PREA AUDIT REPORT ☒ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: December 1, 2016

Auditor Information			
Auditor name: Maureen G. Raquet			
Address: P.O. Box 274, Saint Peters, Pa. 19470-0274			
Email: mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: July 11, 12, 13, 2016			
Facility Information			
Facility name: LaSaQuik			
Facility physical address: 651 St. Michael's Road, Cogan Station, Pa. 17728			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 570-998-9261			
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: 34			
Designed facility capacity: 20			
Current population of facility: 18			
Facility security levels/inmate custody levels: Secure			
Age range of the population: 12-18			
Name of PREA Compliance Manager: Christopher A. Moser		**Title:** Program Supervisor/PREA Manager	
Email address: Christopher.moser@adelphoi.org		**Telephone number:** 570-998-9261	
Agency Information			
Name of agency: Adelphoi Village			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1119 Village Way, Latrobe, Pa.15650			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 724-840-7000			
Agency Chief Executive Officer			
Name: Nancy Kukovich		**Title:** CEO	
Email address: nancy.kukovich@adelphoi.org		**Telephone number:** 724-804-7000	
Agency-Wide PREA Coordinator			
Name: Jennifer McClaren		**Title:** Quality Assurance Director/PREA Coordinator	
Email address: Jennifer.mcclaren@adelphoi.org		**Telephone number:** 724-804-7000	

AUDIT FINDINGS

NARRATIVE

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

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 in Pennsylvania. A previous Audit of the 6 units on the main campus was conducted in August 2014. Subsequent Audits of the other group homes were conducted in April and June of 2015 and April 2016. This Audit was conducted at LaSaQuik, 651 St. Michael's Road, Cogan Station, Pa, about 20 minutes from the city of Williamsport, Pa. Two other residential units were also audited at this time. LaSaQuik is a 20 bed male Sexual offender Treatment unit with ages ranging from 12-18, and licensed under the Pa. Dept. of Human Services 3800 regulations. In 2015, there were 20 admissions and the average length of stay was about 6 months. On the date of the Audit, there were 18 residents in this unit; including residents who have transferred from other Adelphoi facilities. This is considered a residential treatment facility and is self contained with all residents living and attending school in the two facility buildings on the LaSaQuik campus. These residents can be either dependent or delinquent and are committed by their respective Juvenile Courts for treatment. The residents attend school, have individual counseling twice a week, group counseling, family counseling if court ordered or warranted. Groups include, Sanctuary, ART, Sexual Issues, Pathways, and BARJ. All residents participate in the Ropes Course Adventure Based Curriculum located on the 70 acre property. There are 34 employees assigned to LaSaQuik, which means "Middle Creek". Staff at LaSaQuik consist of line staff who are full and part time and work first and second shifts. Third shift personnel work permanent 3rd, with permanent days off. There is a Master's Level Program Supervisor who is a Sexual Victimization expert and an LSW. There are Caseworkers, two teachers from the local Intermediate Unit who are contracted employees, a dietary coordinator, and a full time Maintanance man.

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. LaSaQuik also is accredited by JCAHO.

DESCRIPTION OF FACILITY CHARACTERISTICS

LaSaQuik is located on the side of a mountain in Cogan Station, Lewis Township, Lycoming County in North Central Pennsylvania. It is 20 minutes from Williamsport, Pa., the home of the Little League World Series. This very rural area is served by the Pa. State Police. There are two buildings: the school building and the main building which is a converted farm house. Together they exceed 13,800 square feet and sit on 70 acres of woodland with resident turkeys, deer and a black bear. There is a vegetable garden, a pond where the residents can fish, a ropes course at the very top of the mountain and an outdoor shed with bicycles. The school building sits on a knoll above the main building and is accessed by wooden stairs. There are two separate classrooms and a teachers' office with a large plexiglass window. These classrooms have traditional desks for both students and teachers as well as non traditional decorations such as dream catchers. Between the school building and the main building are gardens. One is a traditional flower garden and one is a sculpture garden with cement markers, all different, with designs, paintings, drawings and hand made mosaics. This garden is used at the end of treatment before discharge to commemorate the victim of the resident. The farmhouse is rented by Adelphoi, who took over this program, the property and the staff in 2011 from another provider. The farmhouse was extensively renovated in the nineties. The building is secure from the outside and there are no cameras. As you enter the front door, you are in a foyer with PREA Postings, a glass enclosed receptionist area with a staff only office behind it. To the left are caseworker offices on both sides of a small hall and then you enter the living area. Other offices line the right side of the open area. A short wall separates a living area with couches from the foyer/office area. The seven bedrooms surround this area, and so do the two bathrooms. The bedrooms are numbered 1-7 with bedrooms 1 and 2 being singles, bedroom 3 a double and 4,5,6, and 7 being Quads. The double and quads have wooden bunk beds. The rooms have windows that do not open with blinds. There is a dressing area with a curtain on a wooden rod and open bureaus. The one common bathroom has two toilet stalls, two urinal stalls, three showers and 4 sinks. The other bathroom has been retrofitted to accommodate a disabled resident. It is next to room one and only he uses it. The single rooms are used for all new residents until they complete the orientation phase and can be used for risk based housing. The third shift post for midnight staff is in the open area outside the bedrooms. All bedrooms are equipped with the "Guard One System" for midnight checks as well as a motion activated grid system in all of the multi-resident bedrooms. This equipment is located at the staff desk. To the right of the living area is a dining room with wooden tables and benches to the rear, a television room with cushioned sofas and chairs and to the front, a full kitchen with large industrial stainless steel appliances. The upstairs, accessed by a stairwell with an outside door used for fire exit, consists of a large conference room and several staff and administrative offices. There is also a room for family therapy. The downstairs is also accessed by this stairwell and is used for indoor recreation and had a weight room with rubber flooring and various weight machines and free weights. There was food and other storage along the hallway and a furnace room. This long hall led to a garage/workshop area for the maintenance man and large garage doors opened to the outside.The ropes course is at the top of the mountain and is used every Monday by the entire population and the staff who are trained facilitators for this outdoor programming. It is accessed by a four wheel drive vehicle on a series of gravel switchbacks. At the top, there is a porta-potty and many high and low ropes elements including a flying squirrel. This area is posted to prohibit hunters and trespassers.

SUMMARY OF AUDIT FINDINGS

A notice of the onsite Audit was posted at LaSaQuik on May 25, 2016. A picture of the posting in several common areas was emailed to me. The flash drive containing the completed Pre-Audit Questionnaire and required important documentation was received in my PO Box on May 31, 2016. Emails and Phone calls were conducted during this pre-audit period to clarify the information received. The on-site portion of the audit was conducted on July 11,12,13,2016, 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 PREA Coordinator, Program Director,and Program Supervisor/PREA Manager. The tour of LaSaQuik took place on July 13, 2016. All residents were present in the living room/television room area during the tour, because there was no school that week.

During the tour, I saw several areas where the Audit itself was posted. I also saw postings for Reporting Sexual Abuse and Sexual Harrasment, Blackburn Center postings, Zero Tolerance Postings and First Responder Duty Postings. I spoke to residents and staff about Reporting and Unannounced Rounds. The residents were very eager to respond to the candid PREA questions. I toured all common areas that the residents have access to, all bathrooms and bedrooms. I toured the school building as described above as well as the Ropes course at the top of the mountain, because it is used frequently. The area used for visiting is also the dining area and had reporting posters in both English and Spanish. Interviews of both staff and residents were conducted on July 13 in staff and caseworker offices on the main floor off of the living areas. Lunch was eaten with 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 that goes directly to a crisis counselor at the Blackburn Center. The phone is located in the living area and there is another in a Caseworker office. During the tour, a resident showed me how and where to use the phone and I spoke to the Blackburn Center, verifying this Hotline. 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 stated that they would offer phone services as described in the MOU, but because of the physical distance they would not be able to accompany residents to the hospital, nor accept reports. They provided Adelphoi staff with contact information for other PICARs that could offer these services. An MOU was in the process of being obtained from this other agency. When this is done, this information will be provided to me and I will contact them. The new reporting information will be disseminated and posted and follow up will be conducted to ensure that the residents and staff are aware. Copies of postings will be sent to the Auditor. The policy and procedure will remain the same. The name of the agency and the phone number will be different. Residents also have a grievance process for reporting, journaling and telephone calls and visits by family, attorneys, probation officers and caseworkers.

As part of the on-site portion of the audit, ten residents were interviewed. Ten random staff from all three shifts were interviewed. Interviews were conducted by phone with the President of Residential Services, the Human Services Director, a volunteer for the agency and a contractor. In person interviews were conducted with the PREA Coordinator, Vice President of Residential Services, the Program Director, the Program Supervisor/PREA Manager/Masters' Level MH Therapist Caseworker the and Director of Nursing.

The part time nurse visits once a month to check the med cabinet and review protocols for the disabled resident. Physicals are conducted by a physician at his office in Williamsport. Medications are self administered and supervised by staff. Many of the residents see a Psychiatrist in the community for Med evaluations. Mental Health Screenings are conducted by the Masters' Level Therapist, who also conducts these screenings for other Adelpoi facilities in the area. Forensic Medical Exams are conducted at the Williamsport Regional Hospital where there are SAFE/SANEs. The Director of Nursing for Adelphoi was interviewed to confirm all Medical and Mental Health arrangements.

There have been no allegations of sexual abuse or sexual harassment in the past 12 months. The Pa. Stae Police would conduct these investigations and there is an MOU with them.

Ten current resident files and two files of discharged residents were reviewed. Ten staff files were reviewed for documentation for various standards. There were no Transgender or Intersex residents. There were four residents who identified as Bi-sexual, three who disclosed a prior sexual abuse, one who was physically disabled and one who had perpetrated a sexual abuse at another Adelphoi facility and all were interviewed during the onsite audit.

Upon completion of the on-site portion of the Audit, on July 13, 2016, an exit interview was conducted with 10 Administrators and upper level staff in person and by conference call. Requested additional documentation for the following standards must be submitted to the Auditor for verification within 60 days of this Interim Report.

Standard #321, Resident access to Outside Support Services, was discussed above. The MOU with the local PCAR must be obtained and submitted. Both staff and residents must be advised of this change and postings must be changed. The dedicated phone button will also be re-programmed. The procedure will not be affected by this. The Auditor will contact the PCAR and will interview staff and residents to confirm. The Director of Nursing has confirmed that SAFE/SANEs are availbale at the Williamsport Regional Medical Center, however there is no MOU. Adelphoi staff is in the process of procuring one. If unable to, they will provide the Auditor with documentation of their efforts to obtain one. This is an open ended timeline for the plan of correction, because it is dependent upon an outside agency.

On 9-27-16, I received the MOU with the Williamsport YWCA, a member of the Pennsylvania Coalition Against Rape, and spoke to the Director to confirm that this agency will provide Emotional Support and Crisis Services to the residents at LaSaQuik. Training logs for staff, educational logs for residents and Spanish and English Posters were submitted with the change from Blackburn to Williamsport YWCA. The PREA Coordinator has confirmed that the dedicated phone button has been changed. An MOU between Adelphoi and Williamsport Hospital was obtained and susbmitted on 8-23-16. This facility will perfom forensic exams for the residents at LaSaQuik.

Standard #322, Referrals for Allegations requires that the numbers and contacts need to be posted on the Agency website. The website lists the Pa. State Police and the Blackburn Center. The website needs to be updated to include the new PCAR contact information when the new MOU is obtained. The Auditor will verify that the website has been updated.

On 9-27-16, I received a signed MOU between LaSaQuik and the Williamsport YWCA. I verified that this information was posted on the Adelphoi website and I spole to the YWCA Director on this date to verify that the services listed in the MOU are being offered. She confirmed that they were. This Standard has now been met.

Standard #341 Vulnerability Assessment requires that residents be re-assessed periodically. Although the Adelphoi PREA policy requires this to be done every six months, not all the resident files contained a 6 month reassessment. Several residents were reaching the six month mark and are due for a re-assessment. This needs to be done for 60 days and submitted to the Auditor.

On 11-30-16, I received a log of all Vulnerabiity Assessments that were conducted or re-conducted on residents per the PREA Zero Tolerance Policy from the date of the Audit until receipt of the information, over a period of four months. I also received the nine individual assessments. Seven were re-assessments that were conducted at six month or yearly intervals as per policy and one was a new admission and the other a transfer from another Adelphoi facility. All were completed in a timely fashion.

This standard has now been met.

Standard #342 requires documentation of risk based housing decisions and although during the tour I was shown where a resident who was identified as aggressive was housed, this was the only documentation of such. Documentation of Risk based housing decisions for 60 days of new Admissions is required to meet this standard.

On 11-30-16, I received nine Vulnerability Assessments, iincluding a new admission and a transfer. The remaing seven were re-assessments conducted every six months as per policy. All nine residents were identified as aggressive becaue of their charges and because this is a sex offender treatment unit. Two were also listed as vulnerable. All residents had documentation as to whether risk based housing was considered and used or not. For example, one resident because of his age was placed in a single room. Although all are listed as aggressive becaue of charges, they may not be aggressive in this setting, because of who their choice of victim may be and this is documented.

This standard has been met.

Standard# 351, Resident Reporting. Although all avenues are available to residents, the "hotline" is the preferred method for reports to outside agencies. The original MOU with the Blackburn Center provided this avenue. When a MOU is obtained with the local PCAR, the Dedicated phone button, postings and education and training for residents and staff must include this new contact information. This is an open ended timeline for the plan of correction, because it requires coordination with an outside agency.

On 10-10-16, I received copies of the posters for the YWCA as the reporting agency attached to the "hotline" in both Spanish and English. Additionally I received training logs for all staff and educational logs for the residents advising them that the procedure was exactly the same, but the agency on the other end of the line receiving the report was the Williamsport YWCA and not the Blackburn Center.

This standard has been met.

Standard #354, Third Party Reporting requires that contact information for agencies that will accept reports be published on the website. The new PCAR information needs to be posted here. This is an open ended timeline as described above.

On 10-10-16, I received a link to the website and verifired that the new reporting information for the Williamsport YWCA was listed on the website. This standard has been met.

There were two standards that are exceeded:Standard #331 Employee Training and #383 Ongoing Treatment. The staff receive the standard agency PREA training as part of orientation, a refresher yearly, as recently as March, and special sex offender treatment training. Adelphoi staff that are assigned to a SOU receive training developed to help them specifically supervise and run sexual issue groups for this specialized population. All staff interviewed demonstrated their understanding of the training. This is a residential treatment facility for sex offenders and the residents are sent here by the Courts for treatment, which they receive as individualized, group and family therapy.

All other Agency Policy and Procedure comply with standards.

After receiving and reviewing additional documentation and conducting additional interviews of both staff and residents, all standards have been met and this facility is in full compliance as of December 1, 2016.

Number of standards exceeded: 2

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 4

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 includes the definitions for sexual abuse and sexual harassment, as well as the agencies efforts to prevent, detect, report and respond to these incidents. The PREA Coordinator holds the position of Quality Assurance Director and reports directly to the Chief of Staff. This is included on the agency's organizational chart. Each of the 22 group homes has a Program Supervisor, who is the designated 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 LaSaQuik. All interviewed state that both the PREA Requriement and the Pa. Dept of Human Services Ratio of 1:8 and 1:16 are always exceeded.

There are always two staff on midnight shift. The "Guard Tour" system records 10 minute checks of the residents while they are sleeping.There are motion detectors in the bedrooms during sleeping hours that allow staff to monitor any child getting out of their bed. A schedule is prepared and posted for a two week period, but is reviewed daily to meet "one on one" supervision of residents, if needed, and other needs of the population. This schedule was provided to me and uploaded. A Facility Vulnerability Assessment is conducted yearly and this includes the physical plant as well as staffing needs.This was provided during the pre audit time period. There have been no instances of not meeting ratio. Mandatory overtime is used if necessary. I reviewed the most recent Licensing and Inspection Summary from the Pa. Dept. of Human Services and there were no citations for not meeting ratio. Unannounced rounds are random and are conducted on all three shifts by the program director and the facility supervisor. The logs of these rounds were provided to me. The policy meets the standard.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Search Policy prohibits any strip or body cavity searches. Cross gender pat down searches are also prohibited. I interviewed 10 random staff and they all stated that cross gender pat down searches are prohibited. They also stated they had been trained in the Transgender and Intersex Search policy, but had not yet had to utilize it. There were no Transgender or Intersex residents in the population. All 10 residents interviewed stated that they had never been subject to a cross gender pat down search. All staff knew of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining that residents genital status. They also stated that female staff knock and announce their presence when coming into the bedroom/bathroom area on the second floor. One resident demonstrated how the female staff announced themselves yelling "Going into Room #4", or "Sue here" . While on the tour, I saw knock and announce posters on the doors leading into the bathroom area. There are two bathrooms and although residents shower three at a time in separate curtained stalls, there is a second bathroom that a disabled resident presently uses alone and any Trasgender or Intersex resident would also use this bathroom.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 was one resident with a physical disability. He was interviewed during the Audit. He has been accommodated for his physical disability by being housed in a single room and having a bathroom retrofitted for his use. He is the only resident that uses that bathroom. Whereas, these accomodations were made for his physical disability, they also offer privacy and protection for a resident who may be vulnerable because of it. He stated during the interview that he did not need any specific PREA accomodations and felt very safe at LSQ. He in fact was the resident who volunteered to show me where the reporting phone was and how to use it. There were no residents who do not speak English. A non-English speaking child would not be admitted because the child would be unable to participate in the program. It is

more likely that parents may not speak English, and a contracted translator would be used to communicate with those parents. A copy of the contract was provided. Spanish and English PREA posters were throughout the facility. The Adelphoi Policy does make accomodations for residents with both physical and intellectual disabilities on a case by case basis. I confirmed this when I interviewed the President of Residential Services. Policy meets standard.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Director of Human Resources by phone, having interviewed her in person less than three months ago during another Audit 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 LaSaQuik, including one recent hire. Adelphoi acquired this program and retained its staff in 2011. All clearances were performed at that time. Child Abuse and Criminal History were performed again in 2013, and although Adelphoi policy requires clearances every two years, the FBI clearance was not conducted again until 2015, along with the Child abuse and criminal history. Although agency policy was not followed in this instance, both PREA and Pa. DHS require every five years, so this standard has been met. A review of the most recent Pa. Bureau of Human Services Licensing Summary showed no citations for failure to have proper clearances. I reviewed both a contractor and a volunteer file. 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.

The facility was acquired in 2011 and is rented by Adelphoi. There have been no expansions or renovations to the building, nor any technological additions or changes since 2012. There are no cameras in this building. This standard does not apply.

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 is attempting to obtain a MOU with Williamsport Regional Medical Center 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 SAFE/SANEs are available and that forensic exams are provided at Williamsport Regional Medical Center and are 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 PCAR, to provide victim support services. I spoke to an Administrator at the Blackburn Center prior to conducting the Audit and although there has been an MOU with Adelphoi in place since 2014, they cannot provide a victim advocate to accompany a resident for a forensic medical exam at this group home because of the physical distance. The name and contact information for a local agency who can provide this service was provided to Adelphoi staff. They are in the process of obtaining an MOU with this local PCAR. When this is completed, it will be provided to me and I will contact them to verify the services in the MOU. This is part of the plan of correction to meet this standard. The timeline is open ended because it is dependent upon an outside agency. While at LSQ, I saw the reporting posters for Blackburn Center and used the designated phone across from the staff office to contact the Blackburn Center. This designated phone button and posters will be changed to reflect the new provider. 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 La Sa Quik, who confirmed his knowledge of the MOUs and necessary procedure. Policy meets standard.
Corrective Action: On 9-27-16, I received an MOU with the Williamsport YWCA and spoke to the director and confirmed emotional support and crisis services listed in the document. I also received both Spanish and English posters with the name change from Blackburn to YWCA and logs of education for residents and training for staff on this change. The procedure and policy remain the same, only the agency providing the services has changed. On 8-23-16 I received an MOU with Williampsort Hospital describing the forensic exmans that would be offered to the residents of LaSaQuik. The PREA Coordinator confirmed that the direct dial button on the phone has been changed to access the YWCA.

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. The site also lists the Blackburn Center as and agency you can report to. 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. This website needs to be updated to include the contact information for the new PCAR, who will accept the reports and who will provide a Victim Advocate. When the website is updated and verified to include this, the standard will be met. This is an open ended timeline for the plan of correction, because it is dependent upon an outside agency. I interviewed the President of Residential Services and he confirms that the policy and procedure are followed.
Corrective Action: On 9-27-16, I received an MOU with the PCAR, Williampsort YWCA and spoke to the director, who stated they will receive reports from LaSaQuik. This was listed on the website and verified by the Auditor on 10-17-16. This Standard has now been met.

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)

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 employees have all received the training required by this standard at orientation and then every year as a refresher. The refresher had just occurred in March 2016, four months prior to the Audit. The curriculum is an on-line power point that was provided to me. The employees test out, demonstrating their understanding of the material. A log of the trainings was provided to me during the onsite. Ten random staff were interviewed and they could all discuss their first responder responsibilities, mandated reporting, and the agency's policy and procedure on preventing, detecting, reporting, and responding to incidents of sexual abuse and harassment. All staff at LaSaQuik receive additional specialized training because it is a sex offender unit. This curriculum has been developed by Adelphoi and is mandatory for those staff working in a SOU. It enables the staff to properly supervise this specialized population and run sexual issues groups. The policy indicates who must receive training, what the training will entail and when training will be received, both at orientation and refresher training. This standard has been exceeded.

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)

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 are no volunteers specific to LaSaQuik. There are specific contractors and during the onsite, I reviewed a contractor book, that has the name off each contractor and a sign off that they have been notified of and have acknowledged the Zero Tolerance Policy at LSQ. During the Audit, I interviewed by phone a HVAC contractor specific to LaSaQuik and a church volunteer from 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)

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 two Intake/Admissions Staff. Both are line staff but are responsible for conducting most of the Intakes and providing information to the resident during the Intake. I interviewed two staff, because one employee was unable to provide me with accurate information . This information was in reference to the agency's zero tolerance policy on sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. They are also responsible for conducting the education that must occur within 10 days of Intake. This is usually done at the same time as the Intake education. They detailed to me when and how they do this. They showed me the information that is given to the resident at Intake, along with a Child's Rights and information on the grievance process. All Intakes are scheduled. Ten residents were interviewed and all stated they received the appropriate information and all education at Intake. The residents also view a PREA Orientation video, entitled , "Safeguarding your Sexual Safety" produced by the Moss Group . Of the twelve files I reviewed, 10 active and two discharged, all but one child had received education at intake. The one child who was the exception had been admitted in 2013 , prior to the 2014 implementation of PREA education at Adelphoi. There were sign offs in the resident files acknowledging receipt of this education. Ongoing education was provided in the way of postings and ongoing sexual issues groups and a Balanced and Restorative Justice Victim's Curriculum. One resident interviewed stated he has received PREA education at least four times at every facility he has been transferred from or committed to. He was able to answer all questions and was eager to demonstrate his knowledge.

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)

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

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Program Supervisor/PREA Manager 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, transfer information, 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 2 discharged files show that this was done in a timely fashion in all but one case, where a child was admitted in 2013, prior to the 2014 PREA implementation by Adelphoi. The file review showed that residents who are transferring to LSQ from other units are having this done upon transfer. The Adelphoi PREA policy also requires this to be administered again for every resident at 6 month intervals. Review of 12 resident files showed that 6 out of 11 files did not have the VAI re-administered at six months. The plan of correction requires that in the next 60 days, that any resident who reaches the six month mark has a VAI re-administered. These will be submitted to the Auditor for review. The Vulnerability instrument itself is a commonly used one that takes into account many variables, including physical traits, prior institutionalization, bullying, sex offenses, LGBTI status or identification. The Policy states that this assessment must be conducted within 72 hours of intake and that the information is confidential. I interviewd the PREA Manager who administers the VAI upon admission and he states that only staff who supervise the residents have access to this information because they all are considered treatment staff and have received specialized training. The contracted teachers, maintenance man and dietary staff would not have access to this information.
On 11-30-16, I received a log of all Vulnerability Assessments that have been completed since the onsite Audit in July. All re-assessments, transfers and admissions have had a VAI completed. The 7 re-assessments were completed at 6 months and annually according to the policy. I received the individual instruments. All were completed in a timely fashion.
The corrective action has been completed and this Standard has been met.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Use of isolation is prohibited by Adelphoi Policy and by the Pa. Department of Human Services 3800 Regulations. I observed no area during the tour where a child could be isolated. Interviews with both Medical and Mental Health staff, the PREA Coordinator, and PREA manager confirm that isolation is never used. I interviewed the Supervisor/PREA Manager who administers the Vulnerability Assessment. He does this within 72 hours of Intake .He states that the information is used to determine housing assignments. There are two single rooms and these are used for every new admission and can and are used for those that require a single room for a variety of reasons including being identified as either vulnerable or aggressive. The resident with the disability was in one room and the other room was occupied by a resident who was identified as aggressive because he had been transferred from another facility due to an allegation of sexual harassment. This was documented on his Vulnerability Assessment and I saw this room when I toured the facility. Because this is a sex offender program, all residents are identified as aggressive because of their charges. It is noted if a resident would be identified as aggressive in this setting. Special consideration is given to those identified as vulnerable. Although there was documentation for the one "aggressive resident" as noted above, there was no other documentation of risk based housing in the other 11 files I reviewed. The PREA Manager could tell me what kids were housed where and why, but there was no documentation of this. A plan of correction will require that sixty days of admissions with documentation of risk based housing be submitted to meet this standard.
There were four residents who identified as bisexual during the interviews and they stated they were not discriminated against because of this or housed differently. 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. The PREA Policy outlines the procedure for use of this information and who can have access to it. I saw where the resident files are kept during the tour and only those working with the resident have access to them.
On 11-30-16, I received a log of 9 VAIs that wer completed wwince the time off theon-site Audit in July. I also received nine individual VAIs with documentation of risk based housing decisions. Seven of these were re-assessments conducted at six months and annually. One was a new admission and one was a transfer from another Adelphoi facility.
All of these residents are identified as aggressive because of their charges, however not all require risb based housing because their victim of preference may not be in the population. If risk based housing is considered and not used documentation is listed as to why it is not. Two of these residents were identified as vulnerable and they were placed in single rooms. It is the practice to place new admissions in a single room upon admission and then they are re-assessed.
This corrective action has been completed and satisfies the 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 living area and in the caseworker office with a dedicated button that went directly to the Blackburn Center. A resident volunteered to show me this phone and how it worked during a tour. There were also posters with addresses for the Blackurn Center and phone numbers for Child Line posted throughout the facility and above the phone. 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 two discharged resident files that I reviewed. Residents also stated that they felt comfortable reporting to a staff person or could go to the caseworker or supervisor. This program requires journaling as part of the treatment modality and residents could report in this way as well. They also have access to parents by visiting once a week and phone calls from parents or grandparents twice a week and confidential communication with their attorneys. 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.Although Adelphoi has a MOU with the Blackburn Center that has been in effect since 2014, during a phone call to the Blackburn Center prior to the onsite, the director stated that they cannot accept these reports as an outside agency because of the physical distance. Blackburn has provided Adelphoi with the name and contact information for a local PICAR

who can provide these services. Adelphoi is in the process of obtaining an MOU. When this is done, I will contact that agency to verify the services provided in the MOU and LSQ will reprogram the telephone button, post new information and train and educate staff and residents as to the change. The policy and procedure for this "hotline" will not change, only the name and number. The Auditor will receive a picture of the new postings and will interview both staff and residents to ensure that they have been notified of the change. This is an open ended timeline for the plan of correction, because they are dealing with an outside agency.
Corrective Action:
On 9-27-16, I received an MOU between Adelphoi Village and the Williamsport YWCA, a local PCAR. I interviewed the director of the YWCA and she confirmed that they will accept reports from the residents of LaSaQuik. On 10-17-16, I received a log of staff training and resident education that had been conducted to advise them of the change in agency from Blackburn to the YWCA. This is not a change in policy or procedure, only a change in what agency is receiving the report. The PREA Coordinator confirmed the re-programming of the "hotline button" to access the YWCA. The postings in both Spanish and English were uploaded with the change to the YWCA as the agency receiving reports. Pictures of the postings in various locations troughout the facility were also uploaded

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 of this to both the resident and their parents at Intake. There were sign offs in the 12 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 LaSaQuik. 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 and some had. 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 caseworker office and living area and about the designated button to access the support. Most were not clear about what kind of services these were, unless cued during the interview. One resident stated that he was well aware of the nature of these services and had utilized them while at home. While on the tour of the facility, I saw the posters

with the information throughout the house, saw and used the phone. Prior to the on-site portion of the Audit, I received a copy of the MOU with the Blackburn Center outlining its services and I called and spoke to the Director, who verified that the support services in the MOU were in effect, even though they could not take reports or accompany residents for forensic exams. 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. The new MOU with the Williamsport YWCA states that they will now offer these services. The direct dial has been reprogrammed to accommodate the change.

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. Once the new MOU is obtained with the local PCAR, the website must be updated to include this reporting information for LaSaQuik. This plan of correction is open ended, because it is dependent upon obtaining the MOU. Revision to this website will be verified by the Auditor.
The MOU with the Williamsport YWCA was received by the Auditor on 9-27-16. A phone call to the Director at the PCAR confirms that they will receive reports from the residents at LaSaQuik. On 10-17-16, the Auditor verifired the revised reporting information for this facility on the Adelphoi website listed above.
This standard has been met.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

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. Although there have been no incidents in the past 12 months that have required a coordinated response, I feel that the interviews demonstrate that a coordinated response would be followed.

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 LaSaQuik Supervisor and he is present in the facility full time. He is responsible for protecting residents from retaliation and when interviewed he was able to tell me what signs he would look for and what actions he could take, including moving, transferring both staff and/or residents if need be. If a staff was involved he would include Human Resources and if a resident was involved, he would initiate contact and monitor for length of stay if need be. The policy states monitoring can continue for up to 90 days. I also interviewed both the President and Vice President of Residential Services and they also described actions that could be taken, including disciplinary acitons against staff up to and including termination. There have been no incidents that have required monitoring against retaliation in the past 12 months.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There is an MOU with the Pa. State Police and mandatory reporting to Child Line. Both of these agencies conduct an investigation of any allegation of sexual abuse. It is outlined in both PREA Policy and Adelphoi 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 , but Adelphoi staff never determine whether an incident is substantiated or not. That is the jurisdiction of both Child Line and the Pa. State Police.

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. In the cases where Child Line does not conduct an investigation, but the police do, Adelphoi keeps in contact with the Police Department and advises the resident, parents and committing agency of the outcome of the police investigation and this is documented. There have been no incidents in the past 12 months that have required notification.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

disciplinary history. The Adelphoi Policy contains all verbiage required by the Standard and by Pa. CPSL.

Standard 115.377 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.378 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents of disciplinary sanctions against residents who have falsely reported in the past 12 months. Both PREA Policy and the Pa. Child Protective Services Law does not allow for any disciplinary sanctions for a report made in good faith. Facility policy and Pa. DHS regulations prohibit all and any sexual contact between residents. 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. If a child did remain in the facility, the act would be addressed therapeutically. A resident would only be disciplined for sexual contact with staff if staff did not consent to such contact. I did interview a resident who was transferred from another Adelphoi facility for an incident of sexual harassment and he stated that he had not been disciplined for the incident, but was transferred to a more intensive treatment unit.

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/or mental health assessments within 14 days of being identified. This is in the PREA Policy. I interviewed the Supervisor/PREA Manager who completes the Vulnerability Assessment and he states that he ensures that follow- up is offered. I interviewed both the Director of Nursing and the Supervisor/ Mental Health Therapist who stated that an assessment/physical is done on every child within 14 days and that a MH assessment can be completed by a therapist or a psychiatrist during that time frame. Community resources are used for both medical and psychiatric services. There are no medical staff assigned to this facility. 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 2 discharged residents. Of those, four residents reported a previous sexual abuse. One resident stated he had been offered counseling and received it within a week and another resident stated he had a physical within two weeks. All but two files showed timely Medical or Mental Health follow up and one of those files was from a 2013 admission before PREA was implemented at LSQ.

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. Williamsport Regional Medical Center provides emergency treatment and has SAFE/SANES in the ER and on call. Adelphoi staff is in the process of obtaining an MOU with this medical facility or will provide documentation of their effforts. The Director of Nursing and the Mental Health Therapist both stated that they believe the level of care that the residents receive 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 in the community for all residents. The PREA Policy meets the standard. An MOU with Williamsport Hospital was provided to the Auditor on 8-23-16.

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. LaSaQuik is a specialized treatment facility for sex offenders. Residents are usually committed directly to LSQ by their respective juvenile courts to receive treatment as sex offenders. However, residents can also be transferred from other Adelphoi facilities. Most are adjudicated delinquent on a sexual offense but during this Audit, one resident was an adjudicated dependent and was committed to LSQ by the county office of Children and Youth. All staff at LSQ receive specialized sex offender training to help them supervise these residents. All residents receive both individual and group counseling, as well as individual therapy and family therapy during visits if requested and warranted. Many also regularly see a psychiatrist for medication evaluations. They must also participate in interactive journaling. There were no residents in the facility who had reported a sexual abuse. LSQ has exceeded this standard.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no sexual abuse incident reviews at LaSaQuik 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. This form was provided. All variables, including staffing, the physical plant, and whether the incident occurred due to gang or sexual status is considered. The staff involved in the review would include supervisors, program directors, caseworkers, PREA Coordinator and Manager, Medical and MH staff and facilities staff and also provides for input from line staff. 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. I also interviewed the Director of Nursing and the Program Director who would participate in a sexual incident review. The Director of Nursing stated she had just participated in a review at another agency facility and they included the physical plant supervisor as part of the staffing. As a result of this review, a change was made to a stairwell to improve the line of sight. The policy contains all necessary requirements for this 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 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 December 1, 2016

Auditor Signature Date