

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: August 10, 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: April 18, 19, 20, 2016			
Facility Information			
Facility name: Saxman			
Facility physical address: 431 Saxman Drive, Latrobe, Pa. 15650			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 724-523-9449			
The facility is:	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input checked="" type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> 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: 16			
Current population of facility: 14			
Facility security levels/inmate custody levels: Non-secure Supervised Independent Living Program			
Age range of the population: 16-21			
Name of PREA Compliance Manager: Michelle Sheffield		Title: Program Supervisor/PREA Manager	
Email address: michelle.sheffield@adelphoi.org		Telephone number: 724-805-4500	
Agency Information			
Name of agency: Adelphoi Village			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 1119 Village Way, Latrobe, Pa. 15650			
Mailing address: <i>(if different from above)</i> 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 is ongoing at the main campus, with both a new residential facility and an office building for the Mental Health staff currently being built. The counselors, teachers, and therapists, along with administrative and supervisory staff, make up a workforce of nearly 650. There are 11 employees assigned exclusively to the Saxman Supervised Independent Living Program, including 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 Saxman Home, 431 Saxman Drive, Unity Township, Westmoreland County, Pa., about 15 minutes from the main campus in Latrobe. Two other residential units were also audited at this time. Saxman is a 16 bed, male supervised, independent living program, with ages ranging from 16-21, and licensed under the Pa. Dept. of Human Services 3800 regulations. This program opened in December of 2015. On the date of the Audit there were 14 residents in this unit; including boys who have "stepped down" from the Boy's Secure Sex Offender program on the main campus. Residents from Saxman are transported to the central Latrobe campus to attend the Robert Ketterer Charter School on the main campus or they are transported to their jobs throughout the Latrobe/Greensburg Area. They are transported to the school in a van by Adelphoi staff. They eat lunch on the main campus and breakfast, dinner and weekend meals at their group home. They prepare their own meals as this is a life skill and part of the program. These residents can be either dependent or delinquent and are committed by their respective Juvenile Courts or transferred from another facility. In addition to education and job experience, all residents receive both individual and group counseling. 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. This facility is JCAHO accredited.

DESCRIPTION OF FACILITY CHARACTERISTICS

Saxman Home is located in a rural neighborhood in Unity Township, Westmoreland County about 15 minutes from the main Latrobe campus. This one story, 4,567 square foot former nursing home is leased by Adelphoi and sits on about 1.5 acres. The building has white siding and sits on a small incline, surrounded by a very large yard with neighbors next door and across the street. In June of 2015, the original Saxman group home located in Greensburg, Pa. was torn down. Adelphoi located this new site and it was completely renovated over a period of six months. The first residents were admitted to the new building in December of 2015. The front door, which is only locked to keep those outside from entering, is located on a handicap accessible wooden deck and opens into a large common area with wings to both sides. There are windows throughout the building and in each of the bedrooms. The open area has a living room, dining room and kitchen area with appropriate wooden furnishings and new appliances in the kitchen. To the left is the staff office with a large window that looks directly out to the common area. The phone to the Blackburn Center is located in this staff office. There are three bedrooms in this wing, all doubles, with either two single beds or bunk beds. Furnishings are sparse and include beds, dressers and personal belongings. There is also a bathroom with a shower/toilet/sink. To the rear of the common area is the supervisor's office, another full bath and a triple bedroom with one single bed and a bunk. To the right is another wing, with a second living room and four bedrooms and a full bath. There are three double rooms and one single which can be used for risk based housing or as a reward. A "Guard Tour System" for midnight rounds was installed during the renovations. The living rooms have sofas, chairs, televisions and video games. There is a full basement that is used for storage and for laundry. The large yard has a small parking area for staff and is going to be fenced in to protect the neighbor's privacy. The lines of sight were excellent and there were no blind spots. Video cameras are not in use. The residents attend school on the main campus about 15 minutes away or they work full time at various jobs in the area. The school was toured during the last Audit and the Vo-tech building and gym/multi-purpose room were toured again during this Audit. Vo-tech consists of Small Engine Repair, Auto Body, Culinary Arts, Computer Tech and an EMT certification. The Saxman residents who attend school eat together in the cafeteria with the other group home residents. This is a large, modern cafeteria with a serving line and long tables with stools.

SUMMARY OF AUDIT FINDINGS

A notice of the onsite Audit was posted in Saxman home on March 7, 2016. A picture of the posting in several common areas was emailed to me. The postings were still present during the tour. 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 facilities. 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 Saxman took place on April 18, 2016. Some residents were at school and work during the tour. Those that were there were in the common area and were watching television or playing video games. During the tour, I saw posters for knock and announce on the doors to the bedroom wings and reporting posters in Spanish and English throughout the one story building. I spoke to residents who told me they received PREA education and one resident showed me where the dedicated phone to the Blackburn Center was located and he demonstrated how to call them. There is a dedicated button, A, and he dialed and reached the hotline. I confirmed that this was the case. I also saw the staff office where resident files are kept and spoke to a staff person who answered affirmatively regarding unannounced rounds being conducted by supervisors. 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 are kept. I saw private rooms where residents can be examined and/or receive treatment. The waiting area for these services looks like a doctor's office. Reporting posters were added to this area while I was onsite. Tours of the gym/multipurpose room and the vo-tech were also completed. On April 18, I observed lunch in the cafeteria for those Saxman residents that attend school. Ratio was met and supervision was more than adequate. 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 Saxman, the Program Director for this Unit, a Registered Nurse, a part time Master's Level Therapist, an Intake staff, an Assistant Principal, Random Staff (10) from all three shifts, (there are 11 total employees at Saxman, a phone interview with a Contractor and Volunteer and in person interviews with 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 staff office. There is a procedure to ensure privacy. As mentioned above, a resident used this phone during the tour and was connected immediately to the hotline. There are Spanish and English 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. 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, and verbal reports have been provided. Many of these residents also work full time jobs in the community and have the ability to report from there. Posters in both Spanish and English detailing how a third party can report sexual abuse are posted in the areas where parents would visit.

Standard #315 is also exceeded. Supervision is well above the mandated ratio of both the standard and by the DPW 3800 regulations. This is a Supervised Independent Living Program and the ratio for a secure program is not required, however, it is adhered to. Random unannounced rounds are not required of non-secure programs, but they are also conducted. The dynamics of the resident population are evaluated on a regular basis, especially when there is a new admission to ensure proper risk based housing. If a child is placed on a safety plan, for a variety of reasons, supervision of that resident can be "one on one". The bedrooms utilize a 10 minute "Watch Tour system". This is 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 were reviewed. This program only opened at the end of December, so there were no discharges to review. There was one resident who self-identified as Gay in the population at Saxman during the time of the on-site Audit. He was interviewed and stated he felt safe and was not labeled or discriminated against. Ten staff files were reviewed for documentation of PREA training and all required Child Abuse, Criminal History and FBI checks. All staff files contained appropriate documentation.

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. 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 #342 requires documentation of risk based housing decisions. During an interview with the supervisor who also administers the Vulnerability Assessment she described weekly staffings where this decision was made, however not documented. While on the tour of Saxman, I was shown the room that would be used to house those that required risk based housing. Documentation of Admissions for 60 days is required to show that this decision is being documented to meet this standard. All other Agency Policy and Procedure comply with standards.

On 6-20-16, I received documentation of the reformatting and use of the Vulnerability Assessment Instrument. However there had been only one admission during the sixty days since the onsite Audit. Therefore, the plan of correction was extended for 30 days in the hope that more admissions would provide documentation of compliance with both Standards. On 8-10-16, I received a spread sheet with documentation of 7 admissions for Saxman since the initial on-site Audit on April 18,19, and 20, 2016. This represents 100 days of use. The reformatting Assessment was provide to me prior to the 30 day interim report and was used for each of the 7 new admissions. All these residents were asked about their sexual orientation and gender identity and it was used to help determine either vulnerability or aggression. Also two of the residents were identified as needing a risk based housing decision. Documentation of both of these decisions was provided to me.

The information and documentation that was provided to me on August 10, 2016 shows compliance with Standards #341 and #342. All other policy and procedure meets the PREA Standards and this facility is in compliance.

Number of standards exceeded: 2

Number of standards met: 36

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 describes the agency’s efforts to prevent, detect, report and respond to incidents of sexual abuse and sexual harassment and meets the standard. The PREA Coordinator is also the Quality Assurance Director and her position is on the agency organizational chart. The Program Supervisor for each unit is the PREA Manager.

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 Saxman. 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, even though this is a non-secure Supervised Independent Living Program and this ratio is not required. Variables such as transportation and

programming on different shifts as well as the other variables listed in the Standard are taken into account. There are always two staff on midnight shift and three staff, not including the supervisor on the awake shifts. 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, even though not required for a non-secure facility. The logs of these rounds were provided to me. A Guard Tour system is used to record 10 minute checks of the resident rooms during sleeping hours. These checks are downloaded onto a computer for monitoring by supervisors and are kept as records. The policy meets the standard and this standard has been exceeded.

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 staff were aware of the policy prohibiting staff from searching or physically examining a Transgender or Intersex resident for the sole purpose of determining that resident’s genital status. 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 each wing. Both staff and residents could demonstrate for me how a female staff announced her presence. 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 and a bathroom door. 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 posted throughout the house. The Adelphoi Policy does make accommodations 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. The policy meets the 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 Saxman, including three 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. I reviewed a volunteer and contractor file and both had the required 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.

In June of 2015, the existing Supervised Independent Living Program in Greensburg was closed and the building was torn down. A new facility, a former nursing home, was located and completely renovated. This facility was re-opened as Saxman Independent Living Program at the end of December 2015. The renovations ensured lines of sight with an open common area and individual bathrooms in the bedroom area. There are no cameras, but there is a “Guard Tour” system used to record 10 minute checks of the residents during the sleeping hours. This information is downloaded and reviewed by supervisors and kept as a record. The President of Residential Services stated during his interview that line of sight is first and foremost for the safety of the residents when any renovation is planned.

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 Excelsa 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 Excelsa 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 Saxman, I saw the reporting posters for Blackburn Center and used the designated phone in the staff office to contact the Blackburn Center. A resident demonstrated how to call the Blackburn Center at my request during the tour. 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 Saxman, who confirmed her knowledge of the MOUs and necessary procedure. The PREA 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)

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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. 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. 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 training including 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. 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 Saxman. 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 Supervisor who is responsible for conducting the Intake and also the Intake person in the Administrative area, who also conducts education and provides information to the resident during the Intake. This information is 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 both detailed to me when and how they do this and it is usually done at the same time on the day of Intake. There is an age appropriate video, obtained from the Moss Group, entitled, “Safeguarding your Sexual Safety” and information contained on both the child’s rights and grievance forms. Ten residents were interviewed and all stated they received the appropriate information at Intake and then more comprehensive education within 10 days. They were able to answer questions during the interviews demonstrating understanding of this education. I reviewed the files of 10 current residents and only one resident did not have timely education at Intake, but they all had the 10 day education in a timely manner. Ongoing education was available through posters and pamphlets available throughout the Saxman house.

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, 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. Policy meets 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 Supervisor for Saxman, 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 show that this was done in a timely fashion in all cases. The file review showed that residents who are transferring to Saxman from other Units are having this done upon transfer and it is also being done at six month intervals. Every resident who had been at Adelphoi and transferred to Saxman had multiple assessments. Upon interview, the Supervisor states she also likes to conduct the Assessment when a resident returns from a home visit. This is a best practice. 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 additional documentation in the form of an admission log. However, there has only been one admission in the 60 days since the onsite portion of the Audit. An additional 30 days will be needed in the hopes that there will be more admissions to show compliance with this standard.

On 8-10-16, I received documentation of 7 admissions in the 100 days since the onsite portion of the Audit. The Vulnerability Assessment that contains all variables including those that request sexual identity and orientation that was previously provided to me as noted above was used for all 7 admissions. This documentation shows compliance with this standard.

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 Supervisor 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 a room when I toured the facility that would be used to house those that required risk based housing. Although the supervisor makes this decision based on the information and it is reviewed at weekly staffings and housing decisions are made, there is no documentation 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. There was one resident who identified as gay and during the interview he confirmed that he was not placed in specialty housing because of this identification. All residents shower separately. The PREA Policy outlines the requirement of this standard. Because there is no documentation of risk based housing decisions, 60 days of admissions documenting it will be necessary to show compliance with this standard.

On 6-20-16, I received a log with documentation of the one admission during the past 60 days. Another 30 days was added to the timeline for the plan of correction in the hope that there will be more admissions to demonstrate compliance with this standard.

On 8-10-16, I received from the PREA Coordinator, a log of 7 admissions in the 100 days since the onsite portion of the Audit. Of these 7 admissions, 2 were identified as requiring a risk bases housing decision. The one resident was identified as sexually aggressive on the VAI ad it was noted that he was placed in a room nearest the staff office and that the roommate was neither at risk for victimization, nor was he aggressive. The other resident was also identified as sexually aggressive and the documentation stated he was placed in a single bedroom with no roommate.

The submitted documentation shows compliance with this Standard.

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 Blackburn 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 sign off was in the 10 current 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 both parents by visiting once a week, phone calls from parents or grandparents twice a week and confidential communication with their attorneys. Most of these residents also have access to outside communications at their places of employment. 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. There were sign offs in the 10 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 Saxman. 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 in the staff office and about the designated button to access the Support. Most were not clear about what kind of services these were. While on the tour of the facility, I saw the posters with the information throughout the house, and I 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. BHSLS requirement that mandates 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 imminent sexual abuse in the past 12 months. The Policy meets the standard.

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 Saxman 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 Saxman receives a report from another facility that a child alleged sexual abuse while at Saxman, 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. All staff could demonstrate 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. Policy meets standard.

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. There have been no incidents within the last 12 months, so there were no examples of this, but it is used for other types of incidents.

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 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 Saxman 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 Resources 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 actions 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 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 Policy 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. If there is only police involvement, Adelphoi staff communicate with the police in order to keep abreast of the investigation and will notify the residents, the parent and the probation department. There were no examples because there have been no incidents within the last 12 months.

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 an incident of sexual abuse or sexual harassment. I interviewed both the President of Residential Services and the Director of Human Resources. Termination is the presumptive PREA Audit Report

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 harassment 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 an incident, the child's mental health, intellectual level, and age as well as other factors 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. Adelphoi Policy and state regulations prohibit any kind of sexual activity between residents. A resident can only be disciplined for sexual activity with staff, if the staff person did not consent to such activity.

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)

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 Saxman Supervisor who completes 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 will be completed by a therapist or a psychiatrist during that time frame if required. 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 they were also interviewed. Of those, two residents reported a previous sexual abuse and their files showed that they had received a physical well within 14 days of identification and the residents confirmed this when asked. 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. The Policy 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 Excelsa 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.

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. Adelphi has the resources to follow through with all necessary treatment for any resident who is sexually abused or has perpetrated sexual abuse either at the agency or by contact in the community. Aftercare for those returning to their homes or being discharged is also arranged.

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 Saxman 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. Policy meets standard.

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 Adelphi. 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

August 10, 2016

Auditor Signature

Date