PREA AUDIT REPORT ☒ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: December 13, 2016

Auditor Information			
Auditor name: Maureen G. Raquet			
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Email: mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: July 11, 12, 13, 2016			
Facility Information			
Facility name: Williams			
Facility physical address: 521 Municipal Drive, Duncansville, Pa. 16648			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 814-695-5080			
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: 18			
Designed facility capacity: 18			
Current population of facility: 13			
Facility security levels/inmate custody levels: Secure andTransitional Living			
Age range of the population: 12-20			
Name of PREA Compliance Manager: Trey Carruthers		**Title:** Program Supervisor/PREA Manager	
Email address: trey.carruthers@adelphoi.org		**Telephone number:** 814-695-5080	
Agency Information			
Name of agency: Adelphoi Village			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1119 Village Way, Latrobe, Pa.15650			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 724-840-7000			
Agency Chief Executive Officer			
Name: Nancy Kukovich		**Title:** CEO	
Email address: nancy.kukovich@adelphoi.org		**Telephone number:** 724-804-7000	
Agency-Wide PREA Coordinator			
Name: Jennifer McClaren		**Title:** Quality Assurance Director/PREA Coordinator	
Email address: Jennifer.mcclaren@adelphoi.org		**Telephone number:** 724-804-7000	

AUDIT FINDINGS

NARRATIVE

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

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. A subsequent Audit of four off campus units was conducted in April 2015, five units in June 2015 and three units in April 2016.

This Audit was conducted at Williams Home, 521 Municipal Drive, Duncansville, Pa, about 5 minutes from the city of Altoona, Pa. Two other residential units were also audited at this time. Williams is a 15 bed male sex offender treatment program, with ages ranging from 12-19, and licensed under the Pa. Dept. of Human Services 3800 regulations. In 2015, there were 24 admissions and the average length of stay was 2.5 months. On the date of the Audit there were 11 residents in this unit; including two boys that were there for a short term diagnostic program. This is a self contained unit, with the residents attending school, eating and living in the same building. These residents can be either dependent or delinquent and are committed by their respective Juvenile Courts or transistioned from a secure facilty at Adelphoi. In addition to education, all residents receive both individual and group counseling and family counseling if warranted. All residents participate in ART, an evidence based Anger Management Curriculum, Sanctuary Groups, Sexual Issues Groups and Balanced and Restorative Justice Groups. They also must participate in daily interactive journaling. Most also see a psychiatrist for medication evaluations and physicals are conducted in the community by a doctor in his office nearby. There are no medical or mental health staff assigned to this facility. The Transistional Living Program, although housed upstairs is completely separate. There are separate staff and the residents have no interaction with those downstairs. There are three beds and there were two residents in the program at the time of the onsite. There is "staff support" rather than supervision. The residents have jobs, and cell phones. One boy had a car. They cook their own food and clean their apartment. They have some life skills classes and must call in from a dedicated phone line in the living unit to their caseworker every night upon return from their job. There were 3 admssions since the program's inception in December 2015 and the average length of stay was about three months. The two programs have separate licenses from the Pa. Dept. of Human Services and separate staff. There are 18 staff assigned to the Williams Sex Offender Treatment Program includimg a Supervisor/PREA Manager, Caseworker, two teachers, line staff and one dietary staff. Line staff are full and part time and work first and second shifts. Third shift personnel work permanent 3rd, with rotating days off. The transistional living unit has a Caseworker and a Program Supervisor. There are no direct care staff in this program.

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. Williams is JCAHO accredited.

DESCRIPTION OF FACILITY CHARACTERISTICS

Williams Home is located on a main highway next to a strip mall and across from a Veterans Home in Duncansville, Allegheny Township, Blair County in North Central Pennsylvania. The town is served by the Allegheny Township Police Department. This one story, 11,000 square foot former restaurant and nursing home is rented by Adelphoi and was completely renovated in 2013 to serve its current clients and sits on about 2.25 acres. It sits directly on the roadway and has employee parking in the front, side and rear. There is also parking for the transitional living residents. Its exterior is sided and it looks like an office building from the road. There is a macadam basketball court to the rear and a large field with a wooded area. Large glass doors are locked only to limit entry and are alarmed to signal that someone is attempting to leave. As you enter the front door, directly ahead is a large living/ dining area, with Welcome, stenciled over the entryway. The room has wooden sofas and chairs with upholstered cushions in front of a television and small tables with individual stools for dining. This area is also used for visiting. There are posters, bulletin boards, and a phone area in this open space. The kitchen is off to the side of the dining room with food storage and a laundry room. To the left of the this living area is the staff/admin area with a locked door between. This area has two offices, an open area with a table, chairs, file cabinets, office equipment, a staff bathroom and a door to the rear parking lot. To the right and behind the living area are 15 single bedrooms. The hallway is shaped like an L with classrooms and bedrooms opening onto it. The bedrooms are sparsely furnished with wooden single beds and an open wooden closet/bureau. All bedrooms have windows that cannot be opened and all have doors that are never permitted to be closed. There are two classrooms with traditional student desks, a teacher's desk and a blackboard. The one classroom has a doorway in both the front and back of the classroom. The second classroom is furnished similarly with only one door. There are windows in the doors. The shower room has three stalls with a separate curtained dressing area in front of each shower. There are two separate bathrooms with three stalls and three sinks that back up to each other on one side of the L. In the middle of this hall, there is a large area for all groups that are run with an easel, posters, and chairs in a circle for staff and residents. There is a private office that has video equipment, for PO/Attorney/Caeworker/ visits and any video conferencing. There are no cameras in the facility. There is a "Guard Tour System" for both room checks and checks of the outside of the building. Staff desks and midnight posts are at the right angle of the L, so that all bedroom and bathroom doors are visible from there. The residents do not have access to the basement or the second floor transitional living program.This program is housed in a second floor apartment that was reonovated from office space in 2015 and resembles a college apartment with a community bathroom, three bedrooms, small kitchen with washer/dryer, stove, refrigerator and a lving room with a television set. Entry is gained by entering the main door of Williams and ascending a stairwell to this apartment. There is a fire door and emergency stairwell to the outside. Entry is restricted from the outside of the building and the first floor. Exit is not restricted in any way.

SUMMARY OF AUDIT FINDINGS

A notice of the onsite Audit was posted in Williams home on May 25, 2016. A picture of the posting in several common areas was emailed to me on that date. 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 and to request additional documentation. 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, Program Supervisor and Caseworker. The tour of Williams took place on July 11, 2016, immediately after this preliminary meeting. All 11 residents were present and in school. Both transisitional living residents were in their upstairs apartment. One resident was sleeping, having worked midnight shift and one resident was getting ready for his day and we had an opportunity to talk to him. He indicated he had PREA Education and also told me he could report by contacting the Blackburn Center and showed me the phone that is also used to call into his caseworker every night when he returns home from his job. There are PREA postings in this area.

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. I toured all Common Areas that the residents have access to: all bathrooms, shower rooms and bedrooms. As part of the tour, lunch with the students was observed to ensure adequate supervision.

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 dining room and the Caseworker office. During the tour, a resident showed me how and where to use the phone and I spoke to the Blackburn Center on the other line. 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 Pa.DHS 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 could not accept reports because of the physical distance to Williams nor would they be able to provide a victim advocate to accompany residents to the hospital. 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 but the name and number will be different. Residents also have a grievance process for reporting, as well as required journaling with staff. Posters in both Spanish and English detailing how a third party can report sexual abuse are posted in the areas where parents would visit.

As part of the on-site portion of the audit, ten residents were interviewed, including one from the transitional living program; this represents 75% of the total population on this date. Ten random staff from all three shifts were interviewed (76% of the total line staff) and a teacher and dietary staff were also 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, Caseworker, Director of Nursing and the Masters' Level Mental Health Therapist from another facility who conducts screens at Williams. The two and only staff assigned to the transitional living program, a program supervisor and caseworker were interviewed. They are assigned to the Hilltop Supervised Independent Living Program that is close by and one of the other facilities being Audited.

There are no Medical or Mental Health Staff in the facility. Physicals are conducted by a physician in the community. Medications are self administered and supervised by staff. Mental Health Screeenings are conducted by Adelphoi staff from the main campus or another facility or in the community. Forensic Medical Exams are conducted at UPMC Altoona where there are SAFE/SANEs. The Director of Nursing for Adelphoi was interviewed to confirm all Medical and Mental Health arrangements.

There have been two allegations of resident on resident sexual harassment in the past 12 months. I reviewed both files for both staff reports and reports to Child Line and the Police. Both files contained the necessary documentation and indicated that all reporting protocol was followed and that staff followed policy and procedure. The first incident resulted in one resident receiving a citation for harassment. He paid that citation and both residents were placed on a safety plan. Both residents have since been discharged. The second incident is ongoing in that the perpetrator who was an adult at the time is still in the court process. He has been charged with Public indecency, but has not had his court hearing as of yet. He was discharged and transferred to another facility. A sexual incident review was conducted for the most recent incident and a report was completed and documented. I interviewed one of the staff involved in the incident and also had the opportunity to interview the resident who perpetrated the abuse, who is at another Adelphoi facility that is also being Audited. There is an MOU with the Allegheny Township Police Department who are responsible for responding to 911 calls and conducting sexual abuse investigations. This Police Departmetn responded to and investigated both of the above allegations.

Ten current resident files and three files of discharged residents were reviewed. Ten staff files were reviewed for documentation for various standards. There were no Transgender or Intersex resdients but there were three residents who identified as Bi-sexual in the population at Williams during the time of the on-site Audit.

Upon completion of the on-site portion of the Audit, 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 #313 requires random unannounced rounds to be conducted on all shifts. A new supervisor has started to conduct these rounds, but there were not enough third shift rounds documented over a period of time to meet this standard.

On 10-10-16, I received a log of random unannounced logs that were consistently conducted by the Supervisor/PREA Manager and the Program Director on all shifts. This log was for the months of July, August and September. This standard has been met.

Standard #321 Evidence Protocol and Forensic Exams requires an MOU with a PCAR for a victim advocate or documentation of efforts to obtain

one. This is an open time line and is currently being worked on by Adelphoi Staff. When obtained the Auditor will contact the PCAR and verify services. The Director of Nursing confirmed SAFE/SANEs at UPMC Altoona. Either an MOU or documentation of efforts to obtain one will be provided to meet this standard.

On 9-27-16, I received an MOU between UPMC Altoona and Adelphoi Village describing the services, including forensic medical exams and emergency services that will be provided to the residents of Williams.

On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Williams with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Williams and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone. He did so and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met.

Standard #322 requires posting on the website of the policy ensuring that allegations of sexual abuse are referred to an agency with the legal authority to conduct such investigatons and shall describe the responsibilities of both the agency and the investigating entity. The website currently lists the Pa. State Police, which is the investigating entity for most of the Adelphoi facilities. It needs to be updated to include the Allegheny Township Police Department.

On 11-3-16, I received information that the website had been updated to include the change from the PSP to the Allegheny Township Police. I verified this revision. On 11-23-16, I verified that the website included the contact information for Family Services of Altoona, who will receive reports. The standard has been met.

Standard #342 requires documentation of risk based housing decisions and although during the tour I was shown where residents who require additional supervision are housed, there is no documentation of such. This information is also used for assigned seating in the dining and living room, but was not documented. Sixty days of admissions and documentation of risk based housing decisions must be provided to meet this standard.

On 10-10-16, I received logs of 5 new admissions to Williams between the time of the onsite and this date. It logged, the date of the vulnerability assessment and the identification of either a vulnerable or aggressive resident. In addition to the Assessments for the 5 new admissions, I received a re-assessment of a resident that was conducted per policy. All assessments were done in a timely manner. All 6 residents were identified as aggressive due to a prior offense; this is a treatment program for sex offenders. All had documentation as to consideration of risk based housing to protect other residents. One resident who was also identified as vulnerable had documentation of risk based housing including what room and why because of the vulnerability. The documentation that was submitted demonstrates compliance with this standard.

Standard #351, Resident Reporting allows for reports to Child Line which meets the requirement for an outside agency, but the "hotline" has been and will be the reporting method of choice. When the MOU with the new PCAR is obtained, 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 policy and procedure will not be affected by this. The Auditor will contact the PICAR and will interview staff and residents to confirm. Pictures of the new postings will be provided to the Auditor. This is an open timeline based on the procuring of the MOU.

As described above, on 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Williams with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Williams and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports (Family Services) and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone. He did so and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met.

Standard #354 Third Party Reporting requires public dissemination through the website on who to report to. This needs to be updated to include the Allegheny Township Police Department and the Local women against Rape contact information. The Auditor will verify this revision to the website. This is an open ended timeline as described above.

On 11-3-16, I received the updated website, which includes the change from PSP to Allegheny Township PD, but still allows the Blackburn Center to accept reports and send to the local PCAR, because an MOU has not been obtained. The Blackburn Center has agreed to accept these reports until an MOU is obtained. This information is listed on the website. On 11-30-16, the website was updated to include the contact information for Family Services of Altoona, with whom Adelphoi has an MOU for reporting and victim support services. This was verified by the Auditor. The standard has

been met.

Standard #381 requires a 14 day Medical or mental health assessment for those who have disclosed a prior sexual abuse and and a 14 day Mental Health follow up for those who have perpetrated a sexual abuse. The review of resident files showed that several students had not received these assessments in a timely fashion. The Supervisor and Caseworker were able to tell me that many of these residents had been offered these services and declined, but there was no documentation of the declination. Documentation of Admissions for 60 days is required to meet this standard.

On 10-10-16, I received logs of 5 new admissions and vulnerability assessments for them and one re-assesssment. Of these, all were identified as aggressive, due to a prior offense and this being a sex offende treatment program. All but one resident declined the offered treatment and this declination was documented. The resident who accepted the services received an assessment within the 14 day window required by the Standard. The resident who was re-assessed as per policy, was offered and received both Medical and Mental Health assessments within 14 days of his re-assessment. The documentation submitted demonstrates compliance with this standard.

Of particular note is the assessment and treatment that is offered to the residents who are victims or perpetrators of sexual abuse. This is a treatment facility and a sex offender unit. All residents at Williams receive specialized and intensive treatment. Most residents see a psychiatrist for Medication evaluation. They are sent to Williams by the Courts for treatment and staff there receive specialized training for working with this type of client. Residents receive both individual and group counseling, including Sexual Issues group counseling. The residents also must participate in daily interactive journaling, that is reviewed by staff. Staff at Williams not only receive the PREA trainings and refreshers required of all staff, but also receive specific training regarding sexual offenders and sexual issues, so they can run groups and monitor the journals the residents are required to keep. During the staff interviews they were able to demonstrate a mastery of the information. Both Standard #331, Employee Training and Standard #383, Ongoing Treatment have been exceeded.

All other Agency Policy and Procedure comply with standards.

Number of standards exceeded: 2

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a PREA Coordinator and the facility has a PREA Manager. I interviewed both during the on site portion of the audit. They both state that they have the time and resources to fulfill their PREA responsibilities. There is a PREA policy that has been submitted and reviewed and contains all necessary information regarding preventing, detecting and responding to sexual abuse and sexual harassment at Williams. The position of PREA Coordinator is on the agency flow chart. She holds the position of Quality Assurance Director. Each facility has a PREA Manager who is also the Program Supervisor. This policy meets the standard.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the President and Vice President of Residential Services, the PREA Coordinator and PREA Manager/Supervisor of Williams. All interviewed state that both the PREA Requirement and the Pa. Dept of Human Services Ratio of 1:8 and 1:16 are always exceeded. While on the tour and throughout the interviews, I saw residents supervised in classrooms and in the dining room, both in groups and

individually. Ratio was always exceeded. There are always two staff on midnight shift and three staff, not including the supervisor and caseworker, on the awake shifts. A schedule is prepared and posted for a two week period, but is reviewed daily to meet "one on one" supervision of residents, if needed, and other needs of the population, such as programming. The PREA Policy contains all 11 factors that need to be included in staffing. A Facility Vulnerability Assessment is conducted yearly and this includes the physical plant as well as staffing needs. There have been no instances of not meeting ratio. Mandatory overtime is used if necessary. I reviewed the most recent Licensing and Inspection Summary from the Pa. Dept. of Human Services and there were no citations for not meeting ratio. The "Guard Tour" system records 10 minute checks of the residents while they are sleeping. The staff desk is posted in an area, where all bedroom and bathroom doors can be seen. There are no blind spots. It is an open living area. Unannounced rounds are random and are conducted on all three shifts by the program director and the facility supervisor and this is in the PREA policy. The logs of these rounds were provided to me. Although they are being conducted and documented, there was only one conducted on an overnight shift in the past 6 months. A new supervisor has just been promoted and has started to conduct and document these rounds. A corrective action plan of at least 60 days of consistent, random, unannounced and documented rounds including all shifts must be submitted in order to meet this standard.
Corrective Action:
On 10-10-16, I received a log of random unannounced rounds that were consistently conducted by both the PREA Manager/Supervisor and the Program Director for the months of July, August and September. This documentation demonstrates compliance with this 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. Ten random staff were interviewed and 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. All staff were aware of the policy prohibiting staff from searching or physically examing a Transgender or Intersex resident for the sole purpose of identifying their sexual status. There were no Transgender or Intersex residents in the population. All 10 residents interviewed stated that they had never been subject to a cross gender pat down search. They also stated that female staff knock and announce their presence when coming into the bedroom/bathroom area. One resident demonstrated how the female staff announced themselves saying "M---- entering the bathroom" . He stated, "we always know she is there". While on the tour, I saw knock and announce posters. The shower policy requires all residents to shower three at a time, in three separate showers with a staff at the doorway. There is a separate curtained changing area in front of each shower. If there was a transgender or intersex resident they would be permitted to shower separately according to interviews with the PREA Manager. The PREA Policy contains all necessary information and the random staff were able to answer questions about it during their interview.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There were no residents with disabilities, nor any residents who do not speak English. A non-English speaking child would not be admitted because the child would be unable to participate in the program. It is more likely that parents may not speak English, and a contracted translator would be used to communicate with those parents. A copy of the contract was provided. Spanish and English PREA posters were throughout the house, including the dining/living area where visiting would take place. 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 telephone, having interviewed her in person less than two months ago during a previous 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. Pa. DHS requires that they be conducted at 5 year intervals. 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 Williams , including one recent promotion and four recent hires. All files had the necessary clearances and also clearances conducted every two years, if they had been employed that long. A review of the most recent Pa. Bureau of Human Services Licensing Summary showed no citations for failure to have proper clearances. I also reviewed the files of both a volunteer and a contractor and they contained the necessary clearances. The policy and the practice comply with both the state law and the PREA Standard.

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.

Williams has no cameras, but has a recently installed "Watch Tour System" that is used during sleeping hours at10 minute intervals. There is a chip installed at each bedroom door as well as in common areas and the outside of the facility, which is checked periodically. The outside doors of the Transistional Living Unit are also checked, but there are no checks inside this unit. These electronic checks are downloaded onto a supervisor's computer and are monitored in that fashion. Williams is leased by Adelphoi Village and was completely remodeled in 2013, for this population. New classrooms, single bedrooms, dining/living area, and office space were reconfigured for better lines of sight and supervision. In 2015, the Transisitional Living Unit on the second floor was changed from office space to a 3 bedroom apartment. Renovations were mostly cosmetic with the addition of kitchen appliannces and a washer and dryer. I interviewed the President and Vice President of Residential Services who state that renovations are planned to ensure safety of the residents and cleaner lines of sight.

Single bedrooms, especially for a SOU are planned if possible and this is what was done at Williams. The policy meets the standard.

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 using UPMC Altoona 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 exam would be free of charge for the residents. Adelphoi staff is in the process of obtaining an MOU with this facility. This MOU will be provided to the Auditor or documentation of attempts to obtain one. There is an MOU with the Allegheny Township Police Department to conduct Sexual Abuse Investigations and this was provided. 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 she stated that her agency would provide training and emotional support services, but because of the geographical distance would not provide a Victim Advocate to accompany residents to the hospital or for police interviews. They would not accept reports from the "hotline", but would either pass on or provide a number for the local PCAR. Blackburn provided Adelphoi with the name and contact of a local agency that could provide these services. They are in the process of getting an MOU. When this is accomplished, the MOU will be provided to the Auditor, who will contact the local Women Against Rape and confirm the services listed in the MOU. Policy will be updated and both residents and staff will be trained. The Auditor will interview both residents and staff to ensure compliance. While at Williams, I saw the reporting posters for Blackburn Center and used the designated phone in the living area. There is also a private one in the caseworker office. One resident volunteered, showed me where the phone was, how to use it and completed the call to the hotline. Although several upper level staff have received investigator training, they do not conduct investigations. They gather enough information to contact Allegheny Township PD and Pa. 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 Williams, who confirmed his knowledge of the MOUs and necessary procedure. Policy meets standard. This plan of correction has an open ended timeline, because of dealing with an outside agency.
Corrective Action:
On 9-27-16, I received an MOU between UPMC Altoona and Adelphoi village to provide forensic medical exams to the residents of Williams.

On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services, who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Williams with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Williams and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone as a test. He did so and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy and the Pa. CPSL require all staff with any knowledge or suspicion of Sexual Abuse or Sexual Harrassment to report to Child Line, under penalty of law, and the Adelphoi Policy requires also reporting to a supervisor and documenting the incident. All staff receive Mandated Reporter Training as part of their orientation. Interviews with 10 random staff, a teacher, and a dietary staff confirm that they know both the policy and the law. During the Audit, it was requested that the website be revised to contain the contact information for both the Allegheny Township Police Department and the Pa. State Police.It also needs to include the name and contact information for the local PCAR. The Auditor will verify the revision to the website. This plan of correction has an open ended timeline due to the involvement of an outside agency. I interviewed the President of Residential Services and he confirms that the policy and procedure are followed. Reviews of the files for the two resident on resident sexual harassment incidents, shows that these policies and procedures were followed in a timely fashion. The Allegheny Township Police Department was called and responded, Supervisors were notified, and Pa. Bureau of Human Services was notified, although they did not conduct an investigation. None off the residents in either incident required medical care. On 11-3-16, I verified that the website had been updated to include Allegheny Township Police Department as the law enforcement agency that would receive reports and conduct investigations.

On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services, who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Williams with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Williams and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident could also tell me of the changes. I asked him to use the hotline while I was on the phone as a test. He did so and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have 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 the standard at orientation and then every year as a refresher. The refresher had just occurred in March 2016. One staff person stated he had received training on cross gender pat down searches during his intial PREA Training. The online curriculum is paired with a power point presentation that was provided to and reviewed by me. The employees test out, demonstrating their understanding of the material. A log of employee training 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 Williams receive additional specialized training because it is a sex offender unit. They are treatment staff who run sexual issues group and participate in the interactive journaling. The policy indicates who must receive training, what the training will entail and when training will be received, both at orientation and refresher training. Due to the specialized training and the competency displayed during interviews, 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.

During the Audit, I interviewed by phone a HVAC Contractor who services Williams. He could tell me about the Zero Tolerance Policy and told me that he would report to the Facility's Director. I was provided with a copy of the brochure that is used to train contractors and volunteers. They are located in the foyer area with a sign in book and a posting of the Zero Tolerance Policy. There are no volunteers specific to Williams, however, I interviewed an agency volunteer by phone. She and her husband were part of a church group and had been educated and knew how to report and who to report to. 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 the Williams Caseworker and the Caseworker from the Hilltop facility who does the education for the Transisitional Living residents. Both are responsible for conducting the Intake and providing information to the resident during the Intake. This information was in reference to the agency's zero tolerance policy on sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. They are also responsible for conducting the education that must occur within 10 days of Intake. They detailed to me when and how they do this. This is usually done during the Intake process, rather than later. I was provided with the handbook that is given to the resident at Intake, along with a Child's Rights and grievance form. The video that they watch is entitled "Safeguarding Your Sexual Safety", a PREA Orientation Video produced by the Moss Group. Ten residents were interviewed and all stated they received the appropriate information at Intake and then more comprehensive education within 10 days. Of the thirteen files I reviewed, 10 active and three discharges, all but one resident admitted to or transferred from another facility received both their Intake and 10 day education on the same day they were admitted. The one exception was a resident who was transferred in July of 2014, before PREA was instituted at Williams. He was subsequently educated. There were sign offs in the resident files I reviewed. The orientation handbook contains basic PREA orientation and in order to move to the next level, the resident must take a test that includes this PREA information. There is ongoing education in the form of postings, but also Sexual Issues groups, and Balanced and Restorative Justice Victim's curriculum. The policy outlines when a

resident must be educated and what the education needs to contain. The 10 residents interviewed demonstrated an understanding of the material during their interviews.

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 Allegheny Township Police Department 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 Police 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 for the Agency and a Master's Level Mental Health Therapist from another facility who is also an LSW. Both stated they received the PREA training that all employees receive, but also receive additional training through Adelphoi and through outside resources. There are no Medical or Mental Helath staff assigned to Williams. The residents receive their physical at a doctor's office in the community. Medication is self administered and supervised by a staff person. A community psychiatrist does medication reviews. The Mental Health Therapist is assigned full time to another Adelphoi facility that is also a SOU and does the 14 day follow ups that are necessary. He is considered an "expert"by the courts in the area of sexual victimization. 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 the Director or Nursing and for this Mental Health Staff person. Policy describes who must receive and training and what the training needs to entail .

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Caseworker for Williams 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 3 discharged files show that this was done in a timely fashion in all cases. The file review showed that residents who are transferring to Williams from the Secure Units are having this done upon transfer and it is also being done at six month intervals. Every resident who had been at Williams for more than six months had multiple assessments. The tool is also used after an incident of sexual abuse/sexual harassment and in fact was used during one of the incidents that was reported in the last 12 months. It was provided to me. The Vulnerability instrument itself is a commonly used one that takes into account prior victimization, prior aggressive sexual acts, physical factors, such as small stature, any disabilities, a problem with bullying in the past, prior institutionalizations and other important variables. The answers are scored to see if any or all of these factors identify a child as vulnerable or aggressive. The Policy states that this assessment must be conducted within 72 hours of intake and that the information is confidential. I saw where the resident files are kept, in a locked file cabinet in the administrative area. All line staff receive specialized training and are treatment staff, they therefore have access to the information. The teachers and dietary staff and any staff from another unit, do not have access to this information.
This standard has been met.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Use of isolation is prohibited by Adelphoi Policy and by the Pa. Department of Human Services 3800 Regulations. I observed no area during the tour where a child could be isolated. Interviews with both Medical and Mental Health staff, the PREA Coordinator, and PREA manager confirm that isolation is never used. I interviewed the Caseworker who administers the Vulnerability Assessment. He does this within 72 hours of Intake. He states that the information is used to determine housing assignments and also seating assignments in the dining room. During the tour I saw several rooms closest to the staff desk that could be used for either vulnerable or aggressive residents. Because this is a sex offender program, all residents are identified as aggressive because of their charges. It is noted if a resident would be identified as aggressive in this setting. Special consideration is given to those identified as vulnerable. There were three residents who identified as bisexual during the interviews and all stated they were not discriminated against because of this or placed in specialized housing. 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. Transgender and Intersex residents would be permitted to shower separately. The PREA Policy outlines the procedure for use of this information and who can have access to it. I saw where the resident files are kept during the tour. The only documentation that I received for a risk based housing decision was the result of a sexual harassment allegation and in the safety plan, it stated where the resident was housed and the increased supervision he would receive based upon the allegation. The Supervisor/PREA Manager and the Caseworker state that they discuss housing and seat assingments during bi-weekly staffings, but there is no documentation of such. A plan of correction is needed to ensure documentation of risk based housing decisions. Sixty days of admissions with timely VAIs and documentation of risk based housing will be submitted and reviewed to ensure compliance with this standard.

Corrective Action:
On 10-10-16, I received logs of 5 new admissions and the Vulnerability Assessment for them as well as a re-assessment conducted as per policy. All residents were identified as aggressive, due to prior offenses and this being a sex offender treatment program. Documentation for consideration for risk based housing was present for all. The one resident who was re-assessed pursuant to an incident, that occurred subsequent to the onsite, documented room assignment for the vulnerability identification.
The documentation submitted demonstrates compliance with this standard.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy dictates that a resident can report verbally, in writing, anonymously, and through third parties. The 10 residents that were interviewed were able to communicate that they understood this. They stated there was a phone in the livng area and the caseworker office with a dedicated button that went directly to the Blackburn Center. There were also posters with addresses for the Blackurn Center and phone numbers for Child Line posted throughout the facility. Residents can use a grievance form to report and they receive and sign off on grievance information at Intake. This grievance sign off was in the 10 current resident files and the three discharged resident files that I reviewed. Parents also receive this information at Intake. 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. Due to the use of daily journaling, all residents have pencils in their rooms. They also have access to parents by visiting once a week, phone calls from parents or grandparents twice a week or more depending on level and confidential communication with their attorneys. One resident stated during the interview that he was not permitted to contact his attorney and the program supervisor was notified. All possible avenues for reporting have been made available to the residents and they know of them. Ten random staff were also interviewed as well as the PREA Manager. All had been trained on how to accept and document reports and how the residents could report. During the tour, a resident volunteered and used the Blackburn phone. A phone call to the Blackburn Center prior to the onsite portion of the Audit revealed that Blackburn will not accept the call but will provide a local reporting number. Obtaining an MOU with a local PCAR is in process. Once this is accomplished, the posters will be updated, the phone button changed and staff and residents advised. There will be no change in procedure. The Auditor will verify these changes. This is an open ended timeline for the plan of correction, due to the involvement of another agency. Child Line still remains an outside resource to call. The residents in the transistional living program have additional resources in that they have cell phones and work in the community.
In both cases of reported resident on resident sexual harassment incidents, verbal reports were made to staff who documented them immediately. This documentation was reviewed by the Auditor onsite as well as the timely report to police.
On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services, who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Williams with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Williams and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports (Family Services) and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone. He did so and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Vice President for Residential Services and the PREA Manager/Supervisor for Williams. They both could tell me that the policy allowing parental visiting once a week, incoming parental phone calls twice a week and confidential calls or visits from attorneys was also practice. The 10 residents that were interviewed also stated they could and did receive visits and phone calls. They also stated they could contact their attorneys but most had not and one resident stated he was not permitted to call his attorney. The PREA Coordinator was advised of this. The residents could talk about the posters with phone numbers and addresses for Victim Support through the Blackburn Center and where the phone was located in the staff office and about the designated button to access the support. Most were not clear about what kind of services these were, unless cued during the interview. A phone call to Blackburn prior to the onsite confirmed that although they cannot accompany the residents due to geograhphics, and another PCAR will do this, they will still offer the confidential support services contained in the MOU. While on the tour of the facility, I saw the posters with the information throughout the house, saw and used the phone. 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. Policy meets standard.
On 10-10-16, I received documentation in the form of a vulnerability assessment for a resident who was involved in an incident at Williams. He requested to contact the Blackburn Center by phone for support. A staff person from the center met with the resident at the facility.
On 11-23-16, I received an MOU between Adelphoi and Family Services of Altoona. This agency will now offer victim support services as a consolidation with reporting for the residents of Williams. I spoke to the Director of Family Services who confirmed the services outlined in the MOU.

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. However, this website must be updated to include the Allegheny Township Police Department to report to for this facility and the contact information for the PICAR that Adelphoi is obtaining the MOU with. When this is completed it will be verified by the Auditor. This is plan of correction has an open ended timeline due to the involvement of an outside agency.
On 11-3-16, I verified that the website had been updated to include Allegheny Township Police Department as the law enforcement agency that would receive reports and conduct investigations.
On 11-30-16, I verified that the website had been updated to include Family Services of Altoona as an outside agency that would receive reports. I called and spoke to the Director of that agency on 11-23-16 and she confirmed that Family Services would receive reports as outlined in the MOU.
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 and the teacher and Dietary staff. 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. I reviewed both files for the two allegations of resident on resident sexual harassment and both of these files contained the HCSIS report that documents the notification of those listed above and it was done within 24 hours of receiving the report. There were no citations on the most recent Licensing and Inspection Summary for not notifying and submitting the report in a timely manner. The agency only performs administrative investigations and in these cases, the police were contacted immediately. However, a supervisor is always notified immediately as per policy and this was done.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PREA Policy requires that if Williams 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 Williams receives a report from another facility that a child alleged sexual abuse while at Williams, 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. The teacher when interviewed stated, "I would get another staff to help me separate the residents and ensure the safety of both victim and perpetrator. After assessing any medical needs, I would call childline and notify my supervisor". All staff could agreed that they knew and understood the agency's protocol for collecting usable physical evidence, which is to secure the scene

and to let the police gather that evidence and to provide medical services to the resident and not to let them shower or change clothes. The separation of the victim and his well being was cited as being of the utmost importance. The first responder duties are posted in the staff office. The two reported incidents of sexual harassment in the last 12 months did not require any 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. Line staff, administrators, the Director of Nursing or nurse on call and the PREA Coordinator and Manager all play a role in this response. In the two cases of resident on resident sexual harassment there was documentation of this response, although there was no medical involvement needed.

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 Williams Supervisor and he is present in the facility full time. He is responsible for protecting residents from retaliation and when interviewed 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. Neither of the two reported incidents involved any retaliation and the Supervisor/PREA Manager had not been promoted when they occurred. However, he was a caseworker at that time and stated that both residents involved were placed on a safety plan that includes constant monitoring and the one resident perpetrator was transferred to another facility, albeit for treatment purposes.

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 Allegheny Townhip Police Department outlining both their and Williams' repsonsibilities and mandatory reporting to Child Line. Both of these agencies conduct an investigation of any allegation of sexual abuse. It is outlined in both PREA Policy and Adelphoi Polcy as to what the responsibilities are for agency staff in conjunction with an allegation of abuse or harassment. Although several staff have received investigator training, their role is limited to gathering enough information to report to Child Line and the PD 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 Program Director indicated that they would and do cooperate with the PD 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. The two allegations were reported to the Police Department and the reports were reviwed during the onsite and they demonstrated cooperation with the investigation. Most of the provisions of this standard are the jurisdiction of the Allegheny Township 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. Agency and Facility staff do not determine whether an incident is substantiated. This is the jurisdiction of Pa. Child Line and/or the Police Agency.

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. There was documentation in the files that I reviewed that residents, both victims and perpetrators were advised as to the outcome of the police investigation for the two incidents of resident on resident sexual harassment. In one case it was a summary citation for harassment. The other case is ongoing and all other parties have been released from Williams. I interviewed the one perpetrator who is at another Adelphoi facility. His case has not yet been resolved, but he is kept abreast of the proceedings. I also interviewed the Program Director and Program Supervisor who communicate with the local Police Department to ensure they are kept abreast of the investigation.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

There have been no incidents in the past 12 months that have required any staff discipline. I interviewed both the President of Residential Services and the Director of Human Resources. Termination is the presumptive disciplinary sanction for a staff person who engages in sexual abuse. The Pa. CPSL prohibits a staff person to have contact with children if they are found to have engaged in sexual abuse. Other sanctions for lesser violations are commensurate with the act 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 and Child Line would be immediately notified. This would not be treated any differently than if it were a staff person. Pa. CPSL requires the same action. PREA Policy meets the standard.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents of disciplinary sanctions against residents who have falsely reported in the past 12 months. Both PREA Policy and the Pa. Child Protective Services Law does not allow for any disciplinary sanctions for a report made in good faith.
In the event that there was an incident, the child's mental health, intellectual level, and age 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. In the two incidents of sexual harassment that were reported in the past 12 months, all residents were immediately placed on safety plans. Resident levels may have been adjusted to reflect treatment goals. The one perpetrator was transferred to another facility and was interviewed by this Auditor. He stated that he was not disciplined, nor were his levels dropped. He was transferred to the other facility for more intensive treatment and his criminal case resulting from the incident is scheduled for August 2016. His transfer to the other facility was a joint decision by Adelphoi and his Probation Officer. Adelphoi Policy and Pa.regulations prohibit any sexual contact between residents. Such activity is only considered to be abuse if it is coerced. A resident may only be disciplined for sexual contact with staff, if staff did not consent. There have been no incidents involving staff.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All residents that have reported a previous sexual abuse or who have perpetrated a sexual abuse are offered medical and mental health assessments within 14 days of being identified. This in the PREA Policy. I interviewed the caseworker who completes the Vulnerability Assessment and he states that he ensures that follow up is offered. I interviewed both the Director of Nursing for Adelphoi and a Mental Health Therapist from another facility who stated that an assessment/physical is done by a doctor in the community on every child within 14 days and that a MH assessment can be completed by a therapist or a psychiatrist during that time frame. A signed consent is obtained from the resident at Intake and both the Medical and Mental Health care staff state that they advise the resident prior to the initiation of services and again if they have to report. Two current residents reported a prior sexual abuse. One resident stated he declined new treatment, because he was in ongoing treatment and the other resident stated he had not been offered treatment. All residents in this facility are perpetrators. Of the thirteen files I reviewed (10 active and 3 discharged) seven did not have timely follow up or documented declination. The PREA Manager who was the former caseworker did these Assessments and was able to tell me which boys refused treatment, however this was not documented. Corrective action is required to ensure that all residents receive follow up within 14 days of the administration of the Vulnerablity Assessment or there is documentation of declination. Sixty days of admissions with documentation will be provided to come into compliance with this standard.
Corrective Action:
On 10-10-16, I received a log of 5 new admissions and one re-assessment. All risk assessments were done in a timely manner and all residents who disclosed a prior sexual abuse, 3 out of 5, refused a medical assessment and this was documented. One resident who had a reassessement pursuant to the PREA policy was offered a medical assessment and accepted it. The physical was performed the next day. All 6 residents were also identified as aggressive due to prior offenses, because this is a sex offender treatment program. All 6 residents were offered a mental health evaluation. Five out of six declined and this was documented. The resident who accepted had a mental health evaluation completed within 7 days.
This documentation demonstrates compliance with this standard.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents that required emergency medical or mental health services. Both reported incidents of resident on resident sexual harassment did not require any medical treatment. There were no residents to interview who reported a sexual assault. UPMC Altoona would provide emergency treatment and has SAFE/SANES in the ER and on call. Adelphoi is workig toward obtaining an MOU for this medical center. The Director of Nursing and the Mental Health Therapist both stated that they believe the level of care that the

residents get is better than if they were home, because of consistency and follow up and is free of charge for the residents. The ten random staff that were interviewed were able to discuss their first responder responsibilities regarding Medical and Mental Health emergency care. The Director of Nursing states that there is always a nurse on call. Any medical follow up regarding STDs is also provided at the hospital and then at the doctor that is used in the community. The PREA Policy meets the standard.
On 9-27-16, I received an MOU between Adelphoi Village and UPMC Altoona, describing all medical services, including emergency services that would be offered to the Williams residents.

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. Williams is a specialized treatment facility for sex offenders. Residents are either transferred from a secure facility at Adelphoi or committed directly to Williams by their respective juvenile courts to receive treatment as sex offenders. All have been adjudicated delinquent on a sexual offense. All staff at Williams receive specialized sex offender training to help them supervise these residents. All residents receive both individual and group counseling, as well as individual therapy. Many also regularly see a psychiatrist for medication evaluations. They must also participate in interactive journaling, a treatment modality for this kind of offender. A copy of the guidlelines and the areas that a resident should consider when journaling were provided to me. There were no residents in the facility who had reported a sexual abuse. Williams 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 has been one sexual harassment incident review at Williams, although two reported incidents of sexual harassment in the past 12 months. The first review was not conducted as called for in policy, because the PREA Coordinator was on leave, however, corrective action was taken and all PREA Managers and Supervisors throughout Adelphoi were given a refresher training for Sexual Incident Review. The logs of attendance were submitted during a prior Audit. The sexual incident review at Williams was also submitted to show adherence to this standard. It was completed within 30 days of the incident. It takes into account all variables, including staffing, the physical plant, and whether the incident occurred due to gang or sexual status is considered. The participants as per policy included the Program Supervisor/PREA Manager, the PREA Coordinator, two program Directors, the Director of Nursing, the Human Services Director, a Senior superisor at Williams and the Facilities Supervisor. Appropriate action in the way of training, policy change or physical plant modification could be recommended and would be followed. In this case there was no recommendation beyond staff redirection. It was concluded that an error in judgement on the part of a new and inexperienced staff person was a factor in this incident. I interviewed both that staff person and the Program Supervisor/PREA Manager regarding this incident. This incident and the resulting documentation followed the PREA Policy. I interviewed three members of the incident review team: PREA Coordinator, Program Director, and Director of Nursing.

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 13, 2016

Auditor Signature Date