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: April18,19,20,2016			
Facility Information			
Facility name: Miller			
Facility physical address: 809 Warren Ave. Apollo, Pa. 15613			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 724-478-3636			
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: 14			
Current population of facility: 8			
Facility security levels/inmate custody levels: Secure			
Age range of the population: 12-19			
Name of PREA Compliance Manager: Maria Carpenzano		**Title:** Program Supervisor/PREA Manager	
Email address: maria.carpenzano@adelphoi.org		**Telephone number:** 724-478-3636	
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. 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 Miller Home, a short term Shelter and Diagnostic unit, including a Caseworker and the Supervisor/PREA Manager. 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 the Leonard Miller Home, 809 North Warren Avenue, Apollo Borough, Armstrong County, Pa. about 50 minutes from the main campus in Latrobe. Two other residential units were also audited at this time. Leonard Miller Home is a 14 bed male short term Shelter and Diagnostic Unit with ages ranging from 12-19, and licensed under the Pa. Dept. of Human Services 3800 regulations. In 2015, there were 63 admissions and the average length of stay was 4.5 months. However on April 15, 2016, one of the programs at Miller closed, leaving only Shelter and Diagnostic, so the average length of stay is only 20 days for these residents. On the date of the Audit there were 12 residents in this facility, however 4 residents absconded on 4-18-16, leaving 8 residents. It should be noted that they were apprehended by the State Police the next day, but only two residents were returned to the Shelter. Residents from Miller are transported to the Kittanning School, a branch of the Robert Ketterer Charter School. This school is about 30 minutes away and is located in a former Catholic School in Kittanning, Pa, the County Seat for Armstrong County. They are transported there in a van by Adelphoi staff. They eat lunch at the school 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, the residents participate in Sanctuary groups and also receive Psychiatric and Psychological as well as Drug and Alcohol assessments if ordered by the Courts. 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

Leonard Miller Home is located in a residential neighborhood in the town of Apollo, Armstrong County in Western Pa. This is a small town with its own one man police force north of Pittsburgh. The house sits on the Main Street across from the Kiskiminetas River. It is in a very rural area surrounded by hills and small steel towns. This three story 5,694 square foot former apartment building was purchased by Adelphoi in the 1980s and sits on about .75 acres. Miller was renovated in 2012 to add a bedroom and increase capacity. It has a side parking lot with a basketball hoop and a side yard with grass that had recently been mowed. Behind the house is another small parking area and an alleyway. It is a brick building with a large front porch with a sidewalk in front. It is an older, mixed use neighborhood with an auto service center across the street and neighbors on either side. As you enter the front door there is a staircase to access the second floor and a living room with a bricked up fireplace and the director's office to the side. Surrounding the front door and in the office are beautiful stained glass windows, original to the building. On the wall next to the fireplace is a picture of Leonard Miller, an Apollo Police Officer, who was killed in the line of duty in 1980. There are posters and a built-in bookshelf. The furnishings are wooden and there is a television in the room. Through the living room is the dining room with 4 round tables and individual wooden stools. To the left of the dining room is a staff office, which houses the telephone for the Blackburn Center, with a dedicated button. This office is also used for storage. To the left of the staff office is a bathroom with a toilet, sink and shower and reporting posters. It is used by both residents and staff. Behind the dining room is the kitchen with a sink, refrigerator, stove, counters and cabinet. One wall had the cabinets removed and was in the middle of having new cabinets installed. There is a back door that leads to the alleyway. It is alarmed and locked to prevent entry from the outside. You are able to open the door from the inside, without unlocking it. There is also a side door which leads to the basement stairs, the upstairs, and out to the side parking lot/basketball court, that is fenced in. The basement contains food storage, a laundry room, weight machines, video games, furnishings and a staff bathroom. The second floor houses the sleeping area. There are doors at the top of both stairs that have Knock and Announce posters on them. There are five bedrooms: two doubles, two triples and one Quad. The rooms are furnished with wooden bunk beds and wooden bureaus. The doors have been removed from all closets. Four of the bedrooms have concave mirrors so that staff in the hall can see all beds and areas of the room. The bedrooms also have a "Watch Guard" System for 10 minute checks during the night, however there are no cameras at Miller. There are windows in all rooms that are restricted from opening all the way. The room next to the night shift post is used for any at risk resident. There is a full bathroom with a shower, toilet and sink. The third floor is a large office used by the caseworker. The boys were at the Kittanning School during the tour, but returned at the end of the school day. The school is in a residential area of Kittanning, about 30 minutes from the group home. It is a former Catholic Elementary School that is next to the Church and is still utilized by the Church on weekends for religious instruction. It houses an Alternative School Program and a Day Treatment Program run by Adelphoi. When you enter the building, there is one long hallway with classrooms on either side. Immediately upon entering the building is the principal's office. There is also a boy's bathroom, a girl's bathroom and a gym/multipurpose room. The Miller residents attend school and eat their lunch in a designated classroom.

SUMMARY OF AUDIT FINDINGS

A notice of the onsite Audit was posted in Miller home on March 7, 2016. A picture of the posting in several common areas was emailed to me. I saw this posting in these areas when I toured the facility. I did not receive communication from anyone at this facility. The flash drive containing the completed Pre-Audit Questionnaire and required important documentation was received in my PO Box on March 9, 2016. Throughout the six weeks period prior to the on-site portion of the Audit, both emails and phone calls were utilized for communication and clarification of the submitted documentation. 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 Administration Building in Latrobe. The tour of Miller Home and the Kittanning School took place on April 19, 2016. The residents were at school during the tour and all but the Unit supervisor were with the residents at the school. The residents and some staff were interviewed at the School. The Educational Supervisor was interviewed at the School and lunch was supervised to ensure proper ratio. Interviews of some speciality personnel and other staff, as well as review of the files, took place at Miller Home. The residents returned to Miller Home at the end of the day and were involved in a Sanctuary group in the dining room while interviews of staff continued. The following were interviewed as part of this Audit: 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, the Educational Supervisor, Random Staff (9) from all three shifts, (there are 13 total employees at Miller, including the Supervisor and Caseworker. One staff was on Vacation and one staff was on Maternity leave) and 8 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 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 observed 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 that is 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 and throughout the house. 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 reporting to staff. One reporting poster was in the basement, but because it is used for visiting, I requested both a Spanish and English poster. This was done before I left Miller home at the end of the day. 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.

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 have concave mirrors to ensure lines of sight. 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 has been one allegation of sexual abuse in the past 12 months. A resident alleged that another resident sexually assaulted him. He reported to staff after the fact and staff immediately reported, calling Child Line. The allegation was not substantiated. Although all reporting procedures were followed by Miller staff, a formal incident review was not conducted and recorded. Therefore, Standard #386, Sexual Incident Review, was not met in this instance. Corrective action in the form of re-education of PREA Managers and supervisors was conducted and submitted to the Auditor in the form of an agenda and the information presented as well as a sign in log. This staff meeting was conducted on May 12, 2016 and the documentation was submitted to and verified by the Auditor on May 16, 2016 Also, a sexual incident review at another Agency facility was conducted and submitted as documentation. This was done on may 16, 2016, prior to the 30 day Interim Report. Therefore this standard has now been met.

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 residents who identified as LGBTI in the population at Miller 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 by the Caseworker, but when a resident is admitted after business hours, in the middle of the night or on a long holiday weekend, although being done as part of the orientation process, 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 this use will be necessary to comply with Standard #341. All other Agency Policies and Procedures comply with standards. On June 20,2016, I received and reviewed documentation of timely education for all Intakes that have occurred during the past 60 days. There were nine admissions. The revised Vulnerability Assessment with the sexual identity question was also administered and documentation was provided. Therefore, all standards have been met.

Number of standards exceeded: 2

Number of standards met: 36

Number of standards not met: Click here to enter text.

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 ia 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 Miller. All interviewed state that both the PREA Requirement 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 concave mirrors in the bedrooms to improve line of sight from the hallways. 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. Policy meets 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 9 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 8 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. They demonstrated how the female staff announced themselves. While on the tour, I saw knock and announce posters on both 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 Enlish. 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 present throughout the house, and a Spanish one was added to the basement area. This basement area is utilized frequently for visiting and the Spanish poster was added to this location at my request prior to my departure from the Miller home. 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.

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 Miller home, including one recent promotion 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 did not indicate 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)

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.

Miller home underwent a renovation in 2012 to add one more bedroom with two additional beds to increase occupancy. In 2015, cosmetic renovations were made to the main floor, supervisor's office and flooring was added throughout the unit. Concave mirrors were added in the four main bedrooms to impove supervision and a "Guard One" system was installed to increase bed check accountability. These checks are conducted every 10 minutes and the "wand" is downloaded by the supervisor to monitor frequency of checks. I saw all of the above during the tour of the facility. There was one room that had a deep closet that even with the door removed, was not in a clear line of sight. After bringing this to the supervisor's attention, she put in a maintenance request to alleviate this. Although this was a best practice suggestion, a picture of the modification was provided to me subsequent to the onsite portion of the Audit and prior to the 30 day report. I also interviewed both the President and Vice-president of residential services who discussed the added security and safety that these changes provide 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 contract and also stated that she was unaware of any problems at Adelphoi Village. While at Miller House, I saw the reporting posters for Blackburn Center and used the designated phone in the staff office to contact Blackburn Center. Although several upper level staff have received investigator training, they do not conduct investigations. They gather enough information to contact and report to PSP and Child Line, and to keep the resident safe. They conduct an administrative incident review after the fact. I also interviewed the PREA Mananger/Supervisor of Miller House, who confirmed her knowledge of the MOUs and necessary procedure. The Policy meets the 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 9 random staff, confirm that they know both the policy and the law. 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. There was one unsubstantiated incident of resident on resident sexual abuse reported to a direct care staff. That staff person was interviewed by me. He reported to Child Line immediately and documented all his actions. I reviewed all staff and police reports. The policy and procedure were 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. 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. I interviewed 9 random staff 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. The Policy meets the standard.

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 Miller House. 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 files indicating that they received and understood the training. When I interviewed them, they told me what information was presented in the training and how and to whom they would report. 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 Caseworker who is responsible for conducting the Intake and providing information to the resident during the Intake. The information was regarding the agency's zero tolerance policy on sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. He is also responsible for conducting the education that must occur within 10 days of Intake. He detailed to me when and how he does this. He showed me the information that is given to the resident at Intake, along with a Child's Rights and information on the grievance procedure. Because this is a Shelter and receives admissions on nights and weekends, the Adelphoi procedure of providing all education at Intake was being done the next business day and not always at Intake. This is the only facility that receives admissions during off hours and although the Intake information is being given, it is not being documented. Eight residents were interviewed and all stated they received the appropriate information at Intake and then more comprehensive education within 10 days. I reviewed the files of 10 current residents and the files of three discharged residents and although both interviews of residents and the Caseworker confirm that the education is occurring, the only documentation in five of the files was for the 10 day education, which includes an age appropriate video. 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 present throughout the house. On 6-20-16, I received documentation that all nine residents that had been admitted during the past 60 days received timely education. Therefore, 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 from conducting 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 avove. 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, all MH staff have a caseload that includes 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 that have occurred either in the community or another institution. I saw training logs for all Medical and Mental Health staff. Policy requiring this training meets the standard.

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 Miller House who administers the Vulnerability Assessment during the Intake process. He states that he uses the questions on the instrument as well as information provided by the Probation Officer or Caseworker, information from previous

placements, a child's charges and a phone interview with the parents to complete the Vulnerability Assessment. He 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 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. Whereas this is not used exclusively to determine if a child is vulnerable or aggressive, 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. Policy meets standard. On 6-20-16, I received documentation of the nine admissions that were received during the past 60 days. All were assessed using the revised Vulnerability Assessment that includes the sexual identification question. This standard has now 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 saw 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. He does this within 72 hours of Intake and the policy states that it will be conducted again in six months. However, this is a short term Shelter and Diagnostic Unit and most residents are there for less than a month. He 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 an identified child was placed in a room closest to the midnight staff post. I saw this room when I toured the facility. There were no LGBTI 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. The residents' files are kept in the supervisor's office 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 8 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 facilty. 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. They also have access to parents through visiting once a week, incoming phone calls from parents or grandparents every day and confidential communication with their attorneys. All possible avenues for reporting have been made available to the residents and they know of them. Nine random staff were also interviwed 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 require a grievance process and notification of such process to both the resident and their parents at Intake. 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. 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 Miller Home. They both could tell me that the policy allowing parental visiting once a week, incoming parental phone calls every day and confidential calls or visits from attorneys was also practice. The 8 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 through the Blackburn Center and where the phone was located in the Staff Office and about the designated button to access the support. Most residents were not clear about what kind of services these were, unles cued by the interviewer. While on the tour of the facility, I observed the posters with the information throughout the house, saw and used the phone. Prior to the onsite 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 sexual abuse. Policy meets the standard.

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 nine 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 all a Pa. BHSL requirement that mandates notification via a HCSIS report. I reviewed the file and incident reports for the one unsubstantiated allegation. Child Line was called by the staff person immediately upon receiving the report and the other parties were notified within 24 hours. 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 nine 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 imminent 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 Miller House 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 Miller receives a report from another facility that a child alleged sexual abuse while at Miller, 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 9 random staff could cite all responsibilities without being prompted. All staff could agreed that they knew and understood the agency's protocol for collecting physical evidence. That is, that staff 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 the victim's well being was cited as being of foremost importance. The first responder duties are posted in the staff office. The only allegation of sexual abuse in the past 12 months was resident on resident and reported after the fact (two weeks) and did not require any first responder duties. That resident had been discharged prior to the onsite portion of the Audit.

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. It is in writing. The one allegation did not require such a response because it was after the fact. However, some of the policy did apply and was followed. I reviewed all the incident reports.

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 Resources Director and the President of Residential Services, who stated that the Adelphoi Policy and the PREA Zero Tolerance Policy preserve the ability for the Agency to protect residents by providing for the transfer or suspension of alleged 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 Miller 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 or transferring both staff and/or residents if need be. If a staff was involved she would include Human Resources and if a resident was involved, she would initiate contact and monitor for length of stay if needed, although the

policy states monitoring can continue for up to 90 days. Length of stay at Miller is short term because it is a Shelter/Diagnostic . 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. Policy meets standard.

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 Services 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 Agency Head Designee indicated that they would and do cooperate with the PSP and Child Line for all investigations. They also 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 procedure 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. The unsubstantiated allegation of resident on resident sexual abuse was documented and was contained in the file that I reviewed on site. Both the resident, his parents, and the alleged perpetrator and his mother were notified of the outcome of this case.

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 for a sexual abuse or sexual harassment incident. 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 of sexual abuse or sexual harrassment 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 is in the PREA Policy. I interviewed the caseworker who completed the Vulnerability Assessment and he states that he follows through to ensure 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 will be completed by a therapist or a psychiatrist during that time frame if indicated. 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. I reviewed the files of 10 current residents and 3 discharged residents. Of those, two residents reported a previous sexual abuse and the files showed that they received a physical well within 14 days of identification. Both residents denied a previous history when interviewed. When I toured the main campus, I saw in the Medical/Mental Health wing, that resident files are privately kept with access only to the Health professionals. During the tour of Miller, I saw where the resident files are kept in the supervisor's office. They are available for the staff working with the residents.

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. It is free of charge for the residents. The nine 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.

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 procedure for this standard. The Miller Home is a short term shelter/diagnostic unit, with the length of stay being around 20 days. However Adelphoi Village offers treatment for sex offenders in several of the facilities. Any discharge plan or report to the court would include recommendations for ongoing care for either a victim or perpetrator. It would also include any necessary follow up for STD treatment or prevention according to the interviews of the Medical and Mental Health care staff that were conducted. There were no residents in the facility who had reported a sexual abuse.

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 was one unsubstantiated allegation of resident on resident sexual abuse at Miller in the last 12 months. Althought the PREA Policy outlines a formal sexual abuse incident review and it describes what staff are to participate and what variables they are to consider, in this case it was not done according to policy. There is also a Sexual Abuse Incident Review form, which was not used. I interviewed the PREA Coordinator, the PREA Manager, and the Program Director, who is member of the incident review team. Although a Police Investigation was completed and an informal Administrataive Review was completed and both were documented, the policy was not followed. The agreed upon Corrective Action is a remedial training conducted by the PREA Coordinator for supervisors/PREA Managers to ensure that they know when a review is needed. Although not founded or indicated, an unsubstantiated allegation requires a review within 30 days. A review conducted at another facility under the agency umbrella was completed and submitted to the Auditor on May 16, 2016. It was reviewed and satisfies this standard. A log of the training for supervisors and the curriculum was submitted on May 16, 2016. This standard has been met.

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