PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: July 1, 2016

Auditor Information			
Auditor name: Matthew A. Burns			
Address: PO Box 164, Kulpmont, PA 17834			
Email: preaauditor2015@gmail.com			
Telephone number: 570-847-4109			
Date of facility visit: June 6 and 7, 2016			
Facility Information			
Facility name: Keystone Adolescent Center (KAC)			
Facility physical address: 270 Sharon Road, Greenville, PA 16125			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 724-588-2520			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Robert S. Gentile			
Number of staff assigned to the facility in the last 12 months: 18			
Designed facility capacity: 24			
Current population of facility: 19			
Facility security levels/inmate custody levels: Non-Secure/Staff Secure			
Age range of the population: 13-20			
Name of PREA Compliance Manager: Matt Gentile		**Title:** Director of Operations	
Email address: matt-gentile@keystone.k12.pa.us		**Telephone number:** 724-589-5546	
Agency Information			
Name of agency: Keystone Adolescent Center, Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 60 South Race Street, Greenville, PA 16125			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 724-589-5546			
Agency Chief Executive Officer			
Name: Robert S. Gentile		**Title:** Executive Director	
Email address: bob_gentile@keystone.k12.pa.us		**Telephone number:** 724-589-5546	
Agency-Wide PREA Coordinator			
Name: Jackie Landfried		**Title:** PREA Coordinator	
Email address: Jackie_landfried@keystone.k12.pa.us		**Telephone number:** 724-589-5546	

AUDIT FINDINGS

NARRATIVE

The Keystone Adolescent Center (KAC) is a private juvenile facility located in Greenville, Pennsylvania. The PREA Audit took place on June 6, 2016 and June 7, 2016. The morning of the first day of the audit, the Auditor met with the following representatives: Robert Gentile (Executive Director), Matt Gentile (Director of Operations/PREA Compliance Manager), Brian Phillips (Program Director), and Jackie Landfried (PREA Coordinator) to discuss the audit schedule. During this meeting, the Auditor was provided a roster of all staff members by shift and job classifications as well as a roster of all residents residing at the facility. Following this meeting, the Auditor conducted an on-site tour of the Keystone Adolescent Center. Prior to arrival at the facility, the Auditor reviewed a thumb drive containing pertinent agency policies, procedures, and related documents to demonstrate compliance with the 41 Juvenile PREA Standards. The thumb drive also contained the pre-audit questionnaire and some other related examples of practice at the facility (including training records, training curicullums, unannounced rounds logs, and intake paperwork).

The pre on-site review of documents, contained in the pre-audit questionnaire submitted by the facility, prompted a few questions. Answers to these questions were submitted to the Auditor by the PREA Coordinator and any additional questions were resolved during the on site audit. The Auditor interviewed 10 residents at random. Residents length of stay for those interviewed ranged from 1 month to 10 months. There were no residents that identified themselves as lesbian, gay, bi-sexual, transgender, or intersex; nor were there any residents who required translation services or other disability related services at the facility. No residents had requested to speak with the Auditor nor had the Auditor received any written or email correspondence from any resident or staff member. In the prior 12 months, there have been 0 allegations of sexual abuse, assault, or harassment. The facility does not use isolation as per Pennsylvania 3800 regulations.

Following the on-site review, additional questions were answered by upper level management staff and the PREA team at the facility. Staff and resident interviews were conducted privately in an office at the facility that was reserved for the Auditor. There are no SANE or SAFE staff employed at the facility. These services are provided at a local hospital (UPMC – Horizon Hospital) located in Greenville, Pennsylvania. Residents receive medical care at SRHS/Mercer Family Medical Center.

The Auditor interviewed members of the Incident Review Team who are charged with monitoring retaliation during a previous PREA Audit in April, 2016, at two other agency programs. A follow up with the Incident Review Team revealed there were no incidents of relalition in the time period between the audits. Admistrative investigations are conducted by the Pennsylvania Office of Children, Youth, and Families (OCYF) and criminal investigations are conducted by the Greenville – West Salem Police Department. There were no contractors or volunteers at the facility to interview during the on site audit. The Auditor interviewed the Program Director, Program Coordinator, 10 random staff members, 4 mid and upper level staff/Supervisors, and staff members who have completed the vulnerability assessment, intakes, and are first responders. The Executive Director, both Directors of Operations, PREA Coordinator, PREA Compliance Manager, and a mental health professional were interviewed during a previoius PREA Audit at two other agency programs in April, 2016. This information was used for this audit. In addition, the Auditor also interviewed (by telephone) a medical professional from SRHS/Mercer Family Medical Center (the facility has an MOU with this agency to provide medical services to all residents).

Keystone Adolescent Center, Inc. has the following mission statement: “Keystone Adolescent Center, Inc. is a non profit organization whose purpose is to provide community based programs that will afford contructive behavior modification, therapeutic counseling, and educational opportunities to at-risk adolescents and offer their families greater involvement in the treatment process because of its community bases nature and emphasis on family preservation”.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Keystone Adolescent Center is a 24 bed staff secure male residential facility. The population at the time of the on-site audit was 19. There have been a total of 70 residents admitted into the program during the past 12 months. The Keystone Adolescent Center is one of 5 programs within the Keystone Adolescent Center, Inc. The facility is located at 270 Sharon Road, Greenville, Pennsylvania, 16125 (approximately 60 miles south of Erie, Pennsylvania). The Keystone Adolescent Center opened in 1993.

Keystone Adolescent Center, Inc. is a non-profit corporation that provides County Placing Agencies in Pennsylvania with an alternative for delinquent and dependent children who are in need of out-of home intervention not afforded by traditional placements. The principle place of business for contracting and billing questions is the corporate office which is located at 60 South Race Street, Greenville, Pennsylvania, 16125.

The Keystone Adolescent Center provides a continuum of of quality residential placement services for males ages 8 to 21 years of age,who have a variety of emotional, behavioral, academic, and family problems. In addition to shelter, food, and supervision, residents are involved in individual, group, and family counseling as needed. Psychiatric, medical, and dental services are available, as needed, by outside providers at their professional offices. Educational programming is provided by the local school district. At the time of admission, a needs-based Individual Service Plan drawing upon the resident's strengths is developed with the input of the resident, family, placing agency worker, and staff members. Upon admission, to the Keystone Adolescent Center, residents receive an Initial Clinical Interview, conducted by a Clinical Consultant. These clinical interviews with Diagnostic Impressions help develop a resident's Individual Service Plan.

The Keystone Adolescent Center has agreements with providers for an array of services. Assessments are on-going and linkages with community providers are established to address needs as necessary.

The Keystone Adolescent Center maintains a positive approach to discipline and behavior management. The program is designed to motivate residents to excel in the school setting while developing adaptive means for coping with their emotional and behavioral difficulties. A staffing pattern of 1:6 (during waking hours) and 1:12 (during nighttime hours) is maintained to allow staff members the opportunity to acquaint themselves with the residents and learn each resident's warning signs or impending behavioral difficulties. These staffing patterns were exceeded during the on-site audit and review of staffing schedules confirmed this practice.

The Keystone Adolescent Center offers comprehensive, effective Evidence-Based programs with fidelity that help residents of Juvenile Probation and Children & Youth Agencies become productive and law abiding members of society. The following is a list of current Evidence-Based Programs that are available to all residents: Aggression Replacement Training (ART), Botvin Life Skills, Olweus Bullying Prevention Program, Brief Intervention Tools (BITS), Safe Dates, Victim/Community Awareness, and Motivational Interviewing (MI).

The program is located in a large, white building which stands alone off of State Route 18. The building is a former restaurant/hall that has been renovated into a residential program. The building consists of a large administrative area which house several offices (including offices for the Program Director, Program Coordinator, and Director of Operations), two large group rooms, a kitchen and cafeteria, resident bathroom, staff bathroom, a shower room (located in the basement of the facility), a medical suite, educational wing (for middle school students), a large recreation yard, picnic area/pavilion, outdoor basketball court, and an outdoor volleyball court. There are a total of 6 bedrooms with a maximum capacity of 4 residents per bedroom. The residents also do their own laundry and the washer and dryer is located in the basement of the facility. There is a video surveillance system which monitors the activities of the residents when they are outside of the facility. There are a total of 9 video surveillance cameras. There is no video surveillance system to monitor the residents while they are inside the program buiding.

During the Auditor's tour of the facility, there were ample staff members present supervising the residents. Although the program description noted the staffing pattern as 1:6 during waking hours, the Auditor witnessed this ratio was exceeded as there were regularly 4 to 6 staff members scheduled per shift. After reviewing the staff schedules, it was also noted the staffing pattern during nighttime hours was met as there were regularly 2 staff members scheduled.

During interviews with staff members at the facility, it was evident that they were very familiar with the residents as they knew their individual names, their background information, treatment needs, characteristics, and their involvement/lack of involvement with families. During interviews and review of the staffing roster, it was noted there were several staff members who had numerous years of experience/service (some staff members had over 10 years of experience at the facility). Staff members spoke highly of management staff, other staff members, and the programs/services that are offered to the residents. All residents who were interviewed stated that they felt safe at the facility and could speak openly with any staff member about any issues/concerns they had. This Auditor interviewed a total of 10 residents (1 resident refused to be interviewed and another resident was selected to take his place). The program is very structured and residents are provided an array of therapeutic activities to participate in (including off grounds trips).

SUMMARY OF AUDIT FINDINGS

The notifications of the on-site audit were posted in various parts of the facility prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to this Auditor, noting their locations. Telephone conversations were held with the PREA Coordinator to review the PREA audit processes prior to the on-site audit.

The on-site portion of this audit was conducted on June 6 and 7, 2016. It started with an introductory meeting on the morning of June 6, 2016, with the Executive Director and the Management Team. A tour of the facility followed the enterance meeting. Accompanying the Auditor on the tour was PREA Coordinator Jackie Landfried, Director of Operations Matt Gentile, and Program Director Brian Phillips. During the tour, the Auditor saw postings for the audit posted in the living area, common areas, and Administration Area of the facility. Additionally, there were Zero Tolerance and Victim Support posters from AWARE, Inc. throughout the facility (in both English and Spanish). These posters were large enough to catch the eye and were age appropriate for the residents. There is a designed observation room where a resident can use the "blue phone" in order to contact Aware, Inc. or Childline to confidentially reports allegations of sexual abuse, assault, and harassment. All of the residents interviewed were able to describe the process to contact Aware, Inc. or Childline by using the "blue phone". Aware, Inc. is a victim advocate program which accepts reports and provides support services. Keystone, Inc. has a signed MOU with Aware, Inc. The Auditor was able to speak to the Executive Director of Aware, Inc. and she confirmed services noted in the MOU and stated they have not received any reports of incidents or issues at the facility.

The Auditor noticed signs posted at the entrance to the living area for staff members of the opposite gender to announce themselves prior to entering. Both staff members and residents confirmed opposite gender staff members announced themselves on a consistent basis by stating "female on the floor" prior to entering the living area. Residents and staff members also both stated that residents are given privacy while changing and that a male staff member is positioned outside of the bathroom while a resident is using the toilet or showering. However, it was noted that the staff member is still able to monitor movement in the bathroom from their position. It was confirmed during interviews that only male staff members supervise the residents while they are in the bathroom using the toilet or showering.

Interviews with staff members, residents, and upper management staff confirmed unannounced rounds are completed on a regular basis and a minimum of 2 times per month (one time during waking hours and one time during nighttime hours). These unannounced rounds are completed by the Program Director and Program Coordinator. The Auditor was able to review the Unannounced Rounds log as well. It was recommended to the PREA Team that alternative higher level management staff (Executive Director, Director of Operations, PREA Coordinator, and PREA Compliance Manager) complete the unannounced rounds during waking hours as the Program Director and Program Coordinator are located in the program and have regular contact with the staff and residents on a daily basis. The PREA Team accepted this recommendations and stated they will make the necessary changes to the protocol.

Interviews with residents, staff members, Management staff, and Medical staff during the on-site audit confirmed they were educated in PREA as they responded candidly to questions about PREA Education and were very familiar with the PREA Standards and the role of the standards in the program. The Auditor was able to review the training curriculum prior to the on-site audit and also reviewed 5 randomly selected staff members training files to confirm they received the training. In addition, all staff members signed an Acknowlegement Form stating they understood the material that was covered in the PREA training. All Upper Level Management Staff, PREA Coordinator, PREA Compliance Manager, and Mental Health Staff completed specialized trainings online and received certificates from the National Institute of Corrections. These certiciates were provided to the Auditor prior to the on-site audit of the facility.

10 staff members, who were randomly selected by the Auditor, from all shifts were interviewed. The Program Director, Program Coordinator, Supervisors, Mental Health professional, first responders, intake staff, and staff members who administer the Vulnerability Assessment were also interviewed during the on-site audit. There were a few staff members that have multiple responsibilities so a few individuals were interviewed more than once if their duties covered more than one specialized area. The Executive Director,, Director of Operations, PREA Coordinator, PREA Compliance Manager, 2 investigators, Incident Review Team members, management staff who monitor retaliation, and a Human Services Representative were interviewed during a previous PREA audit in April, 2016, when the auditor audited two other agency programs. This information was used for this audit as well. In all, the Auditor conducted 20 interviews of staff and 10 resident interviews. In addition, the Auditor also interviewed a medical professional from SRHS/Mercer Family Medical Center by telephone (the facility has an MOU with this agency to provide medical services to all residents).

Interviews with residents clearly indicated they were well informed about PREA, their rights, and how to report allegations of sexual abuse, assault, and harassment. New residents are informed about PREA upon admission to the facility. The residents are given a Resident Handbook which contains information pertaining to filing grievances and reporting sexual abuse/assault/harassment. The Resident Handbook has telephone numbers for Aware, Inc. and Childline included in it as well. All residents are given the facility Zero Tolerance policy and are required to view a PREA video upon admission (the video is shown to residents every Wednesday following their intake). All new residents are given a Vulnerability Assessment upon admission. If a resident scores high enough on the Vulnerability Assessment to be listed "Vulnerability to Victimization" or "Sexually Aggressive", a Safety Plan is developed by the Program Director and implemented to ensure the safety of the resident(s).

Staff training is comprehensive and it was obvious during interviews with staff members that they had all received and understood the PREA training and that the training has been implemented to become a part of the culture at the Keystone Adolescent Center. The staff

members were able to describe procedures for protecting residents from harm or threats of retaliation and the mandatory reporting requirements. Management staff as well as Mental Health staff described the online, specialty PREA Trainings they received through the National Institute of Corrections. It also should be noted; all staff members received a pre test and post test during their PREA training in order to measure competence. In order to pass this test and receive credit for the training, the staff members needed to earn an 80% on the final exam or post test.

The Auditor spoke to the Chief of Police at the Greenville-West Salem Police Deparment on June 8, 2016. He stated an MOU had been signed that covers all of the programs of Keystone Adolescent Center, Inc. (including the Keystone Adolescent Program) and he understood the PREA standards specific to sexual abuse, assault, and harassment allegations. He confirmed there have been 0 investigations pertaining to sexual abuse, assault, or harassment at the Keystone Adolescent Center during the past 12 months.

The following MOU's have been signed and were reviewed by the Auditor during the audit process:

1. Aware, Inc.
2. Greenville/West Salem Police Department
3. UPMC – Horizon
4. SRHS/Mercer Family Medical Center

The Auditor conducted an exit meeting with the Executive Director and Management Team at the Keystone Adolescent Center on June 7, 2016, at approximately 4:30pm. The Auditor shared the findings of the audit and thanked Executive Director Robert Gentile, PREA Coordinator Jackie Landfried, and the staff members at the Keystone Adolescent Center for their hard work and commitment to the full implementation of PREA in their facility. It was also noted; the staff members were extremely curtious to the auditor during the entire on-site audit and this was extremely helpful as the staff members were knowledgable of the program and policies, protocol, and practices within the program.

This Auditor found the Keystone Adolescent Center to be materially compliant with all PREA Juvenile Standards.

Number of standards exceeded: 2

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 4

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Keystone Adolescent Center's Student Handbook, Resident Confirmation of receipt – PREA Orientation Video, and Keystone Adolescent Center's Organizational Chart

Policy 900: Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment includes mandatory reporting, zero tolerance towards all forms of sexual abuse and harassment, outlines the facility's approach to prevention, detection, and responding to such allegations. This policy meets all requirements including deffinitions or prohibitive behaviors regarding prevention planning, supervision/monitoring, response planning, training and education screening for risk of sexual victimization and abusiveness, and reporting. The residents receive detailed information about their rights, grievances, and reporting during their admission via an educational PREA video (this video is shown to residents every Wednesday). The Resident Handbook also educates the residents about their rights, grievances, and reporting sexual abuse and harassment. Residents receive a copy of this handbook upon enterance into the facility. I reviewed a copy of this handbook and it properly educates residents on their rights. A full time PREA Coordinator is employed by Keystone Adolescent Center, Inc and reports to the Director of Operations. Keystone Adolescent Center, Inc also has a PREA Compliance Manager who also serves as the Director of Operations. Both the PREA Coordinator and Compliance Manager oversee all of the programs of Keystone Adolescent Center, Inc and appear to the have sufficient time to complete their duties. Both were present during the entire on site audit. In addition, interviews with both the PREA Coordinator and Compliance Manager confirm compliance with this standard.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable: The Keystone Education Center does not contract for the confinement of residents with other private agencies/entities so this standard does not apply.

Standard 115.313 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized the verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Staffing Plan/Staff Schedules, and Unannounced Rounds Tracking Forms

Policy 900 relating to the staffing plan, unannounced rounds, and staffing ratios clearly document PREA requirements and compliance with all components. This facility exceeds both the ratio mandated by these standards as well as Pennsylvania DPW 3800 regulations. I witnessed supervision of the residents in the living areas during my tour of the facility. There were 19 residents at the time of the on-site portion of the audit and all shifts had a minimum of 4 staff members scheduled. Random unannounced rounds are completed by middle and upper level management on a regular basis. These unannounced rounds are completed during waking hours and sleeping hours and was verified by reviewing documentation. During interviews, both residents and staff members were able to verify that these unannounced rounds were completed by management staff/supervisors. Policy 900 clearly states that staff members are prohibited from notifying other staff members of unannounced rounds. The staffing plan is reviewed on a daily basis by management staff to insure ratios are met.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, PREA Training Curriculum,Training Logs, and Resident/Staff Interviews

Cross-gender strip searches, pat down searches, and cross-gender visual body cavity searches are prohibited by Policy 900 (except in exigent circumstances). All searches peformed on a resident, are completed by a same sex staff member with a Supervisor witnessing the search. Resident interviews confirmed that staff respect the privacy of the residents and only same sex staff members complete searches on residents. Signs leading in to each living area instruct staff members of the opposite gender to announce themselves prior to entering. Interviews with residents and staff members confirmed this practice was being adhered to on a regular basis as female staff members announce themselves by stating "female on the floor". During the tour, I also witnessed this practiced. Policy prohibits staff members from searching or physically examining a transgender or intersex resident for the sole pupose of determining the resident's genital status. Interviews with staff members confirmed adherence to this policy. There were no transgender or intersex residents in the population at the time of the audit. It was also noted; there has never been a transgender or intersex resident residing in this facility.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interviews with Staff Members/Residents

In the past 12 months, there have been 0 incidents of residents being used as resident interpretors; however, appropriate services are available if needed. An interview with the Executive Director confirmed that necessary accomidations would be made for those residents admitted with minor disabilities. At the time of this audit, there were no residents who were limited in the English language. Interviews with staff members verified resident interpretors are not to be used at the facility if a resident is limited English proficient. PREA posters were posted in all areas of the facility, in both English and Spanish. These posters were large enough to catch the eye and were age appropriate for the residents in the facility.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 102 – Employee Screening, and Interviews with Executive Director, PREA Coordinator, and Human Resources Representative

I interviewd the Administrative Assisstant/Human Resources Representative and was able to confirm that Child Abuse Clearances and Criminal History checks were conducted every 3 years. I reviewed the files of 5 randomly selected staff members (a mix of veteran staff and newer staff) and their files contained the necessary clearances (all of which where obtained prior to their working with residents). The same is required of contractors and volunteers by the Pennsylvania CPSL. I reviewed the most recent Pennsylvania BHSL Licensing and Inspetion Summary and it did not list any citations for not meeting this requirement.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Interviews with the Executive Director and PREA

Coordinator

Interviews confirmed that the Keystone Adolescent Center has not made any modifications of the existing facility since August 20, 2012. There is a video surveillance system which monitors the outside of the facility. There are a total of 9 cameras. This video surveillance system is viewed by the Program Director and Coordinator on a regular basis to monitor the movement and activities of the residents.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 901 – Reporting and Investigation of Alleged Child-Resident Abuse, Sexual Abuse, and Sexual Harassment, MOU with UMPC - Horizon, and MOU with AWARE, Inc

Keystone Adolescent Center does not conduct Forensic Medical Examinations. Exams will be conducted at UPMC Horizon by a SANE or other qualified medical practitioner. I reviewed a signed MOU between Keystone Adolescent Center, Inc and UPMC Horizon. In addition, upon notification of an allegation of sexual abuse, the staff member receiving the allegation shall notify Childline and then the Program Director and other management staff immediately. The Office of Children, Youth, and Families (OCYF) shall act as the sole civil agency responsible to investigate reports of alleged child abuse. In the event a crimal offense was committed, the Greenville West Salem Police Department becomes responsible for additional investigation and actions. This was confirmed with the Greenville West Salem Police Department during the on-site audit. All forensic examinations are provided without cost to residents and are completed at UPMC Horizon. This was confirmed upon review of the MOU and interviews with upper level management staff. There have been no forensic examinations in the past 12 months. Victim advocates are available through AWARE, Inc. The PREA Coordinator stated that she conducts follow-ups on all investigations. In addition, there were no residents who had reported sexual abuse to interview.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 901 – Reporting and Investigating Alleged Child-Resident Abuse, Sexual Abuse, and Harassment and MOU with Greenville West Salem Police Department

All policies and procedures are in place to ensure referrals of allegations to Childline and the Greenville West Salem Police Department. All random staff interviewed were able to discuss these policies and their role in reporting. It should be noted; the staff members appeared extremely knowledgable in the area of reporting. The Executive Director was interviewed and confirmed that all allegations are reported as

per Policy 901. It should be noted; OCYF is the sole civil agency responsible to investigate reports of child abuse and criminal investiagtions are completed by the Greenville West Salem Police Department. There were 0 incidents of sexual abuse or sexual harassment reported during the past 12 months. This was confirmed with with the Greenville West Salem Police Department during the on-site audit.

Standard 115.331 Employee training

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

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, PREA Training Curriculum, First Responder Protocol for incidents of Sexual Assault, and Random Staff Interviews

This auditor reviewed the policy, the training curriculum, and the employee training log. All staff members were adequately trained and were able to answer questions regarding their training and understanding of it during interviews. All employees signed an acknowledgement form following the training stating they understood it. 18 employees received this training during the past 12 months. I reviewed the files of 5 random staff members during the on-site audit and the necessary documentation was present in each employee file. During an interview with the PREA Coordinator, it was reported all staff members will receive a refresher training on an annual basis. Upper and mid level management staff have reviewed PREA policies on a regular basis during staff meetings in the program. In addition, there are PREA posters throughout the facility to re-inforce the standards.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 906 – Intern and Volunteer Services, Contractor Volunteer Tri-Fold, and Volunteer Orientation Checklist

During the past 12 months, 3 volunteers and contractors have been trained in the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. A Volunteers/Contractors Orientation Checklist record was reviewed during the on-site audit. This document verified the volunteers/contractors understood the policy/procedure and was signed. I also reviewed the volunteer/contractor tri-fold and it contained the required information to educate volunteers/contractors entering the facility. Policy 906 requires all volunteers/contractors who enter the facility to sign an acknowledgement form prior to interacting with any resident. There were no volunteers or contractors present to interview during the on-site audit.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 907 – Transitional Services, Resident Confirmation of Receipt – PREA Video, Resident Handbook, and PREA Posters

During the past 12 months, 70 residents were admitted to the facility. Residents are shown a PREA Video upon intake to the facility and sign a confirmation of receipt after viewing the video. A review of 5 randomly selected resident's file verified this practice. Residents also receive a handbook upon intake which clearly notes the Zero Tolerance Policy at the facility and how to report incidents of sexual abuse/harassment orally or in writing. I was able to review this handbook to verify the language in it is appropriate. In addition, there are PREA Zero Tolerance posters hung throughout the facility and also posters which detail how a resident can report alleagtions of sexual abuse/harassment. All residents interviewed during the on-site audit confirmed they were educated in PREA by watching an educational video as well as it being noted in the resident handbook they receive upon intake into the facility.

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.

Not Applicable: This standard does not apply.

The Office of Children, Youth, and Families (OCYF) and the Greenville West Salem Police Department are responsible for investigating allegations of sexual abuse, assault, and harassment at the Keystone Adolescent Center.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Training Records, Medical and Mental Health Staff Interviews, and MOU with SRHS/Mercer Family Medical Center

All mental health staff have completed the NIC training (PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting) as well as basic training that is required for all staff members. There are no medical staff located at the facility. However, all residents are seen by medical personnel at SRHS/Mercer Family Medical Center (contracted medical provider). The staff members at this facility have been educated on the requirements regarding this standard. In addition, an MOU has been signed and outlines the responsibilities of the medical staff members. I was able to interview a medical practioner at this agency during the on-site audit and they were able to verify their responsibilities as outlined in the MOU.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Admission Health and Safety Assessment, Alleged Abuse and Sexual Assault Checklist, and Interviews with Intake Staff and Residents

Policy 900 requires that within 72 hours of intake, and periodically throughout their confinement, the vulnerability assessment (Risk of Victimization and/or Sexually Aggressive Behavior) is administered to obtain information about each resident's personal history and behavior to reduce the risk of sexual abuse by others or directed towards other residents. This assessment notes prior sexual victimization/abusiveness, gender non-conforming appearance or manner/indentification, and whether the resident may be vulnerable to sexual abuse. Information obtained through their responses are provided only to designated staff members who work directly with the resident to ensure sensitive information is not exploited. I was able to verify this process during random resident and staff interviews. All residents stated they received this assessment upon intake. In addition, I interviewed 3 intake staff members who verified this process. If a resident scores high in the areas of "Vulnerability Victimization" or "Sexually Aggressive", a Safety Plan is developed by the Program Director to ensure the safety of the resident(s). Examples of these Safety Plans were reviewed during the on-site audit.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Vulnerability Asessment and Vulnerability Assessment Summary

I reviewed the Vulnerability Assessment which is conducted by an intake staff upon the resident's admission to the facility. This assessment is used to incease the awareness of of potential safety concerns. A summary of the Vulnerability Assessment is completed by the Program Director and shared with members of the resident's treatment team. The housing/room assignments are considered on an individual basis to ensure the safety of each resident. Lesbian, gay, bi-sexual, transgender, and intersex resdients are housed in the general population. There were no residents in the facility at the time of the on-site audit who identified themselves as lesbian, gay, bi-sexual, transgender, or intersex.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 901- Reporting and Investigating Alleged Child-Resident Abuse, Sexual Abuse, and Sexual Harassment, Resident Handbook, Resident Interviews, and Staff Interviews

Residents are provided multiple ways to report sexual abuse, assault, and harassment. Staff are required to report all verbal allegations to the Supervisor on shift and document such allegations (CY47 form and an Incident Report) immediately. Residents and staff members may privately report allegations confidentially through private telephone communication with Childline or AWARE, Inc. In addition, residents may report allegations of sexual abuse, assault, and harassment in writing by using a the Grievance Procedure at the facility. The resident does not have to submit the Grievance to the staff member accused of the allegation. Interviews with residents and staff members confirmed they were aware of multiple ways to report allegations of sexual abuse, assault, and harassment.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Emergency Grievance Memo, and Resident Handbook

Policy 900 contantains the necessary information regarding grievances. In addition, a memo was sent out to all staff members to notify them of the emergency grievance protocol. All residents and parents/guardians are advised of the grievance policy at intake and they sign off an acknowledging receipt. Interviews with residents and staff members verify this practice. I also reviewed 5 randomly selected resident's files and the signed acknowledgement receipt was present in each file. . In addition, residents interviewed during the on-site audit stated they were able to file anonymous grievances.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 901 – Reporting and Investigating Alleged Child-Resident Abuse, Sexual Abuse, and Sexual Harassment, MOU with AWARE, Inc, and Resident Handbook

The facility provides residents with outside victim advocates (AWARE, Inc) for emotional support services related to sexual abuse. This information has been provided to all residents via the Resident Handbook and PREA posters which are posted throughout the facility. I also interviewed 10 residents and all of them were able to describe these services and how to access them. I called AWARE, Inc and spoke to the Executive Director who was able to confirm this service is provided to residents as described in the MOU.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilitzed to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment

Third party reporting information is posted in both English and Spanish in the public and visiting areas of the facility. It is also posted on the company website (verified by this auditor prior to the on site audit). Policy 900 also clearly notes protocol for third party reporting. Residents and staff members at the facility were both aware of third party reporting.

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.

The following information was utilized to verify compliance with this standard: Policy 901 – Reporting and Investigating Alleged Child/Resident Abuse, Sexual Abuse, and Sexual Harassment

Policy 901 describes the requirements for all staff members to immediately report any knowledge, suspicion, or information received related to incidents or allegations of sexual abuse/harassment. Staff members are required to report this information to the Supervisor on shift and document the information (CY47 form and/or Incident Report) immediately. Interviews with random staff, Program Director, Supervisors, and PREA Coordinator verified they were all aware of the policy and their role as mandated reporters.

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.

The following information was utilized to verify compliance with this standard: Policy 901 – Reporting and Investigating Alleged Child/Resident Abuse, Sexual Abuse, and Sexual Harassment and Interviews with the Program Director, PREA Coordinator, PREA Compliance Manager, and Random Staff Members

I interviewed the Program Director, PREA Coordinator, PREA Compliance Manager, and 10 random staff members during the on-site audit. All knew what actions they were to take to ensure the safety of a resident or staff member who report allegations of sexual abuse, assault, or harassment. Protective measures may include but are not limited to housing changes, removing the resident or staff member abuser from having contact with the victim, heightened supervision, or the development of a Safety Plan. In addition, there are emotional support services for residents or staff members who fear retaliation for reporting allegations of sexual abuse, assault, or harassment.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interviews with the Executive Director, Program Director, and PREA Coordinator

Policy 900 clearly states reporting requirements when an allegation of sexual abuse of a resident is made while the resident was at another facility. Notification to the other facility must be made within 72 hours by Management staff and must be documented. Although there were no incidents reported during the past 12 months, interviews with the Executive Director, Program Director, and PREA Coordinator verified they were aware of the requirements.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 901 – Reporting and Investigating Alleged Child-Resident Abuse, Sexual Abuse, and Sexual Harassment, Policy 902 – Response to Reports of Sexual Abuse and/or Sexual Harassment, First Responder Protocol, and Random Staff Member Interviews.

Policies 900, 901, and 902 clearly state how staff members will respond when he/she is a first responder to sexual abuse. The facility also developed a First Responder Protocol for staff members to follow in the event of an incident of sexual assault. All staff members interviewed stated they received training and reviewed the First Responder Protocol and understood their requirements. Most staff members stated there is a "checklist" that they would follow in the event they are a first responder. I reviewed this checklist during the on-site audit and it is visible and available to all staff members on shift to follow in the event of an incident.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 901 – Reporting and Investigating Alleged Child/Resident Abuse, Sexual Abuse, and Sexual Harassment, and Policy 902 – Responding to Reports of Sexual Abuse and/or Sexual Harassment.

While interviewing the Executive Director, he was able to describe the coordinated response that is noted in Policies 900, 901, and 902. The facility also has a written plan to coordinate action taken in response to an incident of sexual abuse or sexual harassment among first

responders, medical and mental health practitioners, investigators, and management staff.

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.

Not Applicable: Keystone Adolescent Center, Inc has not entered into any collective bargaining agreements since August 20, 2012, nor do they have a Union for staff members at their facility.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interviews with the Executive Director, Program Director, and PREA Compliance Manager.

Protection from retaliation is noted in Policy 900. I interviewed the Executive Director, Program Director, and PREA Compliance Manager who reported there were no incidents of retaliation during the past 12 months. The PREA Compliance Manager is the person charged with monitoring retaliation at the facility. This person also serves as the Director of Operations.

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.

Not Applicable: This standard does not apply because the facility does not utilize isolation. It is prohibited by Pennsylvania DPW 3800 regulations. I interviewed the Executive Director, Program Director, and PREA Coordintor and they confirmed this. During my tour, I did not see any locations a resident could be isolated.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 901- Reporting and Investigating Alleged Child/Resident Abuse, Sexual Abuse, and Sexual Harassment, MOU with Greenville West Salem Police Department, and Interview with the Executive Director.

The Office of Children, Youth, and Families (OCYF) and the Greenville West Salem Police Department are the 2 primary agencies designated to investigate allegations of sexual abuse and sexual harassment at the Keystone Adolescent Center. Investigations are not terminated should the source of the allegation recant the allegation. Should criminal procecution be considered, interviews of the alleged victim, suspected abusers, and witnesses are conducted by the Greenville West Salem Police Department. I interviewed the Executive Director and he confirmed this process. It is also noted in policies 900 and 901. There have been no incidents/allegations during the past 12 months. This was confirmed during a telephone interview with the Director of Public Safety at the Greenville West Salem Police Department.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interview with the Executive Director.

Policy 900 states the agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. This was verified during an interview with the Executive Director.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 901 – Reporting and Investigating Alleged Child/Resident Abuse, Sexual Abuse, and Sexual Harassment, and Interviews with the Executive Director and PREA Coordinator.

Policies 900 and 901 state the victim be informed (verbally or in writing) as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. Interviews with the Executive Director and PREA Coordinator confirmed this practice. There were no incidents in the past 12 months, so there was no documentation to review or residents to interview.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interviews with the Executive Director and Human Resources Representative.

There have been no incidents in the past 12 months. Policy 900 meets this standard as it states termination will be the presumptive discipline for sexual abuse. This was confirmed during nterviews with the Executive Director and Human Resources Representative.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interviews with the Executive Director and Program Director.

Policy 900 states that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies and to relevant licensing bodies. There have been no incidents during the past 12 months. Interviews with the Executive Director and Program Director confirmed the this policy would be followed and appropriate actions would be taken to ensure the contractor or volunteer does not have any contact with residents.

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.

The following information was utilized to verify compliance with this standard: Policy 901 – Reporting and Investigating Alleged Child/Resident Abuse, Sexual Abuse, and Sexual Harassment and Interviews with the Executive Director and Program Director.

There were no incidents during the past 12 months. Policy 901 meets this standard as it states there would be no discipline for any allegation made by a resident in good faith. In addition to reviewing Policy 901, I also interviewed the Executive Director and Program Director to verify and determine compliance with this standard.

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.

The following information was utilized to verify compliance with this standard: Policy 902 – Responding to Reports of Sexual Abuse and/or Sexual Harassment, Health & Safety Assessment, and Interviews with Medical Practitioners, Mental Health Staff Members, and Residents.

Policy 902 and procedures are consistent with the requirements of this standard. Medical Practitioners and Mental Health Staff both stated that residents who disclosed prior victimization during the initial screening were offered a follow up meeting with medical practitioners or mental health staff members. Interviews confirmed agency policy expectations and staff were aware of their responsibilities.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 902 – Response to Reports of Sexual Abuse and/or Sexual Harassment, and Interviews with Executive Director, Program Director, and Medical Practitioners.

All residents have access to emergency care, free of charge. This is provided at UPMC – Horizon. All parties interviewed confirmed this. There were no reports of this during the past 12 months. Policy 902 states treatment services shall be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperated with any investigation arising from the incident. This was verified during interviews with the Executive Director, Program Director, and Medical Practitioners.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment, Policy 902 – Response to Reports of Sexual Abuse and/or Sexual Harassment, and Interviews with Medical Practitioners and Mental Health Staff.

Policies 900 and 902 state the facility offers medical/mental health evaluations and treatment are provided at no cost to sexual abuse victims and abusers. Interviews with Medical Practitioners and Mental Health Staff confirm timely, approparite care for these residents.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interviews with the Executive Director, PREA Coordinator, and Incident Review Team Members.

Although there have been no incidents in the past 12 months, there is a system in place for reviewing all incidents. I interviewed the Executive Director, PREA Coordinator, and a member of the Incident Review Team to verify protocol would be followed in the event of an incident. They were all able to confirm this process as well as explain their roles in detail.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment.

There have been no incidents and therefore no data to collect. However, there is a system in place to do so in the event of an incident. It would be collected by the PREA Coordinator and a report made; which would be reviewed by the Directors of Operations and the Executive Director.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment and Interviews with the Executive Director and PREA Coordinator.

Data would be reviewed and corrective action would be taken on a yearly basis after comparing data. The annual report provides an assessment of the agency's progress in addressing sexual abuse. This is noted in Policy 900 and was verified during interviews with the Executive Director and PREA Coordinator.

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.

The following information was utilized to verify compliance with this standard: Policy 900 – Prevention, Detection, and Response to Sexual Abuse, Assault, and Harassment.

Policy 900 states the annual report shall be approved by the Executive Director and be made readily available to the public through the Keystone Adolescent Center, Inc's website. Keystone Adolescent Center, Inc shall remove all personal identifiers from the reports. Keystone Adolescent Center, Inc shall maintain sexual abuse data collected for at least 10 years after the date of its initial collection unless Federal, State, or Local Law requires otherwise. The PREA Audit Report will be posted on this website as well.

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.

Matthew A Burns _____ July 1, 2016

Auditor Signature Date