

**PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES**

Date of Report: August 10, 2016

Auditor Information			
Auditor Name: Sharon G. Robertson			
Address: P.O. Box 10, Linville Falls, NC 28647			
Email: sharongr@bellsouth.net			
Telephone number: (828) 765-8180			
Date of facility visit: July 18-19, 2016			
Facility Information			
Facility name: Independent Living Program at George Street			
Facility physical address: 1298 N. George Street, York, PA 17404			
Facility mailing address: <i>(if different from above)</i>			
Facility telephone number: (717) 846-8226			
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: Dr. Vincent LaSorsa			
Designed facility capacity: 12			
Current population of facility: 12			
Facility security levels/inmate custody levels: N/A			
Age range of population: 16-20 years old			
Name of PREA Compliance Manager: Terri Spiegel		Title: I.L. Supervisor	
Email address: tspiegel@choyork.org		Telephone number: (717) 846-8226	
Agency Information			
Name of agency: Children's Home of York			
Governing authority or parent agency: <i>(if applicable)</i>			
Physical address: 77 Shoe House Road, York, PA 17406			
Mailing address: <i>(if different from above)</i>			
Telephone number: (717) 755-1033			
Agency Chief Executive Officer			
Name: Dr. Vincent LaSorsa		Title: Chief Executive Officer	
Email address: vlasorsa@choyork.org		Telephone number: (717) 846-8226	
Agency-Wide PREA Coordinator			
Name: Edward Watson		Title: Vice President of Program Services	
Email address: ewatson@choyork.org		Telephone number: (717) 755-1033, ext. 1241 / (717) 887-7573	

AUDIT FINDINGS

NARRATIVE

A Prison Rape Elimination Act (PREA) Audit of the Children's Home of York Independent Living at George Street ("ILP@GeoSt") was conducted on July 18-19, 2016. The purpose of the audit was to determine compliance with the Prison Rape Elimination Act standards for juvenile facilities which became effective August 20, 2012. The Notice of the PREA Audit was posted on May 30, 2016 at ILP@GeoSt and the Children's Home of York main office located at 77 Shoe House Road, York, PA 17406.

The ILP@GeoSt Mission Statement is to provide young men with a trauma-informed, therapeutic community that teaches the skills necessary to function independently as positive, productive citizens.

The ILP@GeoSt facility is licensed by the Pennsylvania Department of Public Welfare and governed by the Children's Home of York ("CHOY"). The Mission Statement for CHOY states the Children's Home of York empowers children to thrive, strengthens families and enriches communities.

CHOY received Accreditation from the Council on Accreditation and is accredited through June 20, 2017 for achieving the Highest Standards of Professional Practice for the Services It Provides. CHOY is also a Certified Sanctuary Programs by The Sanctuary Institute of the Andrus Center for Learning and innovation. CHOY is also regulated by PA Code Title 55, Chapter 3800.

CHOY was founded in 1865 by area civil leaders and volunteers to care for children of soldiers who died in the Civil War. For 150 years CHOY has been evolving to care for children and families in need. Today's Children's Home provides specialized residential programs to adolescents in need. CHOY offers expansive foster care and adoption services to children and families – with the ultimate goal of finding a forever home for every child in their care.

ILP@GeoSt is a community-based program serving dependent and delinquent males from the ages of 15 to 21 years old from York County and the State of Pennsylvania. CHOY will need to secure a waiver from the Pennsylvania licensing commission before ILP@GeoSt can house a 15 year old. The program implements Sanctuary® principles and equips residents with the skills they need to function as positive, productive citizens in the family, workplace and community. Residents learn to take responsibility for their actions and their future.

The length of stay for residents at ILP@GeoSt depends on their extended goals, and can range from 30 days to two years. ILP@GeoSt is a step-down facility from treatment programs and secured facilities. Referrals to ILP@GeoSt are made through Juvenile Probation (Probation Officer) or through Child Welfare (Social Worker). CHOY receives funding from the County of York and federal reimbursement.

Following a Casey Life Skills Assessment, individual services plans are developed for all residents beginning at the time of referral and is continually updated throughout the resident's treatment. Upon entry to the program, age-appropriate, short and long-term goals for the youth, community supports, and plan of care are developed. The plan is used as an outline and details the resident's goals and strategies, as well as addresses a plan for family involvement and support.

Each resident participates in an individualized independent living curriculum focused on instruction, positive therapeutic mediations, and real-life experiences. Residents work on developing pro-social, anger management, and conflict resolution skills. Additionally, residents learn basic skills, such as cooking, cleaning, and doing laundry, as well as key independent living skills like completing job applications, interviewing, maintaining employment, money and time management, utilizing public transportation, and meeting housing needs. Residents also have access to treatment support and prevention services.

Residents attend public high school, community college, or other educational programs; receive vocational and independent living skills training; and benefit from an individualized program of socialization and treatment services. Residents are strongly encouraged to find employment in the community when they arrive at ILP@GeoSt in keeping with the mission program to be independent and learn productive work. Almost all of the residents have jobs working any place they can get hired, including restaurants and warehouses. Residents are paid a minimum wage or higher. The resident retains one-half of their wage earnings and the other half is placed into a savings account for the resident. The resident can use their half of the earnings to pay for pizza, cell phones, or whatever they want to spend the money for.

Including supervisory and management, there are a total of 13 staff working at ILP@GeoSt. On the date of the audit, 7 staff members were interviewed with at least one staff member interviewed from each category, except for non-medical staff involved in cross-gender searches and contractors and volunteers as these interview types are not applicable to this facility. Three staff members reported in sick on the dates of the audit and other staff members were on vacation. Staff interviews were conducted with staff from all three shifts.

A total of 10 residents were interviewed with at least one resident interviewed from each category, with the exception of residents placed in segregated housing for risk of sexual victimization, resident disabled, limited English, and resident placed in isolation as these interview types were not applicable to this facility. On the day of the audit, there were 12 residents housed at ILP@GeoSt.

Telephone interviews were conducted with the CHOY Vice President of Human Resources, and a SANE/SAFE Nurse with WellSpan York Hospital.

Throughout the pre-audit and on-site audit, open and positive communication was established between the Auditor and facility staff. During this time, the Auditor discussed her concerns with PREA Coordinator Edward Watson and PREA Compliance Manager Terri Spiegel. All concerns were addressed to the Auditor's satisfaction prior to the completion of the Final Report.

When the on-site audit was completed, the Auditor conducted an exit briefing on July 19, 2016. The Auditor gave an overview of the audit and thanked the staff for all their hard work and commitment to the Prison Rape Elimination Act.

DESCRIPTION OF FACILITY CHARACTERISTICS

The facility is located at 1298 North George Street in York, Pennsylvania. ILP@GeoSt is housed in two-story Victorian home built in the late 1880's that includes a basement and an attic and has been remodeled several times. The main floor consists of the staff offices, kitchen, dining room, a weight room, and a game room with TVs, pool table, and video games. Windows are located in the wall and in the door of the Youth Counselor's office allowing the staff member to monitor the dining room and hallways. Residents can be viewed while in the Youth Counselor's office. Residents who enter the Supervisor's and Program Coordinator's office are supervised by other staff. The second floor consists of two single person bathrooms, an office for the 3rd shift staff located in the middle of the floor, and 4 bedrooms with 2-3 beds per bedroom where the 12 male residents reside. The third floor is a storage area where residents do not have access and the door is kept locked. The basement is used for storage where the boiler room, food, supplies, and chemicals are kept behind locked door. A washer and dryer are also located in the basement where residents do their own laundry. The keys are retained in the supervisory staff office.

There is no camera or video monitoring system at ILP@GeoSt. Supervisors and CHOY management have discussed every year when reviewing the budget the possibility of obtaining a video/camera system, and have concluded it is not feasible at this time due to the age and design of the building, and the cost of hiring additional staff to monitor the video system. Currently, the decision is to hire additional staff instead of a camera/video surveillance system.

Residents must meet certain requirements and undergo a vigorous screening prior to being allowed to live at ILP@GeoSt. A resident must have a 5th grade reading level, understand English in order to be able to seek employment outside the house, and have limited disabilities due to age of the house.

Room assignments are based on the vulnerability of the resident and a history of bullying. Supervisors try to pair new residents with established residents as a way of mentoring. Residents are allowed to write a proposal to the Supervisor suggesting change of roommates.

Residents are allowed to retain tablets, laptops, and MP3 players at all times. A resident's individual treatment plan is taken into consideration when allowing the resident access to mobile devices, and mobile devices will be taken away if ordered as part of the treatment plan. The facility does not provide Wi-Fi or any other internet access, and residents access free Wi-Fi from local businesses. Residents have access to a cordless phone during Level I, allowed to retain a cell phone during the day after progressing to Level II, and can retain their cell phone at all times while on Level III.

Residents are allowed to walk in and out of ILP@GeoSt at any time. Residents can sign out with a Youth Counselor for a "5" minute unescorted walk in the community a day when they first arrive in order to alleviate stress or tension. Residents then earn up to "15" minute sign-out the longer they stay at ILP@GeoSt. A staff member will start looking for the resident when they are late in returning for their walk in the community.

Residents are provided privileges based on the following levels:

Level I – Orientation period; resident has access to a cordless phone; allowed one 15 minute walk a day during 1st and 2nd shift; allowed 2 hour community pass a week; a family pass and maybe a one-night overnight with family.

Level II – allowed to have cell phone during the day; must turn it in at 10:00PM; two 15 minute walks a day during 1st and 2nd shift; allowed 4 hour community pass a week; a family pass and maybe a one-night overnight with family.

Level III – allowed to have cell phone all the time; three 15 minute walks a day during 1st and 2nd shift; allowed 6 hour community pass a week; a family pass and maybe a one-night overnight with family.

Food is prepared by staff and residents in the kitchen. ILP@GeoSt purchases the food supplies. Residents are encouraged to prepare their own food as part of their learning to live independently. The kitchen area is located near the Youth Counselor area. The kitchen is locked up at 11:00PM.

"House Rules" state the resident must be dressed and downstairs on the main floor by 10:00AM during the summer hours, and by 7:00AM during school time. The resident will remain downstairs for the remainder of the day unless he has a reason to go upstairs. The resident must first ask permission from the Youth Counselor before being allowed to go back upstairs to his bedroom. There is a standing rule that residents are not allowed in other residents' bedrooms. Staff visually "lay eyes" on all residents every 30 minutes at random times. Residents are required to be upstairs in their bedroom, bathroom, or in the 3rd shift supervisor's office by 10:30PM. The kitchen and basement are locked by 11:00PM. Residents are required to be in their own bedroom by 12:30AM.

First shift staff work from 7:00AM to 3:00PM, second shift from 3:00PM to 11:00PM, and third shift from 11:00PM to 7:00AM. There are usually 2-3 Youth Counselors, along with the Program Supervisor and Programming Coordinator, working first and second shift, and 2 counselors working third shift.

Staff do not perform pat-down or strip searches on any resident. Male staff will do a limited pat down search consisting of having the resident empty their pockets and show their ankles, when the resident has been gone too long during their community walk or staff suspect anything unusual. Staff do not physically touch residents and will call the local police when they suspect the resident will need a more thorough search.

Medical services are not provided on-site. Physical and health and safety assessments (mental health assessments) are completed by Concentra Medical Center medical personnel within 24 hours of admission. Medical appointments are provided by Family First Health and are accessed by residents completing and submitting a sick call request. Mental health services are provided through WellSpan, with Family First Health being the gap provider for continuation of medications until the resident is seen by mental health provider at WellSpan. Mobile Crisis and the Victim Assistance at the YWCA of York provide immediate, emergency mental health services.

SUMMARY OF AUDIT FINDINGS

After reviewing all information provided during the pre-audit and onsite audit, including, staff and inmate interviews, the auditor has determined the following:

Number of standards exceeded: 3

Number of standards met: 33

Number of standards not met: 0

Number of standards not applicable: 5

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.

Independent Living at George Street (“ILP@GeoSt”) PREA Policy page 1, states:

- (a) This procedural description outlines the program’s expectations regarding our zero tolerance toward all forms of sexual abuse and sexual harassment and outlines our approach to preventing, detecting, and responding to such conduct.
- (b) The agency-wide PREA coordinator is the Vice President of Programs.
- (c) The PREA Compliance Manager is the Supervisor of Independent Living Services.

The PREA definitions are provided in a separate document “PRISON RAPE ELIMINATION ACT NATIONAL STANDARDS – JUVENILES” which state:

Definitions related to sexual abuse.

Sexual abuse includes

- (1) Sexual abuse of an inmate, detainee, or resident by another inmate, detainee, or resident; and
- (2) Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer.

Sexual abuse of an inmate, detainee, or resident by another inmate, detainee, or resident includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse:

- a. Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;
- b. Contact between the mouth and the penis, vulva, or anus;
- c. Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument; and
- d. Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation.

Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer includes any of the following acts, with or without consent of the inmate, detainee, or resident:

- (1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;
- (2) Contact between the mouth and the penis, vulva, or anus;
- (3) Contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;
- (4) Penetration of the anal or genital opening, however slight, by a hand, finger, object, or other instrument, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;
- (5) Any other intentional contact, either directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

- (6) Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1)-(5) of this section;
- (7) Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate, detainee, or resident, and
- (8) Voyeurism by a staff member, contractor, or volunteer.

Voyeurism by a staff member, contractor, or volunteer means an invasion of privacy of an inmate, detainee, or resident by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals, or breasts; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions.

Sexual harassment includes-

- (1) Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one inmate, detainee, or resident directed toward another; and
- (2) Repeated verbal comments or gestures of a sexual nature to an inmate, detainee, or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gesture.

Interview with the PREA Coordinator, who is also the CHOY Vice President of Programs, indicates he is allotted ample time to oversee the agency's efforts to ensure PREA compliance in its facility. The PREA Coordinator reports to the CHOY President/CEO.

Interview with the PREA Compliance Manager indicates she is allotted ample time to oversee the facility's efforts to ensure PREA compliance which go hand-in-hand with all the agency's policy and procedures. Staff will notify their supervisor whenever they identify any issue that is related to complying with the PREA standards. The PREA Coordinator will work with staff to develop an Action Plan to correct the deficiencies noted by staff. The Programs Supervisor will then follow-up to make sure the Action Plan is implemented.

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)
- NA

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.

ILP@GeoSt PREA Policy, page 1, states this section is N/A.

As of the date of the audit, the facility reports that they have not entered into any contract with other entities for the confinement of residents since August 20, 2012.

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.

ILP@GeoSt PREA Policy, page 1, states:

§115.313 Supervision and monitoring.

(a) The program will ensure that the program is staffed as per expectations outlined by BHSL and outlined in the Program Description to protect clients against sexual abuse. Video monitoring is not employed by the program.

(b) The program shall remain in compliance with the aforementioned staffing expectations at all times.

(c) The Program Leadership will monitor staffing ratio to assess, determine, and document whether adjustments are needed to the staffing plan as per Supervision/Monitoring Program Policy.

The CHOY PREA Compliance-Supervision and Monitoring Policy states:

Policy: The Children's Home of York is committed to ensuring that all facilities offer adequate levels of staffing and monitoring in our ongoing effort to offer clients a safe environment, free from any type of abuse or neglect.

Procedure:

1. The Program Leadership (Program Supervisor and Program Coordinator) will monitor staffing patterns and ensure that the program is staffed in a ratio that matches the status of the current milieu.
2. The Program Leadership (Program Supervisor and Program Coordinator) will ensure an environment that allows open and honest communication from staff regarding staffing levels.
3. The Program Leadership (Program Supervisor and Program Coordinator) will conduct and document unannounced visits to the program on a schedule developed by the Program Supervisor and approved by the Vice President of Programs.
4. The Program Supervisor will keep the Vice President of Programs updated regarding compliance to this Program Procedure, and the two will discuss additional options (up to and including video monitoring or other additional needs) deemed necessary.

During the pre-audit, the Auditor was provided a copy of the yearly assessment for ILP@GeoSt dated June 28, 2016, which showed an operating capacity of 12, current capacity of 12, there were 4 staff on duty and a staffing ratio of 1:3, and the staffing plan addressed all components of the facility's physical plant.

During the pre-audit, the Auditor was provided a copy of the ILP@GeoSt Unannounced Rounds Tracking form showing documented unannounced rounds beginning May 3, 2016 for only the second and third shifts by the Independent Living Coordinator and Supervisor at random times and on random dates. During the on-site audit the Auditor was provided documentation showing that unannounced rounds were made during all three shifts. The Program Supervisor stated to the Auditor that unannounced rounds are being made by supervisory staff during all three shifts at a minimum of twice a month.

As of the date of the audit, the facility reports there have not been any deviations from the staffing plan within the past 12 months. The facility reported to the Auditor that the staffing plan is predicated on a daily average

of 12 residents, and they are averaging 9 residents. The Auditor was provided a summary of the ILP@GeoSt daily population on the 1st, 10th, and 20th of the month beginning June 1, 2015 through June 20, 2016. At no time did the facility house more than 12 residents on these dates. On the date of the on-site audit, there were 12 residents.

Interviews with Director and Program Supervisor indicate that staffing levels are reviewed yearly in accordance with Pennsylvania regulations and to make sure they are in compliance with the accreditation. The Auditor was informed the facility makes sure they have a higher staff to resident ratio than required by this standard.

Standard 115.315 Limits to cross-gender viewing and searches.

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

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

ILP@GeoSt PREA Policy, page 1, states:

§115.315 Limits to cross-gender viewing and searches.

(a) The program shall not conduct cross-gender strip searches or cross-gender visual body cavity searches.

(b) The program shall not conduct cross-gender pat-down searches.

(c) The program enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia.

(d) All staff of the opposite gender must announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

(e) The program staff shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

(f) Any and all necessary pat-down searches, and searches of transgender and intersex residents, shall be done in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

During the on-site audit, the Auditor confirmed that staff do not conduct pat-down and strip searches. Interviews with staff and residents confirmed that staff do not search residents, and they have not viewed residents undressed. All staff reported during the interviews that female staff will announce their presence at the bottom of the stairs before coming up the stairs to the bedrooms and, at times, will send a male staff member up the stairs to make sure residents are dressed before they come up the stairs. The bathrooms located on the second floor are designed for use by only one resident at a time. Interviews with residents confirm there is only one person in the bathroom at a time.

Standard 115.316 Residents with disabilities and inmates 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.

ILP@GeoSt PREA Policy, page 2, states:

§ 115.316 Residents with disabilities and residents who are limited English proficient.

(a) In the event that a client enrolled in the program has a disability (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), the program will utilize the organizations Risk Management process to ensure that the client has an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Possible assurances may include:

- Purchasing equipment that will allow communication with communication with residents who are deaf or hard of hearing,
- Providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively,
- Providing written materials in formats or through methods that ensure effective communication with these residents.

During the pre-audit, the Auditor was provided a copy of the Juvenile PREA Intake Orientation which states at the bottom it is to be read aloud should a resident be disabled or has limited reading skills. The intake orientation provides residents with information on sexual assault and how to report, the grievance procedure, reporting retaliation, and the consequent of false reporting of sexual assault. The Auditor reviewed a sample of completed resident orientation forms.

During the on-site audit, the Auditor verified through staff interviews and resident interviews that residents readers or resident assistants are not used to explain PREA policy and procedures to other residents. The Program Supervisor reported to the Auditor that residents must be proficient in English in order to be accepted at ILP@GeoSt to meet the program’s mission statement of seeking employment and independent living.

As of the date of the audit, the facility reported that in the past 12 months there have been no instances where resident interpreters, readers, or other types of resident assistants have been used; and it was not the case that an extended delay in obtaining another interpreter could compromise the resident’s safety, the performance of first-response duties under § 115.364, or the investigation of the resident’s allegations.

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.

ILP@GeoSt PREA Policy, page 2, states:
§ 115.317 Hiring and Promotion Decisions.
See the agency Hiring Policies.

During the pre-audit, the Auditor was provided with a copy of the CHOY hiring policies which states on page 36 under the Section Background Checks, Qualifications and Training, that, “Anyone who works in or wishes to work in a child residential or day treatment facility must have three types of background checks: a Pennsylvania Child Abuse History Clearance, a Pennsylvania State Police (PSP) Criminal Background Check, and a Federal bureau of Investigations (FBI) Criminal Background Check.” As of the date of the audit, the facility reports that all employees have completed background checks, and existing employees are required to have background re-checks completed every two years.

During the pre-audit, the Auditor was provided with a copy of The Child Abuse Clearance Form Procedure with instructions to potential employees securing clearance by the PA Department of Public Welfare.

During the on-site audit, the Auditor verified that all ILP@GEOST employees who have contact with residents have had criminal background record checks and reviewed a sample of employee background checks.

During the on-site audit, the Auditor interviewed CHOY’s Vice President of Human Services who confirmed that any employee who has direct contact with the residents undergo criminal background checks, and all current employees undergo criminal background checks every two years. The Auditor was also informed that CHOY does consider prior incidents of sexual harassment in hiring and promotion decisions for employees and contractors.

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.

ILP@GeoSt PREA Policy, page 2, states:
§ 115.318 Upgrades to facilities and technologies.
N/A

The facility has reported it has not acquired a new facility or made a substantial expansion or modification to the existing facilities since August 20, 2012.

Both the Vice President of Programs and the Program Supervisor confirmed during the on-site audit that they consider upgrades to facilities and technologies every year during budget consideration.

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.

ILP@GeoSt PREA Policy, page 2-3, states:

§115.321 Evidence protocol and forensic medical examinations.

(a) The agency/program will follow a uniform evidence protocol (as directed by the Northern York County Regional Police Department, who will be called in the event that a client makes an allegation of Sexual abuse or sexual harassment) that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(b) In the event that a client makes an allegation of sexual abuse, the program will engage the assistance of Wellspan Health Systems and the local Child Advocacy Center to secure a forensic medical examination without financial cost to the client. This examination will be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs), or another qualified medical practitioners.

Also engaged will be the Comprehensive Victim Services of the York YWCA. This organization provides the following services:

- 24 hour confidential hotline
- Support groups
- Hospital response and medical advocacy
- Legal advocacy
- Individual and group counseling

During the pre-audit, the facility provides copies of letters written to Northern York County Regional Police Department, Wellspan Health System (which operates York Hospital), and York YWCA informing them they will be contacted in the event a sexual abuse allegation is made.

During the on-site audit, the Auditor was made aware that York Hospital has SANEs/SAFEs staff on duty and have conducted training for CHOY staff. The Auditor was also made aware that the Victims Assistance staff at the YWCA of York are available 24/7 for victim’s assistance.

The Auditor spoke on the telephone with a SANE/SAFE Nurse from WellSpan York Hospital who stated she is a member of a team of emergency room Nurses who conduct forensic medical examinations and are available on-call 24/7. The Nurse further stated that all the SANE/SAFE Nurses on the team are RNs and have received adult, adolescent and pediatric training.

During the audit, the Auditor verified through interview with a Detective from the Northern York County Regional Police Department that they follow the evidence protocol set out by this standard.

As of the date of the audit, the facility reported in the past 12 months there have been no forensic medical exams conducted; there have been no exams performed by SANEs/SAFEs; and no exams have been performed by a qualified medical practitioner.

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.

ILP@GeoSt PREA Policy, page 3, states:

§115.322 Policies to ensure Referrals of allegations for investigations.

(a) In the event that a client makes an allegation of sexual abuse or sexual harassment, the program staff on duty will immediately notify a member of the Program Leadership (Program Supervisor or Program Coordinator). The member of the Program Leadership will direct the program staff to notify the Northern York County Regional Police Department of the allegation. Program staff will follow all directives given by the Northern County Regional Police Department regarding securing the area and any evidence handling.

(b) The organization procedure regarding incident reporting will be followed, completing the appropriate Children’s Home of York Incident Reporting forms as well as The Sexual Abuse Incident Review Form.

(c) The Alleged Abuse and Sexual Assault Checklist will be completed throughout the process to ensure that all necessary steps are taken in response to an allegation.

The ILP@GeoSt website <http://childrenshomeofyork.org/about/about-zero-tolerance> publishes information on referrals for criminal allegations of sexual abuse or sexual harassment.

During the pre-audit, the Auditor was provided and reviewed a copy of the Alleged Abuse and Sexual Assault Checklist referred to in ILP@GeoSt PREA Policy, §115.322 (c).

During the on-site audit, the Auditor confirmed that the facility has a procedure to document all referrals of sexual abuse or sexual harassment for criminal investigation through the use of the Alleged Abuse and Sexual Assault Checklist.

As of the date of the audit, the facility reported they have received no allegations of sexual abuse and sexual harassment that resulted in administrative or criminal investigation.

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.

ILP@GeoSt PREA Policy, page 3, states:

§ 115.331 Employee training.

All staff working at ILP@GeoSt will be trained in the following:

- (1) The program's zero-tolerance policy for sexual abuse and sexual harassment;
- (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- (3) Residents' right to be free from sexual abuse and sexual harassment;
- (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
- (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;
- (6) The common reactions of juvenile victims of sexual abuse and sexual harassment;
- (7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
- (8) How to avoid inappropriate relationships with residents;
- (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
- (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
- (11) Relevant laws regarding the applicable age of consent.

All current employees who have not received such training will be trained within one year of the effective date of the PREA standards. Each employee will be provided a mandatory refresher training every two years. The aforementioned training will be documented on the employee's training record.

During the audit, the Auditor was provided a copy of the Employee Training Curriculum and Employee Training Breakdown. The Auditor was also provided with a copy of the CHOY Zero Tolerance of Sexual Abuse and/or Harassment for Contracted Employees & Volunteers pamphlet, and a copy of the Understanding the Age of Consent in Pennsylvania to review. A review of these training documents indicates all topics in this standard are covered during training. Training is tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the facility.

During the pre-audit, the Auditor was provided with a copy of the Training Attendance Sheet for all staff with their signed signature verifying the date they attended the training on the PREA requirements enumerated above.

Staff interviews indicate staff had received the required PREA training.

Standard 115.332 Volunteer and contractor training.

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

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.

ILP@GeoSt PREA Policy, page 4, states:

§ 115.332 Volunteer and contractor training.

The program will ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures as well as be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

During the pre-audit, the Auditor was provided and reviewed a copy of the following:

- (1) A copy of the CHOY Zero Tolerance of Sexual Abuse and/or Harassment for Contracted Employees & Volunteers pamphlet,
- (2) A copy of the Confirmation of Receipt – Pamphlet: Zero Tolerance for Sexual Abuse and Harassment to be initialed by the contractor.

During the pre-audit, the Auditor was informed at the current time the facility does not have any volunteers or contractors who have direct contact with residents. This was confirmed by the Program Supervisor during the on-site audit.

During the on-site audit, the Auditor interviewed with CHOY Vice President of Human Services who confirmed that any employee, including contractors and volunteers, with direct contact with residents will undergo criminal background checks.

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.

ILP@GeoSt PREA Policy, page 4, states:

§115.333 Resident education.

During the intake process, all residents will receive information explaining, in an age appropriate fashion, the program's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

Within 10 days of intake, the program will provide comprehensive age-appropriate education to residents regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

The program will maintain documentation of resident participation in these education sessions. In addition to the aforementioned client education experiences, the program will ensure that key information is readily available or visible to residents through posters, resident handbooks, or other written formats.

During the pre-audit, the Auditor was provided and reviewed the following documents:

- (1) A copy of the End the Silence – Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA) pamphlet;
- (2) A copy of the PREA Resident Education Training Log;
- (3) A copy of the Juvenile PREA Intake Orientation;
- (4) A copy of the Resident Orientation Notice of Understanding to be signed by the resident;
- (5) A copy of English and Spanish posters for the residents.

During the on-site audit, the Auditor viewed posters in both English and Spanish located throughout the facility on the main floor and second floor providing residents with information on sexual abuse and sexual harassment, and how to report.

During the on-site audit, the Auditor reviewed a sampling of signed PREA Intake Orientation forms and the PREA Resident Education Training Logs. The Program Supervisor stated that children who are visually impaired and hearing impaired are not eligible for the program due to facility's age and design.

Interviews with residents indicate they have been provided information on the agency's zero tolerance; have seen the posters posted in the facility; know how to make a report; and have been provided a copy of the above-referenced pamphlet.

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)
- NA

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.

ILP@GeoSt PREA Policy, page 4, states:
§115.334 Specialized training: Investigations.

N/A- Program staff do not conduct investigations of sexual abuse.

During the pre-audit, the Auditor was provided with a copy of a letter sent to the Northern York County Regional Police on June 15, 2016, stating that they would be contacted if/when any resident makes an allegation of sexual abuse or sexual harassment.

During the on-site audit, the Auditor met with an Investigator from the Northern York County Regional Police who confirmed that the investigators have received training on investigation of sexual abuse in juvenile confinement settings.

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)
- NA

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.

ILP@GeoSt PREA Policy, page 4, states:

§ 115.335 Specialized training: Medical and mental health care.

N/A- Program staff do not conduct medical/mental health follow-up to abuse allegations.

All program staff are expected to complete the State mandated CPSL Training and Sanctuary Training.

During the pre-audit, the Auditor was informed that the facility does not have any medical or mental health workers on staff, nor any that work on-site. Medical and mental health services are provided off-site by Concentra Medical Center and Family First Health. Residents complete sick call requesting medical services from Family First Health, and mental health services provided through Mobile Crisis and Victim Assistance from the YWCA.

Interviews with residents indicate they know how to make a written request to receive medical and/or mental health services.

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.

ILP@GeoSt PREA Policy, page 4-5, states:

§ 115.341 Obtaining information from residents

Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's placement, the program obtain information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

These assessments are conducted using the standard Health and Safety Assessments and the Vulnerability Assessment Instrument.

At a minimum, the information obtained pertains to:

- (1) Prior sexual victimization or abusiveness;
- (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
- (3) Current charges and offense history;
- (4) Age;
- (5) Level of emotional and cognitive development;
- (6) Physical size and stature;
- (7) Mental illness or mental disabilities;
- (8) Intellectual or developmental disabilities;
- (9) Physical disabilities;
- (10) The residents own perception of vulnerability; and
- (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

This information may also be gathered vis-à-vis conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The sharing of this information is managed through the agency's confidentiality policy.

During the pre-audit, the auditor was provided with a copy of the ILP@GeoSt Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Violent Behavior for review which included all of the elements required under 115.341(c).

During the on-site audit, the Auditor reviewed a sample of completed ILP@GeoSt Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Violent Behavior and confirmed these screenings were done within 24 hours of admission.

During the on-site audit, the Auditor was informed that the Program Supervisor conducts all risk screening. Prior to acceptance into ILP@GeoSt, the Program Supervisor receives and reviews documentation from the referral agency, which includes psychological evaluations, criminal history, family history), and will interview each prospective resident. The Programs Supervisor will then consult with the Vice President of Programs and create a Risk Management Plan outlining the conditions the prospective resident will have to meet while at ILP@GeoSt prior to the resident's arrival at the facility. The Risk Management Plan can include mental health treatment, taking medications, and counseling sessions. Residents are screened for risk of victimization and abusiveness prior to their entry into the program and within the 24-hour period of their entry into the facility. Risk assessments are made at least once a year and more often if required due to a resident's victimization or aggressive behavior. The Auditor was informed that only the program administrators have access to the risk screening forms which are kept in a locked drawer.

As of the date of the audit, the facility reported that all residents have been screened using the risk screening assessment instrument referred to above within the past 12 months.

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.

ILP@GeoSt PREA Policy, page 5, states:

§115.342 Placement of residents in housing, bed, program, education, and work assignments. The program will use all information obtained to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Lesbian, gay, bisexual, transgender, or intersex residents are not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. Placement and programming assignments for each transgender or intersex resident are reassessed during quarterly case reviews to review any threats to safety experienced by the resident. A transgender or intersex resident's own views with respect to his or her own safety is given serious consideration. As is the case with all residents of the program, transgender and intersex residents shall be given the opportunity to shower separately from other residents.

ILP@GeoSt does not utilize isolation or protected custody.

During the on-site audit, the Auditor reviewed sample completed screening forms to verify that the facility uses information from the risk screening to inform housing, bed, work, education and program assignments.

Interviews with the PREA Compliance Manager, PREA Coordinator, and Supervisors confirmed risk screening is being used to determine room assignments to match roommates to prevent an unsafe environment, and determine if follow-up care and treatment is needed. The views of transgender and intersex residents are taken into consideration during placement. All residents at ILP@GeoSt are provided an opportunity to shower and use the bathroom separately.

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.

ILP@GeoSt PREA Policy, page 5-6, states:

§ 115.351 Resident reporting.

The program provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The program also provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request.

Staff who receive reports verbally, in writing, anonymously, or from third parties must promptly document any verbal reports.

The program provides residents with access to tools necessary to make a written report.

The program provides a method for staff to privately report sexual abuse and sexual harassment of residents through the organization's Harassment Policy as well as the fact that they are all Mandated Reporters, and it is expected that all staff comply with these expectations.

During the pre-audit, the Auditor reviewed the PREA Verbal Report Log for staff to use to document the name of the staff member who received the report, the date and time of the verbal report, the name of the resident making the report, and a place to write down the details as reported by the resident. As of the date of the audit, no verbal reports had been made to staff.

During the on-site audit, the Auditor viewed posters, in both English and Spanish, located in hallways, at the foot of the stairwell leading to the upstairs bedrooms, recreation room, office door and foyers that provided information on reporting sexual abuse or sexual harassment to staff, by filing a grievance, or by calling a toll-free number for the Childline and Abuse Registry for the Commonwealth of Pennsylvania, 911, and a local telephone number (which is the telephone number for the ILP@GeoSt Compliance Manager) and the YWCA of York telephone number.

An example of tools provided to residents necessary to make a written report referred to in the above-mentioned policy are the grievance forms located in the same folder with other forms (sick call, 15-minute walks) available in the dining room. Residents are allowed to turn in a grievance unsigned and do not have to hand them to a staff member. Residents can also tell their parent/guardian, teacher, probation officer and social worker.

During interviews with staff and residents the Auditor was able to determine that residents and staff can make private reports to any ILP@GeoSt staff member, telephone calls to ChildLine (the Pennsylvania hotline), and make anonymous calls to Victim Services of YWCA.

ILP@GeoSt does not accept residents detained solely for civil immigration purposes.

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.

ILP@GeoSt PREA Policy, page 6, states:

§115.352 Exhaustion of administrative remedies.

All clients are covered under the organization’s Client’s Rights Policy and Client Grievance Policy.

The program does not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.

The program ensures that:

a. A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and

b. The client’s grievance is not referred to a staff member who is the subject of the complaint.

Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, are permitted to assist residents in filing request for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.

During the pre-audit, the Auditor was provided and reviewed a copy of the CHOY Policy 300.29, titled, “Other Relevant Policies: Parent/Guardian Rights §300.29a, Client Grievance Procedure §300.14a”. During the on-site audit, the Auditor reviewed a sample of the above-referenced completed forms signed by residents and the legal guardian/parent.

ILP@GeoSt does have a means for exhausting administrative remedies through the CHOY grievance process. During the pre-audit, the Auditor was provided and reviewed the ILP@GeoSt Client Grievance Procedure, the Parent/Guardian Grievance Procedure, and the Client Grievance Investigation Form for compliance with this standard

The Auditor was able to determine through interviews with residents that they are aware of the grievance process.

As of the date of the audit, no grievances alleging sexual abuse had been filed with ILP@GeoSt staff, and ILP@GeoSt staff had not received any emergency grievances alleging substantial risk of imminent sexual abuse within the past 12 months. No resident has been disciplined for filing a grievance in bad faith within the past 12 months.

Standard 115.353 Resident access to outside confidential support services.

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

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

ILP@GeoSt PREA Policy, page 6-7, states:

§ 115.353 Resident access to outside support services and legal representation.

The program provides residents with easy access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The program enables reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

The aforementioned services are not monitored unless court ordered.

During the pre-audit, the Auditor was provided with a copy of the pamphlet entitled "End the Silence Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA)" that provided information on reporting sexual abuse or sexual harassment to staff, by filing a grievance, or by calling a toll-free number for the Childline and Abuse Registry for the Commonwealth of Pennsylvania, 911, and a local telephone number (which is the telephone number for the ILP@GeoSt Compliance Manager).

During the pre-audit, the Auditor was also provided a copy of Attachment A to the ILP@GeoSt Resident Handbook entitled, "You have the right to be safe from sexual abuse and harassment" which provides information on how residents can report sexual abuse and sexual assault. Attachment A further states that counseling services are provided through YWCA and VAC (Victim's Assistance Center) and provides the telephone number and website for these services.

During the on-site audit, the Auditor observed posters in both English and Spanish posted in the living areas letting residents know how they can report sexual abuse and sexual harassment.

The Auditor was able to determine through interviews with residents that they are aware of how to access support services in cases of sexual abuse.

Standard 115.354 Third-party reporting.

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

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

ILP@GeoSt PREA Policy, page 7, states:

§115.354 Third-party reporting.

The Children's Home publically distributes information on how to report sexual abuse and sexual harassment on behalf of a resident via the organizations website.

During the pre-audit, the Auditor reviewed the posters, in both English and Spanish, the facility's website at <http://childrenshomeofyork.org/about/about-zero-tolerance>; and Attachment A to the Resident Handbook that contain information on how resident can report sexual abuse or sexual harassment. The facility's also provides

a way for third-party reporting by calling the Childline and Abuse Registry for the Commonwealth of Pennsylvania.

During the on-site audit, the Auditor observed posters in both English and Spanish posted in the living areas letting residents know how they can report sexual abuse and sexual harassment.

The Auditor was able to determine through interviews with residents that they are aware of how to access support services in cases of sexual abuse.

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.

ILP@GeoSt PREA Policy, page 7, states:

§ 115.361 Staff and agency reporting duties.

The Children’s Home requires all staff to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

The Children’s Home also requires all staff to comply with any applicable mandatory child abuse reporting laws.

Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Medical and mental health practitioners are required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws. Such practitioners are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

Upon receiving any allegation of sexual abuse, the program will promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified.

During the pre-audit, the Auditor was provided with a copy of the Alleged Abuse and Sexual Assault Checklist and the Children’s Home of York Incident Report that is used when an allegation of abuse and sexual assault is made by a resident.

Through interview with the PREA Compliance Manager, the Auditor was informed that the facility must report any allegation of sexual abuse to ChildLine, the local police utilizing 911, HCKSS (Pennsylvania's mandatory reporting site) and the facility where the incident happened.

Through interviews with staff it was determined that all staff have a duty to immediately report any knowledge, suspicion, or information related to sexual abuse or sexual harassment to ChildLine, calling 911, to their supervisor, to the facility if the incident happened at another location, and through HCKSS. The facility will also immediately report the incident to the Children's Youth Worker or the Probation Officer and victim's attorney. Staff are also required to report any retaliation towards any inmate or staff for reporting and any staff neglect that may have contributed to an incident or retaliation.

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.

ILP@GeoSt PREA Policy, page 7, states:

§115.362 Agency protection duties.

When the program learns that a resident is subject to a substantial risk of imminent sexual abuse, it must take immediate action to protect the resident.

Through interviews with staff the Auditor was told that staff would immediately separate the residents, remove the victim from danger, make sure the resident feels safe, and notify their supervisor.

As of the date of the audit, the facility reported that no resident has been determined to have been subject to substantial risk of imminent sexual abuse within the past 12 months.

Standard 115.363 Reporting to other confinement facilities.

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

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

ILP@GeoSt PREA Policy, pages7-8, states:

§ 115.363 Reporting to other facilities.

Upon learning of an allegation that a client was sexually abused while at a previous facility, the following steps will be taken:

- The Program Supervisor will report this allegation to the PREA Coordinator. The PREA Coordinator will notify agency leadership. The appropriate investigative agency will be notified by the PREA Coordinator, PREA Compliance Manager, or designee. The Program Supervisor will notify the head of the facility where the abuse was alleged to have occurred as soon as possible but within 72 hours.
- The Program Supervisor will ensure that the allegation is reported as per this PREA Procedure and according to CPSL expectations.
- The Program Supervisor will document all notifications.

In the event that the Program Supervisor receives a report from another facility, the same process shall occur.

During the pre-audit, the Auditor was provided a copy of the PREA Notification Log 115.363 which states that the program supervisor or VP of programs must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred as soon as possible, but no later than 72 hours from the time the allegation was made. The log documents the date/time, person making notification, date of allegation, facility where allegation occurred, facility personnel informed of allegation, method of notification, and a signature block. During interviews with both the Vice President of Programs and the Program Supervisor, the Auditor was told they were aware of their duty to report to other facilities any allegation of sexual abuse they may receive.

As of the date of the audit, the facility reported that they have received no allegation that a resident was abused while confined at another facility and has not received any allegation of sexual abuse from other facilities within the past 12 months.

Standard 115.364 Staff first responder duties.

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

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

ILP@GeoSt PREA Policy, page 8, states:

§ 115.364 Staff first responder duties.

Upon learning of an allegation that a client was sexually abused, the first staff member to respond to the report shall be required to:

- (1) Separate the alleged victim and abuser;
- (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
- (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence,

including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and

(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

Through interviews with staff it was determined that all staff are aware of their responsibilities as a first responder upon first learning of any allegation of sexual abuse. Staff reported they separate the parties, notify their supervisor, protect the incident locations, and call the police and ChildLine.

As of the date of the audit, the facility reported that they have received no allegation that a resident had been sexually abused in the past 12 months.

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.

ILP@GeoSt PREA Policy, page 8, states:

§115.365 Coordinated response.

The Children’s Home of York’s Director of Compliance, who ensures that the organization conforms to all legal and oversight expectations, will coordinate the agency’s response to an allegation of sexual abuse and/or harassment.

During the on-site audit, the Auditor spoke with the CHOY Director of Compliance who confirmed that she is aware of the duties as set forth in this standard. The State of Pennsylvania already requires that the program file yearly monitoring reports through HCKSS. Her job includes overseeing quality and compliance; reviews; debriefing of any incident looking to see how the incident happened, if policy was followed, if adjustments in treatment plans are needed, and if a new policy is needed to guide practice the next time; and looks at outcomes.

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.

During the pre-audit, the Auditor was provided a copy of the CHOY Employee Handbook, revised June 2014, which states on page 40 that,

“At all times, the relationship between Children’s Home of York and any of its employees shall remain that of ‘at will’ employment. Children’s Home of York reserves the right to take any action in any order, which it deems appropriate or necessary in any given case. Children’s Home of York also reserves the right to terminate employees for any conduct which Children’s Home of York, in its sole discretion, considers to violate the standards it may expect of employees or renders the employee unfit for further work.”

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.

ILP@GeoSt PREA Policy, page 8-9, states:

§115.367 Agency protection against retaliation.

The Children's Home of York prohibits any form of retaliation against any individual (client or staff) who, in good faith, reports sexual abuse or harassment and/or cooperates with sexual abuse or sexual harassment investigations.

The PREA Compliance Manager will be sensitive to and monitor retaliation and report any suspicion of retaliation to the PREA Coordinator.

The PREA Compliance Manager will monitor (for at least 90 days) the treatment of client’s and/or staff who report sexual abuse to ascertain if there may be retaliation in play.

The PREA Coordinator will perform periodic one-on-one checks with those involved to ask if they feel that retaliation has been an issue.

Multiple protective measures will be instituted such as removal of alleged abuser, limiting contact with victims and witnesses, emotional support services for residents and/or staff.

During the pre-audit, the Auditor was provided a copy of the Sexual Abuse Retaliation Monitoring form to be completed upon receipt of a sexual abuse allegation for monitoring of staff and residents who report sexual abuse or for monitoring residents who are an alleged victim of sexual abuse.

As of the date of the audit, the facility reported that the Vice President of Programs is the agency’s designated staff person who monitors for possible retaliation. The Vice President of Programs reported to the Auditor that he will monitor the reports made by staff and supervisors. Supervisors cannot initiate the process without first talking with the Vice President of Programs and then talking with Human Resources. A supervisory meeting is

held every two weeks. The Vice President of Programs stated that the PREA monitoring works hand-in-hand with the other monitoring requirements other child welfare programs in Pennsylvania.

As of the date of the audit, the facility reported there have been no incidents of retaliation during the past 12 months.

Standard 115.368 Post-allegation protective custody.

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

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.

Through interview with the Program Supervisor and Vice President of Programs, the Auditor confirmed that ILP@GeoSt does not utilize protective custody or segregated housing.

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.

ILP@GeoSt PREA Policy, page 9, states:

§115.371 Criminal and administrative investigations.

The Organization does not conduct criminal investigations of sexual abuse reports.

ILP@GeoSt PREA Policy, page 3, states:

§115.322 Policies to ensure Referrals of allegations for investigations.

(a) In the event that a client makes an allegation of sexual abuse or sexual harassment, the program staff on duty will immediately notify a member of the Program Leadership (Program Supervisor or Program Coordinator). The member of the Program Leadership will direct the program staff to notify the Northern York County Regional Police Department of the allegation. Program staff will follow all directives given by the Northern County Regional Police Department regarding securing the area and any evidence handling.

(b) The organization procedure regarding incident reporting will be followed, completing the appropriate Children’s Home of York Incident Reporting forms as well as The Sexual Abuse Incident Review Form.

(c) The Alleged Abuse and Sexual Assault Checklist will be completed throughout the process to ensure that all necessary steps are taken in response to an allegation.

ILP@GeoSt PREA Policy, page 2-3, states:

§115.321 Evidence protocol and forensic medical examinations.

(a) The agency/program will follow a uniform evidence protocol (as directed by the Northern York County Regional Police Department, who will be called in the even that a client makes an allegation of Sexual abuse or sexual harassment) that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

ILP@GeoSt does not conduct its own administrative or criminal investigations. Investigations are conducted and completed by the Northern York County Regional Police.

During the on-site audit, the Auditor interviewed a Detective from the Northern York County Regional Police Department responsible for handling and investigating cases of sexual abuse, assaults, and harassment. The Detective indicated he is usually called in by the patrol officer and/or ChildLine. The Detective reviewed this Standard and confirmed to the Auditor that his office will comply with the subsections of this standard.

As of the date of the audit, the facility reported there have been no sustained allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012.

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.

ILP@GeoSt PREA Policy, page 9, states:

§115.372 Administrative investigations:

Any administrative investigation includes the organization Compliance Office as lead investigator. The Children’s Home of York will impose no higher standard than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated and responded to in an appropriate manner.

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.

ILP@GeoSt PREA Policy, page 9, states:

§115.373 Reporting to residents.

The program or agency is not the primary investigator of an accusation of sexual abuse by a client. The program will ensure that the client is informed of any Safety Plan put into place in response to their allegation.

The program will ensure that the client be kept updated as to the status of the allegation (substantiated, unsubstantiated, unfounded, etc.) as it received information from the investigative agency. This obligation shall terminate upon the client's discharge from the program.

During the pre-audit, the Auditor was provided with a copy of the following ILP@GeoSt documents for review:

- (1) Alleged Abuse & Sexual Assault Checklist to be used to document any investigation and notification.
- (2) A copy of the written notification entitled, "Substantiated Allegation/Complaint Notification", informing the resident the outcome of the investigation.
- (3) PREA Notification Log 115.373 (Reporting to Residents) to be used when any residents makes an allegation of sexual abuse.

As of the date of the audit, the facility reported there has not been any substantiated or unsubstantiated complaint of sexual abuse committed by a staff member against a resident in the past 12 months. The facility also reported that no notifications to residents were made pursuant to this standard in the past 12 months.

Standard 115.376 Disciplinary sanctions for staff.

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

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

ILP@GeoSt PREA Policy, page 9, states:

§ 115.376 Disciplinary sanctions for staff.

See attached Discipline Policy.

During the pre-audit, the Auditor was provided a copy of the CHOY Employee Handbook, revised June 2014, Section 5.4-4 Disciplinary Procedures, page 42, which states, "Misconduct or continuous poor performance will result in the employee's dismissal."

As of the date of the audit, the facility reported in the past 12 months no staff from that facility have violated the facility's sexual abuse and sexual harassment policies; no staff have been terminated or resigned prior to termination for violating the facility's sexual abuse and sexual harassment policies; no staff have been disciplined, short of termination, for violating the facility's sexual abuse and sexual harassment policies; and no staff from the facility have been reported to law enforcement or licensing boards following their termination or resignation for violating the facility's sexual abuse and sexual harassment policies.

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)
- NA

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.

ILP@GeoSt PREA Policy, page 9-10, states:

§ 115.377 Corrective action for contractors and v olunteers.

The program does not use volunteers.

If a client makes an accusation against a contractor, the program will respond in the same manner as if the accusation was made against a staff member, including a formal safety plan insuring that the contractor has no contact with the client until the investigation has been completed.

As of the date of the audit, the facility reported they do not use contractor and volunteers. Auditor verified this information during the on-site audit.

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.

ILP@GeoSt PREA Policy, page 10, states:

§115.378 Interventions and disciplinary sanctions for residents.

(a) A client may be subject to disciplinary action following an administrative finding that the resident engaged in sexual abuse of a peer or following a criminal finding of guilt.

(b) A report of sexual abuse made in good faith cannot be addressed as a disciplinary issue.

(c) Consensual sexual activity between residents does not constitute "sexual abuse" unless otherwise stipulated by Commonwealth law.

During the pre-audit, the Auditor was provided a copy of the George Street Program Rules, Expectations, Rewards and Consequences, which discusses on page 4 under the section entitled, "Sexual Abuse and Sexual Harassment" the consequences if a resident is found to have engaged in the behaviors set forth under this section.

As of the date of the audit, the facility reported in the past 12 months there have been no administrative findings of resident-on-resident sexual abuse; and there have been no criminal findings of guilt for resident-on-resident sexual abuse. The facility does not isolate any resident for any reason.

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.

ILP@GeoSt PREA Policy, page 10, states:

§ 115.381 Medical and Mental Health Screenings

(a) The program will ensure that all follow-up medical and/or mental health appointments are available to the client.

(b) If the screening pursuant to §115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

(c) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law

(d) Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

During the pre-audit, the Auditor was provided with a copy of the Health and Safety Assessment that is to be completed by CHOY staff within 24 hours of admission that includes questions on page 2 regarding gender identity and sexual abuse history. A consent form is provided on page 3 for any resident 18 years of age or older.

During the pre-audit, the Auditor was provided a copy of the PREA Medical/Mental Health Follow Up Appointment Form for review. This form also has block asking for consent of treatment for resident 18 year of age or older.

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.

ILP@GeoSt PREA Policy, page 10-11, states:

§115.382 Access to emergency medical and mental health services.

- (a) Victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.
- (b) Staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners.
- (c) Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.
- (d) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

During the pre-audit, the Auditor was provided with a copy of the Health and Safety Assessment that is to be completed by CHOY staff within 24 hours of admission that includes questions on page 2 regarding gender identity and sexual abuse history. A consent form is provided on page 3 for any resident 18 years of age or older.

During the pre-audit, the Auditor was provided a copy of the PREA Medical/Mental Health Follow Up Appointment Form for review. This form also has block asking for consent of treatment for resident 18 year of age or older.

Emergency and on-going medical appointments are provided at no cost to the resident by Family First Health, and are accessed by residents completing and submitting a sick call request. Mental health services are provided at no cost to the resident through WellSpan with Family First Health being the gap provider for continuation of medications until the resident is seen by mental health provider at WellSpan. Mobile Crisis and the Victim Assistance at the YWCA of York provide immediate, emergency mental health services.

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.

ILP@GeoSt PREA Policy, page 11, states:

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

- (a) The program shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse while in program.
- (b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.
- (c) The program shall provide such victims with medical and mental health services consistent with the community level of care.
- (d) Client victims of sexual abuse shall be offered tests for sexually transmitted infections as medically appropriate.
- (e) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.
- (f) The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

ILP@GeoSt houses only male residents.

Emergency and on-going medical appointments are provided at no cost to the resident by Family First Health, and are accessed by residents completing and submitting a sick call request. Mental health services are provided at no cost to the resident through WellSpan with Family First Health being the gap provider for continuation of medications until the resident is seen by mental health provider at WellSpan. Mobile Crisis and the Victim Assistance at the YWCA of York provide immediate, emergency mental health services.

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.

ILP@GeoSt PREA Policy, page 11, states:

§ 115.386 Sexual abuse incident reviews.

The program shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation through the agency’s Serious Incident Review Process.

During the pre-audit, the facility reported that all reviews will be conducted utilizing the agency's Serious/Critical Incident Debriefing process. Members of the review team are the PREA Coordinator, PREA Compliance Manager, and the agency's Director of Compliance. Other CHOY staff members and the CHOY Vice President of Human Resources, if a staff person is involved, may also be invited.

During the pre-audit, provided with a copy of the ILP@GeoSt Serious/Critical Incident Form that will be used by the agency's Serious/Critical Incident Debriefing team.

During the on-site audit, the Auditor spoke with the CHOY Director of Compliance who explained that the review team will be looking the incident to see how the incident happened, if policy was followed, if adjustments in treatment plans are needed, if a new policy is needed to guide practice the next time, and looks at outcomes.

As of the date of the audit, the facility reported in the past 12 months no criminal and/or administrative investigations of alleged sexual abuse were completed at the facility.

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.

ILP@GeoSt PREA Policy, page 11, states:

§ 115.387 Data collection.

(a) The program collects data from every allegation of sexual abuse.

(b) This data is aggregated on an ongoing basis and shared with the organization's Compliance and CQI Director.

(c) The data is collected and reported via the Survey of Sexual Violence Summary.

(f) Upon request, the agency shall provide all aforementioned data to the Department of Justice.

During the pre-audit, the Auditor was provided with a copy of the ILP@GeoSt Survey of Sexual Violence Summary that will be used to collection information as required by this standard. The facility reported that all incidents of reported sexual abuse, sexual assault or sexual harassment are reported to the CHOY Director of Compliance. The Director of Compliance maintains the original Surveys of Sexual Violence and compiles the data as part of the annual Program Assessment. This assessment includes: reporting period; number of client served; number of incidents of sexual abuse/assault or harassment; corrective action; and comparison to previous years. These reports will be available on the Main Campus of the Children's Home of York.

During the pre-audit, the Auditor was provided with a copy of the ILP@GeoSt Survey of Sexual Violence Summary that will be used to collection information as required by this standard.

During the on-site audit, the Auditor spoke with the CHOY Director of Compliance who confirmed she is responsible for collecting this information. The Auditor was also provided with a draft copy of the Annual

Report from July 1, 2015 to June 20, 2016 report to be reviewed and signed by the Chief Executive Officer, and will be made available to the public when signed.

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.

ILP@GeoSt PREA Policy, page 12, states:

§ 115.388 Data review for corrective action.

All related data will become part of the organizations Continuous Quality Improvement efforts as well as the organizations Formal Risk Management process.

All incidents, as well as the annual data, will be reviewed by the Director of Compliance.

The Risk Management process is an agency-wide Clinical Risk Management Team that includes Vice presidents, Directors, Clinicians, and Program Supervisors. The purpose of the Clinical Risk Management Team is the management of risks in a professionally competent and clinically sound manner by evaluating real or perceived risks against the current professional literature representing the current knowledge base of the profession. The primary goal of the process is to identify and put into place accommodations needed to successfully manage the presenting concerns; and confounding and mitigating circumstances.

During the pre-audit, the Auditor was provided with a draft copy of the PREA Report for the period July 1, 2015 to June 30, 2016 which showed there were no incidents of sexual abuse/assault during this time period. This report is approved by Children’s Home of York Chief Executive Officer.

The facility reported that the CHOY website will indicate that the Annual PREA Report will be made available to the public at the Main Campus for Children’s Home of York. During the on-site audit, the Auditor was provided with a draft copy of the Annual Report from July 1, 2015 to June 20, 2016 report to be reviewed and signed by the Chief Executive Office and will be made available to the public when signed.

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.

ILP@GeoSt PREA Policy, page 12, states:

§115.389 Data storage, publication, and destruction.

All information and data collected pursuant to § 115.387 are securely retained as per Children’s Home of York’s record keeping procedures.

All data and information collected pursuant to §115.387 will be kept for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

The facility reported to the Auditor that CHOY Compliance Manager will be responsible for maintaining this information.

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.

Sharon G. Robertson
Sharon G. Robertson

August 10, 2016
Date