Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on January 18, 2017. Report # LA18-06.

Background

Nevada Revised Statutes 218G.570 through 218G.585 authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of governmental and private facilities for children.

As of June 30, 2016, we had identified 56 governmental and private facilities that met the requirements of NRS 218G: 20 governmental and 36 private facilities. In addition, 124 Nevada children were placed in 20 facilities in nine different states as of June 30, 2016.

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. During the period from July 1, 2015, through June 30, 2016, we received 1,723 complaints from 30 facilities in Nevada. Twenty-six facilities reported that no complaints were filed during this time.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. This report includes the results of our reviews of 4 children's facilities, unannounced site visits to 4 children's facilities, and a survey of 56 children's facilities. As reviews and not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

The purpose of our reviews was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities, and whether the facilities respect the civil and other rights of the children in their care. These reviews included an examination of policies, procedures, processes, and complaints filed since July 1, 2014. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from January 2016 through December 2016.

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Review of Governmental and Private Facilities for Children

January 2017

Summary

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at three of the four facilities reviewed provide reasonable assurance that they adequately protect the health, safety, and welfare of the youths at the facilities, and they respect the civil and other rights of youths in their care.

The policies, procedures, and processes at one of the four facilities reviewed were not adequate to provide reasonable assurance that they protect the health, safety, and welfare of the youths at the facility. We reported our concerns to this facility's licensing agency in August 2016 after our visits to the facility in June and July 2016.

We also conducted unannounced site visits to four children's facilities and did not note anything that caused us to question the health, safety, welfare, or protection of the rights of the children in those facilities.

Facility Observations

ART Homes' policies, procedures, and processes need substantial improvements related to: medication administration and documentation; ensuring treatment plans are complete and accurate; maintaining comprehensive personnel records related to background investigations and training; and ensuring the safety of the youths in its foster homes. There was no documentation of consent by the person legally responsible for the psychiatric care of the youths for any of the psychotropic medications administered to the three youths whose files we reviewed who were administered psychotropic medications. We also observed a filing cabinet in the ART Homes' office that was filled with expired and unexpired psychotropic medications and expired non-psychotropic prescription medications, including physicians' samples. All nine treatment plans reviewed were missing signature, dates, and the number of approved hours of Medicaid treatment services. Finally, ART Homes did not comply with NRS 424.135, which requires comprehensive personnel records, and was unable to provide 8 of 11 clearance letters upon our request. Clearance letters provide evidence that employees or potential employees have satisfactorily completed the background investigation process. (page 6)

Three of the four facilities reviewed for this report needed to improve their processes and procedures for obtaining consent to administer psychotropic medications to youths from the persons legally responsible for the psychiatric care of each youth. One of the facilities' forms for obtaining consent did not include the information required by statute, and its policy did not address all the required elements of a consent. The other two facilities were missing signed consent forms for one or more youths whose files indicated they received psychotropic medications while at the facilities. (page 8)

Three of the four facilities reviewed did not have evidence that employees who are statutorily required to attend medication administration training had received the training in the timeframe required. At these three facilities, there was no evidence in half (13 of 26) of the employees' files that they had received the training in the timeframes required. NRS 424.0365 and NRS 63.190 require employees who have direct contact with youths to receive certain training, including the administration of medication, within 30 days of employment and annually thereafter. There was no evidence two employees received any medication training even though they had worked at the facility for 3 and 5 years. Another employee had not received training since 2012, and another was missing evidence of training between January 2011 and May 2015. (page 9)All four of the facilities reviewed either did not complete youths' treatment plans timely or the treatment plans were incomplete. In addition, two of the facilities did not review treatment plans periodically or have updated treatment plans in the youths' files. (page 10)

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