PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: June 21,2016

Auditor Information			
Auditor name: Maureen G. Raquet			
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Email: mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: Apri18,19,20,2016			
Facility Information			
Facility name: Hall			
Facility physical address: 109 North 2nd Street, Jeanette, Pa. 15644			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 724-523-9449			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Nancy Kukovich			
Number of staff assigned to the facility in the last 12 months: 12			
Designed facility capacity: 15			
Current population of facility: 13			
Facility security levels/inmate custody levels: Secure			
Age range of the population: 12-19			
Name of PREA Compliance Manager: Jackie Kaputa		**Title:** Program Supervisor/PREA Manager	
Email address: jackie.kaputa@adelphoi.org		**Telephone number:** 724-523-9449	
Agency Information			
Name of agency: Adelphoi Village			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1119 Village Way, Latrobe, Pa.15650			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 724-840-7000			
Agency Chief Executive Officer			
Name: Nancy Kukovich		**Title:** CEO	
Email address: nancy.kukovich@adelphoi.org		**Telephone number:** 724-804-7000	
Agency-Wide PREA Coordinator			
Name: Jennifer McClaren		**Title:** Quality Assurance Director/PREA Coordinator	
Email address: Jennifer.mcclaren@adelphoi.org		**Telephone number:** 724-804-7000	

AUDIT FINDINGS

NARRATIVE

Adelphoi Village came into existence in 1971 when Fr. Paschal Morlino, a Benedictine monk, set out with a plan to open a home for boys. This program, which he called Adelphoi, is Greek for "my brothers for whom I am concerned". In 1978, foster care was added, followed by a private academic school in 1981. Today, Adelphoi provides an extensive network of community-based programs and services to over 1,200 youth and families on a daily basis. Group homes, foster/adoptive care, a charter school, in-home services such as multisystemic therapy, education programs, mental health services, secure care and other services overlap to provide a complete continuum of care to children, youth and families. In 2015, Adelphoi served 2,347 youth and families. Anchored by a 20-acre campus in Latrobe that includes a school building, administration building, three secure units, a substance abuse residential facility, two sex offender group homes, and a multipurpose recreational center, Adelphoi has program sites in over 30 counties throughout Pennsylvania. Construction on the main campus is ongoing with the building of a new residential facility and a office building for Mental Health staff. The counselors, teachers, and therapists, along with administrative and supervisory staff, make up a workforce of nearly 650. There are 13 employees assigned exclusively to Hall Home, a sex offender unit, including a Caseworker and the Supervisor/PREA Manager and one dietary staff. Line staff are full and part time and work rotating first and second shifts. Third shift personnel work permanent 3rd, with rotating days off.

Adelphoi Village is a component of Adelphoi U.S.A. The juvenile residential component is comprised of 22 group homes of which 5 are female, and the rest are male. These units are located in Westmoreland, Blair, Fayette, Lycoming, Somerset and Armstrong Counties. A previous Audit of the 6 units on the main campus was conducted in August 2014. A subsequent Audit of four off campus units was conducted in April 2015 and five units in June 2015. This Audit was conducted at Hall Home, 109 North Second Street, Jeannette, Westmoreland County, Pa., about 15 minutes from the main campus in Latrobe. Two other residential units were also audited at this time. Hall is a 15 bed male sex offender treatment program, with ages ranging from 12-19, and licensed under the Pa. Dept. of Human Services 3800 regulations. In 2015, there were 28 admissions and the average length of stay was 3.5 months. On the date of the Audit there were 13 residents in this unit; including boys who have "stepped down" from the Boy's Secure Sex Offender program on the main campus. Residents from Hall are transported to the central Latrobe campus to attend the Robert Ketterer Charter School on the main campus. They are transported there in a van by Adelphoi staff. They eat lunch on the main campus and breakfast, dinner and weekend meals at their group home. These residents can be either dependent or delinquent and are committed by their respective Juvenile Courts. In addition to education, all residents receive both individual and group counseling and family counseling if warranted. All residents participate in ART, an evidence based Anger Management Curriculum. Most also see a psychiatrist for medication evaluations. Adelphoi contracts with 64 of the 67 Counties in Pa. and infrequently has had children committed from Delaware, West Virginia, Maryland, Nebraska, and Ohio. Because Adelphoi Village offers both foster care and adoption services, children from 0-21 are served. Adelphoi is considered a juvenile treatment facility and has a large sex offender population. Adelphoi Village has undergone training in the Sanctuary Model over the past three years and received their certification last year. Sanctuary is the Organizational Culture and Philosophy at Adelphoi.

DESCRIPTION OF FACILITY CHARACTERISTICS

Hall Home is located in a residential neighborhood in the town of Jeannette, Westmoreland County in Western Pa. This is a small town with its own police force north of Pittsburgh. This two story, 8000 square foot former funeral home was purchased by Adelphoi in the nineties and sits on about .4 acres and shares a parking lot with the church next door. It is a brick/siding building with a large front porch with a sidewalk in front. It is located in an older residential neighborhood and the facility was renovated in 2014. At this time a staff office was renovated to become a bedroom, increasing the bed number from 13 to 15. The staff office was moved to a former storage space near the kitchen and a window was added for better supervision. A "Guard Tour System" was added within the past year but there are no cameras. Doors are locked only to limit entry and are alarmed to signal that someone is attempting to leave. As you enter the front door, there is a staircase to access the second floor and to the right a recreation area with a pool table and a bathroom with a toilet and sink. Directly behind it is a wing with outside access to the side parking lot that houses the supervisor and casework offices, storage and the "token room" used to "shop" for behavior level rewards. To the left of the center hall is another living room used for group therapy and a second recreation area behind it. To the rear of this area is the laundry and a bathroom with a tub/shower, toilet and sink. There is a back stairway to the second floor and a stairway to the basement. There is a small patio area in the rear of the building and a very small yard. The second floor can be accessed by both front and back stairways. The front stairs lead directly to the bedrooms. There is a door at the top of the stairs. There are five bedrooms numbered one through five. The five bedrooms: 1 Quad, 3 Triples and 1 double are on either side of a hallway, where there is a desk, so that midnight staff can perform 10 minute "Watch Tour" checks and monitor the motion alarm system used during sleeping hours in the multi resident rooms. Bedroom #4, a Quad, has a bathroom with tub/shower, sink and toilet that is accessed from within the room. This room is used for any "high-risk" students who require special housing, because it is directly across from the "staff station". A second bathroom in the hallway also has a tub/shower, sink and toilet. The bedrooms are sparsely furnished with wooden single and bunk beds. There are wooden bureaus and the closets have all had their doors removed. The bedrooms have windows that can only be partially opened. Next to the bedroom wing is the staff office, a staff bathroom, the kitchen, the dining room and the back stairway. The dining room has three large wooden tables with wooden benches and two smaller tables. One of the smaller tables also acts as a desk, with the phone for resident calls. This phone can be seen from the staff office. This second floor is considered to be the main floor. The attic is not accessible to staff and residents and houses HVAC units. The large basement is also not accessible to the residents and has low ceilings, boilers and large garage doors. It should be noted that this building will be closing and the program will be moving to the main campus, upon completion of the new group home, which will have individual bedrooms for all residents. Ground was broken in April 2016 and completion is expected by the end of the summer. The boys were at school on the main campus during the tour; only the supervisor was present. I toured this school building during a previous audit. On 4-18-16, the residents were observed as a group at the school during lunchtime. Interviews of both staff and children were conducted in the administration building across the parking area from the school.

SUMMARY OF AUDIT FINDINGS

A notice of the onsite Audit was posted in Hall home on March 7, 2016. A picture of the posting in several common areas was emailed to me. The flash drive containing the completed Pre-Audit Questionnaire and required important documentation was received in my PO Box on March 9, 2016. The on-site portion of the audit was conducted on April 18, 19,20,2016, in conjunction with Audits of 2 other Units. An additional staff person, trained and contracted by the Auditor, was used to help conduct interviews of both residents and random staff. The Audit commenced with a brief entrance interview with the Vice President of Residential Services and the PREA Coordinator at the Kral Administration Building in Latrobe. The tour of Hall took place on April 18, 2016. The residents were at school during the tour and all but the Unit supervisor were with the residents at the school. Hall was renovated in 2014 as described above. On April 18 and 20, I returned to the main campus and toured the building that houses both the Medical and Mental Health staff and saw where the Medical files were kept and where residents can privately meet with their therapists or medical staff. Tours of the gym/multipurpose room and the vo-tech were also completed. Interviews of staff and residents took place in the Kral Administrative Building across from the school. The following were interviewed: COO, Vice President of Residential Services, PREA Coordinator, PREA Manager/Supervisor for Hall, the Program Director for this Unit, a Registered Nurse, a part time Master's Level Therapist, a Caseworker, a phone interview with a Volunteer and a Contractor, an Intake staff, an Assistant Principal, Random Staff (10) from all three shifts, (there are 13 total employees at Hall, including the Supervisor, Caseworker and Dietary Staff) and 10 Residents.

Residents have several means to contact independent agencies to report instances of sexual abuse and/or sexual harassment. One is a "Hotline" to the Blackburn Center, a 24 hour hotline for crisis support and a Rape Crisis Center. There is a dedicated button on the phone (A) that goes directly to a crisis counselor at the Blackburn Center. This phone is located in the dining room across from the staff office. There is a procedure to ensure privacy. I used this phone during the tour and was connected immediately to the hotline. There are posters regarding reporting, zero tolerance, and knock and announce throughout the house, that I also saw during the tour. This information is included in the PREA Orientation resident handbooks and is given to the residents during Intake. There is also an age appropriate video watched by the residents during Intake. Also posted are the numbers for Child Line, another 24 hour reporting line run by DPW for any sort of alleged abuse. Additionally, addresses were posted for the Blackburn Center directly above the Phone. I spoke to a staff person at the Blackburn Center prior to the on-site Audit and they confirmed the services offered in the MOU, and stated they were not aware of any allegations of sexual abuse or harassment. Residents also have a grievance process for reporting, as well as journaling with staff. Standard #351, Resident Reporting, has been exceeded, because every possible avenue, including a "hotline", addresses, grievances, phone calls to parents, POs, Caseworkers, Attorneys, visiting, home visits, journaling and verbal reports have been provided. Posters in both Spanish and English detailing how a third party can report sexual abuse are posted in the areas where parents would visit.

Of particular note is the assessment and treatment that is offered to the residents who are victims or perpetrators of sexual abuse. This is a treatment facility and a sex offender unit. All residents at Hall receive specialized and intensive treatment. All residents are assessed by a psychiatrist shortly after Intake and most continue to see the psychiatrist for Medication evaluation. They are sent to Hall by the Courts for this reason and staff there receive specialized training for working with this type of client. Therefore, Adelphoi exceeds the PREA standard #383. Standard #313 is also exceeded. Supervision is well above the mandated ratio of both the standard and by the DPW 3800 regulations. The dynamics of the resident population are evaluated on a regular basis, sometimes daily, to ensure adequate supervision of a child. If a child is placed on a safety plan, for a variety of reasons, supervision of that child is many times "one on one". The bedrooms utilize a 10 minute "Watch Tour System" and also Motion Detectors so that, if a resident gets out of their bed, an alarm immediately goes off. These are used to complement the supervision provided by the staff during sleeping hours. All staff were well versed in their responsibilities and could spontaneously discuss first responder actions.

There have been no allegations of sexual abuse or sexual harassment in the past 12 months. Ten current resident files and three files of discharged residents were reviewed. Ten staff files were reviewed for documentation for various standards. There were no Transgender or Intersex resdients but there was one resident who identified as Gay in the population at Hall during the time of the on-site Audit.

Upon completion of the on-site portion of the Audit, an exit interview was conducted with 11 Administrators and upper level staff. Requested additional documentation for the following standards must be submitted to the Auditor for verification within 30 days of this Interim Report. Standard #333 requires that residents must receive education regarding the Zero Tolerance Policy and Reporting during the Intake process. This Intake process is completed on the Main Campus, but when a resident is admitted after business hours or on a long holiday weekend, although being done during the Intake at Hall home, it is not being documented. Documentation of the timely education of admissions needs to be submitted. Two months of Admissions will provide enough documentation that this standard has been met. The Agency policy and procedure requires that a resident be asked whether they identify as LGBTI, and this was included on the Vulnerability Assessment and verified during previous Audits of other facilities at this agency. However, the question was omitted on the new copy of the Assessment. The Assessment will be re-formatted to include this information and 60 days of documentation of its use will be necessary to comply with Standard #341. Standard #381 requires a 14 day Medical assessment for those who have disclosed a prior sexual abuse and and a 14 day Medical or Mental Health follow up for those who have perpetrated a sexual abuse. The review of resident files showed that several students had not received these assessments in a timely fashion. Documentation of Admissions for 60 days is required to meet this standard. All other Agency Policy and Procedure comply with standards. On 6-20-16, 60 days worth of documentation was received for Hall. A spread sheet with dates of admission, date of education and and identification of vulnerable and aggressive residents was submitted. Timely follow up for both medical and for mental health assessments were listed and a refusal for services was also submitted. The documentation was reviewed and it meets the standards listed above. Therrefore this facility is in compliance with all Standards.

Number of standards exceeded: 3

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has a PREA Coordinator and the facility has a PREA Manager. I interviewed both during the on site portion of the audit. They both state that they have the time and resources to fulfill their PREA responsibilities. There is a PREA policy that has been submitted and reviewed and meets the standard.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Adelphoi Village does not contract with any other agencies to care for their residents. This standard does not apply.

Standard 115.313 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed the President and Vice President of Residential Services, the PREA Coordinator and PREA Manager/Supervisor of Hall. All interviewed state that both the PREA Requriement and the Pa. Dept of Human Services Ratio of 1:8 and 1:16 are always exceeded. There are always two staff on midnight shift and three staff, not including the supervisor and caseworker, on the awake shifts. The "Guard Tour" system records 10 minute checks of the residents while they are sleeping.There are motion detectors in the bedrooms during sleeping hours that allow staff to monitor any child getting out of their bed. A schedule is prepared and posted for a two week period, but is reviewed daily

to meet "one on one" supervision of residents, if needed, and other needs of the population. A Facility Vulnerability Assessment is conducted yearly and this includes the physical plant as well as staffing needs. There have been no instances of not meeting ratio. Mandatory overtime is used if necessary. I reviewed the most recent Licensing and Inspection Summary from the Pa. Dept. of Human Services and there were no citations for not meeting ratio. Unannounced rounds are random and are conducted on all three shifts by the program director and the facility supervisor. The logs of these rounds were provided to me. The policy meets the standard

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Search Policy prohibits any strip or body cavity searches. Cross gender pat down searches are also prohibited. I interviewed 10 random staff and they all stated that cross gender pat down searches are prohibited. They also stated they had been trained in the Transgender and Intersex Search policy, but had not yet had to utilize it. There were no Transgender or Intersex residents in the population. All 10 residents interviewed stated that they had never been subject to a cross gender pat down search. They also stated that female staff knock and announce their presence when coming into the bedroom/bathroom area on the second floor. One resident demonstrated how the female staff announced themselves yelling "female on the floor" . He stated, "we always know they are there". While on the tour, I saw knock and announce posters on the doors leading into the bedroom area. There is one toilet, sink and shower in each bathroom. The shower policy requires all residents to shower alone. The PREA Policy contains all necessary information and the random staff were able to answer questions about it during their interview.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There were no residents with disabilities, nor any residents who do not speak English. A non-English speaking child would not be admitted because the child would be unable to participate in the program. It is more likely that parents may not speak English, and a contracted translator would be used to communicate with those parents. A copy of the contract was provided. Spanish and English PREA posters were throughout the house. The Adelphoi Policy does make accomodations for residents with both physical and intellectual disabilities on a case by case basis. I confirmed this when I interviewed the President of Residential Services. Policy meets standard.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed the Director of Human Resources and she confirmed the Hiring and Promotion Policy that was provided to me. Both Adelphoi Policy and the Pa. Child Protective Services Law require a Child Abuse Clearance, a Criminal History Check, and a FBI clearance prior to employment. Adelphoi Policy requires that these be conducted every two years. Both the employment application and the personal interview ask whether the person applying has ever been arrested for any of the enumerated offenses listed in PREA Policy. The employee has an ongoing duty to report any such arrest after employment. I reviewed the files of 10 employees at Hall, including two recent promotions and two recent hires. All files had the necessary clearances and also clearances conducted every two years if they had been employed that long. A review of the most recent Pa. Bureau of Human Services Licensing Summary showed no citations for failure to have proper clearances.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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In 2014, the staff office was moved to a location beside the kitchen and the space that had been the staff office became a bedroom. This increased the number of clients from 13 to 15. The area that was renovated for the staff office was an existing space that was used for storage. A large window was added to the wall for supervision. A Guard Tour system was added in the bedroom area. This allows for 10 minute checks of each of the rooms. These checks are downloaded onto a computer and randomly checked by supervisors. A new facility is in the process of being built on the main campus. Each resident will have their own bedroom. This is scheduled to be completed in August 2016. I also interviewed both the President and Vice-president of residential services who discuseed the added security and safety that these changes made for both staff and residents.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Adelphoi has an MOU with Excela Health to perform forensic exams. SAFE/SANES are available at this ER and are also on call. I interviewed the Director of Nursing who confirms that the MOU is in effect and that forensic exams are provided at Excela Health free of charge for the residents. There is an MOU with the Pa. State Police to conduct Sexual Abuse Investigations. There is also an MOU with the Blackburn Center, a PICAR, to provide victim support services. I spoke to an Administrator at the Blackburn Center prior to conducting the Audit and she confirmed the services in the Audit and also stated that she was unaware of any problems at Adelphoi Village. While at Hall, I saw the reporting posters for Blackburn Center and used the designated phone across from the staff office to contact the Blackburn Center. One resident, when interviewed, stated that there are posters up all over with 800 numbers. Although several upper level staff have received investigator training, they do not conduct investigations. They gather enough information to contact PSP and Child Line, and to keep the resident safe. They conduct an administrative incident review after the fact. I also interviewed the PREA Manager/Supervisor of Hall, who confirmed her knowledge of the MOUs and necessary procedure. Policy meets standard.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA Policy and the Pa. CPSL require all staff with any knowledge or suspicion of Sexual Abuse or Sexual Harrassment to report to Child Line, under penalty of law, and the Adelphoi Policy requires also reporting to a supervisor and documenting the incident. All staff receive Mandated Reporter Training as part of their orientation. Interviews with 10 random staff, confirm that they know both the policy and the law. One staff stated, "I am a mandated reporter, and I would call Child Line". Posted on the Adelphoi website is the Policy that all incidents will be referred to the State Police for investigation. I interviewed the President of Residential Services and he confirms that the policy and procedure are followed.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The employees have all received the training required by the standard at orientation and then every year as a refresher. The refresher had just occurred in March 2016, a month prior to the Audit. One staff person stated he had just received training on cross gender pat down searches. The curriculum is a video and a power point that was provided to me. The employees test out, demonstrating their understanding of the material. A log of the most recent refresher was provided to me during the onsite. Ten random staff were interviewed and they could all discuss their first responder responsibilities, mandated reporting, and the agency's policy and procedure on preventing, detecting, reporting, and responding to incidents of sexual abuse and harassment. All staff at Hall receive additional specialized training because it is a sex offender unit. The policy indicates who must receive training, what the training will entail and when training will be received, both at orientation and refresher training.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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There were no contractors or volunteers specific to Hall. However, during the Audit, I interviewed by phone a plumber who was a contractor and a volunteer who runs girls' groups at the Main Campus. When I interviewed them, they both stated they had received a pamphlet with information regarding the zero tolerance policy and mandated reporting. The brochure was provided to me. The amount of education is commensurate with the amount of time they spend with the residents. I saw sign offs in both a contractor and a volunteer file that they received and understood the training. When I interviewed them, they told me what information was in the training and how and who they could report to. The policy meets the standard.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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I interviewed the Intake/Admissions Staff and the Hall Caseworke. Both are responsible for conducting the Intake and providing information to the resident during the Intake. This information was in reference to the agency's zero tolerance policy on sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. They are also responsible for conducting the education that must occur within 10 days of Intake. They detailed to me when and how they do this. They showed me the information that is given to the resident at Intake, along with a Child's Rights and information on the grievance procedure. When an admission comes in after business hours or is transferred on a holiday weekend, sometimes the Intake education is not being docuemtned. Ten residents were interviewed and all stated they received the appropriate information at Intake and then more comprehensive education within 10 days. Of the thirteen files I reviewed, the files of three current residents and 2 out of the three discharged residents did not have documentation of timely Intake education. At the Exit interview, we discussed changing the acknowledgement form at Intake, so that a resident could sign off and therefore document that they received the required education at Intake. Sixty days of admissions will be provided showing documentation of timely Intake education. Ongoing education was available through posters and pamphlets throughout the Hall house.
On June 20,2016, I received documentation of 60 days of admissions:4 residents. The date of admission and the date of education was listed and documentation that it was done at Intake. This standard has been met.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Adelphoi Staff do not conduct investigations. This is done by the Pa. State Police and Child Line. The law prohibits a facility to conduct an investigation prior to Child Line conducting one. Staff gather enough information to establish that a report is necessary and to provide a protective action plan for the resident. An Administrative investigation will be conducted after the PSP and Child Line conduct their investigation as part of a sexual incident review. Several administrators received investigator training as part of a "best practice" but do not conduct investigations. Policy confirms the staff role as described above. This standard does not apply.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed both the Director of Nursing and a part time Master's Level Mental Health Therapist. Both stated they received the PREA training that all employees receive, but also receive additional training through Adelphoi and through outside resources. Because there are several sex offender programs at Adelphoi and Hall is one, all MH staff have a caseload that include both victims and perpetrators and are specially trained to deal with these issues. All residents sign a consent form at Intake regarding mandated reporting, but both the nurse and therapist always advise a child of their roles prior to the initiation of services and then again if they have to report. Both state that they have reported incidents that have been disclosed to them, but have occurred either in the community or another institution. I saw training logs for all Medical and Mental Health staff.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed the Caseworker for Hall who administers the Vulnerability Assessment during the Intake process. She states that she uses the questions on the instrument as well as information provided by the Probation Officer or Caseworker, information from previous placements, transfer information, a child's charges and a phone interview with the parents to complete the Vulnerability Assessment. She states that this

is completed within 72 hours of Admission and most times is conducted right at Intake. Review of 10 current resident files and 3 discharged files show that this was done in a timely fashion in all cases. The file review showed that residents who are transferring to Hall from the Secure Units are having this done upon transfer and it is also being done at six month intervals. Every resident who had been at Hall for more than six months had multiple assessments. The Vulnerability instrument itself is a commonly used one that takes into account prior victimization, prior aggressive sexual acts, physical factors, such as small stature, any disabilities, a problem with bullying in the past, prior institutionalizations and other important variables. The answers are scored to see if any or all of these factors identify a child as vulnerable or aggressive. I have audited this agency several times, and the instrument has always included all variables, however, when recently reformatted, the question regarding sexual identity and orientation was omitted. Although this is not used exclusively to determine if a child is vulnerable, it is a very important variable. A revision was made to include this information again. The new form was provided to and approved by me subsequent to the on site Audit. In order to meet this standard, 60 days of admissions and timely administration of this instrument will be provided to me. The Policy states that this assessment must be conducted within 72 hours of intake and that the information is confidential. I saw where the resident files are kept. Only staff who supervise the residents have access to this information. On 6-20-16, I received documentation that the revised Vulnerability Assessment was being administered on the 4 admissions that occurred during the 60 days after the on-site. This standard has been met.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Use of isolation is prohibited by Adelphoi Policy and by the Pa. Department of Human Services 3800 Regulations. I observed no area during the tour where a child could be isolated. Interviews with both Medical and Mental Health staff, the PREA Coordinator, and PREA manager confirm that isolation is never used. I interviewed the Caseworker who administers the Vulnerability Assessment. She does this within 72 hours of Intake .She states that the information is used to determine housing assignments and also seating assignments in the dining room, in school and in the school van. I saw "case notes" which document that a child was placed in a room closest to the midnight staff post. I saw this room when I toured the facility. Because this is a sex offender program, all residents are identified as aggressive because of their charges. It is noted if a resident would be identified as aggressive in this setting. Special consideration is given to those identified as vulnerable. There was one resident who identified as gay during the interviews and he stated he was not discriminated against because of this. There were no transgender or intersex residents in the population during the Audit. However both the PREA Manager and PREA Coordinator state that there is no pre-determined housing for an LGBTI resident and that they would take into account that resident's concerns regarding their health and safety before assigning a room. All residents shower separately. The PREA Policy outlines the procedure for use of this information and who can have access to it. I saw where the resident files are kept during the tour and only those working with the resident have access to them.

Standard 115.351 Resident reporting

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

The PREA Policy dictates that a resident can report verbally, in writing, anonymously, and through third parties. The 10 residents that were interviewed were able to communicate that they understood this. They stated there was a phone in the staff office with a dedicated button that went directly to the Blackburn Center. There were also posters with addresses for the Blackurn Center and phone numbers for Child Line posted throughout the facility. Residents can use a grievance form to report and they receive and sign off on grievance information at Intake. This grievance sign off was in the 10 current resident files and the three discharged resident files that I reviewed. Residents also stated that they felt comfortable reporting to a staff person or could go to the caseworker or supervisor. This program requires journaling as part of the treatment modality and residents could report in this way as well. They also have access to both parents by visiting once a week, phone calls from parents or grandparents twice a week and confidential communication with their attorneys. One resident stated during the interview that he wanted to contact his attorney and the program supervisor was notified. All possible avenues for reporting have been made available to the residents and they know of them. Ten random staff were also interviewed as well as the PREA Manager. All had been trained on how to accept and document reports and how the residents could report. During the tour, I saw and used the Blackburn phone and also saw pencils available for written reports. A phone call to the Blackburn Center prior to the onsite confirms that they will accept these reports as an outside agency. They will in turn call Child Line, who will notify the facility. This standard has been exceeded.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA policy provides for a grievance process to be used if desired to report Sexual Abuse and Sexual harassment. The Pa. Department of Human Services 3800 regulations requires a grievance process and notification to both the resident and their parents at Intake of this. There were sign offs in the 13 resident files reviewed and no citations on the most recent BHSL Licensing and Inspection Summary for not providing this information. There is no requirement for a child to use this process to report. Reporting is more likely to utilize the many other means. The necessary timeline as well as the provision for an emergency grievance process is in policy. There have been no grievances reporting sexual abuse or sexual harassment in the past 12 months.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed the Vice President for Residential Services and the PREA Manager/Supervisor for Hall. They both could tell me that the policy allowing parental visiting once a week, incoming parental phone calls twice a week and confidential calls or visits from attorneys was also practice. The 10 residents that were interviewed also stated they could and did receive visits and phone calls. They also stated they could contact their attorneys but most had not. The residents could talk about the posters with phone numbers and addresses for Victim Support

throughout the Blackburn Center and where the phone was located across from the staff office and about the designated button to access the Support. Most were not clear about what kind of services these were, unless cued during the interview. One resident stated there were posters with 800 numbers throughout the house, but he didn't pay attention to the services offered. While on the tour of the facility, I saw the posters with the information throughout the house, saw and used the phone. Prior to the on-site portion of the Audit, I received a copy of the MOU with the Blackburn Center outlining its services and I called and spoke to the Director, who verified that the services in the MOU were in effect. Residents are aware that these services are confidential, but there is a mandated reporter exception. There were no residents in the current population who had reported a sexual abuse.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The policy states that the facility will provide a means to publicly disseminate information for third party reporting. The website, www.adelphoi.org contains the appropriate information, describing the Pa. State Police as the investigative agency and the appropriate contact person at Adelphoi to report to either by email or by phone. The website also lists the Blackburn Center with a phone number and address as a reporting resource. This website was verified by the Auditor.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Both the PREA Policy and the Pa. Child Protective Services Law require mandatory reporting. All staff receive Mandatory Reporting training as part of their orientation. All ten random staff interviewed were able to describe their responsibility, as were the Medical and Mental Health Staff that I spoke to. I interviewed the Vice President of Residential Services and the PREA Manager. They both could state that, in addition to Child Line, the facility would also notify the parents, legal guardians, Probation Officer, Caseworker, and the attorney of record, if there was one. This is a Pa. BHSL requirement that requires notification via a HCSIS report. The agency only performs administrative investigations. However, a supervisor is always notified immediately as per policy.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed the President and Vice President of Residential Services and ten random staff. The Administrators state that the policy requires the immediate action by staff to protect a resident from imminent sexual abuse. This can be accomplished by moving the resident to another facility, placing the child in a different bedroom, always putting a safety plan into effect or suspending or transferring a staff person. The PREA policy requires immediate action. All staff interviewed could describe appropriate actions that they would take immediately. There have been no reports of immenent sexual abuse in the past 12 months.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

PREA Policy requires that if Hall receives a report from a resident that he was sexually abused at another facility, Adelphoi will contact the head of that facility within 72 hours and will notify Child Line. If Hall receives a report from another facility that a child alleged sexual abuse while at Hall, a Child Line report will be made immediately and an investigation will commence. Both instances are reported to Child Line and documented. I interviewed both the President and Vice President of residential services who confirm that they would be the designated point of contact for a report from another agency. There have been no incidents of this in the past 12 months.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA Policy and the Staff Training specifically delineate the staff first responder duties. Most of the 10 random staff could cite all responsibilities without being prompted. One staff person when interviewed stated, "first and foremost, I would ensure the safety of the victim." All staff could agreed that they knew and understood the agency's protocol for collecting usable physical evidence, which is to secure the scene and to let PSP gather that evidence and to provide medical services to the resident and not to let them shower or change clothes. The separation of the victim and his well being was cited as being of the utmost importance. The first responder duties are posted in

the staff office.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA Policy and the Adelphoi Policy and Procedure manual describe a coordinated response for incidents of sexual abuse as well as other incidents. Nurses, line staff and administrators all play a role in this response

Standard 115.366 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There is no union representation or collective bargaining agreement. I interviewed both the Human Resoureces Director and the President of Residential Services, who stated that the Adelphoi Policy and the PREA Zero Tolerance Policy preserves the ability for the Agency to protect residents by being able to transfer or suspend abusers pending the outcome of the investigation.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed the PREA Coordinator and the PREA Manager. The PREA Manager is the Hall Supervisor and she is present in the facility

full time. She is responsible for protecting residents from retaliation and when interviewed she was able to tell me what signs she would look for and what actions she could take, including moving, transferring both staff and/or residents if need be. If a staff was involved she would include Human Reources and if a resident was involved, she would initiate contact and monitor for length of stay if need be. The policy states monitoring can continue for up to 90 days. I also interviewed both the President and Vice President of Residential Services and they also described actions that could be taken, including disciplinary acitons against staff up to and including termination.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Adelphoi Policy and the Pa. Department of Human Service 3800 regulations prohibits use of isolation. All administrators and Medical staff interviewed state that there is no use of isolation. A tour of the facility confirmed that there is no area where a child can be isolated. This standard does not apply.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There is an MOU with the Pa. State Police and mandatory reporting to Child Line. Both of these agencies conduct an investigation of any allegation of sexual abuse. It is outlined in both PREA Policy and Adelphoi Polcy as to what the responsibilities are for agency staff in conjunction with an allegation of abuse or harassment. Although several staff have received investigator training, their role is limited to gathering enough information to report to Child Line and the PSP as well as ensuring the child's safety by implementing a protective action plan. Policy requires that they cannot interfere with a Child Line investigation. Interviews with the PREA Coordinator, the PREA Manager and the COO indicated that they would and do cooperate with the PSP and Child Line for all investigations and perform administrative investigations after the fact that look at factors such as the physical plant, policy, etc, as a form of incident review. Most of the provisions of this standard are the jurisdiction of the Pa. State Police.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The evidentiary standard of preponderance of the evidence is in the PREA Policy and meets the standard .

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

PREA Policy contains all necessary procedures to meet this standard. I interviewed the President of Residential Services and he states the procedure is followed. In the event that Child Line completes an investigation, a letter to both the resident and the facility is sent advising them of the outcome of the investigation.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There have been no incidents in the past 12 months that have required any staff discipline. I interviewed both the President of Residential Services and the Director of Human Resources. Termination is the presumptive disciplinary sanction for a staff person who engages in sexual abuse. The Pa. CPSL prohibits a staff person to have contact with children if they are found to have engaged in sexual abuse. Other sanctions for lesser violations are commensurate with the action and are on a case by case basis taking into account an employee's disciplinary history. The Adelphoi Policy contains all verbiage required by the Standard and by Pa. CPSL.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There have been no incidents in the past 12 months involving contractors or volunteers. The Policy requires immediate removal of a contractor or volunteer from contact with children in the case of an allegation of sexual abuse or sexual harassment. The President of Residential Services states that they would not be permitted at any facility and that their parent agency would be immediately notified. This would not be treated any differently than if it were a staff person. Pa. CPSL requires the same action. PREA Policy meets the standard.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There have been no incidents of disciplinary sanctions against residents who have falsely reported in the past 12 months. Both PREA Policy and the Pa. Child Protective Services Law does not allow for any disciplinary sanctions for a report made in good faith. In the event that there was such an incident, the child's mental health, intellectual level, and age would be taken into account, when determining what sanction would be appropriate. Previous sanctions for similar incidents by other residents are considered, so that discipline would be consistent. Most times the Court and Probation Department would determine whether a resident would be permitted to stay in the facility according to an interview with the President of Residential Services.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

All residents that have reported a previous sexual abuse or who have perpetrated a sexual abuse are offered medical and mental health assessments within 14 days of being identified. This in the PREA Policy. I interviewed the caseworker who completed the Vulnerability Assessment and she states that she ensures that follow- up is offered. I interviewed both the Director of Nursing and a Mental Health Therapist who stated that an assessment/physical is done on every child within 14 days and that a MH assessment can be completed by a therapist or a psychiatrist during that time frame. A signed consent is obtained from the resident at Intake and both the Medical and Mental

Health care staff state that they advise the resident prior to the initiation of services and again if they have to report. When I toured the main campus, I saw in the Medical/Mental Health wing, where resident files are privately kept with access only to the Health professionals. I reviewed the files of 10 current residents and 3 discharged residents. Of those, three residents reported a previous sexual abuse. Although during the interviews they stated they had not received follow up, their files showed that they had received a physical well within 14 days of identification. However, three of the files I reviewed did not show timely follow-up by a Mental Health Care provider for those that had previously perpetrated a sexual offense. Corrective action is required to ensure that all residents receive follow up within 14 days of the administration of the Vulnerablity Assessment. Sixty days of admissions with documentation of timely follow up will be provided to come into compliance with this standard
On 6-20-16, I received documentation that all admissions (4) within the past 60 days had been offered and either received or refused Medical and/or Mental Health Assessments. A signed refusal of services was also submitted. This meets the standard.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There have been no incidents that required emergency medical or mental health services. There were no residents to interview who reported a sexual assault. However, there is an MOU with Excela Health that provides emergency treatment and has SAFE/SANES in the ER and on call. The Director of Nursing and the Mental Health Therapist both stated that they believe the level of care that the residents get is better than if they were home, because of consistency and follow up and is free of charge for the residents. The ten random staff that were interviewed were able to discuss their first responder responsibilities regarding Medical and Mental Health emergency care. The Director of Nursing states that there is always a nurse on call. Any medical follow up regarding STDs is also provided. The PREA Policy meets the standard. Policy meets standard

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA Policy contains the necessary proedure for this standard. Hall is a specialized treatment facility for sex offenders. Residents are either transferred from a secure facility at Adelphoi or committed directly to Hall by their respective juvenile courts to receive treatment as sex offenders. All have been adjudicated delinquent on a sexual offense. All staff at Hall receive specialized sex offender training to help them supervise these residents. All residents receive both individual and group counseling, as well as individual therapy. Many also regularly see a psychiatrist for medication evaluations. They must also participate in journaling. There were no residents in the facility who had reported a sexual abuse. Hall has exceeded this standard.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There have been no sexual abuse incident reviews at Hall because there have been no incidents in the past 12 months to review. However, an interview with the Program Director and a review of the policy show that there is a form that is used agency wide to formally document this review. All variables, including staffing, the physical plant, and whether the incident occurred due to gang or sexual status is considered. Appropriate action in the way of training, policy change or physical plant modification could be recommended and would be followed. This review would take place within 30 days of the completion of the investigation.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA Policy outlines the Data Collection for this Standard. This Data is collected by the PREA Coordinator from the 22 facilities at Adelphoi. She aggregates this data for the agency rather than the individual facilities. This annual report was first published in November of 2015 and is posted on the website. It includes definitions, general information regarding the number of admissions, graphs and ongoing trainings and policies in response to any reports. The report has been viewed and verified by the Auditor.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The PREA Policy requires that data be reviewed in an ongoing manner and in an aggregated fashion as well. The ongoing review provides

for immediate changes to be made if necessary, whereas the annual review shows the bigger picture comparing from year to year. I interviewed the COO and the PREA Coordinator. The PREA Coordinator prepares the report and presents it to the leadership team. It is approved by the COO before being publicly disseminated to the Board and on the website.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed the COO, PREA Coordinator and PREA Manager and reviewed the PREA Policy which meets this standard. All personal identifiers for staff and residents are removed from any reports that are made public. All reports are kept for a minimum of 10 years or for whatever length of time required by law, whichever is longer. These reports are securely kept.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Maureen G. Raquet June 21, 2016

Auditor Signature Date