renew that certification every 2 years. Appropriate procedures have been generated for steps taken to prevent a youth from running once they are identified as a runaway risk and how to handle tools and kitchen utensils, such as sharp knives.

The Corporate Compliance Program and Policy noted above is a WestCare policy applied to all regions, including WestCare Nevada. As part of the staff

WestCare–Harris Springs Ranch (continued)

orientation, each staff member is trained on the Corporate Compliance Program. An information sign has been posted in waiting areas including a general overview of the Corporate Compliance Program and contact information for filing a complaint. Information on the Corporate Compliance Program was also added to the Harris Springs Ranch Client and Parent Handbook to inform them of their right to file a complaint. The program was revised by WestCare Foundation for all regions in September 2009.

A policy matching the current procedure of staff key control was written in April 2009. A policy to match the current operating procedures addressing emergency care plans related to the supervision of youths on suicide precaution has been written. A Treatment Planning Policy was written to include timeframes of treatment plan development and reviews.

All policies and procedures related to the inconsistencies noted were reviewed with staff to ensure understanding and compliance, and all policies or procedures are now consistently followed. Additionally, an audit of staff badges was conducted to ensure all staff members are in possession of a badge. All staff now have WestCare identification and wear this consistently while on WestCare property.

Complaint Process

WestCare HSR needs to strengthen its complaint process. The youth cabin did not contain a locked box for youths to file complaints. A locked complaint box helps ensure the integrity of information filed. According to management, youths can ask permission to walk to the Director's office to place a complaint under the door. However, walking to the Director's office requires supervision, which could deter some youths from submitting a complaint. In addition, this process reduces the staff-to-youth ratio for other youths and could result in a potentially unsafe environment for both youths and staff. Changes to the process of filing complaints should be added to policy.

WestCare–Harris Springs Ranch (continued)

Facility Response

A locked complaint box was installed inside the client common room in a place where youths do not have to depend on staff permission to access. An additional complaint box and supply of appropriate forms is located outside the staff cabin area that parents and visitors can access at any time. The Harris Springs Ranch Director and WestCare Nevada Deputy Administrator are the only staff who have keys to access this complaint box. The complaint policy is posted in all facilities in a central location as well as on every program unit.

Background Checks

WestCare HSR needs to improve its practices related to fingerprint background checks. It can take from 2 to 5 weeks to receive state and Federal Bureau of Investigation (FBI) background check results. In addition, one employee was not fingerprinted; a second employee was fingerprinted, but the fingerprints were not sent to the State and FBI so a background check was not conducted; and the background check results were not received by WestCare HSR for a third employee. Because it took up to 5 weeks to receive results and no results were received for three employees, WestCare allowed staff to have direct contact with youth when it had little assurance the staff did not have prior, excluding criminal convictions.

In addition, WestCare HSR did not require employees be re-screened every 5 years as required by its policy. Without regular, periodic employee background checks, WestCare HSR may be unaware of an employee's involvement in or conviction of a criminal activity incompatible with the facility's mission.

Although WestCare HSR's policies require employees to obtain fingerprint background checks, they do not address what convictions would disqualify an applicant from employment. Counselors or interns who are licensed by the Board of Examiners for Alcohol, Drug, and Gambling Counselors must meet requirements established by that Board. However, WestCare HSR has not established standards for unlicensed employees. Furthermore, NRS 449.188 contains a list of convictions that would disqualify an individual from employment at other medical facilities

WestCare–Harris Springs Ranch (continued)

licensed by the Health Division, but NRS 449.173 excludes facilities for the treatment of abuse of alcohol or drugs from the requirements of NRS 449.188. By not establishing documented standards for criminal convictions, WestCare HSR has no assurance it consistently applies standards to its employee screening process.

In addition, WestCare HSR has not established a process to verify the disposition of a case when a background check does not show the outcome of the case. Seven employees' files indicated positive background check results. Positive background check results indicate a person was arrested, but do not always indicate if the person was convicted of the crime for which he was arrested. Unless WestCare HSR follows up with the appropriate criminal justice agencies, it has no assurance whether the arrest resulted in a conviction or not. We searched the Eighth Judicial District Court's case inquiry database and found records indicating that four of the seven employees with positive background check results had felony convictions, including assault with a deadly weapon and theft.

Facility Response

The process for background/fingerprint checks has improved and WestCare is now receiving responses back in 3 to 4 weeks. All employment candidates are required to have their fingerprints electronically scanned and submitted to the Nevada Criminal History Repository and the FBI. The employee then returns a copy of the "inked" prints back to WestCare as proof that they were submitted.

In Spring of 2009, when we had not received fingerprint results in quite some time, WestCare contacted the Board and was informed that there was an error in the coding system used to process the fingerprint cards. As a result, without our knowledge or notification, the State destroyed many of the reports requested on WestCare employees. At that time, the coding error was corrected and WestCare had those employees whose criminal history reports were not received resubmit fingerprints to the Repository. WestCare has since received clearances for those individuals. The Human Resources Department

WestCare–Harris Springs Ranch (continued)

now tracks the submission of background/fingerprint checks and monitors weekly to ensure that WestCare receives the results.

WestCare completely agrees for the need to periodically conduct criminal history searches of long-time employees. WestCare's re-screening policy for conducting background checks for every employee every 5 years was implemented in April 2009. This practice is being followed and all employees that have been employed over 5 years underwent a new criminal background check. The Human Resources Department now tracks the submission of background checks and monitors weekly to ensure that WestCare receives the results.

Upon receipt of the fingerprint results, the Human Resources Director, Senior Vice President of Nevada, and Senior Vice President of Administrative Services review any positive results to make certain a) the individual's previous convictions do not exclude them under NRS 449.176 through 449.188, and b) to determine if those individuals are suitable to work at WestCare. Additionally, all employees, at the time of hire, are required to complete a certification for employment and criminal history statement. WestCare has sought the advice of legal counsel to address the exclusionary criteria for which an individual may not be employed by the organization due to their criminal history background.

If a person's background check result is positive and he is not automatically excluded from employment due to a) or b) above, each individual is provided the opportunity to ascertain the appropriate paperwork from the court to determine the disposition of the case. In the event that an individual does not comply with the request for disposition, his employment is terminated.

WestCare strives to ensure that all employees meet the proper guidelines and uphold the philosophy of WestCare's mission, vision and guiding principles. WestCare welcomes clear guidelines from the State as to

WestCare–Harris Springs Ranch (continued)

what criminal histories should exclude a person from employment at any facility that provides services to youth.

Mandatory Reporting Requirements

WestCare HSR did not document compliance with the mandatory reporting requirements of NRS 432B. NRS 432B.220 requires those who know or have reasonable cause to believe that a child has been abused or neglected to make a report within 24 hours to child welfare services or law enforcement. There were two instances where youths disclosed an allegation of abuse or neglect. However, we did not find evidence the allegations were reported to child welfare services or law enforcement. Not reporting allegations of abuse or neglect may result in a youth being returned to an unsafe situation.

Facility Response

It is WestCare Nevada policy to always report when there is a belief of or knowledge of a child being abused or neglected. An additional step of completing a file chart note as well as an agency incident report each time a report is completed was added to the policy. A chart note is a part of the client file and can reference the incident report number, so a supervisor or the director can review the report if necessary.

Other Items Noted

Other items noted during our review include: a facility vehicle did not contain a first aid kit; the smoke detector in the youth cabin was missing; and exercise weight equipment was not in good working condition.

Facility Response

To address the facility maintenance concerns, a system of self inspection was established where facility checks are completed in residential programs three times a month, once on each shift. This is done to help ensure that all equipment is in working order and the facility is properly maintained, and includes inspection of smoke

WestCare–Harris Springs Ranch (continued)

detectors and vehicle checks. In addition to first aid kits, vehicles at Harris Springs Ranch must also contain a flashlight, emergency tools and lights, tire changing tools, at least one gallon of water, and a set of either snow chains or cables.

The concerns with the facility's exercise weight equipment was resolved by discarding all equipment not in good working condition. In May 2009, a donation allowed for the purchase of new equipment to redo the "work out" area.

Eagle Valley Children's Home

Background Information

Eagle Valley Children's Home (EVCH) is a private, not-for-profit, intermediate care facility for the mentally retarded (ICF/MR). The facility is located in Carson City, Nevada, and houses males and females of all ages. The purpose of EVCH is to provide individualized skill training in a caring and home-like environment and to support programs providing the highest quality of service to people with mental retardation and developmental disabilities.

EVCH is a locked facility with a maximum capacity of 18 individuals. During calendar year 2008, the daily population averaged 18 individuals of various ages; the average length of stay varied because of the long-term care provided. During the month of the visit, November 2008, the average population of youth (under 18 years of age) was two.

EVCH is licensed by the State of Nevada Department of Health and Human Services, Health Division, and operates under the regulations of Centers for Medicare and Medicaid Services. During calendar year 2008, the facility had 83 employees: 70 full-time and 13 part-time.

Purpose of the Review

The purpose of our review was to determine if EVCH adequately protects the health, safety, and welfare of the children in EVCH 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 processes for the period July 1, 2007, to October 31, 2008. In addition, we discussed related issues and observed related processes during our visit in November 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 EVCH provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, EVCH needs to improve

Eagle Valley Children's Home (continued)

its documentation of medication administered, develop policies and procedures, and update the Client Rights form.

Principal Observations

Medication Administration Process

EVCH needs to improve its documentation of medication administered. During our review of medication files, we noted one of three files did not contain clear documentation of dispensed prescribed medication. Because documentation on the medication form was incomplete, it was unclear if the prescribed medication was administered and not documented, refused, or forgotten. Procedures require documentation of all medication administered. However, clients can refuse prescribed medication; this must also be documented. Alternatively, medical staff may have forgotten to administer prescription medication. EVCH has a medication administration form and it requires staff administering medication to initial the form after administering medication. If the medication was not given, procedures require the nursing staff to initial the form in the appropriate place, circle it, and then write the reasons on the back of the form.

Facility Response

Nursing staff have been instructed to review the medication administration policy, which states "the medication shall be charted as soon after administration as possible". There are different levels of importance to the client with regard to prescribed medications and treatments. The following actions refer to "critical" medications for which documentation of administration is absent: 1) The nurse discovering the missed administration documentation will call the identified nurse to determine if the medication was given. 2) If the medication was given, the nurse will be reminded to initial the medication administration record within 72 hours. 3) If it is determined that the medication had not been given, the nurse will complete an Incident/Accident report, take appropriate action with regard to the medication, and inform the Director of Nursing of the findings. 4) If unable to resolve the issue, the nurse discovering the omission will inform the Director of Nursing of the incident for

Eagle Valley Children's Home (continued)

further investigation. The discovering nurse will monitor the client for adverse effects from a possible missed medication.

Policies and Procedures and Civil Rights Form

EVCH should develop policies and procedures and update the employees' Client Rights form. In addition, we noted EVCH's Admission Packet, which is reviewed and discussed with clients and their guardians at intake, states complaints may be voiced free of discrimination or reprisal. However, the Client Rights form discussed with new employees does not address staff reprisal. Without clearly documented policies and procedures and updated documents discussed with new employees, management and staff may be unclear of the facility's processes.

Facility Response

Although EVCH is a locked facility serving youths and adults, all residents have a diagnosis of severe or profound mental retardation. In this respect, the population we serve has significantly different issues and requirements as compared to the other facilities in the process of this review.

EVCH is an ICF/MR licensed by the State of Nevada and certified according to the regulations outlined in the Code of Federal Regulations as specified by the Centers for Medicare and Medicaid. These regulations specify the basic policies governing staff conduct, treatment and care of individuals residing in our facility as well as the rights of clients in residence. Prior to contact with any client, every new hire receives individual training on these policies from the Executive Director. Policies required by 42CFR clearly outline the expectations that all clients will be treated with respect and dignity under all circumstances, and that the rights of clients will be protected. Although these policies do not utilize the term "reprisal", it is our contention that reprisal would be clearly contrary to these policies. However, we are not averse to revising these documents to include the term to ensure staff understand that under no circumstance –

Eagle Valley Children's Home (continued)

including the filing of a complaint by a guardian – would a client be subjected to any acts of reprisal.

Background Checks

Although new hires are not added to the work schedule until the fingerprint process has been started, new hires have direct contact with youth prior to receipt of all background check results.

Facility Response

After fingerprints are submitted to the Department of Public Safety, the rate of return of the results is outside our control. It is unreasonable to defer employment pending receipt of the results. However, when the background check returns with a disqualifying conviction under NRS 449, EVCH acts without delay as per Bureau of Licensure (now Bureau of Health Care Quality and Compliance) requirements.

Carson Valley Children's Center

Background Information

Carson Valley Children's Center (CVCC) is a nonprofit corporation that provides emergency shelter residential services and is located in Carson City, Nevada. The facility houses male and female youths from birth to 18 years of age. The purpose of CVCC is to provide a safe haven for any child in need due to abuse or neglect. CVCC accommodates youth until they are reunited with their families, or an appropriate home can be located.

CVCC is a staff-secured facility with a maximum capacity for 10 youths. During calendar year 2008, daily population averaged six youths with an average length of stay of 49 days. During the month of our visit, November 2008, the average population was eight youths. During calendar year 2008, CVCC had 16 employees: 6 full-time and 10 part-time.

Purpose of the Review

The purpose of our review was to determine if CVCC adequately protects the health, safety, and welfare of the children in CVCC 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 processes for the period September 1, 2007, to September 30, 2008. In addition, we discussed related issues and observed related processes during our visit in November 2008. We also reviewed complaints for the period September 2007 to November 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 CVCC provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, we noted some areas for improvement. Specifically, CVCC needs to improve its medication administration process, develop and update policies and procedures, improve the complaint process, and ensure the facility's intake/referral form is complete.

Carson Valley Children's Center (continued)

Principal Observations

Medication Administration Process

CVCC needs to improve its medication administration process. Specifically, we noted: unclear documentation of medication administered; lack of checking for cheeking procedures; and no physician-approved, over-the-counter standing medication order form.

CVCC needs to improve its medication administration process and update its medication administration form. During our review of medication files, we noted two of five files did not contain clear documentation. Specifically, medication logs did not always clearly indicate if prescribed medication was administered or the dosage administered. Although policies require documentation each time medication is dispensed, youth can refuse prescribed medication. Alternatively, staff may have forgotten to administer prescribed medication, which is considered a medical error. Because medication and dosages were not clearly documented in medication files, it is unclear if prescribed medication was administered and not documented, refused, or not administered. To improve documentation of medication administered, medication refused, or medical errors, CVCC should add a menu to the medication log and develop policies consistent with the menu.

CVCC should develop a procedure to check youth for "cheeking" of medication. Cheeking is a method used to conceal medication. Based on our discussion with management and our observation of the administration of medication, we noted staff does not observe youths to ensure they did not "cheek" medication. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Failure to complete a mouth sweep increases the risk of medication being cheeked for unauthorized use at a later time.

CVCC needs to develop an over-the-counter, physician-approved, standing medication order form. A standing order form identifies physician-approved over-the-counter medication the facility may administer to youths. Not having a form could result in medication being administered to youths that is no longer approved or recommended for use by the Federal Food and Drug Administration.

Carson Valley Children's Center (continued)

Other items noted include no indication medication files were independently reviewed to identify potential fraud or abuse by staff or management. Medication administration forms should include photographs of youths to assist new and part-time staff in administering medication. This would help ensure youths do not receive another youth's medication.

Facility Response

We have revised our policies and procedures relating to the administration of medication to children. The Program Director does a daily check of the medication log against the documented prescription to ensure all medications were administered as ordered and performs medication counts on prescription medications. We have added a photo of the child to the personal medication bag and a menu to the medication log. We have also added a cheeking check to our medication administration procedures and have requested a physician-approved standing medication order for over-the-counter medication. We have documented these revised procedures and trained our personnel.

Policies and Procedures

CVCC should develop and update policies and procedures. During the period of our review, we did not note policies specific to the following: youth/attorney calls and visits; administration of pre-prescribed drugs at intake; a system of privileges; nutritional guidelines; and suicide prevention, including cutting. While policies and procedures provide a definition for suicide, they do not specifically address suicide risk and prevention, including cutting. Without clearly documented, updated policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Facility Response

We have added an item to the listing of Children's Rights relating to the child's rights to contact or meet with their caseworker or attorney. In addition, we have revised policy related to administration of pre-prescribed drugs at intake. We respectfully disagree that a "system of

Carson Valley Children's Center (continued)

privileges" needs to be specifically defined for such a small facility. However, we are considering options to institute a system for older youth to earn money for specific tasks while in residence.

We are in the process of defining an established nutritional program and will document the new system when it is selected. We expect this to occur by April 1, 2009. We have scheduled staff and management training on suicide prevention and will document revised procedures based on the trainer's recommendations by March 30, 2009.

Complaint Process

CVCC should improve its complaint process. CVCC does not have a handbook accessible to youths. CVCC should develop a youth handbook, accessible to all youths, that includes the complaint process. In addition, complaint forms are not readily available to youths; youths must request forms from staff. Forms that are not readily available to youths may decrease a youth's willingness to express a complaint in writing, resulting in a complaint going undocumented. We also noted locked boxes are not available for youths to place their complaint forms. Locked boxes provide reasonable assurance the integrity of an issue will be maintained. Furthermore, CVCC should develop a policy clearly stating staff will not retaliate against a youth for filing a complaint.

Facility Response

We have developed and distributed a youth handbook and informational packet. In addition, we have installed a locked box for completed complaints and have placed blank complaint forms in the family room for older youths. We have also added a non-retaliation policy regarding complaints and have trained personnel.

Intake/Referral Form

CVCC should ensure its "intake/referral form" (intake form) is complete. Specifically, we noted youths' allergies were not clearly documented on the intake form in two of five files reviewed.

Carson Valley Children's Center (continued)

Although management did confirm youths' allergies were included in the family data system, this information was not clearly indicated on the intake form. Facility policy states the intake form shall be filled out and signed. In addition, facility policy instructs staff, in the event of a medical emergency, to provide a copy of the intake form from the youth's file to emergency personnel which would include pertinent information, such as allergies. Because CVCC provides emergency shelter to youths, some of the intake information is received from a youth's caseworker. As a result, some intake information may not be complete. Because some intake information may be incomplete, we encourage CVCC to continue working closely with caseworkers and youths to complete all items on the facility intake form. By ensuring the intake form is complete, CVCC may indentify potential issues to better serve youths.

Facility Response

We have added a Program Director sign-off to the intake form to ensure completeness. However, it should be noted that missing information is often unknown by the caseworker and may not become available during the time the child is residing at CVCC.

Background Checks

CVCC should develop a protocol to ensure employees receive clearance from the Division of Child and Family Services (DCFS) to have direct contact with youth. We noted two of three files did not contain evidence of background check results. Although management indicated the employees were fingerprinted, they could not provide evidence of DCFS's background clearance. Management also stated employees are supervised until the results of all background checks are completed. However, employees had direct contact with youths prior to the results of all background checks being received. A protocol to follow-up with DCFS to ensure clearance is received for every employee provides increased assurance appropriate employees are hired to work with youths.

Facility Response

CVCC does not consider a staff member cleared to work independently with youths until we have received a

Carson Valley Children's Center (continued)

written notification of clearance, either via email or letter. We do allow staff to work with youths under the supervision of another staff member after an internet background check is completed. We will work with DCFS to shorten the time it takes to obtain clearance. The current lead time of 3 months would make it very difficult to hire employees, since we would need to be able to hire an employee, but not schedule them to work for several months.

Other Items Noted

Other items noted during our review include: a list of items considered contraband was not posted within the facility, visible to youths, staff, and visitors; and the facility vehicle did not include a fire extinguisher and first aid kit.

Facility Response

We have posted a list of contraband items in both the public and private areas of the facility and have put a fire extinguisher and first aid kit in the van.

Briarwood South

Background Information

Briarwood South (Briarwood) is a private, for-profit, sex offender treatment facility. The facility is staff-secured, serves male youths between the ages of 13 and 20, and is located in Las Vegas, Nevada. Briarwood's mission is to provide a continuum of services for sex offenders or youths with sexual behavior problems in a structured and safe environment. Briarwood's mission places emphasis on relapse prevention techniques and concepts by providing early intervention to maintain the safety of clients and the community. Briarwood is licensed by the Clark County Department of Family Services.

Briarwood's maximum capacity is 15 youths. During calendar year 2008, the daily population averaged 14 youths with an average length of stay of 12 months. During the month of our visit, May 2009, the average population was 13 youths.

Briarwood is primarily funded by Medicaid through contracts with the State and Clark County. During calendar year 2008, the facility had 15 employees: 13 full-time and 2 part-time.

Purpose of the Review

The purpose of our review was to determine if Briarwood adequately protects the health, safety, and welfare of the children in Briarwood 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 processes for the period July 1, 2007, to March 31, 2009. In addition, we discussed related issues and observed related processes during our visit in May 2009. We also reviewed complaints for the period July 1, 2007, to March 31, 2009.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Briarwood provide reasonable assurance that it adequately protects the safety and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, there are significant medication administration issues which could affect the health of youths. We also noted some other areas that need improvement. Specifically, Briarwood needs to develop policies

Briarwood South (continued)

and procedures; strengthen its complaint process; strengthen and develop policies and procedures to ensure all employees are fingerprinted for licensing; and document compliance with the mandatory reporting requirements of NRS 432B.

Principal Observations

Medication Documentation and Administration

Briarwood's medication files contained significant medication administration issues which could affect the health of youths. Specifically, 7 of 10 medication files reviewed were missing significant documentation or documentation that was present was incomplete. In addition, physicians' orders were not always followed, medications received were not consistently documented, and medication errors were not adequately documented. Other medication administration items included: mouth sweeps were not completed, a standing order form was not developed and approved by a physician, and there was no evidence medical files and records were independently reviewed.

Documentation Weaknesses

Briarwood's documentation of the administration of medication had significant weaknesses which could affect the health of youths. Specifically, 7 of 10 medication files reviewed were missing significant documentation. The other three files did not contain information indicating if the youths were supposed to receive medication.

Of the 10 youths' medication files reviewed, 5 were missing one or more physician prescriptions for medication administered to the youth or medication discontinued. We also noted physicians' orders were not always followed. For example, Briarwood continued to administer prescribed medication to a youth a month after the youth's physician ordered Briarwood to discontinue administering the medication. Five files were missing medication administration records for up to 4 months, the records were blank for entire months, or the records did not include all the medications the youths were prescribed.

In addition, medication administration forms were not completely filled out. Blank spaces on the forms could indicate a youth was

Briarwood South (continued)

administered medication and staff forgot to complete the form, the youth refused the medication, or the youth did not receive medication for some other reason. Some forms were also missing dates, such as the month medication was administered, or the name and dosage of the medication administered to the youth.

Also, Briarwood staff does not consistently document medication received. According to staff, they are to document medication received on a Medications Received Log. Although staff's statement was consistent with an existing log, 7 of 10 files contained incomplete documentation of medications received by Briarwood. Logs in all seven files were missing documentation of at least one medication received by Briarwood for a youth, even though the youth's file contained a prescription for the medication or the medication administration record showed the youth took the medication.

Briarwood does not adequately document medication errors. According to management, medication errors should be documented using a Resident Medication Error Report. Based on our review of files, one instance should have been documented on a report as a medication error. However, there was no evidence to indicate a report was completed.

Briarwood should independently review medication files and records. During our review of medication files, we did not find evidence that medication files and records were independently reviewed, and policies do not require reviews. Without policies and procedures to require independent reviews, errors, fraud, or abuse could occur and go undetected.

Administration of Medication

Briarwood should develop procedures to require staff observe youths complete mouth sweeps. Although management indicated staff observe youths to ensure medication isn't cheeked, staff do not require youths to complete mouth sweeps. Cheeking is a method used to conceal medication. A mouth sweep is a generally accepted method used to ensure medication has not been cheeked. Failure to complete a mouth sweep increases the risk of medication being cheeked for unauthorized use at a later time.

Briarwood South (continued)

Briarwood does not have a physician-approved, over-the-counter medication standing order form. A standing order form identifies over-the-counter medication the facility may administer to youths. Not having a physician-approved form could result in medication being administered to youths that is no longer approved or recommend for use by the Federal Food and Drug Administration.

We also noted youth files do not contain a photo of the youth. Photos help identify and match youth with his medication. Further, we noted a youth may not have received prescribed medication due to potential insurance issues.

Facility Response

We have adopted new medication documentation and policies and procedures; this should remedy all of the issues noted as deficient in the review.

Policies and Procedures

Briarwood needs to develop policies and procedures. During the period of our review, management confirmed policies and procedures did not exist. Although Briarwood's Handbook for Families and Residents addresses some of the following items, we did not note facility policies specific to health, safety, welfare, treatment, civil rights, privileges, complaints, and the facility in general.

Missing health policies included: disposal of medication, including the appropriate forms; medical emergencies; pre-prescribed medications; exercise; recreation; and intake health assessments. Subsequent to our review, management at Briarwood's sister facility in Reno indicated a medication administration policy existed; however, management at the Las Vegas facility was unaware of the policy. Missing safety policies included transportation of youth, injury, and de-escalation and non-physical intervention. Missing welfare policies included education, behavior code, social skills, and visitation. Missing treatment policies included intake, mental health and substance abuse, suicide prevention, runaway, and treatment plan re-evaluation. Missing civil rights policies included policies to prevent discrimination based on gender, ethnicity, religion, disability, or sexual orientation. Missing privilege policies included: the types of items considered privileges; off-campus

Briarwood South (continued)

activities, including but not limited to, the sufficiency of staff-to-youth ratios; and staff training to identify and handle emergency situations, such as heat stroke or dehydration. Missing complaint policies included: the complete complaint process, including resolution, timeframes, and a quality assurance process to independently review complaints; prohibition of staff retaliation; staff, visitor, and parent complaints; and youth attorney visits. Missing general policies included: mandatory reporting of allegations of child abuse and neglect; safekeeping of youth records, including records retention; staff qualifications and training; and control of keys, tools, and kitchen utensils. Without clearly documented policies and procedures, management and staff may be unclear of the facility's processes and provide inconsistent services to youths.

Briarwood also needs to clarify if it allows use of force techniques. Specifically, Briarwood's admission information states use of force may be necessary. However, management confirmed staff is not trained in use-of-force techniques as Briarwood is a "hands-off" facility. Inconsistencies can cause confusion and result in harm to youths or staff.

Facility Response

Policies have been developed for areas in which we were found deficient.

Complaint Process

Briarwood needs to strengthen its complaint process. The complaint process addressed in the facility's handbook was incomplete. The handbook discussed addressing a complaint with the individual involved and then management. However, based on our discussion with management, youths could also use a blank piece of paper to document a complaint. Inconsistencies can cause confusion and result in complaints going undocumented and uninvestigated. Since our review, management has developed complaint policies and procedures.

We also noted the Client's Bill of Rights, signed by youths at intake, does not address youths' right to file a complaint. Therefore, youths may be unaware of their right to file a complaint. Further, a complaint box is not available for youths to file their complaints. A

Briarwood South (continued)

complaint box provides reasonable assurance that the integrity of information is maintained. Without a secured area for youth complaints, a complaint may go undocumented and uninvestigated.

Facility Response

We are following the guidelines as set forth by the new policies and procedures book. We reviewed the complaint policy in groups with the residents and posted it on a corkboard for the residents. They place their complaints under the administrative door, which is a locked office. Only the Program Director and the Administrative Assistant have keys to this office. It has been explained to both the residents and the staff that there is to be no retaliation and there is an open door policy. We are in the process of updating our facility handbook to be consistent with revised policies and procedures.

Background Checks

Briarwood needs to strengthen and develop policies and procedures to ensure all employees are fingerprinted for licensing. Nevada Revised Statutes and Administrative Code require Briarwood's licensing agency to complete background checks of all employees. During our review, we noted one of Briarwood's employees had not been fingerprinted by its licensing agency. According to Briarwood's licensing agency, the employee had not been fingerprinted because the licensing agency was not aware of the employee. Therefore, the employee had direct contact with youths even though only a local background check was performed in 1999. In addition, we noted licensing letters issued to Briarwood by its licensing agency were not always available or part of an employee's personnel file.

We also noted background checks are not completed on a periodic basis for all employees after employment. Some facilities are required to obtain background checks on employees every 6 years. Without complete hiring policies and procedures, Briarwood may be unaware of an employee's involvement in criminal activity which may be incompatible with the facility's mission.

Briarwood South (continued)

Facility Response

One employee did not have a current background check by our foster care licensing agency, but had a complete licensing packet upon his hire date in 1999, which included his clearance letter dated in 1999. Since the review, his file has been cleared again with the licensing agency and he has been cleared to work with Briarwood.

Mandatory Reporting Requirements

Briarwood did not document compliance with mandatory reporting requirements of NRS 432B. NRS 432B.220 requires those who know or have reasonable cause to believe that a child has been abused or neglected make a report within 24 hours to child welfare services or law enforcement. During our review, we noted an instance where a youth disclosed an allegation of abuse. However, we did not find evidence the allegation was reported to child welfare services or law enforcement. Not reporting allegations of abuse or neglect may result in a youths being returned to an unsafe situation.

Facility Response

All staff are now required to report any and all abuse allegations to either the Unit Coordinator or the Program Director, who then report all allegations within 24 hours to both Child Protective Services and to the resident's caseworker or probation officer and document these allegations and contacts in the resident's progress notes. Since the review, we have developed a more formal form and ongoing contact logs to record such contacts.

Other Items Noted

Other items noted during our review include: neither of the two facility vehicles had a fire extinguisher; the smoke detector in the day room was missing; all staff are not CPR trained and certified; and a list of prohibited items and contraband, daily schedules, and a description of the complaint process were not posted in a place visible to youths.

Briarwood South (continued)

In addition, management stated Briarwood does not follow an established nutritional protocol. Consistent with this statement, we noted youths prepare dinner and menus are not maintained to track the nutritional content of meals. Failing to follow nutritional protocols increases the risk of not meeting the nutritional needs of youth. Not tracking meals served increases the risk of being unable to identify food served to youths following an illness outbreak that may be food related.

Facility Response

The vans now have fire extinguishers. In addition, small first aid books have been purchased and put in the group home and both vans. A larger, more comprehensive copy for the group home has also been purchased. A list of contraband is signed by the residents and is now posted in a conspicuous area for the residents and staff to see, as well as the daily schedule and the complaint procedure.

We are currently following the federal food pyramid guidelines and have posted some of those charts in the kitchen. We are also keeping a year's worth of menus in a binder.

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 A

Assembly Bill 103
2009

Section 1. Chapter 218 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this act.

Sec. 2. "Family foster home" has the meaning ascribed to it in NRS 424.013.

Sec. 3. 1. "Governmental facility for children" means any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is owned or operated by a governmental entity and which has physical custody of children pursuant to the order of a court.
2. The term does not include any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is licensed as a family foster home or group foster home, except one which provides emergency shelter care or which is capable of handling children who require special care for physical, mental or emotional reasons.

Sec. 4. "Group foster home" has the meaning ascribed to it in NRS 424.015.

Sec. 5. 1. "Private facility for children" means any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is owned or operated by a person and which has physical custody of children pursuant to the order of a court.
2. The term does not include any facility, detention center, treatment center, hospital, institution, group shelter or other establishment which is licensed as a family foster home or group foster home, except one which provides emergency shelter care or which is capable of handling children who require special care for physical, mental or emotional reasons.

Sec. 6. The Legislative Auditor, as directed by the Legislative Commission pursuant to NRS 218.850, shall conduct performance audits of governmental facilities for children.

Sec. 7. The Legislative Auditor or his designee shall inspect, review and survey governmental facilities for children and private facilities for children to determine whether such facilities adequately protect the health, safety and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care.

Sec. 8. The Legislative Auditor or his designee, in performing his duties pursuant to section 7 of this act, shall:

1. Receive and review copies of all guidelines used by governmental facilities for children and private facilities for children concerning the health, safety, welfare, and civil and other rights of children;
2. Receive and review copies of each complaint that is filed by any child or other person on behalf of a child who is under the care of a governmental facility for children or private facility for children concerning the health, safety, welfare, and civil and other rights of the child;
3. Perform unannounced site visits and on-site inspections of governmental facilities for children and private facilities for children;
4. Review reports and other documents prepared by governmental facilities for children and private facilities for children concerning the disposition of any complaint which was filed by any child or other person on behalf of a child concerning the health, safety, welfare, and civil and other rights of the child;
5. Review the practices, policies and procedures of governmental facilities for children and private facilities for children for filing and investigating complaints made by children under their care or by any other person on behalf of such children concerning the health, safety, welfare, and civil and other rights of the children; and
6. Receive review and evaluate all information and reports from a governmental facility for children or private facility for children relating to a child who suffers a fatality or near fatality while under the care or custody of the facility.

Sec. 9. Each governmental facility for children and private facility for children shall:
1. Cooperate fully with the Legislative Auditor or his designee in the performance of his duties pursuant to sections 7 and 8 of this act;
2. Allow the Legislative Auditor or his designee to enter the facility and any area within the facility with or without prior notice;
3. Allow the Legislative Auditor or his designee to interview children and staff at the facility;
4. Allow the Legislative Auditor or his designee to inspect, review and copy any records, reports and other documents relevant to his duties; and
5. Forward to the Legislative Auditor or his designee copies of any complaint that is filed by a child under the care or custody of a governmental facility for children or private facility for children or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child.

Sec. 10. NRS 218.862 is hereby amended to read as follows:
218.862 As used in NRS 218.862 to 218.867, inclusive, and sections 2 to 9, inclusive, of this act, unless the context otherwise requires, the words and terms defined in NRS 218.863, 218.864 and 218.865 and sections 2 to 5, inclusive, of this act have the meanings ascribed to them in those sections.

Sec. 11. This act becomes effective on July 1, 2009.

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.
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. Mandatory reporters are required by Nevada law to report allegations of child abuse or neglect to law enforcement or CPS.
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.
Federal Food and Drug Administration	Federal Food and Drug Administration is a federal agency responsible for protecting public health by assuring the safety, efficacy, and security of medications. The agency is also responsible for determining if approved medications are no longer safe for administration to youth.
Floor Stock Room	A floor stock room is a designated space within a facility used to secure and store additional supplies of controlled substances, which are administered to youth based on a physician's order.

Appendix B

Glossary of Terms
(continued)

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. Group homes generally consist of detached homes housing 12 or fewer children.

Home Pass — A home pass is a privilege earned by a youth and approved by a facility. During an approved home pass, youth can visit with his parent(s) or guardian(s) for a specified length of time. In general, passes do not occur on a facility's campus.

NCIC — National Crime Information Center is a computerized index of criminal justice information from the Federal Bureau of Investigation. It is a database for prompt disclosure of information from criminal justice agencies about crimes and criminals.

Mandatory Reporter — A mandatory reporter includes any person in his professional or occupational capacity who knows or has reasonable cause to believe that a child has been abused or neglected.

Mental Health Facility — Mental health facilities provide mental health services to youth with serious emotional disturbances by providing acute psychiatric (short-term) and non-acute psychiatric programs. Mental health facilities also provide services to behaviorally disordered youth. Services provided include a full range of therapeutic, educational, recreational, and support services by a professional interdisciplinary team in a highly structured, highly supervised environment.

POST — Peace Officers' Standards and Training Commission is responsible for training, certification, and recertification of peace officers.

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.

Appendix B

Glossary of Terms
(continued)

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.
Substance Abuse Facility	Substance abuse facilities provide intensive treatment to youth addicted to alcohol or other drug substances in a structured residential environment. Substance abuse facilities focus on behavioral change and services to improve the quality of life of residents.
Sweep	A method used to detect medication concealed in the mouth.
Use of Force	Use of force is a technique used to prevent a youth from harming themselves or others. Techniques include restricting or reducing a youth's ability to move.
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 Observations at Facilities Reviewed

Observations	Facilities
Policies and Procedures	
Policies and procedures were not developed, not complete, or needed to be updated	13
Medication Administration Process and Procedures	
Incomplete or unclear documentation of dispensed prescribed medication	10
No independent review of medication files and records	10
Staff did not check for “cheeking” of medication	6
No over the counter standing order form	6
Medication administration records needs to be revised or updated	4
No photo of youth in medication file	4
No controls over prescribed medications returned to a pharmacy, physician, or clinic, or no controls over unused prescribed medications	3
Incomplete allergy information	3
Background Checks	
Employee(s) had or may have had direct contact with youth prior to all background check results being received	11
Periodic or post employment background checks were not completed	9
Policies and procedures did not address hiring employees with a prior criminal history	6
Facility did not require employees to obtain fingerprints from an agency using electronic scanning	2
One or more employees were not subject to a background check, fingerprints were not forwarded for a background check to be completed, or background check results were not returned to the facility	3
Complaints and Grievances	
Youth did not always sign or no form for youth to sign to indicate they understand their right to file a complaint or grievance	6
Complaint or grievance process was not posted or visible to youth	5
No locked box for youth to file complaints or grievances	3
Information or handbook provided to youth at intake did not address the complaint or grievance process	2
Mandatory Reporting	
No evidence an allegation of abuse or neglect was reported	2
An allegation of abuse or neglect was not documented consistent with policy	1
Other Significant Items	
List of prohibited items and contraband was not posted	7
Facility vehicle(s) did not contain a fully stocked first aid kit	7
Facility first aid kits(s) was not adequately stocked or available	3
Supervision of staff needs improvement	1
Supervision of youth needs improvement	1

Source: Reviewer prepared from facility conclusions.

Note: This is not a comprehensive list of findings.

Appendix D

Nevada Facility Information
Calendar Year 2008

Table 1: Correction and Detention Facilities	Background			Population for CY 2008		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	105	84	0
China Spring/Aurora Pines	Multiple Counties	Gardnerville	12 to 18	64	60	38	1
Clark County Juvenile Detention Center	Clark County	Las Vegas	8 to 18	192	180	176	91
Douglas County Juvenile Detention Center	Multiple Counties	Stateline	8 to 18	16	12	9	1
Jan Evans Juvenile Justice Center	Washoe County	Reno	8 to 18	108	57	46	0
Leighton Hall	Multiple Counties	Winnemucca	8 to 17	24	12	12	1
Murphy Bernardini Regional Juvenile Justice Center	Carson City	Carson City	8 to 18	22	15	16	0
Nevada Youth Training Center	State	Elko	12 to 18	160	149	102	0
Northeastern Nevada Juvenile Detention Center	Multiple Counties	Elko	8 to 17	24	10	12	0
Rite of Passage-Silver State Academy(1)	Private	Yerington	14 to 18	225	193	128	8
Spring Mountain Youth Camp	Clark County	Las Vegas	12 to 18	100	95	48	10
Summit View Youth Correctional Center	State	Las Vegas	12 to 18	96	76	70	0
White Pine Boys Ranch(1) (5)	Private	Lund	12 to 18	32	0 (5)	0 (5)	0
Total - 13 Correction and Detention Facilities				1,203	964	741	112

Table 2: Resource Centers	Background			Population for CY 2008		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Don Goforth Resource Center	Multiple Counties	Hawthorne	8 to 17	32	16	9	11
Western Nevada Regional Youth Center	Multiple Counties	Silver Springs	8 to 18	40	21	18	4
Total - 2 Resource Centers				72	37	27	15

Table 3: Child Welfare Facilities	Background			Population for CY 2008		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Boys Town-Emergency Shelter(2)	Private	Las Vegas	12 to 18	15	15	19	7
Carson Valley Children's Center	Private	Carson City	0 to 18	10	6	6	10
Child Haven	Clark County	Las Vegas	0 to 18	80	43	59	21
Kids' Kottage	Washoe County	Reno	0 to 18	82	33	39	3
Unity Village	Private	Las Vegas	8 mo to 18	6	5	4	5
Volunteers of America(2)	Private	Carson City	0 to 17	12	8	5	0
WestCare-Emergency Shelter	Private	Las Vegas	10 to 17	20	13	12	1
Total - 7 Child Welfare Facilities				225	123	144	47

Table 4: Mental Health Treatment Facilities	Background			Population for CY 2008		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Adolescent Treatment Center	State	Sparks	12 to 17	16	16	20	0
Desert Willow Treatment Center	State	Las Vegas	6 to 18	58	51	110	0
Montevista Hospital	Private	Las Vegas	5 to 18	28	22	168	21
Oasis On-Campus Treatment Homes	State	Las Vegas	6 to 17	27	26	37	2
Spring Mountain Treatment Center	Private	Las Vegas	12 to 18	66	56	88	41
West Hills Hospital	Private	Reno	3 to 17	30	8	13	3
Willow Springs Center	Private	Reno	5 to 17	76	73	96	53
Total - 7 Mental Health Treatment Facilities				301	252	532	120

Appendix D

Nevada Facility Information
Calendar Year 2008
(continued)

Table 5: Substance Abuse Treatment Facilities	Background			Population for CY 2008		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Vitality Center-ACTIONS of Elko	Private	Elko	12 to 17	13	1	35	1
Vitality Center-ACTIONS of Washoe County[2]	Private	Sun Valley	12 to 17	20	2	25	0
WestCare-Harris Springs Ranch	Private	Las Vegas	13 to 17	16	16	10	0
WestCare-Young FACES	Private	Las Vegas	13 to 17	12	10	10	0
Total - 4 Substance Abuse Treatment Facilities				61	29	80	1

Table 6: Group Homes	Background			Population for CY 2008		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Boys Town-Homes	Private	Las Vegas	10 to 18	30	27	22	0
Briarwood North	Private	Sparks	12 to 20	42	38	37	4
Briarwood South	Private	Las Vegas	13 to 20	15	14	13	2
Casa de Vida	Private	Reno	12 to 24	10	7	4	5
City of Refuge [6]	Private	Minden	Various	8	4	0	0
Eagle Quest of Nevada, Inc.	Private	Las Vegas	0 to 20	130	128	50	15
Eagle Valley Children's Home[4]	Private	Carson City	All Ages	18	18 *	70	13
Family Learning Homes	State	Reno	5 to 18	15	15	12	1
Hand Up Homes for Youth	Private	Reno	12 to 18	12	7	13	3
Palmer House[3]	State	Reno	12 to 18	6	6	3	0
Rite of Passage-Qualifing Houses	Private	Minden	14 to 18	14	12	3	0
St. Jude's Ranch for Children	Private	Boulder City	0 to 21	73	62	33	0
Visions LLC	Private	Elko	0 to 18	10	9	3	2
Total - 13 Group Homes				383	347	263	45

Table 7: Residential Centers	Background			Population for CY 2008		Staffing Levels	
Facilities	Funded By	Location	Ages Served	Maximum Capacity	Average Population	Full-Time	Part-Time
Charles M. McGee Center	Washoe County	Reno	8 to 17	24	11	13	0
Fresh Start Services LLC	Private	Las Vegas	10 to 18	15	8	5	2
HELP of Southern Nevada Youth Center	Private	Las Vegas	16 to 21	62	30	10	0
Spring Mountain Residential Center	County	Las Vegas	14 to 18	12	10	6	3
Total - 4 Residential Centers				113	59	34	5
Total - 50 Facilities Statewide				2,358	1,811	1,821	345

Source: Reviewer prepared from information provided by facilities.

* During our review of Eagle Valley, there were two youth under the age of 18.

[1] These facilities also accept non-court ordered youth.
[2] Closed between August 1, 2008, and June 30, 2009.
[3] Effective June 2009, became part of Family Learning Homes.
[4] Provides services to mentally retarded youth and adults.
[5] Facility opened in December 2008.
[6] Facility is operated by volunteers.

Appendix E

Unannounced Nevada Facility Visits

Facility Name	Facility Type	Date of Visit
Vitality Center-ACTIONS of Washoe County	Substance Abuse Treatment	December 17, 2008
Hand Up Homes for Youth	Group Home	December 18, 2008
Volunteers of America	Child Welfare	December 18, 2008
Jan Evans Juvenile Justice Center*	Detention	December 18, 2008
Willow Springs Center	Mental Health	December 18, 2008
Visions LLC	Group Home	January 9, 2009
Briarwood South*	Group Home	February 12, 2009
St. Jude's Ranch for Children	Group Home	February 13, 2009
Unity Village	Child Welfare	February 13, 2009
Casa de Vida	Group Home	April 16, 2009
Fresh Start Services	Residential Center	May 7, 2009
Boys Town-Homes	Group Home	May 8, 2009
HELP of Southern Nevada Youth Center	Residential Center	May 8, 2009
West Hills Hospital	Mental Health Treatment	November 18-19, 2009

Source: Reviewer prepared from unannounced facility visits.

*Indicates the facility was also reviewed.

Appendix F

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 reviewed Assembly Bill 103 (AB 103). We also interviewed management of the Division of Child and Family Services and reviewed applicable state laws and regulations.

To identify facilities pursuant to the requirements of AB 629 and AB 103, we reviewed state accounting records for facilities funded directly by the State and the Substance Abuse Prevention and Treatment Agency's website for facilities indirectly funded by the State. In addition, we reviewed the website of the Bureau of Health Care Quality and Compliance, formerly the Bureau of Licensure and Certification, 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 or AB 103. 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.

To establish criteria pursuant to AB 629 and AB 103, we reviewed *Performance-based Standards* developed by the Council of Juvenile Correctional Administrators, Child Welfare League of America's *Standards of Excellence for Residential Services and Health Care Services 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 by 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.
Next, we developed a plan to review facilities. We judgmentally selected a sample of facilities for review. Our selection was partially based on our assessment of risk and the type of facility. As reviews and not audits, our work was not conducted in accordance with generally accepted government auditing standards, as outlined in Governmental Auditing Standards issued by the Comptroller General of the United 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 or AB 103, to determine if facilities adequately protected the health, safety, and welfare of children in the facility and whether facilities respected the civil and other rights of children in their care. Reviews included a review of policies, procedures, processes, and complaints filed since July 1, 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.

In addition to 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 E, which is on page 113.

Our work was conducted from November 2008 to December 2009, pursuant to the provisions of Assembly Bill 629, Section 6, of the 74th Nevada Legislative Session and Assembly Bill 103 of the 75th Nevada Legislative Session.

In accordance with NRS 218.821, 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 18.

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