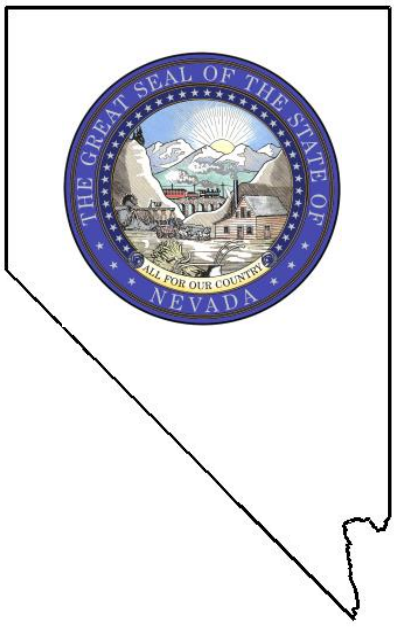
LA14-21

STATE OF NEVADA

Review of Governmental and Private Facilities for Children

October 2014



Legislative Auditor

Carson City, Nevada

Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on October 6, 2014. Report # LA14-21.

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, 2014, we had identified 63 governmental and private facilities that met the requirements of NRS 218G: 21 governmental and 42 private facilities. In addition, 105 Nevada children were placed in 25 facilities in 13 different states as of June 30, 2014.

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, 2013, through June 30, 2014, we received 833 complaints from 29 facilities in Nevada. Thirty-two facilities reported that no complaints were filed during this time, and two facilities did not provide us with complaint information.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. The report includes the results of our reviews of 4 children's facilities, unannounced site visits to 2 children's facilities, and a survey of 63 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, 2012, for three of the facilities, and since December 2013 for Rite of Passage-Red Rock Academy. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from January 2014 through September 2014.

Review of Governmental and Private Facilities for Children

October 2014

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.

We concluded that the policies, procedures, and processes in place at the Rite of Passage-Red Rock Academy did not provide reasonable assurance that it adequately protects the health, safety, and welfare of the youths, and respects the civil and other rights of youths in its care. The facility is owned by the State and is located in Las Vegas on the campus of the former Summit View Youth Correctional Center. The Academy is operated through a contract between the Nevada Department of Health and Human Services, Division of Child and Family Services, and Rite of Passage, a private, not-for-profit organization. The Academy's policies and procedures need improvement, and management needs to take additional steps to ensure staff comply with all policies and procedures. For example, the Academy's noncompliance with requirements for administration of medications, noncompliance with requirements for staff-to-youth ratios, lack of control over tools and contraband, poor reporting of corrective room restrictions, and lack of notification of youth rights do not ensure the youths at the Academy are adequately protected.

We did not note anything that caused us to question the health, safety, welfare, or protection of rights of the children in the two facilities where we conducted unannounced site visits.

Facility Observations

Many of the facilities had common weaknesses. For example, policies and procedures needed to be developed or were outdated, medication administration processes and procedures needed to be strengthened, and facilities needed to improve background investigation processes and policies. (page 6)

All four facilities reviewed needed to develop or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated included: establishing identity kits for each youth served for use during an emergency; implementing the Prison Rape Elimination Act requirements; specifying the timeframe in which a treatment plan must be developed; and claryifying what types of actions constitute corrective room restriction and tracking the use of corrective room restrictions. (page 6)

Medication administration processes and procedures needed to be strengthened at all four facilities reviewed. Some youths' files were missing key documentation, such as physicians' orders, at two of the four facilities. In addition, at three facilities, some youths' medication administration records contained errors or blank spaces, such as documentation of an incorrect dosage of medication or documentation of medication administered to a youth on a day that didn't exist. At one facility, youths' files showed some youths did not receive their medication for up to 22 days after it was prescribed. Medication policies and procedures that needed improvement at three facilities included: verifying and documenting the amount of medication received by the facility; addressing the process and documentation of disposing of medications; and conducting independent reviews of medication files. (page 6)

All four facilities reviewed needed to improve their background investigation processes and policies. Policies at two facilities did not include an accurate list of the convictions which would preclude a person from working at the facilities. One facility obtained fingerprint background checks for all of its employees, but cited incorrect statutes as authority for the checks. This resulted in the background check results being compared to more lenient conviction standards than required. Finally, two facilities could improve their background investigation policies and procedures by including a requirement for all new employees to be subject to a search of the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child (CANS). Although neither facility is required to request information about employees from CANS, NRS 432.100 allows the Division of Child and Family Services to release information from CANS to employers if the employees have regular contact with children. (page 7)

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Carson City, Nevada

We have conducted a series of reviews of governmental and private facilities for children in the State of Nevada. These reviews were authorized by Nevada Revised Statutes 218G.570 through 218G.585. The purpose of these reviews is to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities and whether the facilities respect the civil and other rights of the children in their care.

We wish to express our appreciation to the management and staff of the facilities for their assistance during the reviews. We are available to discuss the report with any legislative committees, individual legislators, or other state and local officials.

Respectfully submitted,

Paul V. Townsend, CPA
Legislative Auditor

September 23, 2014
Carson City, Nevada

STATE OF NEVADA
REVIEW OF GOVERNMENTAL AND PRIVATE FACILITIES FOR CHILDREN
October 2014

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INTRODUCTION

This report includes the results of our work as required by Nevada Revised Statutes 218G.570 through 218G.585. The report includes the results of our reviews of four children's facilities (page 7), unannounced site visits to two children's facilities (page 58), and a survey of 63 children's facilities (pages 55 - 57).

BACKGROUND

Nevada Revised Statutes (NRS) authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of residential children's facilities. Copies of NRS 218G.500 through 218G.535 and NRS 218G.570 through 218G.585 are included in Appendix A of this report.

Number and Types of Facilities

Nevada Revised Statutes require reviews of both governmental and private facilities for children. Governmental facilities include facilities owned or operated by a governmental entity that have physical custody of children pursuant to the order of a court. Private facilities include any facility that is owned or operated by a person or entity and has physical custody of children pursuant to the order of a court.

As of June 30, 2014, we had identified a total of 63 governmental and private facilities that meet the requirements of NRS 218G: 21 governmental and 42 private facilities. Exhibit 1 lists the types of facilities located within Nevada and the total capacity of each type during the year ended June 30, 2014.

Exhibit 1

Summary of Nevada Facilities
Year Ended June 30, 2014

Facility Type	Number of Facilities	Population		Staffing Levels	
		Maximum Capacity	Average Population	Average Full-time	Average Part-time
Correction and Detention Facilities	13	1,067	632	609	105
Resource Center [(1)]	1	-	-	-	-
Child Welfare Facilities	4	164	124	96	25
Mental Health Treatment Facilities	6	280	216	337	90
Substance Abuse Treatment Facilities	5	66	37	56	7
Group Homes	17	259	197	167	57
Residential Centers	3	309	97	48	7
Foster Care Agencies	14	629	436	190	78
Total – Facilities Statewide	63	2,774	1,739	1,503	369

Source: Reviewer prepared from information provided by facilities.

[(1)] The Don Goforth Resource Center closed during the fiscal year ended June 30, 2014.

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 substance abuse treatment and detention services.
- Child welfare facilities provide emergency, overnight, and short-term services to youths who cannot remain safely in their homes or their basic needs cannot be efficiently delivered in their homes.
- Mental health treatment 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 youths. Services include a full range of therapeutic, educational, recreational, and support services provided by a professional interdisciplinary team in a 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 are 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.
- 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.
- Foster care agencies are business entities that recruit and enter into contracts with foster homes to assist child welfare agencies and juvenile courts in the placement of children in foster homes. Foster care agencies may operate multiple family foster homes, including specialized foster homes and group foster homes. Foster care agencies often train foster parents, and place youths either in the foster parents' homes or in homes provided by the foster care agency. Foster parents are responsible for providing safe, healthful, and developmentally supportive environments where youths can fully interact with the community.

In addition to youths placed in facilities within the State of Nevada, an additional 105 youths were placed in out-of-state facilities by a District Court or the State as of June 30, 2014. Nevada youths were placed in 25 different facilities in 13 different states across the United States. In general, a youth may be placed in an out-of-state facility because the youth has been denied at least two placements within the State, the youth has a combination of diagnoses that cannot be treated in Nevada, or the youth is sexually aggressive.

Exhibit 2 lists the entities that placed youths in out-of-state facilities and the number of youths placed in out-of-state facilities as of June 30 of the past 3 years.

Exhibit 2

Summary of Nevada Youths Placed in Out-of-State Facilities
As of June 30, 2012, 2013, and 2014

Placing Entity	As of June 30, 2012	As of June 30, 2013	As of June 30, 2014
8th Judicial District Court (Clark County)	61	34	33
2nd Judicial District Court (Washoe County)	29	27	23
3rd Judicial District Court (Churchill and Lyon Counties)	7	5	6
5th Judicial District Court (Esmeralda, Mineral, and Nye Counties)	5	8	4
4th Judicial District Court (Elko County)	2	9	1
9th Judicial District Court (Douglas County)	3	1	0
1st Judicial District Court (Carson City and Storey Counties)	7	1	3
6th Judicial District Court (Humboldt, Lander, and Pershing Counties)	0	0	2
7th Judicial District Court (Eureka, Lincoln, and White Pine Counties)	0	0	1
State of Nevada Division of Child and Family Services	35	28	32
Total	**149**	**113**	**105**

Source: Reviewer prepared from information provided by entities.

Complaints

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, or civil and other rights of the child.

During the period from July 1, 2013, through June 30, 2014, we received 833 complaints from 29 facilities in Nevada. Thirty-two facilities in Nevada reported that no complaints were filed by youths during this time. In addition, two facilities did not provide us with complaint information. We also received complaint information from out-of-state facilities.

SCOPE, PURPOSE, AND METHODOLOGY

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. 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, 2012, except the review of Rite of Passage-Red Rock Academy included a review of policies, procedures, processes, and complaints filed since December 2013. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from January 2014 through September 2014.

A detailed methodology of our work can be found in Appendix F of the report, which begins on page 59.

FACILITY OBSERVATIONS

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 youths at the facilities, and they respect the civil and other rights of youths in their care.

We concluded that the policies, procedures, and processes in place at the Rite of Passage-Red Rock Academy did not provide reasonable assurance that it adequately protects the health, safety, and welfare of the youths, and respects the civil and other rights of youths in its care. The facility is owned by the State and is located in Las Vegas on the campus of the former Summit View Youth Correctional Center. The Academy is operated through a contract between the Nevada Department of Health and Human Services,

Division of Child and Family Services, and Rite of Passage, a private, not-for-profit organization. The Academy's policies and procedures need improvement, and management needs to take additional steps to ensure staff comply with all policies and procedures. For example, the Academy's noncompliance with requirements for the administration of medications, noncompliance with requirements for staff-to-youth ratios, lack of control over tools and contraband, poor reporting of corrective room restrictions, and lack of notification of youth rights do not ensure the youths at the Academy are adequately protected.

We did not note anything that caused us to question the health, safety, welfare, or protection of the rights of the children in the two facilities where we conducted unannounced site visits.

Many of the facilities had common weaknesses. For example, policies and procedures needed to be developed or were outdated, medication administration processes and procedures needed to be strengthened, and facilities needed to improve background investigation processes and policies.

Facilities Need to Develop or Update Policies and Procedures

All four facilities reviewed needed to develop or update policies and procedures. The types of policies and procedures that were missing, unclear, or outdated included: establishing identity kits for each youth served for use during an emergency; implementing the Prison Rape Elimination Act requirements; specifying the timeframe in which a treatment plan must be developed; and clarifying what types of actions constitute corrective room restriction and tracking the use of corrective room restrictions.

Documented, up-to-date policies and procedures help ensure management and staff understand the facility's processes. In addition, documented policies and procedures help ensure consistent services are provided to the youths residing at the facilities.

Medication Administration Processes and Procedures Need to Be Strengthened

Medication administration processes and procedures needed to be strengthened at all four facilities reviewed. Some youths' files were missing key documentation, such as physicians' orders, at two of the four facilities. In addition, at three facilities, some youths'

medication administration records contained errors or blank spaces, such as documentation of an incorrect dosage of medication or documentation of medication administered to a youth on a day that didn't exist. At one facility, youths' files showed some youths did not receive their medication for up to 22 days after it was prescribed. Medication policies and procedures that needed improvement at three facilities included: verifying and documenting the amount of medication received by the facility; addressing the process and documentation of disposing of medications; and conducting independent reviews of medication files.

State laws contain requirements for children's facilities to establish methods to reduce medication errors and improve documentation of medication administered. The medication administration process should include documentation of the orders of the physician and of medications administered to youths, controls over prescribed medications, and the process used to ensure the accuracy of medication files and records.

Facilities Need to Improve Background Investigations

All four facilities reviewed needed to improve their background investigation processes and policies. Policies at two facilities did not include an accurate list of the convictions which would preclude a person from working at the facilities. One facility obtained fingerprint background checks for all of its employees, but cited incorrect statutes as authority for the checks. This resulted in the background check results being compared to more lenient conviction standards than required. Finally, two facilities could improve their background investigation policies and procedures by including a requirement for all new employees to be subject to a search of the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child (CANS). Although neither facility is required to request information about employees from CANS, NRS 432.100 allows the Division of Child and Family Services to release information from CANS to employers if the employees have regular contact with children.

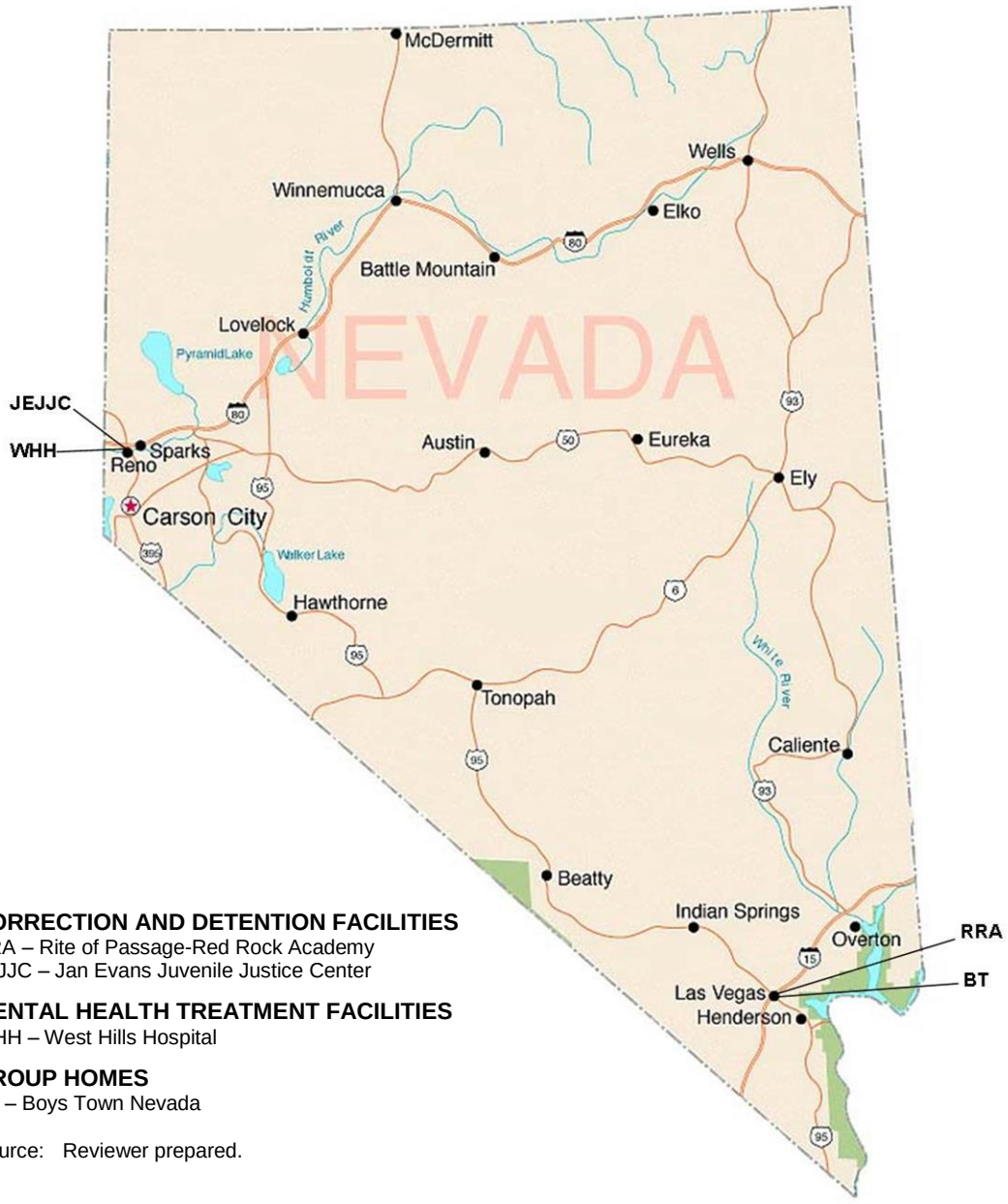
REPORTS ON INDIVIDUAL FACILITY REVIEWS

This section includes the results of reviews at each of the four facilities. Exhibit 3 lists the facilities and shows their locations. These results were provided to each facility and a written response

was requested. A summary of each facility's response is included after each applicable issue.

Exhibit 3

Map of Facilities Reviewed



CORRECTION AND DETENTION FACILITIES
RRA – Rite of Passage-Red Rock Academy
JEJJC – Jan Evans Juvenile Justice Center

MENTAL HEALTH TREATMENT FACILITIES
WHH – West Hills Hospital

GROUP HOMES
BT – Boys Town Nevada

Source: Reviewer prepared.

Rite of Passage-Red Rock Academy

Background Information

Rite of Passage-Red Rock Academy (Academy) is a secure correctional facility for male youths. The facility is owned by the State and is located in Las Vegas on the campus of the former Summit View Youth Correctional Center. The Academy is operated through a contract between the Nevada Department of Health and Human Services, Division of Child and Family Services (DCFS), and Rite of Passage, a private, not-for-profit organization. The Academy is not a licensed facility, but operational oversight is provided by DCFS through the contract with Rite of Passage.

The Academy provides residential treatment services to at-risk male youth who are given skills and opportunities to turn their lives around. The Academy's program uses evidence-based practices and a cognitive behavioral approach, and is guided by the belief that each youth has strengths. The Academy's mission is to improve the lives of youth. The Academy received its first youths in December 2013.

As of June 30, 2014, the Academy:

- Served male youths between the ages of 15 and 18.
- Had a maximum capacity of 96 youths.
- Had an average daily population of 43 youths.
- Had an average of 38 full-time staff.

Purpose of the Review

The purpose of our review was to determine if the Rite of Passage-Red Rock Academy adequately protects the health, safety, and welfare of the children at the Academy and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period from December 2013 through June 2014. We discussed related issues and observed related processes during our visit in July 2014.

Rite of Passage-Red Rock Academy (continued)

Results in Brief

Based on the results of the procedures performed, the policies, procedures, and processes in place at Rite of Passage-Red Rock Academy do not 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. The Academy's policies and procedures need improvement and management needs to take additional steps to ensure staff comply with all policies and procedures. For example, the Academy's noncompliance with requirements for administration of medications, noncompliance with requirements for staff-to-youth ratios, lack of control of tools and contraband, poor reporting of corrective room restrictions, and lack of notification of youth rights do not ensure the youths at the Academy are adequately protected.

Principal Observations

Health Policies and Procedures

Red Rock Academy could improve its policies and procedures for protecting the health of the youths at the Academy, and should take steps to help ensure staff follow the policies and procedures. Examples of areas that could be improved include:

- Policies for preparation of treatment plans were not clear or consistent with management's expectations. Policies require all intake assessments be completed within 30 days of intake. According to management, treatment plans are part of the intake assessments. However, management also stated that treatment plans should be prepared within 6 weeks of admission. As a result, treatment plans in 13 of the 20 youths' files reviewed were prepared between 34 and 60 days after admission. In addition, there was no evidence a treatment plan was prepared for 3 of the 20 youths whose files we reviewed.
- Staff did not always follow the Academy's policy for documenting levels of observations of youths based on the youths' suicide risks or precautions. The Academy's policy includes establishing levels of observation and the observations are required to be documented on a suicide observation checklist. The higher the level of risk, the more

Rite of Passage-Red Rock Academy (continued)

frequently the youth must be observed. Six youths' files contained evidence of being placed on increased supervision based on suicide risk. Observation documentation in one of those files did not contain any indication of the level of risk. Two other files did not contain any documentation of increased supervision.

- One youth was placed on the fourth suicide watch level, which is described in the Academy's Suicide Prevention and Intervention Policy as the highest level of risk to self and others. The policy also states this classification is used for students awaiting transport to a hospital for emergency psychiatric treatment or assessment. However, there was no evidence in the youth's file that he was referred to or assessed by a psychologist or psychiatrist during the 10 days he remained on suicide precaution.

- Policies do not require documentation of compliance with the Academy's policy that medications brought to the Academy by a DCFS representative or an out-of-state placement representative shall be counted and logged. In addition, the policy does not require medications brought to the Academy by persons other than a DCFS representative or an out-of-state placement representative, such as a county official, be counted, logged, or documented. We found that 10 of the 20 youths whose files we reviewed arrived at the Academy with prescribed medications; however, none of the 10 youths' files contained evidence the medication received was verified or counted prior to being administered to the youths.

- The Academy's policy regarding the refusal of medications by a youth is not complete and is not consistent with the processes used by the staff. In addition, the processes used by the staff when a youth refuses his medication are not consistent. The policy states medical staff will discuss the reason for refusal with the youth and request the youth sign a Medication Refusal Form. The policy does not require the refusal be documented on the Medication Administration Record or that a youth's physician be contacted. One staff indicated she completes an incident report and a Medication Refusal Form, and documents the refusal on the Medication Administration Record, but she does not contact the youth's physician. Another staff indicated she documents the refusal

Rite of Passage-Red Rock Academy (continued)

on the Medication Administration Record, completes a Medication Refusal Form, and contacts a nurse practitioner. We did not find any Medication Refusal Forms in the files for any of the 15 youths who received medication while at the Academy and whose files we reviewed, even though Medication Administration Records for 10 of those youths contained blank spaces. Blank spaces could indicate the youth refused the medication, staff forgot to administer the medication, the youth did not receive the medication for some other reason, or the youth received the medication and staff forgot to complete the Medication Administration Record.

- The Academy's policies do not address the process used by staff to destroy medications and do not require complete documentation of medications destroyed. For example, the medication disposition record does not include the method used to destroy medication or require a date. In addition, the destruction of wasted medications (for example, medications dropped, spilled, or opened in error) is not documented. Furthermore, the policies do not require the destruction of a youth's medication be documented on the youth's Medication Administration Record. NRS 62B.240 requires juvenile correctional facilities develop policies and procedures to store, handle, and dispose of medications.

- The Academy's policies do not require an independent review of medication files and records and the documentation of any reviews completed. Independent review of medication files and records is a way to minimize and address medication errors, as required by NRS 62B.240. Our review found 12 files for the 15 youths who received medication contained errors. Examples of the errors included: medication administered twice on the same day; acronyms used on the Medication Administration Record when the Medication Administration Record did not have a menu of acronyms; documentation indicating a youth was administered double the amount of the prescribed dosage for 8 days; documentation of medication being administered for 5 days after the physician ordered the medication be discontinued; 4 of the 15 youths' files were missing copies of some physicians orders; 14 of the 15 files were missing some pharmacy instructions; and 10 of the 15 youths did not receive their medication for 2 to 22 days after a physician prescribed the medication.

Rite of Passage-Red Rock Academy (continued)

- The Academy's policies do not require a face sheet or identity kit for all youths. There is a policy that requires a DCFS sentencing face sheet, a re-commitment face sheet, and a photo be filed with the legal documents of youths' files, and a list of contacts be placed in the admissions section of youths' files. However, the policies do not require, nor did we find, face sheets that included important information for quick reference in the event of an emergency. This information should include the youth's full name and aliases, emergency contacts, a photo, a list of medication the youth is prescribed, allergies, and distinguishing features, such as tattoos and scars.

  Facility Response

  Student, staff, and public safety is the top priority for Red Rock Academy. All of the items listed in the review details have been either corrected, clarified, or are in progress of being implemented. During the first 7 months, the program has experienced a very low incident rate. We have developed several meaningful community partnerships, and several students have experienced significant treatment breakthroughs. However, both Rite of Passage and DCFS acknowledge much work remains.

  (Reviewer's note: the following bullets are responses to the bullets in this section of the report in the order presented in the report.)

  - *This documentation issue has been corrected. All current Red Rock Academy students have a current and comprehensive treatment plan. A calendar and tracking system has been created to ensure the creation of the initial treatment plan is completed within 30 days of admission.*
  - *The review revealed that the "documentation of" did not always match the level of services "provided to" the youth. All students that have been placed on suicide watch have been*

Rite of Passage-Red Rock Academy (continued)

Facility Response (continued)

appropriately supervised. Since the review, the direct care staff have been re-trained on what to include when completing a written report on personal observation of student behavior.

- *This documentation issue has been resolved. The multi-agency collaboration on the treatment the youth actually received is commendable. Prior to the 10 days that the student remained on suicide precaution, he had been evaluated by a qualified Mobile Mental Health Crisis Team. As a result, he was admitted to a psychiatric hospital, discharged to Red Rock, and was readmitted soon after. His being on level four (Close Observation) at Red Rock was part of his agreed upon discharge plan from the second psychiatric hospital discharge. Rite of Passage, the psychiatric hospital staff, and DCFS Mental Health staff were all involved in the development of the student's treatment and discharge plan. The documentation of this process was dispersed between the hospital, the student's program file, the student's medical file, and the student's mental health file. Any future related incidents will be documented in one location.*
- *This documentation omission has been corrected. A section was added on the initial screening form that the Red Rock Academy nurse completes when a new intake arrives on campus. The section includes the name of the medication at time of intake, an inventory of the amount of medication (i.e. number of pills), and signed verification by a medical professional.*
- *Staff have been re-trained and the documentation issue has been corrected. Specifically, the Red Rock Academy policy has been revised to include the appropriate procedure to document medication refusal by a student. If a student refuses medication, it is*

Rite of Passage-Red Rock Academy (continued)

Facility Response (continued)

now included on the Medical Administration Record and the youth's physician is notified. Medical staff have been instructed to be specific in documenting why the refusal happened, (i.e. refused, missed, etc.). All youth medication refusal forms are now being filed in the youth's medical chart.

- *Staff have been re-trained and the documentation issue has been corrected. Policies and procedures address the storage, handling, and disposal of medications. They were revised to address the process of medication destruction logs being utilized. Medication destruction logs are required for every medication destroyed. The procedure must be completed by a medical personnel with a witness present. The documentation must include each individual's initials, the amount of medication destroyed, and the appropriate means of disposal.*
- *The documentation issue has been corrected. An audit checklist has been added to each medical file for monthly independent reviews by a medical professional.*
- *The documentation issue has been corrected. Due to staff turnover in the responsible position, the face sheet development process lapsed for a short period of time. All youth case files and medical files have been updated with new face sheets that include the youth's full name, picture, emergency contact information, allergies, and tattoos/scars. Due to the sometimes fluctuating of youths' medications, the current medication regime of each youth is kept in the Medication Administration Record's book.*

Rite of Passage-Red Rock Academy (continued)

Safety Policies and Procedures

Red Rock Academy needs to develop and improve many of its policies and procedures and ensure staff comply with existing policies and procedures related to protecting the safety of the youths, staff, visitors, and public.

- Staff-to-youth ratios were not in compliance with federal standards or Rite of Passage's contract with DCFS. Federal standards adopted by the U.S. Department of Justice to implement the Prison Rape Elimination Act (PREA) suggest, and DCFS's contract requires, a ratio of 1 staff to 8 youths during awake hours and 1 staff to 16 youths during sleeping hours. The standards require that only direct care staff should be counted in calculating the ratios. The Academy's policy also requires the same ratios and clarifies supervision as having the ability to see, hear, prevent, intervene, and respond to situations. We observed the following ratios during awake hours: 2 unsupervised youths in the kitchen; 1 unsupervised youth in the kitchen on a different day; 1 staff to 11 youths; 2 staff to 24 youths; and 1 staff to 9 youths. In addition, Academy control room staff document the staff-to-youth ratios as radioed to them by the direct care staff. We reviewed the Academy's documentation for 2 additional months and found a total of 98 instances where ratios exceeded 1 staff to 8 youths during awake hours, including one instance of 1 staff to 18 youths. In addition, we observed a staff member watching television with his back to the youths he was supposed to be supervising.
- The Academy did not comply with its own policy or federal standards relating to the implementation of PREA. The Academy's policy states it has a zero tolerance policy for sexual abuse, assault, or misconduct. It also states it will implement a comprehensive sexual contact prevention program. Federal standards require facilities to ascertain within 72 hours of intake information to reduce the risk of sexual abuse by or upon another youth. The Academy's Admission and Orientation Policy states all incoming youths will receive a complete orientation to the facility's programs, procedures, expectations, and services. Also, within 24 hours, each youth will complete reception procedures, including a

Rite of Passage-Red Rock Academy (continued)

Sexual Contact Prevention-Zero Tolerance Acknowledgement Form. After youths have completed the orientation process, they will be integrated into the daily program and general population. However, of the 20 youths' files we reviewed, 9 did not have documentation the youths were informed of the facility's zero tolerance policy, and 5 were placed in the general population before signing the required form.

- Inventory logs of tools were not readily available during the review. The Academy's policy requires tools be inventoried and logs be accurate and up-to-date. A physical count of tools must be completed at the beginning and end of each program element and unaccounted for items must be reported to the Shift Supervisor. Although the Academy provided us with a list of tools after our request for the inventory logs, the list was not an inventory log. It was not dated and did not indicate a comparison of tools to the tools listed on a prior inventory log so missing tools could be identified. Failure to routinely inventory tools could result in missing tools being missing for an extended time, allowing either misuse or theft. For example, three youths were able to escape using cutting tools obtained during a prior work detail.

- Some areas of the facility were not always secured. According to Academy management, all areas are to be secured when not in use. However, we found some areas of the facility were unlocked during our observations, even though the areas were not in use. These areas included the laundry room, the dining hall between meals, the medication room (medications are stored in a locked cart inside the medication room), the computer library room, a lounge used by upper level youths, and a utility closet. As a result, youths could have unauthorized access to potentially dangerous items like chemicals and tools.

- We observed one instance during our review where staff did not follow security procedures. Staff allowed both doors into the entrance sally port to be open at the same time. The Academy's policy is that control center staff will lock and unlock the doors for deliveries, visitors, staff, and students. One of the doors or fences must be securely closed before the second door or fence is opened in order to maintain security.

Rite of Passage-Red Rock Academy (continued)

Failure to follow this procedure could result in a person either entering or leaving the facility without authorization.

- Two of the twenty youth files reviewed did not contain required documentation to show the Academy assessed the risk of the youths escaping. A third file did not contain evidence the youth was assessed for self-harm or suicide, even though assessments prepared prior to the youth's placement indicated the youth was at a high risk for self-harm or suicide. The Academy's policy states the intake screening process, including an assessment of risk of escape, self-harm, or suicide, should be completed within 30 days of intake.
- The Academy's policies do not address youths' access to computers, including access to the internet, and documentation and investigation of potential misuse of computers or the internet. According to management, youths have supervised, limited access to computers and the internet. However, there was evidence that the Academy was made aware of two youths accessing their Facebook accounts while at the Academy.
- The fire escape route was not posted in one of the two dayrooms of the occupied living unit. The Academy's policies do not require fire escape routes be posted in all areas of the living unit.
- During our review, we requested a list of facility cameras, used for surveillance, that were not working. The list provided showed eight cameras were not working, but the list was not complete. Our observation of the control room where the cameras are monitored found four additional cameras were not working.
- During our review, we observed several instances of staff not controlling youths and not holding the youths accountable for rule violations. Some examples of these instances included: youths wrestling, rough housing, and horse playing; youths attempting to trip one another; youths shouldering one another; a youth dragging another youth across the dirt; youths jumping from one side of a couch to the other; and empty food packaging in youths' cells. All of these activities are minor rule violations, yet we did not observe facility staff take any actions to stop or correct the youths' behaviors.

Rite of Passage-Red Rock Academy (continued)

- The Academy's contraband policy is not consistent with the information provided to the youths in their handbook. In addition, the contraband policy does not list items commonly considered contraband at juvenile facilities or correctional facilities. For example, the policy does not include toxic materials; movies with restricted ratings; pictures of drugs, tobacco, or alcohol; pictures or drawings related to gangs or gang activities; posters or drawings containing hateful or derogatory messages; or pictures of a sexual or provocative nature. The youth handbook did not include the following items on the list of contraband that were listed in the Academy's policy: unauthorized medicines, credit cards, explosives, and fireworks. As a result, we observed numerous types of contraband, including: 29 movies with restricted ratings; pictures of females in provocative poses; pictures of alcohol and tobacco; gang references in drawings; a picture of a weapon; sharp objects or objects that could be used as weapons, such as pipes, screws, bolts, and broken pieces of Plexiglas; and foul and derogatory language and drawings in cells.
- The Academy did not comply with NRS 62B.270 when obtaining employee background investigations. While all 20 personnel files reviewed contained evidence the Academy obtained fingerprint background investigations, the investigations requested from the criminal history repository were made using incorrect statutes, resulting in background investigations not using the proper set of disqualifying convictions for employee clearance. All 20 background investigations requested conviction information using NRS 179A.190 (Dissemination of Information Relating to Certain Offenses) or NRS 449.174 (Medical Facilities and Related Entities), which are both more lenient than NRS 62B.270. For example, background investigations conducted under NRS 179A.190 show only felony convictions within the past 7 years; sexual offenses; or aiding, abetting, attempting, or conspiring to engage in any such acts. However, disqualifying crimes listed in NRS 62B.270 do not include the 7 year limit for all felonies, but only includes the 7 year limit for non-violent crimes, such as fraud or embezzlement. The disqualifying crimes listed in NRS 449.174 include a 7 year limit for sexually related and controlled substance convictions punished as

Rite of Passage-Red Rock Academy (continued)

misdemeanors. In contrast, disqualifying crimes listed in NRS 62B.270 do not place a 7 year limit on sexually related or controlled substance convictions, whether punished as felonies or misdemeanors.

Facility Response

- *This training and documentation issue has been corrected. The facility has maintained or exceeded the minimum number of staff required. The positioning of the staff and related documentation has not always been correct. All direct care staff have received additional training on interactive supervision. All staff responsible for documenting the staff-to-student ratios have been retrained on the student count process. Additionally, Rite of Passage sought and received feedback from the American Correctional Association on what positions are considered in the ratio. The clarification proved valuable and allowed the inclusion of a number of positions that were previously present, but not previously counted in the documented staff-to-student ratios. Policy includes the proper procedures to be used when students are present in the kitchen.*
- *This documentation issue has been corrected. Again, the documentation reviewed in the review did not match the operational practice. The Clinical Director is now responsible for conducting and scoring the PREA vulnerability assessment and filing it in the mental health file. Additionally, upon admission, the case management assistant goes over policies and has the student sign policies which include the Sexual Contact Prevention Zero Tolerance Acknowledgement Form.*
- *This documentation issue has been corrected. In accordance with the policy, Red Rock*

Rite of Passage-Red Rock Academy (continued)

Facility Response (continued)

Academy has established a tool inventory process that includes procedures to check tools into and out of the facility. Training was completed with maintenance staff and the Central Control Clerks.

- *This operational issue has been corrected and processes established for continued compliance. Regular facility checks include checking door security. Staff that work in the areas in question have been re-trained. It should be noted that the door in the medical department found to be unlocked does not give access to the medication storage room. There are three other locking barriers to gain access to that area.*
- *This operational issue has been addressed. Two Red Rock staff have received disciplinary action for not following the approved pedestrian and vehicle Sally Port door procedures. All Central Control Center staff have been re-trained to ensure they all understand the importance of this issue.*
- *This documentation issue has been corrected. In an effort to improve the 90-95% assessment documentation compliance rate, the Clinical Director is now responsible for all intake documents. If the Clinical Director is unavailable, the qualified Therapeutic Manager will complete the assessments and forward them to the Clinical Director or Director of Student Services to verify the assessments were completed.*
- *The youth involved has been held accountable and the computer/internet access and use process has been defined. The only student computer use, to date, has been by six students. The student access was permitted to attain a state Health Card for their culinary class. During the one time internet access, one youth*

Rite of Passage-Red Rock Academy (continued)

Facility Response (continued)

accessed a Facebook account. The youth was held programmatically accountable. In anticipation of a student computer lab opening, a policy has been written to address student access to computers, the internet, and the related procedures.

- *This documentation issue has been addressed. Red Rock Academy is subject to all fire codes and American Correctional Association standards. Red Rock policy addresses the posting of evacuation routes. The facility did pass a thorough inspection prior to opening. The fire escape route posting reported as missing has been replaced.*
- *Prior to opening, Red Rock Academy began collaborating with DCFS on repairing and upgrading the inoperable facility video surveillance system. Since the review, additional cameras have been repaired. All cameras that cover areas deemed essential to safety or security are in working order. The current system does exceed all other state juvenile facility surveillance capabilities.*
- *The typical teenage male behavior is not permitted at Red Rock Academy, and it is acknowledged that such conduct can lead to larger correctional facility rule violations. The staff and student culture has progressed significantly in recent months. Constant staff vigilance and always holding the students accountable for their behavior is essential. Special student supervision and conduct staff training sessions were completed and the frequency of the minor rule violations has since decreased.*
- *These operational and documentation issues have been corrected. Staff have been re-trained concerning room searches and what is allowed*

Rite of Passage-Red Rock Academy (continued)

Facility Response (continued)

in each youth's room as far as pictures, gang references, drawings, pencils, and other contraband items. All items listed as contraband have been removed from the site. The applicable policies related to contraband have been revised and the student handbook is being revised.

- *One hundred percent of the Red Rock Academy staff backgrounds are compliant with the background requirements of NRS 62B.270. None of the current or former employees have had convictions which would disqualify them under 62B.270. Rite of Passage contacted the Department of Public Safety for an opinion regarding Red Rock Academy's background check procedures and compliance with NRS 62B.270. The Department of Public Safety confirmed the following: "At this time your agency has been using Adam Walsh Act since 07/2012 per your account file. Since that date you have been receiving the full rap sheet, which would be the same information you would receive if you were using NRS 62B.270." DCFS requested a review of this issue by the Nevada Attorney General's Office. The opinion received from the Deputy Attorney General supports the current background check practices at Red Rock Academy.*

Reviewer's Comment

We have also spoken with officials at the Department of Public Safety (DPS) and reviewed the Deputy Attorney General's informal opinion regarding the Academy's background checks. The informal opinion states that the Academy's employees are subject to NRS 62B.270, as well as any contractor of the Academy who works directly

Rite of Passage-Red Rock Academy (continued)

Reviewer's Comment (continued)

with children. Officials at the DPS informed us that background checks obtained using NRS 449.174 or 179A.190 will not provide the requestor sufficient information to evaluate the criminal history of the person being investigated pursuant to NRS 62B. Furthermore, according to officials at the DPS, background checks obtained under the Adam Walsh Act pertain only to teachers, educators, foster parents, and child welfare agencies, not to juvenile correctional facilities. Therefore, we believe our conclusion that the Academy did not comply with NRS 62B.270 when obtaining employee background investigations is correct.

Welfare Policies and Procedures

Red Rock Academy's youths' welfare policies and procedures are not complete or consistent with the information provided to youths in the student handbook. For example:

- Policies are not clear on the classifications and uses of corrective room restrictions and are mute on tracking and reporting on the length of time youths are placed on corrective room restrictions. For example, the Academy's policies include administrative seclusion (youths placed in a locked room), refocus (which may or may not include room restriction), staff-directed timeout (which may not exceed 30 minutes), self-initiated timeout (which may not exceed 60 minutes), and protective custody. Most of these types of room restriction meet the definition of corrective room restriction contained in NRS 63.505 (8): confinement of a child to his or her room as a disciplinary or protective action, including administrative seclusion, behavioral room confinement, corrective room rest, and room confinement. However, the policy is not clear whether "timeout" is a de-escalation technique or a form of room restriction. Further, NRS 63.505 (7) requires a facility to report monthly to the Juvenile Justice Programs Office of DCFS the number of youths subjected to

Rite of Passage-Red Rock Academy (continued)

corrective room restriction during that month and the length of time each youth was in corrective room restriction. Because the Academy's policies are not clear that all types of corrective room restrictions should be reported to DCFS, the reports were not complete. In addition, the reports were not traceable to the documentation that was supposed to have been used to prepare the reports.

- Policy states youths placed on "timeout" will have face to face meetings with staff at irregular intervals, not to exceed 10 minutes, while the handbook states the meetings will occur at least every 15 minutes.

  Facility Response

  - *Staff have been retrained and the documentation issue has been corrected. Monthly, Red Rock Academy submits a room restriction report to the State Juvenile Justice Specialist. The report includes how often and how long the youth remained behind locked doors during the previous month. The applicable site policies relating to any type of room confinement are being revised to clarify procedures and ensure consistency with state statutes.*
  - *This documentation issue is being corrected. The student handbook update to mirror the corresponding policy will be completed by October 1, 2014.*

Civil and Other Rights Policies and Procedures

Red Rock Academy's youths' rights policies and procedures are not complete or consistent with the information provided to youths in the student handbook. For example:

- The Academy's staff did not comply with statutory mandatory reporting requirements or the Academy's policy related to mandatory reporting. Our review of 20 youths' files found 4 youths made allegations of abuse or neglect. There was no

Rite of Passage-Red Rock Academy (continued)

evidence in the files that two of the youths' allegations were ever reported; evidence in the other two youths' files showed their allegations were not reported within the statutory timeframe of 24 hours.

- There was no evidence some youths were notified of their right to file a complaint or grievance in a timely manner or in accordance with the Academy's policy. Policy states youths will be advised of the grievance procedure within 24 hours of placement; however, the policy does not require documentation that the youths were advised within 24 hours of their right to file a grievance. The grievance procedure provided to and signed by the youths includes the youths' right to file a grievance. However, of the 20 youths' files reviewed, 2 files did not contain evidence youths were notified of their right to file a grievance, and 11 showed the youths were not advised of the procedure and their rights in a timely manner.
- The grievance procedure described in the youth handbook is not consistent with the procedure described in the Academy's policy. The handbook says grievances are reviewed, documented, and forwarded to the appropriate staff by the Therapeutic Manager, while the policy says the grievances are handled by the Deputy Superintendent. In addition, the handbook states grievance resolutions are provided to the youth by the Therapeutic Manager or the Clinical Director, while the policy states resolutions are provided to the youth by the staff who resolved the grievance. Finally, the handbook explains the appeal process is 3 days but does not mention the number of days a youth has to make an appeal, while the policy states a youth has 5 days to make an appeal.
- Grievance forms were not always readily available to youths. The Academy's policy states grievance forms shall be located in each unit where the youths may have access to the forms without requiring the assistance of staff. However, the forms were not available in one of the two dayrooms of the occupied living unit, and youths do not have access to both dayrooms.

Facility Response

- *This documentation and procedural issue has been addressed. When the facility opened*

Rite of Passage-Red Rock Academy (continued)

Facility Response (continued)

(December 2013), four students made allegations about abusive treatment in the facilities from which they had been transferred. The allegations were documented in the youths' files and reported to numerous local and state agencies. All of the allegations have been reported and the entire abuse reporting process has since been clarified and agreed upon by all applicable agencies.

- *This documentation issue has been corrected. Grievance acknowledgements are in each file as issued and signed by the youth upon intake. The intake staff have been re-trained on the intake process to assure that both the form is signed and put into the student's file within 24 hours of admission.*
- *This documentation issue is being corrected. The Grievance Policy is being revised to state that the Deputy Superintendent reviews all grievances. After the policy is revised, the handbook will be revised to mirror the policy.*
- *This operational and documentation issue has been corrected. It was discovered that students were taking the forms and using the back of the forms as scratch paper to draw. The staff and students have been addressed on the importance of the availability of the forms at all times. Additional scratch paper has been supplied for the students to draw. The availability of grievance forms is being checked daily and documented in the unit log. It should be noted that all youths are informed that they can file a grievance, at any time, on any piece of paper.*

Jan Evans Juvenile Justice Center

Background Information

Jan Evans Juvenile Justice Center (JEJJC) is a secure, temporary holding facility in Reno. JEJJC is operated by the Washoe County Department of Juvenile Services. JEJJC's mission is to provide a continuum of services and sanctions to juveniles and their families to help create a safer community. JEJJC's goals include:

- Provide for the juvenile's basic needs, including shelter, food, clothing, and medical care;
- Protect the rights of juveniles during residence;
- Provide for the educational, physical, emotional, and social needs of detained juveniles;
- Administer programs, rules, discipline, and controls in a firm, fair, and consistent manner; and
- Nurture and encourage acceptable behavior.

As of June 30, 2014, JEJJC:

- Served male and female youths between the ages of 8 and 17.
- Had a maximum capacity of 108 youths.
- Had an average daily population of 35 youths with an average length of stay of 14 days.
- Had an average of 51 staff: 49 full-time and 2 part-time.

Purpose of the Review

The purpose of our review was to determine if Jan Evans Juvenile Justice Center adequately protects the health, safety, and welfare of the children at JEJJC and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period from July 2012 through December 2013. We discussed related issues and observed related processes during our visit in January 2014.

Jan Evans Juvenile Justice Center (continued)

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Jan Evans Juvenile Justice Center 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, JEJJC could improve its medication and background investigation policies and procedures.

Principal Observations

Administration of Medications

JEJJC needs to improve its policies and procedures for the administration of medications. Some policies and procedures were not complete, some were not up to date, and some did not match the actual processes used by staff.

- Policies and procedures do not address the processes used to dispose of medications, including alternative methods available to dispose of medications. Disposal procedures are addressed in unofficial policies, which are notes attached to minutes of staff meetings. In addition, the official policies do not require documentation of the method used to destroy medications and the alternative methods available for destruction.
- Policies and procedures do not address the independent review of medical files and records, or documentation of the reviews completed. According to staff, these reviews are conducted; however, medical files for four of five youths who were prescribed medication and whose files we reviewed contained no evidence of independent review.
- Policies and procedures for documenting medication errors are not up to date or complete. Policies state that medical errors should be documented using an incident report. Management and staff stated that, if a medication error was made by the medical staff, an incident report and a medical occurrence report should be completed.
- The process used to re-order medications from the pharmacy is only partially addressed in the policies. The complete re-

Jan Evans Juvenile Justice Center (continued)

order process was discussed at a staff meeting and is documented in minutes of the staff meeting, but is not formally addressed in the policies and procedures.

- Policies and procedures refer to a standing order medication form and contain a list of non-prescription medications that may be administered; however, JEJJC did not have a dated standing order form signed by a physician or nurse practitioner.

In addition, JEJJC could better document its key controls over medications. For example, medical files for two of the five youths whose files we reviewed and who received prescription medications while at JEJJC did not indicate the number of pills with which the youths were discharged. Furthermore, the medication administration record for one of the youths did not indicate the youth's allergy to penicillin.

Facility Response

We are looking at better ways to dispose of medication including the documentation of destruction. Once we have found a sufficient and safe manner, it will be added to our current policies and procedures.

We are currently looking for a better system to offer independent review of medical files, including the appropriate documentation of the review.

Medication errors will be further detailed in incident reports regardless of the staff involved, including medical. These reports will also include a medical occurrence report completed by the staff involved and signed off by the Detention Manager or Administration.

Medication refill orders that appear in our minutes will be added to the current policy manual to reflect all changes and current policy.

All medical orders, including the standing order form will be submitted to the overseeing doctor and signed.

Jan Evans Juvenile Justice Center (continued)

Facility Response (continued)

We are additionally working on policy to include the counting of medications of juveniles prior to being released to another agency or guardian.

Background Investigations

JEJJC could improve its background investigation policies and procedures, which are not consistent with the processes being used. First, policies and procedures do not address the practice of not hiring potential employees until their background check results have been received. Second, policies do not contain an accurate list of convictions which would preclude hiring a potential employee. Policies do allow JEJJC to refuse employment of a person with any convictions other than minor traffic convictions; however, policies do not require JEJJC to refuse employment to a person with the disqualifying convictions listed in NRS 62B.270. Third, policies do not address the timeframe in which employees must undergo subsequent background checks. NRS 62B.270 requires JEJJC to conduct fingerprint-based background investigations of employees at least every 5 years.

JEJJC requests a search of the Statewide Central Registry For The Collection of Information Concerning The Abuse or Neglect of a Child (CANS) be conducted for potential employees. However, this search is not addressed in JEJJC's employment policies. JEJJC's policies do not require evidence of CANS screenings be maintained in the employees' files. Although NRS 62G.223 requires a search of CANS only for employees of Clark County's Department of Juvenile Justice, the information contained in the CANS system can be valuable for screening applicants and ensuring employees do not have a history of abusing or neglecting children.

Facility Response

We will be updating our current personnel manual to be consistent with NRS 62B.270 with a list of disqualifying charges. This update will also include not placing new employees in a hired/working position until all background checks have been completed and cleared. Our department currently requires background checks of all employees and

Jan Evans Juvenile Justice Center (continued)

Facility Response (continued)

volunteers every three years and this will be noted in the updated personnel manual.

All background checks will also include the CANS system, which will also be noted in the updated personnel manual.

Other Issues

JEJJC's policies and procedures do not address the Prison Rape Elimination Act (PREA) requirements. PREA-related processes and requirements have been discussed with staff and are documented in the minutes of the staff meeting. However, these processes and requirements should be included in JEJJC's official policies and procedures.

Youths could be better supervised during classroom time. Although the school program is administered by the Washoe County School District, according to management and JEJJC's policy, detention staff should monitor the youths while in class. We found a discharged youth's personal contact information in a word processing document on one of the two school computers used by youths.

Facility Response

All portions of PREA noted in the minutes to staff and other recommendations are currently being added to the policy manual for Detention and Probation.

We have also been working with school administration and teachers for better supervision of computer use by the juveniles in detention. New equipment has been installed to help the teachers monitor the systems, as well as removal of some systems that were enabling juveniles to work and hide items in the system.

West Hills Hospital

Background Information

West Hills Hospital is a mental health treatment facility located in Reno, Nevada. The Hospital is a secure, acute inpatient psychiatric hospital that provides care to adults and youth. Acute residential care is considered short-term for conditions that cannot be safely or effectively treated on an outpatient basis. The purpose of acute care is to quickly stabilize patients to allow transition to a less intensive level of care. West Hills Hospital is licensed by the Nevada Department of Health and Human Services, Division of Public and Behavioral Health.

For the year ended June 30, 2014, West Hills Hospital:

- Served male and female youths between the ages of 5 and 18.
- Had a maximum capacity of 24 youths.
- Had an average daily population of 12 youths with an average length of stay of 6 days.
- Had an average of 29 staff: 28 full-time, and 1 part-time.

Purpose of the Review

The purpose of our review was to determine if West Hills Hospital adequately protects the health, safety, and welfare of the children at West Hills and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period from July 2012 through April 2014. We discussed related issues and observed related processes during our visit in May 2014.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at West Hills Hospital provide reasonable assurance that it adequately protects the health, safety, and welfare of youths at the facility and respects the civil and other rights of youths in its care. However, West Hills Hospital could improve its policies, procedures, and background investigation process.

West Hills Hospital (continued)

Principal Observations

Policies and Procedures

West Hills Hospital's policies and procedures were incomplete and outdated. Policies and procedures that need to be developed or updated include:

- The Abuse Assessment and Reporting Policy and the Rape/Sexual Molestation Policy need to be updated to include the 24-hour timeframe in which disclosures of abuse or neglect must be reported. The policies require reporting such disclosures to appropriate authorities, but do not include the 24-hour timeframe required by statute (NRS 432B.220).
- Policies and procedures do not require an identity kit be prepared for each youth. An identity kit should contain critical information for use during an emergency, such as a medical emergency or a run away. The information should be easily accessible and should include the youth's full name, aliases, date of birth, photo, emergency contacts, a list of medications, allergies, and identifying marks. None of the 10 youths' files we reviewed contained complete identity kits.
- Policies and procedures do not address West Hills Hospital's system of privileges for youths or its education practices. The Hospital has instituted a system of privileges, and educational services are provided by the Washoe County School District. However, neither of these processes are documented in the policies and procedures.
- The complaint form in the policies needs to be updated. It was significantly different from the form used by the youths at the Hospital.

In addition, we noted two instances where staff did not follow West Hills Hospital's policies. First, 4 of the 10 treatment plans we reviewed were missing either the youth's or guardian's signatures or the dates. Policies require treatment plans be signed by either the youth or guardian. Dating treatment plans help ensure they were prepared timely. Second, 1 medication record of the 10 youths whose medication files we reviewed contained blank spaces for four prescribed medications for 1 day. The medication administration record did not contain documentation indicating why the youth may

West Hills Hospital (continued)

have missed receiving the medications or whether staff did not document the administration of the medications. Policy requires staff to document medication administered on the medication administration record.

Facility Response

West Hills is committed to the ongoing review of all of our policies and procedures to meet best practice and compliance changes. We were pleased to learn that, overall, our policies and procedures protect the health, safety, and welfare of the youth population that is served at our hospital. As suggested, opportunities for improvement exist in a few areas; therefore, we have made some revisions.

Our Abuse Assessment and Reporting Policy has been amended to specifically outline the requirements set forth in NRS 432B.220. This includes the 24-hour timeline for reports. Education is provided to all staff on this topic during orientation and subsequently as part of our annual competency requirements. We have also modified our Rape/Sexual Molestation Protocol policy to reflect the "within 24-hour timeframe" required by statute.

Should a medical or potential elopement emergency occur, the need for critical information in a central location would expedite communication to law enforcement or those that act to resolve such emergencies leading to a positive outcome. An identity kit was suggested. We have taken the opportunity to revise our "Kardex", which will contain all of the elements of the identity kits described during our review, therefore meeting this requirement. A protocol outline is being developed on the changes and requirements for the newly revised Kardex. Every registered nurse who staffs the Youth Unit will be in-serviced on the protocol for the Kardex, which will serve as our "Identity Kit".

West Hills Hospital (continued)

Facility Response (continued)

We have reviewed and revised our policies and procedures regarding education to reflect the Washoe County School District provision of educational services to our patients. In addition, our policies and procedures and handbook now outline our system of "privileges" for our youth population.

Our policy on the receipt and follow-up for Patient Concerns/Complaints was revised in 2013. The policy will not be amended at this time; however, the correct Compliment/Complaint/Suggestion form will be an attachment to the policy. During the review, the incorrect form was attached to the policy while the correct form was being used.

Policies and procedures on Treatment Plans and Medication Administration Records were also noted in the review as being inconsistently followed. Treatment plans and medication records are two very important elements in the care of our patients. Currently, our policy reflects the documentation expectations for these two items. Our performance improvement process to monitor compliance for this requirement has been enhanced. In addition, our staff members have been educated about our policies on our individualized Treatment Plans and Medication Administration Record.

Background Investigations

West Hills Hospital could improve its background investigation processes, policies, and procedures. Policies do not address or refer to the disqualifying crimes listed in NRS 449.125. NRS 449.125 requires employees be terminated if convicted of certain crimes. Including the list of crimes or referring to NRS 449.125 will help the Hospital ensure background check results are being compared to an appropriate list of crimes. In addition, the Hospital's policies do not state that a fingerprint background check is required or that it is required within 10 days of hire, as specified by NRS 449.123. As a result, our review of 10 employee files found that 3 were subjected to

West Hills Hospital (continued)

name and social security number based background checks, not fingerprint background checks, and 5 employees were not subjected to a background check within 10 days.

Although not required by law, West Hills Hospital could improve its background investigation process, policies and procedures by requiring a search of the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child (CANS). NRS 432.100 allows the Division of Child and Family Services to release information from CANS to employers if the employees have regular contact with children. The Hospital is required to terminate any employee with a substantiated report of abuse or neglect of a child.

Facility Response

West Hills has improved its background investigation process, and our policy and procedure outlines the criminal history check (per NRS 449.123) required as a condition of employment. Fingerprints are checked against Nevada and FBI records. Criminal conviction will be considered when decisions are being made to hire, retain, suspend, or discharge employees or applicants.

In addition, the Background Policy reflects our participation in the Statewide Registry for the Collection of Information Concerning the Abuse and Neglect of a Child (CANS) per NRS 432.100. West Hills can now receive information from CANS about employees that have regular contact with children. The hospital takes action on any employee that is known to have a substantiated report of abuse or neglect of a child.

Other Issues

The handbook provided to youths needs to be updated and is missing information that should be provided to the youths. First, the handbook does not mention the youths' right to an education and does not clearly state the youths have the right to file a complaint. Second, the handbook is not consistent with the Hospital's visitation

West Hills Hospital (continued)

policies: policies state visitors are not allowed in youths' rooms, while the handbook states visits are discouraged in youths' rooms. In addition, the handbook is not consistent with the Hospital's practices regarding locking of room doors: the Hospital's practice is to lock bedroom doors when a room is unoccupied, while the handbook states bedroom doors will remain open except when changing clothes. The handbook is also inconsistent with the Hospital's policies and the posted list for contraband. For example, the handbook lists movies with restricted ratings, backpacks, and large suitcases, while the list and policies do not. Conversely, the policy and list include gum, pens, pagers, and electronic games, while the handbook does not.

Facility Response

West Hills is in the process of reviewing and revising the Handbook for our Youth Services Program. Our handbook will now reflect that a youth has a right to an education. It will also outline the process to file a complaint. A complaint can be filed by either a youth or their guardian. Our policies and procedures on "Visitation" will also be accurately reflected in the revised Handbook. We will include an outline about how the safety of the environment will be maintained by the policy and practice for locking the patients' rooms. Our revised handbook will reflect the contraband list that was recently updated in our policy earlier this year. This will ensure consistency with contraband information that will be given to and enforced with our patients. Our target date for completion is September 2014.

Boys Town Nevada

Background Information

Boys Town Nevada operates five group homes in Las Vegas. Boys Town is a private, not-for-profit facility and is licensed by the Clark County Department of Family Services. Its mission is to change the way America cares for children, families, and communities by providing and promoting an Integrated Continuum of Care that instills Boys Town values to strengthen body, mind, and spirit. Boys Town provides intensive care and interventions to children with serious emotional or behavioral problems.

As of June 30, 2014, Boys Town:

- Served male and female youths between the ages of 10 and 18.
- Had a maximum capacity of 30 youths.
- Had an average daily population of 26 youths with an average length of stay of 6 months.
- Had an average of 20 staff: 17 full-time and 3 part-time.

Purpose of the Review

The purpose of our review was to determine if Boys Town Nevada adequately protects the health, safety, and welfare of the children at Boys Town and whether the facility respects the civil and other rights of the children in its care. The review included an analysis of policies, procedures, and processes for the period from July 2012 through February 2014. We discussed related issues and observed related processes during our visit in March 2014.

Results in Brief

Based on the results of the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at Boys Town Nevada 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, Boys Town could improve its medication policies and documentation of medications received, administered, and destroyed; and its other operational policies and procedures.

Boys Town Nevada (continued)

Principal Observations

Administration of Medications

Boys Town could improve its documentation of medications received, administered, and destroyed.

- Staff verify the number and type of pills received at intake; however, the verification is not documented. One youth's medication file showed 60 pills were received; however, the file also showed 22 pills were administered, and 48 pills were destroyed, for a total of 70 pills. The file did not indicate where the 10 additional pills came from or whether there was an error in recording the number of pills received at intake.
- Two of the seven youths' medication files reviewed did not indicate the number of pills transferred to other entities when the youths were discharged.
- Six of the seven youths' medication files reviewed were missing pharmacy instructions.
- Two of the seven youths' medication files reviewed were missing physicians' orders.
- One youth's medication administration records were missing either the youths' or the staff's initials for multiple days and multiple medications; records also indicated the youth received medication on a date that does not exist. In addition, one medication administration record was missing the month and year the medications were administered.
- Finally, three of the seven youths' whose files we reviewed did not receive prescribed medication on at least one day, and the medication administration record did not indicate the reason for the missed medications.

Some documentation errors may have been partially due to incomplete policies and procedures for handling and administering medications. For example, policies do not require documentation of the verification of medications received at intake; policies only require the medication be verified. Furthermore, policies only require the completion of a medication disposal form for controlled substances and not for all prescription medications. Policies do require

Boys Town Nevada (continued)

documentation of all prescriptions transferred between employees for destruction, including the date and the number of pills; but the documentation does not include a place for the signature of a witness to the disposal, the actual date of the disposal, or the method of disposal.

Boys Town documents independent reviews of youths' medication records; however, the documentation is filed in a different location than the youths' medication administration records, and staff do not note on the medication records whether or when they were reviewed. Therefore, it is cumbersome to determine which medication records were reviewed. Boys Town could improve its controls over the review process by adding space on each record for the independent reviewer to initial or sign and date when the independent review is completed.

Finally, we observed a foster parent handle a youth's medication without washing or sanitizing his hands.

Facility Response

We are in agreement that the review identified areas that we can strengthen. Boys Town Nevada will utilize our Quality Improvement structure to improve our processes in the following areas.

Current Medication Administration policy outlines that all medications received for a youth must be verified for identification and clarification of administration reasons. The Quality Improvement Team will be addressing and creating a program procedure that will give guidance to program staff on the most effective process for documenting medication received, at intake and during treatment, to include a count verification.

The Quality Improvement Team will also address the concern around documentation of medications destroyed. Boys Town's regular medication inspection processes are documented separately from each youth's medication administration record. The Quality Improvement Team will be evaluating the forms in place for the administration of medication to

Boys Town Nevada (continued)

Facility Response (continued)

address how to demonstrate when a record has been inspected.

Program staff currently receive training on medication administration prior to caring for youth or administering medication. They also receive on-going training with a minimum standard of an annual refresher training and review of policies. Ongoing consultation services address the outcomes of audits with staff members which include errors made and missing documentation. Boys Town Nevada is confident that the medication administration policies in place clearly meet the requirements as prescribed by the State of Nevada's Policy on Psychiatric Care and Treatment. Program practices and procedures will be reviewed and altered or created if necessary to allow for improvements to meet the LCB's best practice standard.

Policies and Procedures

Several of Boys Town's operational policies and procedures were incomplete or outdated. Some examples of policies and procedures that need to be developed, expanded, or updated include:

- There were no policies and procedures to control keys, tools, and kitchen utensils.
- There were no policies for preparing youth identity kits.
- There were no policies for school or how educational needs will be met.
- There were no policies for control of youths' use of computers.
- Policies do not specify the timeframe within which a youth's treatment plan must be completed.
- Policies do not require documentation of increased supervision of a youth based on the youth's suicidal statements or indicators.

Boys Town Nevada (continued)

- Policies do not address the timeframe in which to resolve complaints.

In addition, Boys Town has not developed policies and procedures specific to Nevada's background investigation requirements. Boys Town's national policies state background checks will be conducted in accordance with state law and regulations and licensing requirements. However, there is no guidance for Boys Town's Nevada staff for helping to ensure staff consistently follow the licensing agency's and Nevada's requirements.

Facility Response

Boys Town Nevada is part of the national Boys Town organization and is governed by policies that apply to all of the operating sites. Each operating site is governed by varying state regulations and individual contract agreements. Program policies are written to include that each site will meet the minimum organizational standard outlined, as well as the site's local regulations and contractual standards. Boys Town Nevada's Family Home Program is comprised of five Specialized Foster Homes per the definition in NRS 424.018, and has the intention of providing as normal a home environment for youth as possible while meeting all of the regulations set forth for that level of care by the State of Nevada as well as the Licensing Authority. The following policies were noted in your report:

- *Policies and Procedures to control keys, tools, and kitchen utensils – Boys Town Nevada does not have policy in place nor is there a regulation in place requiring specialized foster homes to have a specified policy on this topic. However, although there is not an actual policy, Boys Town Nevada does have practices in place that control keys with the direct intention of not allowing youth access to keys, locked areas, or vehicles. Tools are regularly kept in safe areas. Kitchen utensils (sharp) are removed from youth accessible areas and*

Boys Town Nevada (continued)

Facility Response (continued)

locked when there are risk factors present for the current population.

- *Policies for preparing youth identity kits – Boys Town Nevada currently uses a face sheet report that contains pertinent information on youth such as their name, a current photo, allergies, medications, and legal guardian contact information. While this is a best practice standard, Boys Town does not have a policy governing the use of this face sheet report. Boys Town recognizes that this audit exposed inconsistencies in the contents of youth face sheet reports and will have the Quality Improvement Team create a standard practice for contents of each youth's face sheet.*
- *Policies for school or how educational needs will be met – Boys Town's Youth Rights outline that youth have a right to attend school and get an education. In practice, Boys Town is extremely committed to the educational success of the youth in our care. As such, staff ensure that each youth is enrolled in the appropriate school setting, monitors attendance, maintains a high level of communication with school teachers and administrators, facilitates school meetings for academic and disciplinary issues, assists with homework, and monitors grades. This is a best practice standard, rather than a policy requirement.*
- *Policies for control of youth's use of computers – At the time of your review, Boys Town was in the process of creating a policy to address youth access to computers and the internet. On June 9th, 2014, Youth Care Policy #13575, titled Youth Internet Safety, was finalized and implemented across the organization.*

Boys Town Nevada (continued)

Facility Response (continued)

- *Policies regarding the timeframe for youth treatment plans to be completed – Currently policy dictates that, as a site, Boys Town Nevada must comply with the local regulations and contractual obligations for timeliness of treatment plans.*

- *Policies that require documentation of increased supervision of a youth based on a youth's statement or indicators – Boys Town's practices call for a youth who has made a self-harm statement or gesture to be monitored within eye contact until that youth can be appropriately assessed for risk. This may be a policy requirement for a higher level program, such as a group home or residential treatment center. In addition, Boys Town Nevada's practice is to contact our Clinical Supervisor who will assess the level of risk and determine a safety plan. If necessary, Boys Town's Psychiatrist is contacted for further consultation.*

- *Policies do not address the timeframe in which to resolve complaints – Boys Town has extensive internal policies and procedures in place that address client grievances. All grievances are responded to in appropriate time frames, calls being responded to within 24 hours or less and internal investigations being completed within 7 days. Boys Town meets the requirement to have a policy that addresses client grievances.*

Boys Town has an organizational policy that states background checks will be conducted in accordance with state law and regulations and that procedures for such checks will follow local contracts, licensing regulations and other applicable accrediting agency requirements. Boys Town Nevada's Quality

Boys Town Nevada (continued)

Facility Response (continued)

Improvement Team will create a guide for employees that outlines the Nevada specific background check requirements that meet the local licensing agency's standards and include it in an Operating Procedure Manual for staff.

Mandatory Reporting

Boys Town did not report an allegation of abuse or neglect to Child Protective Services or law enforcement within the statutorily required timeframe of not later than 24-hours. Of the ten youths' files we reviewed, one youth made an allegation of abuse during May 2013; however, the allegation was not reported until March 2014. NRS 432B.220 requires allegations be reported not later than 24-hours after disclosure to Child Protective Services or law enforcement.

Facility Response

By policy, all Boys Town Nevada employees are required to report any allegations of abuse or neglect to Child Protective Services, and/or law enforcement agencies as specified by contract and state law. During the review, at intake a child and legal guardian had disclosed an incident of abuse that occurred at another facility and the legal guardian verified that the incident had been reported. There was no documentation found in the file that Boys Town Nevada verified the report. Boys Town Nevada has adjusted reporting practices to include contacting Child Protective Services and/or law enforcement agencies, regardless of whether or not a child's legal guardian reports that the allegation was reported. Documentation of these reports is now being included in youth files.

Other Issues

A list of prohibited items and contraband was not posted and visible to youths in any of the three homes visited. In addition, chemicals used for cleaning were not secured in two of three homes visited.

Boys Town Nevada (continued)

Although there were emergency disaster policies and procedures unique to the Nevada facility, staff were unable to easily locate them.

Facility Response

Your review noted that a list of prohibited items and contraband was not posted and visible to youth in the homes visited. It is the practice of Boys Town Nevada to review prohibited items with the youth and legal guardians at intake and when completing the youth's inventory of belongings. Safety meetings are regularly held with all of the youth during which topics such as prohibited items are discussed. Boys Town Nevada employees receive training at pre-service and annually thereafter on safety in the home. Boys Town Nevada also regularly completes safety meetings with the youth and has an established process in which youth can report any safety concerns. Feedback was also provided in the report that chemicals used for cleaning were not secured. It is the practice of Boys Town Nevada to keep cleaning chemicals locked when they are not being used. This feedback was shared with staff members of the program.

Boys Town Nevada's Disaster Plan is updated on a yearly basis after having been reviewed and updated through the quality management process, specifically the Safety and Health Committee. Nationally, the organization has specific policies that identify what actions need to be addressed and what information needs to be updated. The current plan is kept in the main office located in Las Vegas. In addition, as of July 2014, each foster home will receive an updated copy of the disaster plan on an annual basis. An electronic version of the plan will be available to all employees through a shared network.

Appendices

Appendix A

Nevada Revised Statutes
218G.500 Through 218G.535 and 218G.570 Through 218G.585

General Provisions

NRS 218G.500 Definitions. As used in NRS 218G.500 to 218G.585, inclusive, unless the context otherwise requires, the words and terms defined in NRS 218G.505 to 218G.535, inclusive, have the meanings ascribed to them in those sections.
(Added to NRS by 2007, 198; A 2009, 4)—(Substituted in revision for NRS 218.862)

NRS 218G.505 "Abuse or neglect of a child" defined. "Abuse or neglect of a child" has the meaning ascribed to it in NRS 432B.020.
(Added to NRS by 2007, 198)—(Substituted in revision for NRS 218.863)

NRS 218G.510 "Agency which provides child welfare services" defined. "Agency which provides child welfare services" has the meaning ascribed to it in NRS 432B.030.
(Added to NRS by 2007, 198)—(Substituted in revision for NRS 218.864)

NRS 218G.515 "Family foster home" defined. "Family foster home" has the meaning ascribed to it in NRS 424.013.
(Added to NRS by 2009, 2)

NRS 218G.520 "Governmental facility for children" defined.

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.
(Added to NRS by 2009, 2)

NRS 218G.525 "Group foster home" defined. "Group foster home" has the meaning ascribed to it in NRS 424.015.
(Added to NRS by 2009, 2)

NRS 218G.530 "Near fatality" defined. "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.
(Added to NRS by 2007, 198)—(Substituted in revision for NRS 218.865)

NRS 218G.535 "Private facility for children" defined.

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. (Added to NRS by 2009, 2)

Appendix A

Nevada Revised Statutes
218G.500 Through 218G.535 and 218G.570 Through 218G.585
(continued)

Facilities Having Physical Custody of Children

NRS 218G.570 Performance audits of governmental facilities for children. The Legislative Auditor, as directed by the Legislative Commission pursuant to NRS 218G.120, shall conduct performance audits of governmental facilities for children.

(Added to NRS by 2009, 3)

NRS 218G.575 Inspection, review and survey of governmental facilities for children and private facilities for children. The Legislative Auditor or the Legislative Auditor's 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.

(Added to NRS by 2009, 3)

NRS 218G.580 Scope of inspection, review and survey. The Legislative Auditor or the Legislative Auditor's designee, in performing his or her duties pursuant to NRS 218G.575, 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.

(Added to NRS by 2009, 3)

NRS 218G.585 Duty of facilities to cooperate with inspection, review and survey. Each governmental facility for children and private facility for children shall:

1. Cooperate fully with the Legislative Auditor or the Legislative Auditor's designee in the performance of his or her duties pursuant to NRS 218G.575 and 218G.580;
2. Allow the Legislative Auditor or designee to enter the facility and any area within the facility with or without prior notice;
3. Allow the Legislative Auditor or designee to interview children and staff at the facility;
4. Allow the Legislative Auditor or designee to inspect, review and copy any records, reports and other documents relevant to his or her duties; and
5. Forward to the Legislative Auditor or 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.

(Added to NRS by 2009, 3)

Appendix B

Glossary of Terms

Child Welfare Facility	Provides emergency, overnight, and short-term services to youths who cannot remain safely in their homes or their basic needs cannot be efficiently delivered in the home.
Civil and Other Rights	This relates to a youth's civil rights, as well as his rights as a human being. It includes protection from discrimination, the right to file a complaint, and protection from racist comments.
Correction Facility	Provides 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.
Corrective Room Restriction	NRS 62B.215 (8) defines corrective room restriction as the confinement of a child to his or her room as a disciplinary or protective action and includes, without limitation, administrative seclusion, behavioral room confinement, corrective room rest, and room confinement.
DCFS	The Nevada Division of Child and Family Services.
Detention Facility	Provides 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.
Foster Care Agency	A business entity that recruits and enters into contracts with foster homes to assist child welfare agencies and juvenile courts in the placement of children in foster homes. Foster care agencies may operate multiple family foster homes, including specialized foster homes and group foster homes. Foster care agencies train foster parents, and place youths in either the foster parents' homes or in homes provided by the foster care agency. Foster parents are responsible for providing safe, healthful, and developmentally supportive environments where youths can interact fully with the community.

Appendix B

Glossary of Terms
(continued)

Group Home	Provides a safe, healthful group living environment in a normalized, developmentally supportive setting where residents can interact fully with the community. Used for children who will benefit from supervised living with access to community resources in a semi-structured environment. Generally consists of detached homes.
Identity Kit	Provides quick access to important information in case of emergency, such as a youth's full name, known aliases, a photograph, a list of allergies and medications, and a list of contacts.
Independent Review of Medication Files	A process to review medication administration records and identify potential errors, fraud, or abuse. Independent review includes assignment of staff who are not routinely involved in the medication administration process to compare medication records with physician and pharmacy orders, and verify medication records are complete.
Mandatory Reporter	A mandatory reporter is any person who, in his professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected. NRS 432B.220 requires mandatory reporters to file a report with a child protective services agency or law enforcement within 24 hours after knowing or having reasonable cause to believe that a child has been abused or neglected.
Mental Health Treatment Facility	Provides mental health services to youths with serious emotional disturbances by providing acute psychiatric (short-term) and non-acute psychiatric programs. Mental health treatment facilities also provide services to behaviorally disordered youths. 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.

Appendix B

Glossary of Terms
(continued)

PREA	Prison Rape Elimination Act of 2003, including the U.S. Department of Justice National Standards to Prevent, Detect, and Respond to Prison Rape (28 CFR Part 115). The National Standards include guidance related to zero tolerance of sexual abuse and sexual harassment, supervision and monitoring, referrals of allegations for investigations, resident education, employee training, and obtaining information from residents.
Privileges	Items considered earned and not considered a right. Items considered privileges may include movies, recreation time, phone calls, and reading material.
Residential Center	Provides a full range of therapeutic, educational, recreational, and support services. Residents are provided with opportunities to be progressively more involved in the community.
Resource Center	Provides more than one type of service simultaneously. For example, a resource center may provide both treatment and detention services.
Safety	Anything related to the physical safety of youths. This includes physical security, environment, protection from inappropriate comments or contact by staff or another youth, and adequate staffing.
Specialized Foster Care	Comprehensive care and services provided to youths who require more intensive therapy or supervision due to serious physical, emotional, or mental conditions.
Substance Abuse Treatment Facility	Provides 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.
Welfare	Anything related to the general well-being of a youth. This includes education and punishments or discipline.
Youths	Children of all ages, including infants and adolescents.

Appendix C

Summary of Observations at Four Facilities Reviewed

Observations	Number of Facilities
Policies and Procedures	
Policies and procedures were not developed, not complete, or needed to be updated	4
Medication Administration Processes and Procedures	
Files contained incomplete or unclear documentation of dispensed prescribed medication	3
Medication files and records were missing key documents	2
Files contained errors	2
Medications received were not always verified or documented at intake, or before they were administered	2
Background Checks	
Hiring policies and procedures need to be developed or updated, including a list of convictions that would exclude a person from employment	3
Policies do not require a search of the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child	2
Background checks were completed based on incorrect, more lenient statutes	1
Other Significant Items	
Disclosures of abuse or neglect were not reported timely and documentation of disclosures reported was incomplete	2
Management did not enforce federal standards or facility policy related to the Prison Rape Elimination Act regarding staff-to-youth ratios	1

Source: Reviewer prepared from facility reviews.

Note: This is not a comprehensive list of observations.

Appendix D

Nevada Facility Information
Fiscal Year Ended June 30, 2014

Table 1: Correction and Detention Facilities	Background			Population for FY 2014		Staffing Levels	
Facilities	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
Caliente Youth Center	State	Caliente	12 to 18	140	113	101	0
China Spring Youth Camp/Aurora Pines Girls Facility	State/Counties	Gardnerville	12 to 18	65	52	43	2
Clark County Juvenile Detention Center	Clark County	Las Vegas	8 to 21	192	132	155	70
Douglas County Juvenile Detention Center	Douglas County	Stateline	8 to 18	16	3	5	4
Jan Evans Juvenile Justice Center	Washoe County	Reno	8 to 17	108	35	49	2
Leighton Hall	Various Counties	Winnemucca	8 to 18	24	8	12	1
Murphy Bernardini Regional Juvenile Detention Center	Carson City	Carson City	8 to 18	16	7	14	8
Nevada Youth Training Center	State	Elko	14 to 18	160	54	67	0
Northeastern Nevada Juvenile Center	Various Counties	Elko	8 to 17	24	8	11	0
Rite of Passage-Red Rock Academy	State	Las Vegas	15 to 18	96	43	38	0
Rite of Passage-Silver State Academy	Private	Yerington	14 to 18	110	72	50	12
Spring Mountain Youth Camp	Clark County	Las Vegas	12 to 18	100	94	54	6
Teurman Hall	Churchill County	Fallon	12 to 17	16	11	10	0
Total – 13 Correction and Detention Facilities				**1,067**	**632**	**609**	**105**

Table 2: Resource Center	Background			Population for FY 2014		Staffing Levels	
Facility	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
Don Goforth Resource Center[(2)]	Various Counties	Hawthorne					
Total – 1 Resource Center							

Table 3: Child Welfare Facilities	Background			Population for FY 2014		Staffing Levels	
Facilities	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
Carson Valley Children's Center	Private	Carson City	0 to 18	10	4	4	6
Child Haven	Clark County	Las Vegas	0 to 17	56	45	47	16
Kids' Kottages	Washoe County	Reno	0 to 18	82	65	38	3
WestCare-Emergency Shelter	Private	Las Vegas	10 to 17	16	10	7	0
Total – 4 Child Welfare Facilities				**164**	**124**	**96**	**25**

Table 4: Mental Health Treatment Facilities	Background			Population for FY 2014		Staffing Levels	
Facilities	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
Adolescent Treatment Center	State	Sparks	12 to 17	16	15	20	0
Desert Willow Treatment Center	State	Las Vegas	6 to 18	58	46	110	0
Montevista Hospital	Private	Las Vegas	5 to 17	38	28	13	4
Spring Mountain Treatment Center	Private	Las Vegas	5 to 17	28	20	26	2
West Hills Hospital	Private	Reno	5 to 18	24	12	28	1
Willow Springs Center	Private	Reno	5 to 18	116	95	140	83
Total – 6 Mental Health Treatment Facilities				**280**	**216**	**337**	**90**

Appendix D

Nevada Facility Information
Fiscal Year Ended June 30, 2014
(continued)

Table 5: Substance Abuse Treatment Facilities	Background			Population for FY 2014		Staffing Levels	
Facilities	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
Nevada Homes for Youth I	Private	Las Vegas	13 to 18	10	10	3	3
Nevada Homes for Youth II [3]	Private	Las Vegas					
Vitality Center-ACTIONS of Elko	Private	Elko	13 to 18	13	2	27	1
WestCare-Harris Springs Ranch	Private	Las Vegas	13 to 17	8	7	9	0
Western Nevada Regional Youth Center	State/Counties	Silver Springs	13 to 18	35	18	17	3
Total – 5 Substance Abuse Treatment Facilities				**66**	**37**	**56**	**7**

Table 6: Group Homes	Background			Population for FY 2014		Staffing Levels	
Facilities	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
Boys Town Nevada	Private	Las Vegas	10 to 18	30	26	17	3
Casa de Vida	Private	Reno	12 to 28	8	8	2	13
Etxea Services I	Private	Reno	13 to 18	6	4	2	2
Etxea Services II	Private	Reno	13 to 18	6	5	2	1
Family Learning Homes	State	Reno	5 to 18	20	18	16	1
Golla Home	Private	Washoe Valley	6 to 18	4	2	2	0
Hand Up Homes for Youth, Inc.	Private	Reno	12 to 18	15	12	12	5
Hope Healthcare Services	Private	Reno	5 to 18	12	7	6	4
My Home, Inc.	Private	Reno	8 to 18	8	8	3	3
New Vista Group Homes	Private	Las Vegas	9 to 18	12	12	9	9
Oasis On-Campus Treatment Homes	State	Las Vegas	6 to 18	29	10	35	0
R House Community Treatment Home	Private	Reno	7 to 18	5	3	2	0
Rite of Passage-Qualifying Houses I	Private	Minden	14 to 18	16	13	4	2
Rite of Passage-Qualifying House II	Private	Gardnerville	14 to 18	8	6	2	1
SAFY Houses	Private	Las Vegas	5 to 18	12	11	16	2
St. Jude's Ranch for Children	Private	Boulder City	0 to 18	62	47	35	10
The Reagan Home	Private	Reno	8 to 18	6	5	2	1
Total – 17 Group Homes				**259**	**197**	**167**	**57**

Table 7: Residential Centers	Background			Population for FY 2014		Staffing Levels	
Facilities	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
HELP of Southern Nevada-Shannon West Homeless Youth Center	Private	Las Vegas	16 to 24	65	55	14	0
Northwest Academy	Private	Amargosa Valley	13 to 18	228	30	27	5
Spring Mountain Residential Center	Clark County	Las Vegas	12 to 17	16	12	7	2
Total – 3 Residential Centers				**309**	**97**	**48**	**7**

Appendix D

Nevada Facility Information
Fiscal Year Ended June 30, 2014
(continued)

Table 8: Foster Care Agencies	Background			Population for FY 2014		Staffing Levels [1]	
Facilities	**Funded By**	**Location**	**Ages Served**	**Maximum Capacity**	**Average Population**	**Average Full-Time**	**Average Part-Time**
A Brighter Day Family Services	Private	Las Vegas	0 to 18	16	13	0	1
Apple Grove Foster Care Agency	Private	Las Vegas	0 to 18	51	42	15	12
Bamboo Sunrise, LLC	Private	Las Vegas	0 to 18	41	20	8	7
Bountiful Family Services	Private	Henderson	0 to 18	20	20	2	2
Eagle Quest of Nevada, Inc.	Private	Las Vegas	0 to 18	250	165	114	5
Genesis	Private	Las Vegas	8 to 18	32	23	12	5
JC Family Services, LLC	Private	Reno	8 to 18	5	3	2	0
KidsPeace National Centers of North America, Inc.	Private	Las Vegas	0 to 18	30	26	4	0
Koinonia Family Services	Private	Reno	3 to 18	55	28	6	2
London Family and Children's Services, Inc.	Private	Las Vegas	4 to 17	16	10	3	26
Maple Star Nevada	Private	Statewide	0 to 18	40	37	15	10
Mountain Circle Family Services	Private	Reno	6 to 18	36	21	4	4
NOVA Behavioral Services, LLC [2]	Private	Sparks					
Olive Crest	Private	Las Vegas	0 to 18	37	28	5	4
Total – 14 Foster Care Agencies				**629**	**436**	**190**	**78**
Total – 63 Facilities Statewide				**2,774**	**1,739**	**1,503**	**369**

Source: Reviewer prepared from information provided by facilities.

[1] Staffing levels do not include foster parents.

[2] Facility closed during fiscal year ending June 30, 2014.

[3] Facility did not respond to our request for information.

Appendix E

Unannounced Visits to Nevada Facilities

Facility Name	Facility Type	Date of Visit
Mountain Circle Family Services	Foster Care Agency	January 31, 2014
Bamboo Sunrise, LLC	Foster Care Agency	March 7, 2014

Source: Reviewer prepared from unannounced facility visits.

Appendix F

Methodology

To identify facilities pursuant to the requirements of statutes, 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 for facilities licensed by the State. We also included a search of the internet for other potential facilities and reviewed youth placement information submitted monthly by certain local governments. Next, we contacted each facility identified to confirm if it met the definitions included in NRS 218G.500 through 218G.535. For each facility confirmed, we obtained copies of complaints filed by youths or other persons on behalf of a youth while in the care of a facility since July 1, 2013.

To establish criteria, 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 for Children in Out-of-Home Care*. In addition, we reviewed the Nevada Association of Juvenile Justice Administrators' *Peer Review Manual*.

We selected criteria that included issues related to the health, safety, welfare, civil and other rights of youths, as well as treatment and privileges. Health criteria included items related to a youth's physical health, such as nutrition and medical care. Safety criteria related to the physical safety of youths. This included physical security, environment, inappropriate comments or contact by staff or other youths, and adequate staffing. Welfare criteria related to the general well-being of a youth. This included education and punishments or discipline. Treatment criteria related to the mental health of youths, not necessarily how youths were treated on a daily basis. This included access to counseling, treatment plans, and progress through the program.

We distinguished between privileges, and civil and other rights. Specifically, we determined privileges included items considered earned, such as movies, recreational time, and reading material. We determined civil and other rights included rights as human beings, such as protection from discrimination, racist comments, and the right to file a grievance.

We reviewed and tracked complaints filed by each facility to determine whether each facility submitted complaints monthly pursuant to NRS 218G.580. In addition, we calculated the number of complaints received.

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 States, or in accordance with the S*tatements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

Reviews were conducted pursuant to the provisions of NRS 218G 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, 2012, except the review of Rite of Passage-Red Rock Academy included a review of policies, procedures, processes, and complaints filed since December 2013. In addition, we discussed related issues and observed related processes with management, staff, and youths.

Issues discussed included:

- The facility in general, such as reporting of child abuse and neglect, background checks, identity kits, and contraband prevention;
- Fatalities or near fatalities;
- The complaint and resolution process;
- Health, including the administration of medication, medical emergencies, and medication disposal;
- Safety, such as use of force and de-escalation, fire safety, and transportation of youth;

- Welfare, such as education, visitation, and room confinement; Treatment, such as intake screening, mental health and substance abuse treatment, and suicide and runaway prevention;
- Civil and other rights, such as discrimination and religion; and
- Privileges, such as activities on-campus and off-campus.

Observations included the sufficiency of operating communication equipment, the security of youth records, administration of medication, and staffing.

Reviews also included reviewing management information and a sample of files. Management information included: reports of child abuse and neglect, 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 required training; and youth files for evidence of a youth's acknowledgement of his right to file a complaint, medication administered, treatment plan, and identity kit information. The extent of the review process, such as discussion, observations, and sample sizes, was sometimes adjusted based on the size of the facility.

During one of our reviews, we examined youths' files for compliance with NRS 432B.607 through NRS 432B.6085. The law relates to emotionally disturbed youths ordered by a court to be treated at a mental health treatment facility and applies to youths in the custody of child welfare services placed in a locked facility on an emergency basis. The law establishes timeframes for placement and notification of youths' rights. Our examination included determining if the facility complied with timeline requirements related to: certification of an emergency admission; notification of youths' rights; and a plan of care.

In addition to facility reviews, we performed two unannounced facility visits. Generally, unannounced facility visits included discussions with management and a tour of the facility. Discussions included medication administration, the complaint

process, and background checks. Tours included all areas accessible to youths. A list of unannounced Nevada facility visits is contained in Appendix E, which is on page 58.

Our work was conducted from January 2014 through September 2014 pursuant to the provisions of NRS 218G.570 through 218G.585.

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 7.

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