

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: March 19, 2018

Auditor Information			
Auditor name: Maureen G. Raquet			
Address: PO Box 274, Saint Peters, Pa. 19470-0274			
Email: Mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: August 14, 15, 16, 17, 2017			
Facility Information			
Facility name: George Junior Republic			
Facility physical address: 233 George Junior Road, Grove City, Pa. 16127			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 724-458-9330			
The facility is:	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input checked="" type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Other
Name of facility's Chief Executive Officer: Richard L. Losasso			
Number of staff assigned to the facility in the last 12 months: 720			
Designed facility capacity: 470			
Current population of facility: 415			
Facility security levels/inmate custody levels: secure			
Age range of the population: 8-20			
Name of PREA Compliance Manager: Erin Speer		Title: Compliance and Outcomes Coordinator/PREA Manager	
Email address: espeer@gjr.org		Telephone number: 724-458-9330	
Agency Information			
Name of agency: George Junior Republic in Pa.			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: s/a			
Mailing address: <i>(if different from above)</i> s/a			
Telephone number: 724-458-9330			
Agency Chief Executive Officer			
Name: Richard L.Losasso		Title: Chief Executive Officer	
Email address: rlosasso@gjr.org		Telephone number: 724-458-9330	
Agency-Wide PREA Coordinator			
Name: Sandy Dillon-Dick		Title: Vice President of Treatment/PREA Coordinator	
Email address: sdillon-dick@gjr.org		Telephone number: 724-458-9330	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) Audit of George Junior Republic was conducted on August 14, 15, 16, 17, 2017 by Maureen G. Raquet, Raquet Justice Consultants LLC, a Department of Justice Certified PREA Auditor for Juvenile Facilities. Another staff person, trained and supervised by the Auditor, participated in the onsite portion of the Audit. This facility was initially audited during the first PREA cycle in November of 2014 and was found to be in full compliance on December 19, 2014. This Audit, conducted on August 14, 15, 16, 17, 2017, is a re-audit of the facility conducted during the first year of the second PREA three year cycle. Notice of the Audit was posted on 7-3-17, and I received an email with pictures of the posting in the living units and common areas on this date. The facility was requested to keep these notices posted during this six week pre-audit period and they were still posted in all areas during the tour on August 14, 2017. There have been no communications received as a result of this posting in the Auditor's Post Office box. On July 13, 2017, I received the Pre-Audit Questionnaire and important documentation on a flash drive. During this period, through emails and conference calls with the PREA Coordinator and PREA Manager, more information was requested and the uploaded information and important documentation was discussed and clarified. The policy was also amended to include all verbiage and was updated. The agenda for the onsite portion of the Audit was emailed to the PREA Coordinator on 8-3-17. The onsite portion of the Audit commenced with a brief entrance interview with the PREA Coordinator and PREA Manager followed by a lengthy tour of all areas of the facility that the children have access to. This included 18 Special Needs Units, 3 Intensive Supervision Units, 2 Crisis Units, a Diagnostic Unit, and 21 Group Homes. The common areas were also toured, including the new visitation center/recreation complex, the old visitation center, the vo-tech building, the school, the ropes course, chapel, medical building, counseling center, five gyms, a recreation complex with two movie theaters, the security office with monitors for cameras and the administration building. During the tour, I saw postings for the upcoming Audit in every living unit and common area. In addition, there were posters in both Spanish and English in most areas, including the visiting area describing PREA, describing Sexual Abuse, providing reporting information to AWARE and providing residents, visitors and staff with reminders of the Zero Tolerance Policy. The following buildings did not have PREA postings or did not have them in Spanish: the new Visiting/Recreation Center, the Vocational Building, Cottage V, and the small gym. They were posted during the onsite and verified.

While on the tour, I asked a boy to show me how he would report Sexual Abuse or Sexual Harassment. He showed me the poster with the phone number for AWARE. He asked a staff person for a flexible pen and he wrote the number down. He asked a staff to use the phone and he was shown into a private glassed in office. He called the number and handed the phone to me. It went to AWARE. He was one of the very few residents who could tell me about AWARE, although the phone number is on the pamphlet that the residents are given during Intake. It was suggested that the AWARE phone number be posted above the phone. This was done during the post onsite Audit period. A picture of the posting was sent to the Auditor. During the pre-Audit time period, I contacted the Director of AWARE, a member of the Pennsylvania Coalition Against Rape (PCAR), who confirmed both the reporting capability and all other services in the MOU provided to me, including crisis intervention and providing a victim advocate for the residents. She stated that she was concerned due to the number of incidents that had been reported at George Junior. She stated that due to the significant turnover in staff at the administrative level that she does not feel that all protocol is being followed. She also advised me that they now have a Child Advocacy Center in Mercer County. This is a resource that allows for one stop forensic interviewing and coordinated forensic examinations. This information was given to the PREA Coordinator who immediately contacted the AWARE director for this information. A MOU is in the process of being obtained with the CAC. There is an MOU with Grove City Medical Center for SAFE/SANE forensic examinations and a MOU with the Pennsylvania State Police for Criminal Investigations.

Due to the concern voiced by the Director of AWARE, I also contacted the Western Regional Director for the Pa. Department of Human Services. Her agency investigates all reports of sexual abuse at child care facilities. She was aware of the allegations and was personally involved in some of the investigations. She stated that the facility had followed all reporting and response protocol. During the onsite, I reviewed the files for all allegations in the past 12 months and saw timely reports to both Child Line and the Pa. State Police. In several of the incidents, AWARE was contacted and provided a Victim Advocate for the resident.

In addition to reporting to AWARE, Child Line numbers are posted and there are dropboxes in every common building such as the school, medical building, counseling building, visitation centers, and the gym. These dropboxes are for grievances that can be used to report sexual abuse and sexual harassment. Residents also receive phone calls and visits from family. George Junior has a bus that brings parents from Philadelphia and Reading Pa. once a month because of the distance. The facility serves the parents lunch when they arrive and packs a bagged lunch for their return. Students from San Francisco, California receive court ordered facetime visits. During the onsite portion of the Audit, over 100 residents returned from home visits. Probation officers, caseworkers and Public Defenders visit on a regular basis.

During the tour, my contracted staff and I spoke to residents and direct care staff regarding PREA training, unannounced rounds conducted by supervisors and reporting. It was apparent that many of the residents we talked to had not seen the video which is part of the PREA education curriculum for residents. Most of the staff and residents did not mention AWARE as a reporting mechanism, although the number was posted in every unit. All staff, including clerical, medical, mental health and direct care stated they receive training on a yearly basis and could answer candid questions regarding their PREA training and mandated reporting. Two contracted employees, a vice principal and a vo-tech receptionist, stated they had not received PREA training. Both staff and residents confirmed that supervisors and administrators conduct unannounced rounds on all shifts. While onsite, I viewed a video recording of a random unannounced round that

was conducted on 8-13-17 at 1:55 AM, a third shift, by an Administrator. Recording capability is for approximately 5 days. Administrators have desktop access to the cameras. I toured the security office where there are a bank of monitors for the over 400 cameras on the campus. They are actively monitored during the night shifts as part of the supervision.

During the tour, I visited the Medical Building with a waiting area, an office area and separate private examining rooms, where a resident can be seen by Medical Staff. I observed the medical files in the office area. The Medical files are now part of the Electronic Health Record. There were PREA postings in the waiting room, but prior to the end of the onsite, they were posted in every examining room and a PREA pamphlet was displayed along with STD pamphlets in the waiting area. There are 20 Nurses and they work around the clock. There is a separate counseling center for the residents of the group homes. It has a waiting area with posters and a receptionist with private offices in the rear.

During the tour, some residents were playing video games in their respective cottages, some were outside playing basketball, others were walking across the campus to therapist appointments or returning from home passes. School had not yet started for the year. I had the opportunity to see the residents supervised in group settings during a lunch period in many of the units. Staffing exceeded both the PREA requirements and that of the Pa. 3800 Child Care regulations. The ratio that is required by the regulations is 1:8 awake and 1:16 sleeping, which it is in the cottages. The ratio of 3:11 or 2:11 is maintained in the crisis intervention, intensive supervision or special needs units. On the units, I did not hear "knock and announce" practiced when female staff entered the male units, although the residents could tell me they are not subject to cross gender viewing.

Directly after the tour of the facility, and for the following three days, my contracted staff and I conducted the following interviews in private offices in the administration building and in a private office in the intensive supervision units and crisis intervention unit:

CEO

PREA Coordinator/Vice President of Treatment Services

PREA Manager/ Compliance and Outcomes Coordinator

Director of Nursing

Clinical Director

Treatment Team Coordinator who administers the Vulnerability Assessment (2)

Treatment Team Coordinator who conducts Intake Education

Campus Director who participates on the Incident review team

Campus Director who monitors retaliation

Campus Director who conducts unannounced rounds

Campus Supervisor who acted as a first responder

Vice Principal of the School, a contracted employee

Human Resources Assistant/Recruiter

Forty five (45) residents (one from each housing unit and two crisis intervention units)

Forty Six (46) random staff from all shifts and all housing units.

Staff are both full and part time and work permanent and rotating shifts. The 21 group homes are staffed by two cottage parents, a husband and wife who live in a wing of the cottage, sometimes with their children. They work from 6:00 AM to 10:00 PM, at which time a night staff relieves them and does the 15 minute room checks of the residents throughout the night. The Special Needs Units, Intensive Supervision Units and Crisis Intervention Units are staffed by direct care staff entitled, Clinical Managers, who work rotating first and second shifts and permanent third shifts. There is no union or bargaining unit at this facility. The Nurses and Mental Health staff are George Junior employees. There are 20 nurses, a contracted doctor who does physicals, and two psychiatrists, psychologist and dentist. The Mental Health Therapists have offices in each of the staff secure units: CIU, SNU, and ISU. They conduct the 14 day follow ups of residents required to have a Mental Health Assessment because of identification on the Vulnerability Assessment as well as see each resident on a weekly basis for individual therapy. The residents in the cottages also see a therapist weekly at the Counseling Center.

There were 415 residents on the first day of the Audit. Forty five residents were interviewed, one from each housing unit and the two

Crisis Intervention Units. I met with the PREA Coordinator so that we could identify any residents in the current population that identified as LGBTI (7), who disclosed a prior sexual abuse (46), who were disabled or non English speaking (0), or who reported sexual abuse at George Junior (2). Of the 415 total residents, we interviewed 45, which represents 10% of the population on the days of the Audit. Among those interviews were one transgender girl, two residents who identified as gay, one as bisexual and two residents, who although identified as bi-sexual state they are currently straight. The other resident who identified as gay was not available during the interviews. Of the 46 residents who disclosed a prior sexual abuse, 18 were interviewed, but 10 of them stated that they had not disclosed a prior sexual abuse. There were no disabled or non-English proficient residents. There were two residents who reported sexual abuse while at the facility, who were still at the facility. Both were scheduled for interviews, however the one resident suffered an epileptic seizure and then reported a sexual assault by another resident which was under active investigation during the onsite. One resident who reported a resident on resident sexual abuse was interviewed.

There were discrepancies between the number of LGBTI identified residents and the number of residents who reported a prior victimization on the Vulnerability Assessment and those that we interviewed who were identified by their therapists. According to staff interviews, those conducting the Vulnerability Assessment are not asking residents about their sexual orientation, gender identification and expression. The PREA Manager is not tracking those residents that were identified in any of the above categories. Therefore, I was only able to see the identifications of the current residents, not prior residents, although resident interviews included boys who had been admitted since 2015.

I reviewed the files of 39 staff for required documentation including 11 hired within the past 12 months and one promoted during the past 12 months. I reviewed the active files of the 45 residents that were interviewed.

During the past 12 months there has been one allegation of resident on resident sexual harassment, which resulted in indecent exposure charges and a plea and citation for disorderly conduct. There have been 10 allegations of sexual abuse. Of these, five were allegations of staff on resident; two were unfounded and three were unsubstantiated. Five allegations were resident on resident; one was unfounded, one was unsubstantiated and three are still under investigation. All of these incident files were reviewed by the Auditor and contained documentation of the reports and response. The Auditor discussed three of the unsubstantiated incidents with the regional director from the Pa Department of Human Services who helped to conduct this investigation. All reports were provided to me. There have been no Sexual Incident Reviews conducted for any of these incidents. Two of the incidents were reports from other facilities of abuse at the facility. They were both unfounded and policy and procedure was followed in both instances. Pa. DHS investigated both incidents. George Junior has not received any reports of sexual abuse at other facilities.

At the conclusion of the fourth day, an Exit interview was conducted with the PREA Coordinator, PREA Manager and two Campus Directors to discuss the preliminary findings of the Audit and a plan of correction.

DESCRIPTION OF FACILITY CHARACTERISTICS

George Junior Republic is a private, not for profit, child residential facility located in Pine Township, Mercer County in Grove City, Pa. Philanthropist William Ruben George founded George Junior Republic in 1909 as a private, non-profit residential treatment community for disadvantaged boys. Initially, the homes were large, three story buildings that housed 50-60 boys. This evolved into single ranch style homes with live-in counselor parents. The campus continues to evolve with the demolition of 5 older 8 bed homes and the closing of 4 more homes and the completion of a new visitor/recreation center. CEO Richard Losasso stated that he would like to keep the number of residents under 500 in the coming years. During the first Audit in 2014, there were 53 campus living units; during this Audit, there are 45 units. There is also a community based component in several Pa. counties and a separate program in Indiana. There is a unique partnership with the Grove City School District and a state of the art vocational program. With over 720 total staff on the main campus, 106 Grove City School District employees and 415 residents, George Junior Republic is one of the largest juvenile facilities in Pa.

The beautiful 425 acre sylvan campus is located in northwestern Pennsylvania, between Pittsburgh and Erie, near the Ohio border. The facility accepts both dependent and delinquent boys from all over the United States, but primarily, Pennsylvania, including Philadelphia. There are a total of 82 buildings including 45 living units with a total of 470 beds. There are 21 group homes with live in cottage parents. There are 18 Special needs units that are staff secure and two of them are Residential Treatment Facilities for those with a Mental Health Diagnosis. There are three Intensive Supervision Units that are staff secure with a ratio of 3:1 and two Crisis Intervention Units that can be used for safety plans to protect children from harm or to house them if going through a temporary crisis and a 90 day Diagnostic unit. Residents are court committed by their respective Juvenile Courts and have either a probation officer or caseworker or both assigned to them. On the date of the Audit, there were 415 residents, ages 8 to 20. During the past year, 2016, there were 632 Admissions, with an average length of stay of 311 days.

The 21 cottages are single story ranch type houses that all have the same floor plan. The cottages have a separate secure "apartment" for the house parents and their families. The residents share a kitchen, where they eat all meals family style, a sunroom, and a living room, with a tv and video games. The bedrooms are primarily doubles and are on the same hallway as the bathroom.

The Special Needs Units, Intensive Supervision Units, and Diagnostic Units have the same open floor plan. The staff secure buildings are entered through a door that is alarmed and locked from the outside. You enter into a common area and the bedroom hallway with two single bathrooms is to the left or right of the common area. The bathrooms have one shower, sink, and toilet. There are no toilets in the bedrooms and all have doors with windows. There are both double and single bedrooms. The glass enclosed staff office looks out onto the common area which includes television and furnishings and an eating area with tables and chairs. There is a glass walled classroom, a kitchen and offices for counselors. Each unit has a "time out" room that has no door and is padded. These units are self contained.

The two Crisis Intervention Units are connected and labeled CIU North and CIU South. There is also a small gym connected to both units. All single bedrooms open onto a large common area. There are no doors on the rooms. There are two bathrooms in each unit with single shower, toilet, and sink, also opens onto the common area. There is a padded "time out" room in the small Intake area. The residents do not reside in these units. They are temporary for either the residents' safety or when a child has absconded and the committing court requests that they be kept there until the county removes them from the program. A resident experiencing a temporary crisis can also be housed there, as can anyone requiring a safety plan. There is a 3:11 staff to resident ratio during awake hours and 3:14 ratio during sleeping hours. This is a staff secure program.

The campus common area includes the campus school building leased and operated by the Grove City School District. School was not in session during the onsite portion of the Audit. The building has a central desk with individual wings radiating from the center and was built with safety and security in mind. There are no blind spots. There are 48 classrooms. One wing is for the younger, middle school age children.

The campus common areas include a small chapel, a large Gymnasium, four smaller gymnasiums, and a Multi-purpose program building with a movie theatre. There are two family visitation centers; the new one has a recreation center attached. There is an indoor ropes course, a vo-tech building with 12 classrooms for masonry, carpentry, welding, auto repair, auto painting, and culinary arts. There is a medical clinic with private exam rooms, and a dental office. The clinic is similar to a small community hospital. There is a new Counseling center with a waiting area, a reception desk and offices for the individual counseling sessions and two large group counseling rooms. There is an auditorium in a staff training building that also houses a small museum. The building also houses a security office where banks of camera screens for the over 400 campus cameras are monitored.

There is also a transportation/fleet garage for all the vans, small buses and cars used to transport children. An administration building has an around the clock telephone/reception area, meeting rooms, offices and conference rooms. This is where Juvenile Probation Officers and Public Defenders regularly meet with their clients. This is where the majority of the PREA staff and resident interviews were conducted during the Audit.

The facility is run by the Chief Executive Officer, Richard Losasso and he reports to a Board of Directors. The facility is licensed by the Pa. Department of Human Services. There are 720 full and part time employees and 550 of them are direct care staff. The contracted employees include the school teachers and school administration who work for the Grove City School District in a beautiful, modern school building in the middle of the campus that is leased by the school district. The 550 direct care or line staff are both full and part time and

work permanent and rotating shifts. The units are staffed by both male and female staff, including the cottage parents. There were a few secure and special need units that currently only have male staff. All residents attend school on campus, in their units or at the public school in the community. Recreation includes an in ground swimming pool, an outdoor track, outdoor basketball courts, five gyms and two movie theatres. All boys attend group and the topics range from Balanced and Restorative Justice to Aggression Replacement Training.

George Junior Republic is licensed by the Pa. Department of Human Services under the Pa. 3800 Child Care Regulations.

SUMMARY OF AUDIT FINDINGS

In summary, after reviewing all pertinent information provided to me prior to and during the onsite portion of the Audit, interviews with staff and residents, and the tour of the facility, it is apparent that there has been significant drift from practice, policy and procedure since the initial Audit in November of 2014. There have been many changes at the Administrative level due to retirements of long time staff. Both the PREA Coordinator, who is the Vice President of Treatment, and the PREA Manager, who is the Compliance and Outcomes Coordinator, have recently been promoted to these positions. Although newly promoted, both have been long time employees of the facility and have worked in many different capacities. The organizational chart shows they have sufficient authority within the organization to implement the changes that are needed to once again become and remain compliant with the PREA standards. Their interviews show that they are both committed to the sexual safety of the residents and making the necessary policy and program changes to ensure that there is adherence to the updated PREA policy. PREA Policy amendments and updates were completed and submitted prior to the 45 day Interim Report.

During a 180 day corrective action period, the PREA Coordinator and Manager worked toward compliance by developing curriculum and training those that required it. They developed new procedure to implement changes to practice to ensure that resident education and risk assessment were completed in a timely fashion. They submitted logs of training for employees and spread sheets with documentation of resident education, risk assessments and risk based housing considerations. A review of all documentation and interviews of random staff, speciality staff and random residents were conducted during the corrective action period to supplement the paperwork. The interviews provided corroboration for the documentation.

There is an ongoing MOU with AWARE that allows for victim advocacy, emotional support and reporting. This agency is a member of PCAR, the Pennsylvania Coalition against Rape. There is an MOU with Grove City Medical Center for Forensic Medical Examinations where there is a SAFE/SANE, and there is an MOU with the Pennsylvania State Police to conduct criminal investigations. This information is posted on the website. Since the last Audit, Mercer County has opened a Child Advocacy Center in conjunction with AWARE. This provides for one stop forensic interviewing and SAFE/SANE forensic examinations. An MOU with the CAC is in progress. Documentation of efforts to obtain a signed MOU with the CAC were provided to me. A signed MOU with the Mercer County CAC was provided to me on 11-20-17.

The PREA policy calls for residents to receive timely education at Intake. All education is conducted during the Intake process. The education includes review of a PREA brochure with names and phone numbers to report to outside agencies and a PREA video about sexual abuse and sexual harassment. The residents then sign an acknowledgement of the information they have received. Most residents interviewed stated they had not seen the video and 17% of the resident files showed they had not received education at Intake, but did receive thereafter. Vulnerability Assessments are conducted by Treatment Team Coordinators. Interviews of two staff who conduct the vulnerability assessment revealed that they are not asking about a child's sexual orientation, gender identity and expression. Additionally, a review of 45 resident files show that 26% of the residents did not have the Vulnerability Assessment conducted within 72 hours of Intake. All residents receive a physical within 14 days, but many times within 72 hours of admission and all residents see a therapist within the first week after admission, because this is a treatment facility. However, the information ascertained from the vulnerability assessment is not used to consider risk based housing. The PREA Manager does not track those that have been identified as having disclosed a prior victimization, those who are LGBTI, those who are disabled, not English proficient, or who are sexually vulnerable or sexually aggressive. There was no documentation of risk based housing. The amended policy calls for re-assessments to be conducted every six months. This was only begun two weeks prior to the onsite Audit. Only one file of the 45 reviewed had a timely reassessment.

All direct care staff logs and files were complete for both education/training, child abuse and criminal history clearances. During the tour two staff, both contracted employees for the school district, stated they did not have PREA training. Medical and Mental Health staff received the all employee training, but new Medical/MH staff had not received specialized training as outlined in the standard.

One standard as noted below has been exceeded. Three standards as noted below do not apply. Nine standards require corrective action. The remaining 28 Standards have been met. All policy and procedure meet the Standards.

The following standard has been exceeded:

Standard # 383 Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

All residents receive a physical within 14 days of admission, and many times within 72 hours of admission and see an individual therapist within the first week after admission and weekly thereafter. Residents also attend group therapy. Many residents see a psychiatrist for medication evaluations and are referred to a contracted psychologist as needed. Residents are committed to George Junior by their respective juvenile courts for treatment and rehabilitation. This standard has been exceeded.

The following standards do not apply:

Standard #312 Contracting with other entities for confinement of residents: George Junior Republic does not contract with any other entities for the confinement of their residents.

Standard #334 Specialized Training; Investigations: George Junior Republic staff do not conduct Investigations. This is done by the Pennsylvania State Police and Pa. Department of Human Services Child Line.

Standard #368 Post Allegation Protective Custody: The Pa. 3800 Child Care Regulations prohibits the use of Isolation. Isolation is not practiced at George Junior Republic.

The following standards require Corrective Action:

Standard #315 Limits to Cross Gender Viewing and Searches: Section (d) requires that staff of the opposite gender announce their presence when entering an area where residents of the opposite gender shower, change clothes or perform bodily functions. Interviews with residents disclosed that female staff are not announcing their presence and this practice was not observed during the tour of the facility. Although no residents stated they had been subject to cross gender viewing, this is an area that requires a plan of correction. Staff must be re-trained and documentation of this needs to be submitted. Residents will be interviewed to demonstrate compliance. Section (f) requires that staff conduct searches of Transgender and Intersex residents in a professional and dignified manner. Although direct care staff do not conduct pat down searches and there is a Gender Variant Search Form, most of the 46 staff interviewed could not discuss this policy. Staff must be retrained and documentation will need to be submitted. Staff will be interviewed to demonstrate compliance. This training and these interviews will take place after the training has been completed.

I received and reviewed the logs of training for all staff, which included a PREA refresher and a specific LGBTI training. I randomly chose ten staff from these logs and conducted telephone interviews on 1-15-18. The logs and the interviews demonstrated compliance with this standard. Telephone interviews were also conducted with 8 current residents. All could state that female staff announce their presence before entering their room or any area where they change clothes, shower or toilet. All could state that female staff never enter bathrooms.

The documentation and interviews satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

Standard #332 Volunteer and Contractor Training: During the tour, two contracted staff stated they had not received PREA training. The Vice Principal of the school, a contracted staff, stated during her interview with the Auditor, that she had not received PREA training. An in-service for the contracted teachers was conducted prior to the beginning of the new school year. A log of this training was submitted to the Auditor. The Auditor will need to interview at least two contractors as part of the plan of correction. This will take place in conjunction with other interviews noted in the plan of correction.

A log of contractors, who were not teachers, was also submitted to the Auditor. These staff also received PREA training.

On 1-11-18, the Auditor conducted telephone interviews of two Grove City School District employees and the licensed Psychologist. All three received PREA training and knew who to report to. In their roles, they are also mandated reporters and the School District staff have received "Mandated Reporter Training" as well.

This documentation and the interviews satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

Standard #333 Resident Education: The PREA policy requires residents to receive PREA education at Intake. Seventeen percent of the 45 resident files reviewed did not show timely education. The curricula requires the review of a PREA pamphlet and viewing a PREA Video. Most residents interviewed stated they had not seen the Video. A majority of the residents could not cite AWARE as a reporting avenue and were unaware of Victim support services. Ninety days of admission logs noting timely education need to be submitted to the Auditor. The Auditor will interview residents to ensure that all education is being conducted and that the residents understand that education.

Logs of education have been submitted for all admissions since October 2017. These logs did not reflect 100% compliance. Therefore, a new procedure was implemented to ensure timely education of all residents in January 2018. The Auditor randomly chose eight residents, two from each month, who were admitted since October 2017. Telephone interviews of these residents were conducted on 1-25-18. An interview was also conducted of a staff person who is part of a team who conducts Education of all residents admitted. The logs of education and the interviews show timely education, which includes viewing the PREA video. The residents could also discuss victim services and reporting. Logs of education will continue to be submitted each week during the remainder of the corrective action period.

A PREA tracking spread sheet of 90 admissions from 1-1-18 through 3-12-18, show timely education during Intake for all residents admitted.

The documentation and interviews satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

Standard #335 Specialized Training for Medical and Mental Health staff: All medical and mental health staff receive PREA training that all employees receive. New Medical and MH staff have not received any specialized medical training. The facility has chosen to use the NIC online specialized training for Medical and Mental Health staff. When all staff are trained a log will be submitted to the Auditor. The Auditor will interview a Medical and MH staff to ensure compliance.

On 1-16-18, a log of the Specialized Medical and Mental Health training for those that require it was submitted to the Auditor. From this list, the Auditor randomly selected a Nurse and two Therapists. Documentation of their individual training demonstrating their understanding of the material was provided to the Auditor. The Auditor conducted telephone interviews of the randomly selected nurse and therapists on 1-18-18 and 1-25-18. They confirmed receiving their specialized training and their understanding of it.

The documentation submitted and the telephone interviews satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

Standard #341 Obtaining information from residents: A review of 45 resident files showed that 26% of the residents did not have a Vulnerability Assessment conducted within 72 hours of Admission. Interviews with two staff who administer the assessment revealed that they do not request the sexual orientation or gender identity and expression of each new admission. This question was added to the Vulnerability Assessment and the new Assessment was submitted prior to the 45 day Interim Report. The PREA Manager needs to track all residents identified on the Risk Assessment to ensure appropriate follow up.

The instrument is not being used to conduct reassessments as required by the standard. The policy was amended to include a reassessment of every resident at six months. This was implemented two weeks prior to the onsite.

Ninety days of admissions need to be submitted demonstrating timely administration of the Risk Assessment and identification of all residents. The PREA Manager needs to track the residents who are identified. This log needs to be submitted to the Auditor. A log of six month reassessments of residents at GJR need to be submitted.

Logs of six month re-assessments were submitted and demonstrate compliance with the standard.

A spread sheet of all admissions since October 2017 shows the date of the administration of the VAI. A new procedure and protocol was implemented to ensure administration within 72 hours as required by the standard. A member of the team who administers the VAI and education to all new admissions stated during a telephone interview on 1-25-18 that this is now done within 24 hours as per the new policy. He described how it is administered. The residents that were interviewed by telephone on 1-25-18, who were randomly chosen from the submitted log, corroborated the timely admission.

Logs of timely admission will be submitted for the entire corrective action period to demonstrate compliance.

A PREA Admission tracking form of 90 admissions from 1-1-18 through 3-12-18 was submitted that documented timely administration for all residents.

The documentation submitted and the interviews satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

Standard #342 Use of Screening Information: There is no documentation of any risk based housing decision for residents identified as sexually vulnerable or sexually aggressive on the risk assessment. During the tour, I observed single rooms that are used to house residents on safety plans for various reasons, but none of the safety plans discuss those identified on the assessment. Ninety days of admission logs with documentation of risk based housing considerations need to be submitted.

Logs of all admissions since October 2017 were submitted and contained documentation of risk based housing. Logs will continue to be submitted for the entire period of corrective action.

A PREA tracking spread sheet of all 80 admissions from 1-1-18 through 3-12-18 was submitted and documents risk based housing decisions for the 29 residents who were identified as either sexually aggressive or sexually vulnerable.

The documentation satisfies the plan of correction and demonstrates compliance with the standard.

This standard has been met.

Standard #367 Agency Protection Against Retaliation: There is no documentation of monitoring for retaliation for those who reported a sexual abuse or who cooperated in the investigation. There are several ongoing investigations of sexual abuse. Documentation of retaliation needs to be documented and submitted to the Auditor.

On 1-4-18, the PREA Manager submitted documentation of retaliation monitoring for the still ongoing resident investigations. She is the one that monitors retaliation and records it on a form that is part of the incident file. She makes a notation with the date and initials it.

Documentation and the interview with the PREA Manager satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

Standard #373 Reporting to Residents: Although staff state they verbally report to residents the outcomes of investigations and a resident who reported sexual abuse knew the status of the investigation, when interviewed, there is no documentation of such. There are several ongoing investigations. Documentation of reports to residents at the conclusion of the investigation needs to be submitted to the Auditor.

Investigations are still ongoing for two incidents. The other incidents did not require notification. During a telephone interview with the PREA Manager and PREA Coordinator on 1-4-18, I was advised that, if Child Line sends documentation of the outcome of the investigation, it will be provided to the resident, parents, and probation department. If there is not a Child Line investigation, the PREA Manager will notify the resident and document it in the incident file. Although I have no documentation, the policy and procedure meet the standard and the interviews with the PREA Coordinator and PREA Manager support this.

The interviews with the PREA Manager and PREA Coordinator satisfy this plan of correction.

This standard has been met.

Standard #386 Sexual Abuse Incident Reviews: There have been no reviews as required by the standard. There are several ongoing investigations that can be reviewed according to the standard at the conclusion of the investigation. These need to be submitted to the Auditor.

On 1-30-18, a SAIR was submitted for two ongoing investigations involving the same youth. This SAIR was submitted to evidence compliance with the standard, although there has been no finding. The procedure outlined in the PREA policy was followed and all criteria was taken into account.

The documentation submitted satisfies the plan of correction and demonstrates compliance with the standard.

This standard has been met.

During the 5 months of corrective action, the PREA Coordinator, PREA Manager and their team have developed and implemented a procedure that works. This entailed changing policy and procedure several times. The resulting documentation of 90 admissions since January 1, 2018, through March 12, 2018, demonstrates compliance with timely education, administration of the risk assessment and the need for risk based housing.

In addition to the documentation of all admissions that was submitted weekly since January 1, 2018, the Auditor interviewed by telephone 10 random staff, 8 random residents, 3 contractors including a psychologist, a nurse, two mental health therapists and a staff who conducts all PREA education and administers the VAI to all new admissions as part of the Intake process.

Additionally, the Auditor re-interviewed by phone the Pa. Bureau of Human Services Regional Director to verify the closure of all incidents and allegations. She confirmed the outcome of the incidents. All incidents have now been closed out. The outcome was unfounded for the two outstanding incidents involving the same resident.

The PREA Coordinator and PREA Manager participated in monthly conference calls with the Auditor to work on this plan of compliance. This perseverance demonstrates the commitment this agency and their staff have to the safety of their residents. At the conclusion of the period of corrective action, a conference call with the PREA Manager and PREA Coordinator was held. They could demonstrate to me that the PREA standards have been institutionalized at George Junior Republic and that a plan is now in place that ensures continuity through whatever changes in staff and leadership that may occur. They now utilize a team approach to anything related to PREA. The PREA Coordinator states that PREA is an Agenda item for her weekly Senior Management meetings. According to the PREA Coordinator, PREA has become part of the culture at GJR.

As of March 15, 2018, this facility is in full compliance with the PREA standards.

Number of standards exceeded: 1

Number of standards met: 37

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.

Documentation Reviewed:

Zero Tolerance Policy
George Junior Republic Organizational Chart

Interviews Conducted:

PREA Coordinator
PREA Manager

There is a PREA Zero Tolerance Policy for preventing, detecting reporting and responding to incidents of sexual abuse and harassment. The policy defines what is sexual abuse and harassment. It details training and education for staff and residents. The Policy describes how the above will be implemented. This policy was revised and updated during the Audit time period. However, not all verbiage for the standard was included in the updated policy. In order to be in compliance, this policy must include all necessary verbiage as required. The review of the policy and the organizational chart and the interviews of both the PREA Coordinator and PREA Manager show that they have both sufficient time and the authority to coordinate the facility’s PREA compliance efforts. The PREA Coordinator is the Vice President of Treatment. The PREA Manager is the Compliance and Outcomes Coordinator. The organizational chart confirms that they have the authority within the organization to ensure compliance. Although both are newly promoted to their positions, both have worked at the facility in many different capacities for many years. They stated in their interviews that they are committed to the sexual safety of the residents and are working together to ensure compliance with the PREA standards.

Prior to the 45 day Interim report, all additions were made to the policy. This was submitted and reviewed by the Auditor.

Subsequent to the corrective action period, both the PREA Manager and PREA Coordinator participated in a conference call with the Auditor and could demonstrate the commitment to PREA compliance and the institutionalization that will ensure the continuity of the plan through whatever staff changes may occur. They were both new to the position prior to the Audit. They have made internal changes that include the Administrative team participating in all PREA related conversations. The team and not just the PREA Coordinator and Manager will prepare for the next Audit. The PREA Manager, who is also the Compliance and Outcomes Coordinator states that she “lives and breathes PREA and it is always on her mind”. The PREA Coordinator states that it is now “part of the culture” and any incident is looked at through the PREA lens.

This standard has been met. There is no need for corrective action.

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.

This standard does not apply. The facility does not contract with any other agency or facility to provide confinement for their residents.

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.

Documentation Reviewed:

Pa. Bureau of Human Services 3800 Child Care Regulations
Pa. Bureau of Human Services Licensing and Inspection Summaries
Staff Schedules
PREA Zero Tolerance Policy
Logs of Unannounced Rounds
Documentation of annual review of staffing by PREA Coordinator
Video of a third shift round conducted on 8-13-17 at 1:45 AM by an Administrator.

Interviews:

Chief Executive Officer
Human Resources Assistant/Recruiter
PREA Coordinator
PREA Manager
Campus Director who conducts unannounced rounds
Staff and Residents during tour

The review of the Zero Tolerance Policy, GJR policies and the above documentation shows compliance with staffing, supervision and ratio. The policy takes into account all eleven of the criteria in the standard. There have been no instances of not meeting ratio and this is confirmed by interview and by review of the most recent Pa. Bureau of Human Services Licensing and Inspection Summaries. The Pa. BHSL inspects staffing during their annual licensing inspection and throughout the year if there is a reportable incident.

I reviewed documentation of the annual review of staffing by the PREA Coordinator. The CEO states that staffing is reviewed daily to ensure one on one supervision and that other resident needs are met. I reviewed staff schedules. They follow a rotation and fill ins as well as voluntary and mandatory overtime are used so that there are never deviations. There is a “recruiter” in the Human Resources Department who I interviewed. He goes to job fairs and speaks to college classes to recruit new staff. The CEO states that they have a very difficult time finding and keeping staff. He states that they will be permanently dropping the number of beds to below 500 to a number closer to 470, because that seems to be the point where they always have enough staff to meet ratio.

The ratio that is required by the Pa. 3800 Child Care regulations is 1:8 awake and 1:16 sleeping. The PREA Manager states the ratios are 1:8 and up to 2:12 in the cottages, and 2:11 for all shifts in the Special Needs Units, 3:11 for all shifts in the Intensive Supervision Units and 3:11 awake and 2:11 sleeping in the Crisis Units.

I was provided with current staff schedules with more than the required ratio. During the tour, I saw residents supervised individually and in group settings. The residents in the cottages move freely with permission from the cottage to the other buildings.

Video surveillance is also used to supplement the supervision of the residents. The 400 plus cameras on the campus can be monitored by the administrators from their desktop computer and by the Vice President off site. The Vice President states she “hops on and off all day to monitor activity in the units”. The cameras are actively monitored by the Campus Supervisors during the overnight shift. They are motion activated and constantly record. A staff person monitoring the cameras can alert a midnight staff person to activity in a hallway. The cameras have an approximately 5 day recording capability.

Administrative staff were conducting rounds as evidenced by the video of a third shift round and logs provided prior to and during the PREA Audit Report

onsite. The logbooks are kept at the doorway of each unit. I requested a random week of logs from all units. The policy requires that Campus Directors conduct random unannounced rounds of the units they supervise on first and second shift. The Campus Supervisor, on third shift, along with fill in supervisors, including a Human Resources Assistant, conduct random unannounced rounds every night . Over the course of a week, all units are subject to a round. Residents and staff confirmed that unannounced rounds are conducted.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:

Zero Tolerance Policy
Search Policy
Shower Policy
Gender Variant Search Preference Form
Staff Training Curriculum
Staff Training Logs
Additional Staff Training Logs

Interviews:

46 Random staff
45 residents including one Transgender girl
10 Random staff via telephone On 1-25-18
8 random residents via telephone on 1-25-18

The GJR Zero Tolerance Policy contains the necessary requirements for this standard. It, along with the Standard Operating Procedure, prohibits any kind of cross gender search including cross gender pat down searches. The Direct Care staff are prohibited from performing any hands on search. Only the Campus Supervisors perform a pat down search. The policy also prohibits the search or physical examination of a Transgender or Intersex resident for the sole purpose of determining that resident's genital status. There have been no cross gender searches of any kind. Staff state they do not conduct them and even in an emergency that a same sex staff would conduct a search. One resident out of 45 interviewed stated that he had been subject to a cross gender pat down search. He provided information as to when and where it happened, however a housing check showed that he had not been housed in that unit. All staff have received training regarding the search of a Transgender or Intersex resident in a respectful and dignified manner however, they were unable to describe for me the procedure and the use of the Gender Variant Search Form.

Staff state that they practice "knock and announce" when entering a housing unit that houses residents of the opposite gender, but residents state it is not practiced. I did not see it practiced during the tour. All residents can shower, toilet, change clothes and perform bodily functions without being viewed by staff of the opposite sex according to interviews.

All bathrooms have one shower. Same sex staff conduct showers. Transgender or Intersex residents would shower alone, according to policy and interviews, as do all residents.

The one transgender resident stated that she has not been searched to determine her genital status and she showers alone. She is not housed in a special unit nor has she been discriminated against in any way. She was asked questions about her safety when she first came to the facility. This is an all male facility and so she can only be housed on a male unit. She was court committed to this all male facility. There are no cameras in the resident rooms or in the bathrooms.

This standard has not been met. There is a need for corrective action.

Corrective Action:

PREA Audit Report

Female staff must announce their presence when entering an area where the residents shower, change clothes or perform bodily functions. Staff must be trained regarding the searches of transgender and intersex residents in a professional and dignified manner. Both of these areas will require staff to be re-trained. Documentation of that training must be submitted to the Auditor. Both residents and staff will need to be interviewed to ensure that “knock and announce” is being practiced. Staff must be interviewed to demonstrate understanding of the Gender Variant Search policy. These interviews will take place in conjunction with other interviews noted in the plan of correction.

I received and reviewed the logs of training for all staff, which included a PREA refresher and a specific LGBTI training. I randomly chose ten staff from these logs and conducted telephone interviews on 1-15-18. All stated they received additional training as noted above. All could state that knock and announce is practiced. I randomly selected and interviewed 8 residents from the current population on the same date. All but two residents could tell me that female staff announce themselves. There were no residents who reported cross gender viewing or searches. All but one staff could discuss the search policy for Transgender and Intersex residents. The logs and the interviews demonstrated compliance with this standard.

This standard has been met.

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.

Documents Reviewed:

Zero Tolerance Policy
Resident PREA Brochure in Spanish and English
Resident Educational Curriculum
Contracts with Translators

Interviews Conducted:

CEO
46 Random Staff

During the Audit, there were no residents who were disabled or who were not English proficient. During the tour, I observed postings in Spanish and English. Three areas did not have Spanish postings and they were subsequently posted and verified before the conclusion of the onsite. There are contracts for translators and, according to the CEO, the school has two ESL teachers. Staff stated that the use of a resident as a translator for reporting sexual abuse or sexual harassment is prohibited by policy and does not occur. The Director stated that all reasonable accommodations would be made for a resident with a disability. The translator service that is used for languages can also be used for resources for residents that are blind or deaf. There is the capacity, through the Educational program for all residents to receive PREA Education. The PREA policy requires these accommodations.

This standard has been met. There is no need for corrective action.

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.

Documentation Reviewed:

Pa. Department of Human Services 3800 Child Care Regulations
 Pa. Bureau of Human Services Licensing and Inspection Summaries
 Pa. Child Protective Services Law
 Zero Tolerance Policy
 Affirmative duty to disclose form
 Files of 39 staff including 11 who had been recently hired and one who had been recently promoted
 File of one Contractor
 Logs of Contractor clearances

Interviews:

PREA Coordinator
 Human Services Assistant/Recruiter

The Zero Tolerance Policy and the Pa. Child Protective Services Law require Criminal History Checks, FBI clearances, and Child Abuse Checks for employees and contractors prior to employment. The policies require a continuing affirmative duty to report prohibited conduct and this information is requested on the employment application and in interviews.

The Pa. Child Protective Services Law requires these clearances prior to employment and all new employee files are inspected during the annual licensing inspection as well as those of contractors and volunteers. A percentage of random employee files are inspected by BHSL as well. There have been no citations for non-compliance in this area.

I checked the files of 39 staff, including 11 who had most recently been hired, one new promotion and one contractor and all had the required clearances.

The policy and the interview with the HR Assistant state that all clearances of all employees will be conducted every three years by the employee and submitted to the facility. This policy went into effect in 2014, when George Jr. became PREA compliant, so employees hired prior to this date have had rechecks conducted. I saw the required rechecks in 16 of the files I checked.

This standard has been met. There is no need for corrective action.

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.

Interviews:

Chief Executive Officer
 PREA Coordinator.

Both the tour of the facility and the interviews with the PREA Coordinator and the Director confirm that there has been renovation, expansion or modification to the facility since the last PREA Audit. Five, 8 bed cottages were razed and four more eight person cottages have been closed, probably permanently according to the CEO. A new visitation/ recreation center was built. It has a three stage shower search that allows for privacy for the residents, while their clothing and possessions are being searched. This was demonstrated for me during the tour. The PREA Coordinator stated that when designing new units, they look at removing any turn in a hallway that would limit line of site and they also make hallways wider for supervision purposes.

There have not been any new residences that have been built.

The PREA Coordinator also stated that there have been improvements to the cameras in that they can now be rotated for a 360 degree view. There was no documentation of these changes. The administrators who were interviewed were reminded that they need to document safety and security when making plans in the future. They state that all building and renovation that is done is for safety and security first and foremost.

Although there was no documentation, the tour of the campus demonstrates that this is always taken into consideration.

This standard has been met. There is no need for corrective action. .

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.

Documents Reviewed:

Zero Tolerance Policy

MOU with Grove City Hospital

MOU with AWARE, a member of the Pa. Coalition Against Rape (PCAR)

MOU with Pa. State Police

Documentation of attempts to obtain a MOU with the Mercer County Child Advocacy Center and the signed MOU

Interviews:

PREA Manager

Director of Nursing

46 Random Staff

One resident who reported a sexual abuse while at the facility

Phone Interview with Director of AWARE prior to onsite

Phone Interview with the Western Regional Director of the Pa. Department of Human Services prior to the onsite and during the corrective action period.

The PREA Zero Tolerance Policy contains all necessary provisions to meet this standard. MOUs are in place for the hospital, Grove City Medical Center, to provide forensic medical exams with a SAFE/SANE. Investigations are conducted by the Pa. State Police and their responsibilities are outlined in the MOU. AWARE, a PCAR, provides a victim advocate to provide crisis intervention, emotional support, information and referrals.

I spoke to the Director of AWARE prior to the onsite portion of the Audit by telephone and she confirmed the services stated in the MOU. She did not feel that AWARE was being utilized as it should be. She also stated that there is now a Child Advocacy Center in Mercer County that AWARE is affiliated with that would allow the victims of sexual abuse to obtain forensic interviewing and coordination of Forensic Medical Services, all at the CAC. This information was relayed to the PREA Coordinator, who immediately contacted AWARE and is in the process of obtaining an MOU with the CAC. I was provided documentation of efforts to obtain an MOU with the CAC. The CAC phone number is on the website.

All MOUs are in place for the necessary services to be offered for a resident outside of the Center. This information is posted on the facility PREA Audit Report

website.

I interviewed a campus supervisor who acted as a first responder and he stated that he closed down the room where the incident occurred and removed both the victim and perpetrator, who were roommates, from the room and transported them to separate crisis units. This was done not only to separate the two residents and keep them safe, but also to protect the crime scene. Random staff were able to discuss protecting the crime scene and the victim's person.

The Nurse confirmed SAFE/SANEs at Grove City Medical Center, as did the Director of AWARE.

One resident who reported a sexual abuse was interviewed. The other resident was not interviewed, because he reported a sexual abuse during the onsite and an investigation was actively occurring. I was provided with the timeline for this investigation and he saw a SAFE/SANE for a forensic exam the same day. The resident we interviewed stated that he called his mother immediately and that AWARE was called and the victim advocate met him at the hospital. If a child preferred a facility staff, their Master's Level mental health therapist would accompany them. There have been four incidents of sexual abuse in the past 12 months that have required Forensic medical exams. All were completed by a SAFE/SANE at the hospital and I saw documentation of that.

This information is posted on the facility website.

A signed MOU with the Mercer County Child Advocacy Unit was obtained and provided to the Auditor prior to the end of the corrective action period.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:

PREA Zero Tolerance Policy

Pennsylvania Child Protective Services Law

George Junior Republic Website

MOU with the Pa. State Police

Interviews:

CEO

PREA Coordinator

Western Regional Director, Pa. Department of Human Services

I interviewed the CEO and the PREA Coordinator and reviewed the PREA Policy and the MOU with the Pa. State Police. All policies and procedures required by both PREA and the Pa. Child Protective Services Law are in place. The CEO states that all incidents are reported and documented. I also verified that the website includes the fact that all allegations are reported to the Pa. State Police and Pa. Child Line. The facility does not investigate any allegation but reports all of them. Contact information is also included on the website.

There have been 11 allegations of sexual abuse or sexual harassment that have occurred at the facility in the past 12 months. I reviewed files for each allegation. All were reported to Child Line or the PSP or both. I contacted the Western Regional Director of the Pa. Department of Human Services. She advised me that all reports were done according to policy and procedure and in a timely fashion.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:

PREA Policy
 PREA Curricula for Employees
 Pa. Dept. of Human Services 3800 Child Care Regulations
 Employee post tests of training
 Logs of employee training
 39 employee files

Interviews:

PREA Coordinator
 46 Random Staff

I reviewed the PREA Zero Tolerance Policy which requires all staff to receive PREA Training. Existing staff received it when PREA was first implemented in 2014 and any staff who were hired after that date receive this training during orientation. I reviewed 39 staff files of staff that I interviewed to ensure training. I saw post tests in every file to demonstrate training. There was initial training and training each year. All 39 files contained appropriate documentation.

The training includes how to detect, prevent, report and respond to allegations of sexual abuse and sexual harassment according to the agencies policies and procedures. The 46 random staff who were interviewed were able to candidly discuss their training which included signs and symptoms of sexual harassment victims, the dynamics of sexual abuse in a confinement setting, how to avoid inappropriate interactions with residents, how to interact with all residents in a respectful and professional manner, including those who may identify as LGBTI.

All line staff also receive mandated reporter training as per the Pa. Department of Human Services 3800 Child Care Regulations and they were able to discuss their mandated reporter responsibilities as well as their first responder responsibilities.

The training contains all provisions required by the standard and the review of files showed all staff receive it and the interviews demonstrate that staff understand it. A special video was made by the facility with a local district attorney discussing child sexual abuse and the prosecution of employees who violate that law. This is shown to every new employee as part of orientation.

I also was shown a video of a live presentation that is for all non-direct care staff, such as clerical and maintenance, that discusses PREA and what actions they should take if they overhear a resident discussing an incident and how to establish boundaries.

This standard has been met. There is no corrective action needed.

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.

Documents Reviewed:

- Zero Tolerance Policy
- PREA Brochure for Volunteers and Contractors
- PREA Volunteer and Contractor Acknowledgement Form
- Training Logs
- Contractor Video

Interviews:

- Contracted Employee (School Vice Principal)
- Telephone Interviews of three contracted employees on 1-11-18

There are no volunteers. I interviewed a Contracted Employee (School Vice principal). She stated that she receives mandated reporter training, but had not received PREA training. She is newly assigned to the facility school. During the tour, both she and a vo-tech receptionist stated they had not received education. During the initial Audit in 2014, the teachers who are contracted had received education. Although she had not received PREA education, the Vice Principal when interviewed was able to tell me that she would report to her immediate supervisor and the PREA Coordinator. She would also call Child Line. The Zero Tolerance policy requires PREA training for all volunteers and contracted employees. There is a PREA pamphlet for volunteers and contractors and a PREA video that was produced from a live training.

This standard has not been met. There is a need for corrective action.

Corrective Action:

During the first week of inservice training in August 2017, all contracted teachers received PREA training. Documentation of this training was submitted to the Auditor. The Auditor will need to interview contractors to ensure receipt of an acknowledgement of this training. These interviews will take place in conjunction with the other interviews noted in this plan of correction.

Logs of Contractor training were submitted to the Auditor. On 1-11-18, the Auditor conducted telephone interviews of two Grove City School District employees and the licensed Psychologist. All three received PREA training and knew who to report to. In their roles, they are also mandated reporters and the School District staff have received “Mandated Reporter Training” as well.

This standard has been met.

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.

Documents Reviewed:

- PREA Zero Tolerance Policy
- Resident PREA Intake Brochures in Spanish and English
- Resident PREA Orientation Acknowledgement Forms
- Resident PREA Video
- Posters for Reporting and Education in Spanish and English
- 45 Resident Files
- Logs of Resident Education since October 2017
- 10 Specific resident acknowledgement of education
- PREA Admission Tracking Sheet 1-1-18 through 3-12-18
- 17 Additional resident educational acknowledgements
- PREA Audit Report

Interviews:

Treatment Team Coordinator who performs Intake Education

45 residents

Staff who conducts Education at the time of admission by telephone on 1-25-18

Eight random residents admitted since October 2018 by telephone on 1-25-18

The facility conducts both initial and more comprehensive PREA education at Intake. In some units, all staff conduct Intakes and education. I interviewed a Treatment Team Coordinator who conducts education. She states that this education occurs within 48 hours of the resident being admitted. She states that she gives the child the PREA Pamphlet, she states that she slowly reads it to them and then shows them the reporting phone numbers for AWARE and Child Line on the back. She then shows them the video: Safeguarding your Sexual Safety. She discusses the video and fields any questions they may have. She then has the resident sign off on a form that confirms receipt of the PREA education. This sign off is placed in the resident's file. I saw this sign off in every resident file that I reviewed. She states that the pamphlet is hung on the unit bulletin board. I did see this on several bulletin boards during the tour. There are also reporting and zero tolerance posters throughout the facility for continuing education.

Although all files contained acknowledgement of this education, 8 out of 45 files did not show that this was conducted in a timely manner. That is 17% of the files reviewed. While on tour, several residents told me they had not seen a video, except at their prior placement and during interviews, although the residents could answer most of the questions, the majority stated they had not seen the video. A majority of the residents could not describe any outside victims' services.

This standard has not been met. There is a need for corrective action.

Corrective Action:

Ninety days of admissions and logs of education need to be submitted to the Auditor. During the Intake process residents must receive education about the facility Zero Tolerance Policy and the reporting of Sexual Abuse. Within 10 days of education, the resident must receive more comprehensive education. If the facility chooses to conduct all Education at Intake, it must be conducted during the Intake process and documented. The Auditor will need to interview the residents to determine if they are receiving all education in a timely fashion. Interviews of randomly selected residents will take place via telephone interview subsequent to the submission of the 90 days of documentation.

Logs of education have been submitted for all admissions since October 2017. From these, the Auditor randomly chose eight residents, two from each month, who were admitted since this time. Telephone interviews of these residents were conducted on 1-25-18. Education was still not 100% compliant. The PREA Manager, PREA Coordinator and their team met to re-evaluate the procedure. It was changed to centralize the process. A team now conducts education as part of the Intake process in each specific unit. An interview was also conducted of a staff person who is part of a team that conducts Education of all residents admitted. The logs of education and the interviews show timely education, which includes viewing the PREA video. Ten specific resident signed acknowledgements were requested by the Auditor. These names were randomly chosen from the logs of education. The residents could also discuss victim services and reporting. Logs of education will continue to be submitted each week for the entire corrective action period.

A PREA Admission tracking log was submitted weekly since 1-1-18. Each week, all admissions from the previous week were reviewed for timely Education. Two specific admissions were randomly selected each week and their individual acknowledgement of their timely education was submitted.

From 1-1-18 through 3-12-18, there have been 90 admissions. All ninety residents received education during the Intake process. Seventeen randomly chosen individual resident acknowledgements from each week of admissions were also received.

The documentation and interviews satisfy the plan of correction and demonstrate compliance with this standard.

This standard has been met.

Standard 115.334 Specialized training: Investigations

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

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.

This standard does not apply. There are no investigators at this facility.

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.

Documents Reviewed:

PREA Policy
Employee Training Curriculum
Employee Training Logs
Medical and Mental Health Specialized Training Logs
Specific signed training acknowledgement of randomly selected Nurse and Therapist

Interviews:

Director of Nursing
Clinical Director
Nurse (by telephone on 1-18-18)
Therapists (by telephone on 1-18-18)

This facility does not perform forensic medical examinations. These are conducted at Grove City Hospital by SAFE/SANEs and there is an MOU with the Hospital.

I interviewed the Director of Nursing and I also interviewed the Clinical Director. Both have completed the PREA training for all staff at the facility. The Director of Nursing stated that the Medical staff received specialized PREA training as part of the first Audit, but new Medical employees have not received it. Both state that the facility does not conduct forensic examinations and that they both have received training regarding the sexual abuse of juvenile victims. The Director of Nursing has received extensive training and has years of medical and psychiatric work experience in the treatment of juvenile victims. She has also had training on preserving physical evidence.

The Clinical Director also has years of education and experience for dealing with a juvenile victim of sexual abuse. Both have received mandated reporter training and would report to Child Line and the PREA Coordinator.

All of the Mental Health and Medical staff have received the PREA training that all employees receive. I reviewed the training logs with this information, however, most have not received specialized training as required by the standard.

This standard has not been met. There is a need for corrective action.

Corrective Action:

All Medical and Mental Health staff will receive the online NIC training for health care professionals. Documentation of this training will be submitted to the Auditor. The Auditor will interview both a Medical and Mental Health staff to ensure training. These interviews will take place in conjunction with the other interviews required by the plan of correction.

On 1-16-18, a log of the Specialized Medical and Mental Health training for those that require it was submitted to the Auditor. From this list, the Auditor randomly selected a Nurse and two Therapists. Documentation of their individual training demonstrating their understanding of the material was provided to the Auditor. The Auditor conducted telephone interviews of the randomly selected nurse and therapists on 1-18-18 and 1-25-18. They confirmed receiving their specialized training and their understanding of it.

The documentation submitted and the phone interviews satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

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.

Documents Reviewed:

PREA Zero Tolerance Policy
Vulnerability Assessment Instrument
Completed Vulnerability Assessment Instruments for 45 Residents
Tracking log of all admissions since October 2017
Ten randomly selected Vulnerability Assessments
PREA Admission Tracking Sheet 1-1-18 through 3-12-18
17 Individual Resident VAIs

Interviews:

PREA Coordinator
Two Treatment Team coordinators who complete Vulnerability Assessments
45 random residents
Staff who Administers education and the Vulnerability Assessment by telephone on 1-25-18
Eight random residents selected from the tracking log

The Vulnerability Assessment Instrument is a commonly used one that takes into account many variables including: age, physical size and appearance, physical or mental disabilities, prior victimization, charges, mental illness, socialization issues, emotional issues, and the resident's own perception of vulnerability. Therapists conduct the Vulnerability Assessments and take into account the Health and Safety Assessment that is conducted at Intake, the Intake interview, conversations with parents, probation officers and caseworkers, court reports and any other information that may accompany the child. They use the VAI as a guideline and use a combination of developing a conversational rapport with the resident and asking direct questions. Both staff stated they do not ask the resident about his sexual orientation, gender identity and expression. The instrument was amended to include LGBTI status prior to the 45 day Interim report. All completed VAIs are kept in the resident files. Only the direct care staff and medical and administrative staff have access to them. A safety plan is written to include the needed information. I reviewed the files of 45 residents that I interviewed. Twelve out of 45 residents did not have the Vulnerability Assessment conducted within 72 hours of Intake. That is 26% of the files reviewed. The policy was amended during the pre-audit period to include a reassessment to be conducted every six months using the VAI tool. This was instituted two weeks prior to the onsite Audit, so only one file that I reviewed had a timely reassessment. Forty-five residents were interviewed and all could state that they were asked questions when they first arrived as to whether they had ever been sexually abused, if they had any disabilities or if they were fearful of sexual abuse. Some of those identified as having previously reported a sexual abuse stated that they had not reported that information to anyone. Some residents identified by their therapists as being gay or bisexual stated that they were not. The PREA Manager is not keeping logs of any identified residents.

This standard has not been met.

Corrective Action:

Ninety days of documentation of all admissions will be submitted to the Auditor demonstrating assessment within 72 hours. The PREA Manager will keep logs of Assessments that are conducted on all identified residents. This log should also include the required follow ups

and needs to be submitted to the Auditor. All residents who require a six month reassessment will receive one and documentation will be submitted to the Auditor.

Logs of six month re-assessments were submitted and demonstrate compliance with the standard.

A spread sheet of all admissions since October 2017 through 12-31-17, shows the date of the administration of the VAI. Not all Risk Assessments were being conducted in a timely fashion. After a phone conference with the PREA Coordinator and PREA Manager, and as a result, a new procedure and protocol was implemented to ensure administration within 72 hours as required by the standard. A member of the team who administers the VAI and education to all new admissions stated during a telephone interview on 1-25-18 that this is now done within 24 hours as per the new policy. He described how it is administered. The 8 residents that were interviewed by telephone on 1-25-18, who were randomly chosen from the submitted log, corroborated the timely admission. Ten randomly selected Assessments were requested and submitted. They showed timely administration.

Logs of timely administration will be submitted for the entire corrective action period to demonstrate compliance.

A PREA Admission Tracking form was submitted weekly with all new admissions from the previous week. This covered the time period from 1-1-18 through 3-12-18. There were 90 admissions during this time. There was documentation of all 90 admissions receiving a Risk Assessment within 72 hours of Intake. In fact, all admissions receive it as part of the Intake process as per the new policy and procedure described above. Individual VAIs were selected weekly from this admission list by the Auditor and provided to her to ensure compliance. Seventeen individual instruments were provided as further documentation.

The documentation and the interviews satisfy the plan of correction and demonstrate compliance with the standard.

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.

Documents Reviewed:

PREA Zero Tolerance Policy
Pa. Department of Human Services 3800 Child Care Regulations
Shower Policy
Vulnerability Assessments of 45 residents
Tracking Log of all Admissions since October 2017
Ten randomly selected Assessments
PREA Admission Tracking Log from 1-1-18 through 3-12-18
17 Individual Risk Assessments

Interviews:

PREA Coordinator
PREA Manager
Two Treatment Team Coordinators who administer Vulnerability Assessment
One Resident identified as Transgender
Three residents identified as bi-sexual or gay
A staff person who administers the VAI by telephone on 1-25-18
Eight randomly selected residents by telephone on 1-25-18

Isolation is not practiced and is prohibited by both facility policy and by the Pa. Department of Human Services 3800 Child Care Regulations.

I interviewed the above staff who state that any resident who is identified as either sexually vulnerable or aggressive on the risk screening is considered for housing in a room that would protect either that resident or the other residents. While on the tour, I saw the single rooms that are closer to the staff office and are within both eye and ear shot of staff. There is no documentation of risk based housing.

I observed the bathrooms that are all single bathrooms. I reviewed the shower policy that requires that all residents shower separately. Only same sex staff conduct showers.

The staff state that there are no specific or segregated housing units for LGBTI residents. Transgender or Intersex resident housing would be determined on a case by case basis and would be formally reviewed at least twice a year. The residents' own views for their safety would be taken into account when making housing decisions as well as the safety and security of all the residents. A LGBTI resident is never identified as sexually aggressive based solely on their LGBTI status.

The policy was amended to include all verbiage in the standard.

Four residents were interviewed: one transgender girl, one bi-sexual boy, one boy who identifies as gay and one resident who stated he was bi-sexual but is currently straight. They state that all residents shower alone and they do not feel discriminated against in any way.

I reviewed the files of 45 residents. There was no risk based housing for the 5 residents identified as sexually vulnerable nor the 2 residents identified as sexually aggressive.

This standard has not been met and corrective action is necessary.

Corrective Action:

The amended Vulnerability Assessment must be used to identify all residents who are sexually vulnerable or sexually aggressive. Risk based housing, education and programming assignments need to be considered and documented. A log of ninety days of admissions with the date of the vulnerability assessment and any identification along with documentation of risk based housing decisions need to be submitted to the Auditor. An interview of a staff who conducts the VAI will also be conducted to ensure compliance.

Logs of all admissions since October 2017 through December 2017, were submitted and contained documentation of risk based housing. Ten randomly selected assessments were requested and submitted and demonstrated appropriate documentation of risk based housing decisions. Logs will continue to be submitted for the entire period of corrective action.

A PREA Admission tracking form from 1-1-18 through 3-12-18 was submitted. It included all 90 admissions and documentation of risk based housing consideration for the 29 residents who were identified as sexually aggressive and/or sexually vulnerable and required risk based housing consideration. Seventeen individual assessments were randomly selected from this list and provided to further document these identifications and decisions.

The documentation provided and interviews satisfy the plan of correction and demonstrate compliance with the standard.

This standard has been met.

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.

Documents Reviewed;
PREA Zero Tolerance Policy
Grievance Policy
Telephone Policy
Visiting Policy
Pa.Child Protective Services Law
Pa. Bureau of Human Services 3800 Child Care Regulations
PREA Intake Pamphlet
PREA Audit Report

Resident Rights Form
MOU with AWARE

Interviews:

PREA Compliance Coordinator

PREA Manager

Director of AWARE, a PCAR (by phone, prior to Audit)

46 Random Staff

45 Residents

Resident who reported Sexual Abuse

I reviewed the PREA Zero Tolerance Policy and it contains all necessary information and provides for residents to make reports verbally, in writing, anonymously and through third parties. It mandates that staff accept resident reports in all these formats and that they document and report to Pa. Child Line and their supervisors immediately. All residents and staff interviewed were able to tell me at least two ways a report could be made and most were able to tell me many ways a report could be made.

The primary reporting mechanism is to an outside agency, AWARE or Pa. Child Line. There is an MOU with AWARE and this reporting avenue allows for receipt of the report and transmission to the facility, anonymously if requested. Prior to the onsite, I completed a telephone interview with the Director of AWARE and she confirmed the services outlined in the MOU. This reporting method is posted throughout the facility. While on the tour, a resident volunteered to show me how he would report. He showed me the phone number to AWARE on the poster in the unit. He asked for and received a "flexible pencil", wrote down the number and asked to use the phone. He was escorted to a private glass walled office and called the number and it worked as described. It was suggested that the phone number for AWARE be posted above the phones. This was done subsequent to the onsite and a picture of the posting was sent to the Auditor.

The residents can also call Child Line and the staff are required to call Child Line as mandated reporters. Most staff and residents cited Child Line as the outside agency they would call.

The Pa. Department of Human Services 3800 Child Care Regulations requires a Grievance Policy and that all residents and their parents receive it and acknowledge it. I saw these grievance sign offs in the residents files. This is another avenue for reporting and is contained in every child's file and is audited by PA. BHS for inclusion.

Residents can also call home twice a week and residents can receive visits from parents and grandparents once a week. Many parents live quite a distance from the facility. Once a month, a bus for parents travels from Philadelphia and Reading, Pa. Parents are served a lunch when they arrive and a bagged lunch is given to them for their return. Residents receive home visits if permitted by their placing agency. Over 100 residents were returning from home visits during the onsite portion of the Audit. Residents from San Francisco have court ordered video conferencing with their parents. Visits by Probation Officers, Caseworkers, and Attorneys are not limited and residents confirm they receive them. I saw a Probation Officer visiting students during the onsite.

There are PREA dropboxes located in all common areas of the facility: Medical center, counseling center, gym and school, and they are checked by the PREA Coordinator or a campus director on a daily basis. The 45 residents interviewed most often answered "tell a staff" as the way they would report.

The allegations that were made in the past 12 months utilized a variety of ways to report. One child used a grievance, one child told a teacher, several residents told staff and one resident told his therapist. One resident who reported sexual abuse was interviewed and he stated that he told a staff person.

There are tools, such as pencils and paper, throughout the living units and in the classrooms for the residents to write letters, grievances or to report. The residents in the special needs units have "flexible pencils" in their rooms.

The residents also attend school that is staffed by Grove City School District employees.

Every possible avenue has been provided for residents to confidentially report sexual abuse, harassment or retaliation. All staff and residents were able to provide me with at least two avenues.

This standard has been met. No corrective action is needed.

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.

Documents Reviewed:

PREA Policy
Grievance Policy
Pa. Department of Human Services 3800 Child Care Regulations
Pa. Bureau of Human Service Licensing Annual Licensing and Inspection Summaries
Resident PREA Orientation Forms
Resident Intake PREA Pamphlet
Grievance Form
Files of 45 residents

Interviews Conducted:

PREA Coordinator

One grievance was filed by a resident alleging resident on resident sexual abuse in the past 12 months, but that resident also verbally reported to a cottage parent. The response to the verbal report was immediate and the grievance was not pursued as the primary reporting avenue. The Policy was amended during the pre audit and requires that grievances can be used to report sexual abuse or harassment, but residents are not required to use a grievance. If they do, they can do so without having to submit or refer to the staff involved in the grievance. The timeline for the resolution of the grievance is 7 days according to the policy and within 48 hours if it is an emergency grievance. There are separate forms for emergency grievances. Residents cannot be disciplined for filing a grievance. The Pa. Department of Human Services 3800 regulations require a grievance policy and notification and acknowledgement of such by both the resident and their parent/guardian. The Pa. BHSL, during their annual licensing inspection, reviews resident files for this signed acknowledgement by both parent and resident. I reviewed 45 resident files and all contained notification of the grievance process. Additionally, the most recent Licensing and Inspection Summaries did not contain any citations for a violation of this regulation. The grievance process was not mentioned as often as the "PREA Box" or "telling a staff" by either residents or staff interviewed, but there are grievance forms and documentation of notification in the child's file.

This standard has been met and requires no corrective action.

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.

Documents Reviewed:

PREA Policy
Visiting Policy
Telephone Policy
Resident PREA Pamphlets
Spanish and English Posters
MOU with AWARE

Interviews:

PREA Coordinator
Forty five Random residents
Resident who reported a sexual abuse
AWARE Director (by phone prior to onsite)
PREA Audit Report

The PREA Policy outlines that the facility will provide residents with access to confidential emotional support services through AWARE. Posters in both Spanish and English, are posted throughout the facility, with the name, phone number and address for this service. The Resident PREA Pamphlets and the education that they receive includes what services are offered and how to contact this agency to access these services.

The PREA Coordinator described the MOU with AWARE, a PCAR, and the services that they offer. The MOU was reviewed and I spoke to the AWARE Director twice by telephone prior to the Audit to confirm the services offered in the MOU.

The residents who were interviewed state that they can make and receive phone calls. All stated that they can make a phone call to parents or guardians at twice a week. Visiting by parents/grandparents/guardians is once a week. Parents from some cities are bussed in once a month. Residents from San Francisco have court ordered video conferencing with parents. Most residents receive home visits. Over 100 residents were returning from home visits during the first day of the onsite.

Probation officers, caseworkers, and attorneys are not subject to the visiting or telephone policy and can visit when it is convenient. The Public Defenders from some counties visit on a monthly basis.

Eight out of 45 residents were able to tell me about the counseling services offered through AWARE, because this information is posted. Most residents could not tell me about these services. However, it is on the Intake pamphlet they receive and it is posted.

The resident who reported a sexual abuse was interviewed and he stated he was permitted to call his mother right away and that the AWARE victim advocate met him at the hospital. That victim advocate continues to provide services to this resident. I reviewed the files of all allegations of sexual abuse. Of the residents who went to the hospital for a forensic exam, documentation showed all were provided with a victim advocate.

This standard has been met and requires no corrective action.

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.

Documents Reviewed:

PREA Policy

George Junior Republic website

Spanish/English posters in visiting areas.

The policy requires Third party reporting avenues. This information on how to report is publicly disseminated by the facility via the website, which was verified and it is also posted in the visiting areas in both Spanish and English. This was seen during the tour of the facility.

This standard has been met and requires no corrective action.

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.

Documents Reviewed:

- PREA Policy
- Pa. Child Protective Services Law
- Training Logs
- Pa. Department of Human Services 3800 Child Care Regulations
- Files of 11 allegations of sexual abuse and sexual harassment

Interviews:

- CEO
- PREA Coordinator
- Forty six Random Staff
- Nursing Supervisor
- Clinical Director

There have been ten reports of sexual abuse and one report of resident on resident sexual harassment. There were five reports of staff on resident sexual abuse; two were unfounded and three were unsubstantiated. Of the five resident on resident allegations of sexual abuse, one was unfounded, one was unsubstantiated and three investigations are ongoing. The Resident on Resident sexual harassment resulted in a charge of Indecent exposure and was reduced to a citation for Disorderly Conduct.

The PREA policy as well as the Pennsylvania Child Protective Services Act requires that all staff immediately report any knowledge or suspicion of sexual abuse, sexual harassment, or retaliation. All staff are mandated reporters. All staff receive mandated reporter training. All staff interviewed knew that they must report to Pa. Child Line under penalty of Law. The two Medical staff interviewed are also mandated reporters. They stated during their interviews that they report to Pa. Child Line and to a Campus Director.

The CEO states that the PA. 3800 regulations require a report within 24 hours, documenting notification of the parent, guardian, probation officer, caseworker and court. He states that if there is an attorney of record they would also be notified and if there was a court order prohibiting a parent from notification they would contact a guardian.

This reporting has been done for all eleven allegations listed above. I reviewed incident files with documentation of reporting and HCSIS reports for each incident. One file had a missing HCSIS report. A HCSIS report is an acronym for a report required by PA. DHS documenting reports to parents, probation officers, caseworkers, guardians, etc. It must be submitted within 24 hours of any incident. This standard has been met and there is no need for corrective action.

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.

Documents Reviewed:

- PREA Zero Tolerance policy

Interviews:

- CEO

Forty six Random staff

There have been no incidents in the past twelve months where a resident was at substantial risk of imminent sexual abuse. After reviewing the policy that was amended during the pre-audit time period and interviewing the 46 random staff and the CEO, I believe that any report of imminent sexual abuse would be handled immediately and properly as outlined in the policy and required by the Standard.

This standard has been met. There is no corrective action necessary.

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.

Documents Reviewed:
PREA Policy
Pa. Child Protective Services Law

Interview:
CEO
PREA Coordinator/Vice President of Treatment Services

There have been two incidents that have required reports within the past twelve months. Both were from other facilities to George Junior and both were unfounded. I saw documentation of the receipt of phone calls from the other facilities and the immediate report to Pa. Child Line by the PREA Coordinator.

The policy clearly states that if a resident reports a sexual abuse at another facility to a staff person, it will be reported to Child Line and documented. The CEO stated the point of contact is the PREA Coordinator/Vice President of Treatment. She will notify the Director at the facility where the alleged abuse occurred and will document that notification. This will occur within 24 hours. There have been no reports of this in the past 12 months.

If a report is made to George Junior Republic from another facility the PREA Coordinator will report to Child Line and/or the Pa. State Police and will document within 24 hours of receiving the report. All other parties, parents, guardians, POs, caseworkers, will also be notified within 24 hours.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Sexual Abuse Incident files

Interviews:
Forty-six Random Staff
Campus Supervisor who acted as a first responder
Resident who reported sexual abuse

There have been four incidents in the past twelve months that have required first responder actions.

The policy contains the following first responder duties: seek assistance, separate the victims, secure the scene, report to your supervisor, document and contact Medical Department. This is contained in the staff training curriculum. When interviewed, the forty six random staff were able to discuss their first responder duties.

I interviewed two staff, one a random staff and the other a campus supervisor who utilized their first responder duties. The random staff person was a cottage parent who had a resident report to him resident on resident sexual abuse. He separated the resident and made sure he was safe. He closed off the bedroom where the alleged abuse happened and per the coordinated response he contacted the campus supervisor. The campus supervisor when interviewed, states that he separated the victim and the perpetrator by transporting them to separate crisis intervention units for safety and also quarantined the room by sealing it off with tape. He instructed the victim and the staff at the CIU that the resident could not shower, change his clothes, etc. He documented all these actions and notified medical and administration as per the coordinated plan. I reviewed documentation of this.

The policy also contains the provision that if a first responder is not a child care staff, they are to protect the scene and immediately notify a child care staff. In two cases, a therapist and a teacher were the first to be notified by the child. In both cases, they notified a supervisor who was a direct care staff. Neither report was within the time frame where evidence needed to be protected, but both residents were taken to the hospital.

I saw documentation of these actions in the individual incident files.

The resident who reported a sexual abuse was interviewed and he stated that there was an immediate response from the facility and he was taken to the hospital the same day he reported it

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA policy
Response forms
Interviews:
PREA Coordinator.

There have been four incidents in the past twelve months that have required the use of the Coordinated Response, which is described in the Zero tolerance policy. The PREA Coordinator stated during her interview that it is used as a step by step guide as to what to do, who to report to and documentation. I saw these sexual abuse response forms in each victim's file . It is detailed and serves as a timeline of
PREA Audit Report

documentation of the response. It is an excellent tool. The Coordinated Plan was updated prior to the 45 day Interim report.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Pa. Child Protective Services Law

Interviews:
CEO

There are no Unions or collective bargaining units at George Junior Republic. The PREA policy states that there is nothing that prohibits the facility from removing the offender from contact with the residents during a sexual abuse investigation.

An interview with the CEO shows that any time there is an allegation, a plan of safety for the specific resident and all the residents is put in place and this always includes removing the staff person from contact with the resident or residents, depending upon the allegation. This is required by the Pa. CPSL.

In a recent unsubstantiated allegation of staff on resident sexual abuse, the cottage parents were required to leave campus until the completion of the investigation.

This standard has been met. There is no corrective action needed.

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.

Documents Reviewed:
PREA Policy
Documentation of Retaliation Monitoring of Residents who reported abuse

Interviews:
CEO

PREA Coordinator
Campus Director who monitors retaliation
Telephone Interview with PREA Manager who is monitoring retaliation.

There have been nine incidents that required monitoring for retaliation, however there is no documentation of such. The PREA policy requires that a staff person monitor retaliation of anyone who reports an incident of sexual abuse or cooperates in the investigation. The staff persons charged with monitoring retaliation at GJR are the campus directors. Each campus director supervises all staff and residents in approximately 7 units. I interviewed a campus director and he stated that he would do a status check daily or weekly if needed and would do so for length of stay. He monitors behavioral changes in residents, including acting out. He monitors work records of staff, including tardiness and absenteeism, among other variables.

He stated that anytime there is a report of sexual abuse, whether it is resident on resident or staff on resident, the Pa. 3800 child care regulations require a safety plan, which includes separation of the alleged perpetrator and victim. This could include changing a staff's work assignment or suspension. It could include moving the child's room or unit. Most times a victim and perpetrator are transferred temporarily to separate crisis units for their safety. The campus director states that, although not specified in the safety plan, retaliation is one of the reasons why they transfer the residents.

In the case of staff, he would probably include Human Resources and this could include emotional support or disciplinary action.

This standard has not been met. There is a need for corrective action.

Corrective Action:

During the onsite, there were three incidents that were part of ongoing investigations and, in these cases, the victims had been transferred to the CIU. Documentation of retaliation needs to be included in the safety plans and there needs to be ongoing monitoring and status checks that are documented and submitted to the Auditor. They need to become part of the incident file. When this documentation for these incidents is submitted, this standard will be met.

The policy was updated to include all mandatory provisions. Documentation of retaliation was submitted to the Auditor on 1-4-18. The procedure has now been changed to ensure adequate monitoring. The PREA Manager now monitors retaliation and documents it on a form designed for this purpose and it is part of the incident file. A phone interview with the PREA Manager on 1-4-18 was also conducted as part of the review of the forms that were submitted.

The change to the policy and procedure gives one person responsibility for this role to ensure compliance.

This standard has now been met.

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.

Documents Reviewed:
PREA Policy

Interviews:
CEO

This standard does not apply. There is no use of isolation.

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.

Documents Reviewed:

PREA Policy
MOU with the Pa. State Police
Pa. Child Protective Services Law
Sexual Abuse incident files
MOU with the Mercer County Child Advocacy Unit

Interviews:

PREA Coordinator
CEO

There have been 10 sexual abuse reports within the past twelve months. All were referred to either Child Line or the Pa. State Police. I reviewed the separate incident files for each allegation. The documentation was appropriate and timely. Three of the incidents are still under investigation. The PREA Policy contains all necessary verbiage and provisions, however most of the sub-standards are the jurisdiction of the investigating agency, the Pa. State Police, with whom the facility has an MOU. The facility has no investigators. The facility does not conduct criminal or administrative investigations. Reports are made to law enforcement and Pa. Child Line. By law, the facility may not conduct or interfere with an investigation. Both the PREA Coordinator and the Director state that they have a very cooperative relationship with the Pa. State Police. The PREA Coordinator states that she receives a card with an incident number and the name of the investigating officer for each report. She routinely contacts them for ongoing reports and to advise them of the status of the residents awaiting discharge, etc. I saw these incident number cards in the files.

The facility would gather enough information to report and to institute a safety plan as required by the Pa. 3800 child care regulations and the Coordinated Response.

By law, the facility reports all allegations, even if the victim has recanted. All allegations, whether by a resident or staff, are reported. All allegations, even if a staff person is no longer employed at the facility, are reported.

The policy meets the standard and no corrective action is needed.

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.

Documents Reviewed:

PREA Audit Report

PREA Policy

The Standard of Proof is in the PREA policy, however, this facility does not conduct investigations, nor do they substantiate allegations of sexual abuse. This is the jurisdiction of Pa. Child Line and law enforcement. The policy was amended to include all provisions. This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:

PREA Policy
Pa. Department of Human Services 3800 Child Care Regulations

Interviews:

CEO
PREA Coordinator
PREA Manager
Resident who reported a sexual abuse

The PREA Policy requires the facility to notify the resident and the parent/guardian of the status of the report and to whom it is reported. The required Safety Plan, under the Pa. 3800 Child Care regulations, describes how the victim and other residents will be kept separate from the staff alleged to have committed the abuse. The CEO stated that the resident and their parents would be continually informed as to the ongoing status of the investigation, whether it was resident on resident or staff on resident. He states that Pa. Child Line notifies the resident, parent/guardian, and the facility upon the completion of the investigation of the outcome. If Child Line is not involved, the facility would notify the resident and parent. According to the PREA Manager, this notification is verbal. There has been no documentation. This will be part of a plan of corrective action.

The one resident who reported a resident on resident sexual abuse stated he had been verbally advised where the perpetrator was and what was going on. There was no documentation of this.

This standard has not been met. There is a need for corrective action.

Corrective Action:

Documentation of Resident Notification in the ongoing investigations must be submitted to the Auditor in order to be in compliance with this standard. There is no timeline, because the investigation is being conducted by an outside agency. The investigation has not been completed. I interviewed both the PREA Coordinator and PREA Manager who state that the new procedure is for the PREA Manager to notify residents, parents and placing agency and to document that information. It is part of the procedural checklist when an allegation is made.

Due to the fact that the investigation has not been completed, there has still been no documentation. However, the interviews adequately demonstrate that this standard will be followed.

By the end of the corrective action period, the ongoing investigation was closed and unfounded by the State police. Unfounded allegations do not require notification.

This standard has been met .

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.

Documents Reviewed:

PREA Policy

Pa. Child Protective Services Law

Interviews:

CEO

There has been one incident within the past twelve months that has required staff discipline for sexual abuse or sexual harassment. This incident did not occur on the GJR campus but involved a former resident and a current female employee. The resident notified another employee who reported it. The female employee was immediately terminated and the incident was classified as a indicated Child Abuse by Pa. Child Line.

The policy contains all provisions, including discipline commensurate with the nature and severity of the incident. Termination is the presumptive discipline for a founded Child Abuse. A staff person may have no contact with children if they have an indicated or founded Child Abuse report. All acts that are criminal in nature are reported, even if a staff person resigns or is no longer employed.

This standard has been met and needs no corrective action.

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.

Documents Reviewed:

PREA Policy

Pa. Child Protective Services Law

Interviews:

CEO

There have been no incidents of this nature in the past twelve months.

Both the PREA Policy and the Pa CPSL prohibit contact with residents if a contractor or volunteer has a founded or indicated child abuse. The CEO states that he would prohibit a volunteer or contractor from entering the facility if they violated the facility zero tolerance policy. If the incident rose to a criminal level, it would be reported to Pa. Child Line and law enforcement. The CEO states he would also contact the

contractor or volunteer's agency.

The policy and the interview confirm that this standard is met. No corrective action is needed.

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.

Documents Reviewed:

PREA Policy

Pa. Child Protective Services Law

Pa. Department of Human Services 3800 Child Care regulations.

Interviews:

CEO

Director of Nursing

Clinical Director

There have been no incidents of resident discipline for violation of the Zero Tolerance Policy in the past twelve months. All resident on resident incidents result in a safety plan for both the perpetrator and the victim as required by the Pa. 3800 Child Care Regulations. There is no punishment that is permitted.

The PREA Policy requires a formal disciplinary process for any child in violation of the agency's zero tolerance policy. The facility prohibits any sexual activity between residents or between residents and staff. The Pa. Department of Human Services 3800 Child Care regulations prohibits sexual activity between residents however, if it is consensual, it is not reported as sexual abuse.

Any report made by a resident in good faith cannot be disciplined according to PREA Policy and the Pa. CPSL.

The PREA policy prohibits discipline of a resident for sexual activity with a staff person, unless the staff person did not consent.

The CEO states that the only sanctions for a violation of the policy are reduction in level. It would be treated as a therapeutic issue.

Isolation is prohibited by regulation. No other discipline is allowed and he states that age, mental illness or disability would be taken into account on a case by case basis for all residents.

Both the Director of Nursing and the Clinical Director state that therapy for both the victim and perpetrator would be conducted. Therapy is voluntary and a resident would not be prohibited from program or educational participation, but could possibly be removed by the court because they are committed there for treatment.

This standard has been met. There is no corrective action needed.

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.

Documents Reviewed:

PREA Policy
Vulnerability Assessment Instrument
Secondary Medical Documentation
Files of 45 residents

Interviews:

Treatment Team Coordinator who administers Risk Assessment
PREA Coordinator
Director of Nursing
Clinical Director
Eighteen Residents who disclosed Prior Sexual Abuse

The policy requires Medical or Mental health follow up within 14 days of disclosure for any resident who discloses a prior sexual abuse. The policy also requires a mental health follow up by a Mental health professional for any resident who has previously perpetrated a sexual abuse. All residents see a Nurse upon Intake and receive a physical within 72 hours of Intake. All residents see a therapist within a week of admission, some the same day.

There were 46 residents in the current population who disclosed a prior sexual abuse, according to their therapists. Eighteen of these residents were interviewed. Half of these residents stated they had not disclosed a prior sexual abuse, demonstrating a problem with the VAI administration or recording of information. Of those that stated they had, 3 stated they had not been offered any follow up. The remaining six commented, “yes, met with counselor the same week”, “was offered counseling, but declined”, “yes, am still receiving counseling”.

I reviewed 45 files of those residents that were interviewed. All residents had timely Physicals and all had documented meetings with their therapists within the first week of admission. I saw the secondary medical documentation.

Interviews of the majority of the residents and all the staff and documentation demonstrate compliance with the standard. There is no corrective action needed. The policy was updated prior to the interim report to include all verbiage.

This standard has been met.

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.

Documents Reviewed:

PREA Policy
Incident Files for Sexual abuse allegations

Interviews:

Director of Nursing
Clinical Director
Forty six Random Staff
Resident who reported a sexual abuse.

In the past 12 months there have been four incidents of sexual abuse that have required emergency medical services. The Policy requires that PREA Audit Report

any resident who requires emergency services be taken to Grove City Hospital for a Forensic Medical Exam by a SAFE/SANE. As part of the response, staff would first protect the resident and then immediately notify a campus supervisor. The campus supervisor transports the resident to the infirmary and the Nurse handles the interview and coordinates the medical care. Medical staff would assess the situation and determine the extent and nature of services needed based on their professional judgement. This would be done immediately and would be free of charge to the resident.

All residents are offered STD testing and follow up. Interviews with the Director of Nursing and the Clinical Director confirmed the policy. I saw documentation of this response and the medical staff are an integral part of the coordinated response. There was one incident where the resident was not transported to the ER until the next morning. The Campus Supervisor emailed the PREA Coordinator and Director of Nursing rather than calling them. The Coordinated Response stated "contact". That has been amended to "call", so that there can be an immediate response. The incident was reported at 10:50 PM and the resident was transported to the hospital at 7:00 AM.

The resident when interviewed stated he received timely medical care.

While onsite, a resident reported a resident on resident sexual abuse. He was transported to the hospital within hours and a SAFE/SANE conducted a forensic exam. I reviewed documentation of this timely response.

There is no need for corrective action. This standard has been met.

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.

Documents Reviewed:

PREA Policy

Interviews:

Director of Nursing

Master's Level Mental Health Therapist

Resident who reported sexual abuse

The two Medical staff who were interviewed both stated that the level of care that the residents receive is comparable to community level of care. They coordinate the follow up and ensure that residents follow medical instructions. They prepare medical aftercare plans for any resident returning to the community or being discharged to another placement.

All residents are offered STD testing.

Any resident on resident offender will be assessed immediately and the issue will be dealt with in therapy.

The resident who reported the sexual abuse has no ongoing medical issues. He sees his therapist weekly.

Residents are committed to this facility by their respective juvenile courts for treatment, rehabilitation and therapy. All residents receive a physical within 72 hours of admission. All residents receive individual therapy at least once a week, sometimes two, and group therapy. Two of the special needs units are Residential Treatment facilities that require a mental health diagnosis for admission.

This standard has been exceeded and there is no need for corrective action.

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.

Documents Reviewed:
 PREA Policy
 Sexual Incident Review Form

Interviews:
 PREA Coordinator
 PREA Manager
 Campus Director who is a member of the Incident Review team

The policy states that an incident review team will convene no more than 30 days after the completion of the investigation for any substantiated or founded allegation. The team is comprised of the Director, PREA Coordinator, Medical and Mental Health staff with input from line staff. I interviewed a campus director who is a member of the incident review team. Although no reviews have been conducted, he responded accurately to the questions posed in the interview. The team will look at any LGBTI identification, gang status or affiliation, other group dynamics, staffing, training, policy and will physically examine where it occurred. The team will complete a report with a recommendation which will be submitted to the CEO. The report would be completed by the PREA manager. The recommendation would be followed or the reason for not doing so would be documented. Although there have been several incidents in the past 12 months, no Sexual Abuse incident reviews have been conducted.

This standard has not been met. There is a need for corrective action

Corrective Action:

The facility must conduct sexual abuse incident reviews on the current ongoing investigations when they are completed and submit the reports to the Auditor. There is not a timeline because an outside agency is conducting the investigations. The policy must include the timeline as outlined in the standard. On 1-30-18, a SAIR was submitted for two ongoing investigations involving the same youth. This report was submitted to evidence compliance with the standard, although there has been no finding. The procedure outlined in the PREA policy was followed and all criteria was taken into account. A team convened and discussed any factor that may have contributed to the allegation. Recommendations for training of staff and video monitoring were outlined in the SAIR. The SAIR submitted shows compliance with the standard. A conference call with the PREA Coordinator and PREA Manager prior to the end of the corrective action period focused on prevention of incidents through SAIR data collection. The PREA Coordinator stated that they review any previous findings to see if there are trends that may lead to incidents. In the case of they physical plant, they are building a new unit and it has wider hallways with staggered doorways. She states that the Facilities Director “gets it” and considers any previous incident when recommending change. Additionally, they are looking at cameras with rotating view for any unit with a hallway with a blind area.

This standard has been met.

Standard 115.387 Data collection

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Annual Report 2016-2017

Interviews:
CEO
PREA Coordinator
PREA Manager

The policy is in place that would require the collection of data that is utilized in the Annual report of Sexual Violence. It is collected using information from reports and any other resources.

The DOJ has not requested information in the past.

The PREA Manager is responsible for compiling this information. Subsequent to the onsite Audit, but prior to the 45 day report, I received documentation of the collection and aggregating of data as required by the Standard.

A conference call with the PREA Coordinator and PREA Manager prior to the end of the corrective action period focused on prevention of incidents through SAIR data collection. The PREA Coordinator stated that they review any previous findings to see if there are trends that may lead to incidents. In the case of they physical plant, they are building a new unit and it has wider hallways with staggered doorways. She states that the Facilities Director “gets it” and considers any previous incident when recommending change. Additionally, they are looking at cameras with rotating view for any unit with a hallway with a blind area.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Annual Report 2016-2017

Interviews:
PREA Coordinator
CEO

There is one Annual PREA Report for the year 2016-2017 that was submitted prior to the 45 day Interim report. The report contains the required information regarding using the data for corrective action The PREA Coordinator, with assistance from the PREA Manager, prepares the report and the CEO approves it. The reports will compare data from year to year in the future. The current report is the first year the facility has aggregated data. The report discusses the facility’s efforts at prevention, detection, and response.

All personal identifiers if removed are noted. There were no personal identifiers in the submitted report. The report has been posted on the website.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA policy

Interviews:
PREA Coordinator
CEO

There is a policy which dictates what data and what reports will be posted publicly and that all personal identifiers will be redacted. The website contains the initial PREA Audit from 2014. The policy states that all records will be retained for ten years. The PREA Manager securely keeps all records and reports related to any PREA incident. Prior to the 45 day Interim report, the Annual Report for year 2016 through June 2017 was submitted and reviewed. It is posted on the website.

This standard has been met. There is no need for corrective action.

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

March 19, 2018

Auditor Signature

Date