Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children, issued on April 13, 2010. Report # LA10-15.

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 governmental and private facilities for children. 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.

We identified a total of 50 governmental and private facilities that meet the requirements of AB 629 and AB 103: 22 governmental and 28 private facilities. In addition, 157 Nevada children were placed in 31 facilities in 16 different states as of December 31, 2008.

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 Nevada facilities.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of AB 629, Section 6, and AB 103. 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.

Recommendations

Specific recommendations based on our observations were made to each of the 13 facilities reviewed. In addition, we are making one recommendation for the Legislature 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; and require background checks be obtained periodically for persons remaining employed at a facility for a specified time.

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Review of Governmental and Private Facilities for Children

2010

Results of Reviews

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the 13 facilities we 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. However, during our visit, we were unable to obtain assurance that one facility adequately protects the health of the youth residing at the facility because of significant medication documentation and administration issues. Subsequent to our visit, the facility 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.

All of the 13 facilities reviewed could improve their background check processes. Many of the facilities' processes do not ensure staff have appropriate backgrounds. At some facilities at least one employee was not subject to a background check, the results of the checks were not received at the facility, or the facility did not follow-up when the results of the checks showed an arrest but no conviction information. As a result, one facility had four employees with felony convictions; however, as a substance abuse treatment facility, it was not required to obtain background checks on all employees. Other common issues at the facilities included not conducting periodic post-employment background checks, policies not addressing hiring employees with prior criminal histories, files not containing the results of background checks, and obtaining background checks based on social security numbers instead of fingerprints.

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 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. Different types of facilities also have different timeframes for obtaining background checks and different requirements for periodic post-employment background checks.

In order to ensure all youths in Nevada facilities are afforded equal protection, the Legislature may wish to consider enacting legislation to make background check requirements consistent for all types of facilities that serve youths.

Facility Observations

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.

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. Youth medical files did not 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 facilities, and medication errors were not adequately documented at 3 facilities. In addition, medical files and records were not reviewed by someone independent of the medication process at 10 of the 13 facilities.

Complaint and grievance processes also 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 5 facilities, and there was no locked complaint box at 3 of the facilities. Finally, information provided to youths at intake did not address the complaint process at 2 of the facilities.

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 the 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.

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