PREA AUDIT REPORT ☒ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: October 14,2015

Auditor Information			
Auditor name: Maureen G. Raquet			
Address: PO Box 274, Saint Peters, Pa. 19470-274			
Email: mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: September 16, 17, 2015			
Facility Information			
Facility name: Gateway Rehabilitation Youth Extended Services Program			
Facility physical address: 100 Moffett Run Road, Aliquippa, Pa. 15001			
Facility mailing address: *(if different from above)* s/a			
Facility telephone number: 724-378-4461			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Dr. Richard A. Foster			
Number of staff assigned to the facility in the last 12 months: 25			
Designed facility capacity: 12			
Current population of facility: 7			
Facility security levels/inmate custody levels: secure			
Age range of the population: 13-20			
Name of PREA Compliance Manager: Nicole M. Kurash		**Title:** Program Director	
Email address: Nicole.kurash@gatewayrehab.org		**Telephone number:** 724-378-4461 x1242	
Agency Information			
Name of agency: Gateway Rehabilitation			
Governing authority or parent agency: *(if applicable)* s/a			
Physical address: 311 Rouser Road,Moon Township,Pa.15108			
Mailing address: *(if different from above)* s/a			
Telephone number: 412-604-8900			
Agency Chief Executive Officer			
Name: Dr. Richard A. Foster		**Title:** Executive VP of Treatment Services	
Email address: Richard.foster@gatewayrehab.org		**Telephone number:** 412-604-8900 x 1181	
Agency-Wide PREA Coordinator			
Name: Dennis Rhodes		**Title:** Corrections Division Director	
Email address: dennis.rhodes@gatewayrehab.org		**Telephone number:** 724-378-5260 x2738	

AUDIT FINDINGS

NARRATIVE

Gateway Rehabilitation was established in 1972 by Dr. Abraham Terski as an Alcohol Rehab for Adults. Since that time, it has grown to over 20 locations in two states, Pennsylvania and Ohio. It includes in-patient treatment, Detox, Halfway Houses, and Community Corrections for both Adults and Juveniles, Males and Females, including Court Committed residents, those on Probation or Parole, Juvenile Court Commitments for both Delinquent and Dependent Children and Private Voluntary Commitments through Individuals, Famliies, and Doctors. Facilities and Programs are separated by Gender, Age and Dual Diagnosis, as well as Court Status. Some of the Adult Programss have contracts with the Pa. Department of Corrections.

The Youth Extended Services Program (YES) is located on a campus in Aliquippa, Pa. that also has 6 other Gateway owned buildings and several other Adult and Juvenile Programs. The YES program is an all male facility with 12 beds, serving both dependent and delinquent residents between the age of 13-20 who have a Drug and Alcohol Diagnosis. The average stay is between 90-120 days and in 2014, there were 53 admissions. During the time of the on-site portion of the Audit, there were 7 residents.

The staff consist of Medical/Therapeutic, Administrative, Educational and Direct Care Staff referred to as Counselor Techs. There are both full and part time staff who work rotating shifts. Midnight staff work a permanent shift. There are a total of 18 staff assigned to this program. Medical staff are shared with the Adult and other Juvenile Facilities in this building and on this campus.

The residents receive both Individual and Group Therapy. Most participate in Family Therapy as well. Groups in ART, and the 12 Step program are also employed. There is an Activities/Life Skills staff and a Ropes Course. This program is operated as a Medical Model. It is licensed by both the Pa. Department of Human Services as a 3800 Reguation facility and also by the Pa. Department of Drug and Alcohol Programs (DDAP) . It is accredited by JCAHO. The per diem is paid by either Commercial Insurance, Medical Assistance or by the referring County. Gateway contracts with approximately 6 Western Pa. Counties, including Allegheny, Erie, Cambria, Mercer, Washington and Westmoreland.

DESCRIPTION OF FACILITY CHARACTERISTICS

The YES Program is located on a 17 acre campus in Center Township, Beaver County, Aliquippa, Pa., about 30 miles west of Pittsburgh Pa. It is located off a busy Interstate, not far from Wheeling, West Virginia and Steubenville Ohio. The campus itself is across the street from a residential housing development of single upper middle class homes. There are 6 Gateway owned buldings and one privately owned residence on this campus.

The YES program and two other Juvenile/Young Adult Programs are located in a separate building, designed and built for juveniles in 2012. It is a "Green" building built of recycled materials, including reclaimed wooden beams, "tactile panels", window walls, a courtyard with a fountain and landscape architecture. The 25,000 square foot building resembles an up scale three story office buiding or small medical center. It has yellow and gray recycled simulated plank siding and is very distinctive. It was conceived and designed by the Facility Administrators for patient safety and it reflects the therapeutic modality. It is well maintained, very quiet and has beautiful large posters of gardens, mountains, etc. throughout the facility, themed by floor.

The building is fronted by a small parking lot for employees and visitors. There is a portico over the front door, which is opened by a key fob or buzzed in from the reception area. The reception area has a large front desk and seating area, with a hallway to the left, leading to administrative offices and a beautiful courtyard next to that. Behind the reception area, there are several mult-use rooms, a bathroom, and a library, where family therapy is conducted and where the PREA interviews took place. To the left of the Library and behind the rear courtyard wall is a short hall leading to the cafeteria and kitchen area. This common area is shared by other programs in this building, but the residents are never together and the programs have separate staff. This dining area is also used for visiting. To the left of the cafeteria are very large rest rooms, which also serve as tornado shelters. As you travel down this short hallway, to the right is another hallway, with the Nurse's office/Med room with a Dutch Door, a GED classroom and Admin offices. To the Left is a classroom for the YES residents, as well as those bused in from another Gateway program, about 30 minutes away. These are all court committed residents. The classroom has traditional desks, but also has a Smart Board and is high tech. Further down the hall are the stairways and the elevator. The residents use the stairs when traveling to and from their third floor unit. The stairs have cameras. The second floor is not accessible to these residents and is only used for those residents that are privately committed. The third floor living unit consists of 4 triple rooms. The rooms have three single beds, three desks, and three wardrobes. There is a sink in the room and a separate toilet room with a door, next to the doorway. A separate single shower room is in the hallway next to each room. There is also a changing area as part of this shower room. There is a lounge area with sofas and a television on the bedroom side of the hallway when you first come up the steps. The opposite side of the hall has the staff area with a desk and computer in the hall. There are also therapist offices and offices for other staff including the Activities/Life Skill Therapist. One room contains boots and equipment for when the residents perform Community Service either on or off campus. This living unit was designed to allow for supervision with no blind spots.Tis building has cameras throughout. During the planning for its construction line of sight, complemented by camera surveillance was carefully considered. The cameras are not continuously monitored but have a recording capability for approximately 30 days. They can be viewd from administrative computers.

There is a large gym behind this Yellow and Gray building. It is used for recreation for all facilities on the campus, but never at the same time. There is an outside basketball court for the the YES residents in the front of the building. On the other side of the adult inpatient building and down a hill is a "Ropes Course" used by all programs that are permitted outside their buildings. It has both high and low elements and is nestled among the trees, with a wood mulch carpet. It is utilized at least once a week by the YES residents for facilitating communication, problem solving and team building among other subjects. It is an open area with no out buildings.

SUMMARY OF AUDIT FINDINGS

This Audit was conducted on September 16, 17, 2015. It commenced with an Introductory Meeting with the Executive Vice President, PREA Coordinator, PREA Manager/Director, YES Program Mananger, Liberty Program Director, and Director of Nursing. Immediatley following this meeting a tour was conducted of the facility. All common areas, including the gym and outside ropes course, as well as the third floor living area were toured. Throughout this facility there were large posters for reporting, victim support, and sexual abuse in both Spanish and English. The nurse's office contained a phone that all children and staff knew could be used to privately report sexual abuse. On the larege bulletin board in the hallway of the living unit of the YES program, there was a poster regarding Victim Advocate Services and tear away phone numbers at the bottom. According to the PREA Manager, she has to put up a new poster often , as the residents all take a phone number. There is a signed MOU with the Women's Center and prior to the on-site I spoke to a staff person there who confirmed the services outlined in the MOU and was not aware of any ongoing problems or incidents at the YES program. During the tour, I spoke to staff including Counselor Techs and Kitchen staff regarding unannounced rounds and their PREA Education. They responded affirmatively regarding unannounced rounds and could spontaneously answer me inquiries regarding education. The residents were in their rooms preparing for school during the tour and could readily answer questions regarding reporting and education. While on the tour, I noticed cameras throughout and direct lines of sight. I reviewed a camera recording for an unannounced round and I also reviewed an electronic file for follow up related to #342 and #381. On Wednesday, 9-16-15, I ate lunch with the residents and staff to view the supervision of the residents while in a group setting. Supervision of the residents troughout my time at the facility far exceeded the PREA and Pa. DPW 3800 regulation ratio. I also toured the large gym behind the Juvenile Building and the Ropes Course on the campus. Subsequent to the tour, I interviewed Specialized Staff, Random Staff, Teachers and all 7 Residents of the YES Program. The Specialized Staff included: the Executie Vice President, PREA Coordinator, PREA Mannager/Director, Two YES Manangers, Two therapists, the Vice President of Human Resources, the Director of Nursing, and a telephone interview with the Psychiatrist, who is a contracted employee. There are no volunteers. As previously mentioned, there are 18 staff assigned to this program. Of these, 8 are direct care staff that are both full and part time; two were out on medical leave and one was not available to be interviewed. I interviewed 5 direct care line staff and 3 teachers, who although are not counted in ratio, are Gateway employees and received all PREA training. As noted above I also interviewed 5 specialized staff, therefore interviewing all employees, but three assigned to this program. There were 7 residents in the population, during the on-site and all were interviewed. None identified as LGBTI, however two disclosed prior sexual abuse and one was identified as sexually aggressive. There have been no reports oof Sexual Abuse or Sexual Harassment in the past 12 months.

I reviewed additional logs of unannounced rounds as well as training logs. I reviewed 10 staff files and all had sign offs that they received and understood their PREA training. They also contained the necessary child abuse and criminal history checks. I reviewed the files of the 7 current residents and the files of 2 dishcarged residents. All contained documentation of timely education. The Vulnnerablity Asseements are kept in the medical files for confidentiality reasons, but were provided to me and all were administered in a timely fashion. Secondary documentation of medical and mental health follow up were also provided to me electronically. Although documentation of risk based housing decisions subsequent to #342 were being done, they were not specific enough. Prior to the 30 day report more specific documentation was provided. Also submitted prior to the 30 day report were changes to and inclusions to policy, as well as Human Resources Policy subsequent to #317 and additional unannounced rounds that included the third shift.

At the conclusion of the onsite portion of the Audit an Exit interview was conducted with the PREA Coordinator, PREA Manager, YES Program Mananger and the Liberty Station Director. Review of Policy, Documenation and Files, as well as personal iterviews of staff and residents show that the YES Program is compliant with all PREA standards. Additionally, one standard, #351, Resident Reporting has been exceeded. All avenues, written, verbal, third party and anonymous were provided to the residents, including phone number tear offs on a bulletin board. Although there was not a signed MOU with a Medical Facility to provide SAFE/SANE access, documentation of ongoing attempts to obtain one with Heritage Valley Hospital were provided. There is a signed MOU with the local Police Department, Center Township, for Investigative Purposes.

All Agency policies and procedures meet PREA Standards. One standard has been exceeded, three do not apply and 37 standards have been met.

Number of standards exceeded: 1

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Zero Tolerance policy meets all standards. There is both a PREA Coordinator for the entire Gateway Agency and a PREA Manager for the YES program. I reviewed the policy and supporting documentation and interviewed both the Coordinator and the Manager.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Gateway does not contract with any other agency for the confinement of its residents. This standard does not apply.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Ratio of staff to residents exceeds both PREA and Pa. DHS 3800 regulations. There were no devaitons from this staffing plan. Upper and mid level management conduct random unannounced rounds. I interviewed two Managers who conduct those rounds, saw a video of a round and documentation of such was submitted to me. There are cameras throughout the facility and there are clean lines of sight. Both therapists as well as managers and the program director work on the "floor" when needed and the use of mandatory overtime is utilized if necessary.

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.

Both staff and residents interviewed confirmed that there is no cross gender viewing or searches. I witnessed knock and announce by female staff. There is a policy in place for cross-gender pat down searches of transgender and intersex residents. There have been no such searches. The training that staff receives incude searches of Transgender ad Inntersex residents in a respectful and dignified manner.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There were no residents with any physical disabilities or who were not proficient in English. However there is a contract in place for translators as needed and there are accomoations for any physical or mental disabilities through the Education Department. Interviews with the Vice President and Random Staff confirm compliance.

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.

An interview with the Vice President of Human Resources showed that the HR policy needed to be amended to include all PREA verbiage. This was done and submitted prior to the 30 day report. A staff evaluation form was also revamped and submitted to me to include the necessary PREA disclosures. A review of 10 staff files showed all child abuse clearances and criminal history checks were being conducted.

There have been no new hires in the past 12 months, but checks are done prior to a staff person being permitted to work. The policy and practice is also compliant with the updated Pa. Child Protective Services Law. I alos reviewed the file of a contractor, who also had the appropriate clearances.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This is a brand new building. It was built in 2011 and openend in 2012. It was designed with open common areas and excellent lines of sight in the living area. Both toilets and showers are single occupancy. All areas of the building have cameras, including stairwells and the adjacent gymnasium.

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.

I interviewed the PREA Manager. There were no residents who had reported a sexual abuse. There is a MOU with the Women's Center and the services were verified during a pre onsite phone call to them. Medical services, free of charge, are provided at Heritage Valley Hospital. There is not currently an MOU, but documentation of continuing attempts to obtain one were provided to me.

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.

I interviewed the agency head and reviewed the Policy. All allegations are reported to Child Line and there is an MOU with Center Township Police Department to investigate any and all allegations. There are no Investigative Staff.

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.

I reviewed the Policy, requiring all staff to have PREA training and refresher training. I reviewed the curriculum. Additional curriculum was added to include Cross Gender Searches of Transgender and Intersex Residents. I saw logs of staff training and there was a signed declaration of understanding in the 10 staff files I reviewed. All but one part time staff had received appropriate training. All staff interviewed confirmed they had been trained and demonstrated an understanding of this 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.

There are no volunteers. All contractors have been trained. I interviewed by phone, the Psychiatrist, who stated she had been trained on the zero tolerance policy and knew her reporting duties.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

I interviewed all 7 residents, who could anwer my questions readily and demonstrated understanding of their education. I also saw resident logs that showed all residents have received education within 72 hours of intake, since the inception of the education in March 2015. I interviewed a therapist, who conducts the education. She stated that it is a three pronged approach that includes review of a power point presentation with the therapist, a checklist with definitions and conducting the risk-assessment. The curricula was age appropriate.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard does not apply. There are no trained investigators. All investigations are conducted by Center Township PD and Pa. Child Line.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This facility does not conduct Forensic Medical Exams, that is done at Heritage Valley Hospital. I interviewed the Director of Nursing who states that all her nurses have completed the NIC online course as well as the PREA training for all employees. I saw the training logs and completion certificates. I also interviewed, by phone, the Psychiatrist, who confirms having received specialized training.

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.

This is conducted by the therapists at Intake. I interviewed one therapist who states that in addition to the assessment itself, interiews and other documentation are used to assess risk. I saw timely assessments for all current residents and two discharged residents. They are kept in the medical files to ensure confidentiality. All residents interviewed stated they had been asked the questions on the instrument. The instrument is a commonly used one that is objective and contains all necessary information

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)

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Interviewed PREA Coordinator, PREA Managaer, Therapist who administers Risk Assessment. I reviewed information in electronic files for risk based housing decisions. Although in file, not specific enough. Additional Documentation was sent to me prior to the 30 day report. There were not LGBTI residents to interview. Both policy and practice meet standard.

Standard 115.351 Resident reporting

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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I interviewed the PREA Manager, 8 random staff and the 7 residents in the population.There were no residents who had reported a sexual abuse. Residents can use the private phone in the nurse's office, can file a grievance, can tell staff, or their therapist. There a tear off phone numbers on the bulletin board in the living unit hallway. Residents can report verbally, in writing, anonymously and through third parties. All avenues are provided and all residents and staff were aware of them. During the tour, I saw the tear off phone numbers, nurse's phone and residents using pencils at the desks in their rooms.This standard has been exceeded.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The grievance policy is signed off on at Intake by both residents and parents. It is in every resident file that I checked. It is required by Pa. 3800 regulations and checkecd by them during the annual inspection. The Policy was incomplete when first submitted, but has been amended to include all required sections. There have been no incidents of a grievance being filed regarding sexual abuse.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Vice President, PREA Manager, and all 7 residents in population. All could tell me that residents have access to visiting 2 x a week, phone calls 2x a week and the ability to speak to their attorneys. Residents also earn home passes and probation officers and caseworkers visit. There is an MOU with the Women's Center for Confidential Support Services and a phone number that is readily available.

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)

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This is in policy, in resident handbook and on posters and grievance forms. There have been no incidents of third party reporting in the past 12 months.

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)

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All administrators and all employees have a duty to report according to PREA Policy and also Pa. Child Protective Services Law. I interviewed the Vice President, PREA Coordinator, PREA Manager, Medical and Mental Health Staff and 8 random staff. All are mandated reporters and all know their responsibilities. The Policy meets the standard.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Vice President of Gateway, the Director of the YES Program and a random sample of staff. All are aware of their responsibilities to protect a resident immediately. Policy meets standard

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.

Both the Agency Head and YES Director were able to enumerate their duties required by their PREA Zero Tolerance Policy as well as the PA. CPSL. There have been no reports in the past 12 months.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

None of the staff have acted as first responders, because there have been no incidents in the past 12 months, however all staff interviewed were able to enumerate their first responder duties that they have been trained on that is also contained in policy and the training curriculum that I reviewed . Several staff wore their first responder duties on a card on a lanyard with their keys.

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.

There were no incidents in the past 12 months, so therefore no first responsders who have acted as such or residents who have reported a sexual abuse, but the coordinated response is in policy and there is a check off sheet to facilitate this.

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.

I interviewed the Vice President of the Agency who states that there are no Union or bargaining units and nothing that would prevent the agency from protecting the resident. A review of policy supports that statement.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the PREA Coordinator and the PREA Manager who also monitors retaliation. There have been no incidents of such, but both would handle the situation properly, up to and including removing a resident from the facility and returning him to his County Detention facility.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and DPW 3800 regulations prohibit use of Isolation for any reason. Interviews with Agency Head, Director, and Medical Staff confirm that there is no use of Isolation. During tour, I did not see anywhere a resident could be isolated. This Standard does not apply.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There is a MOU with Center Township PD for Criminal Investigations and a requirement to report to Child Line for investigations. YES Staff do not conduct investigations, but collect enough information to report and to keep a child safe. Any Administrative Investigation is done after the fact as a form of incident review. There are no investigators on staff, There were no incident within the past 12 months to review. Policy meets standard.

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.

Policy meets standard. There have been no incidents in the past 12 months.

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.

There have been no incidents in the past 12 months, but policy requires reporting to residents and others. Pa. DPW also requires reporting in a timely fashion through HCSIS. There were no residents who reported an abuse, but I interviewed the Vice President of Gateway.

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.

I interviewed the Vice President of Gateway as well as the Vice President of Human Resources. Discipline for staff is contained in both the PREA Zero Tolerance Policy and the HR policy. There have been no incidents in the past 12 months.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Interviews with both the Vice President of Gateway and the HR Vice President confirm the policy for corrective action for contractors. There are no volunteers. There have been no incidents in the past 12 months.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There are no sanctions for a resident reporting in good faith according to the PREA Zero Tolerance Policy and also Pa. CPSL. Interviews with Agency Designee, and both Director of Nursing and Mental Health staff confirm that policy is practice.

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.

Reviewed 7 files of current residents and 2 files of discharged residents. All residents have the vulnerability assessment completed at Intake and Physicals are completed within 72 hours. I saw secondary documentation in the electronic files of timely assessments for any identified youth. I interviewed two therapists, the Director of Nursing, and the Psychiatrist. Alsothough several residents were identified through the risk assessment, they did not identify to me during interviews for specific questions.

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.

All residents have access to emergency medical and mental health services. This is a hospital setting with round the clock nursing and therapists on awake shifts. There is a psychiatrist on call. Although there is not an MOU with Heritage Valley Hospital, a resident would be brought there for emergency treatment. Both Medical and Mental Health Staff confirm that there would be immediate access to Emergency care that would meet community level of care.

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.

This is an all male facility with a relatively short length of stay. Ongoing care would be provided as needed at the facility or in the community to either a victim or perpetrator free of cost. Interview with Director of Nursing, Psychiatrist and therapist confirm this care. Policy meets standard.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed two staff who would participate on an incident review team, and the Agency Vice President and PREA Manager. This is already in practice for other incidents as part of regualtions as an inpatient rehab. Policy meets standard. There have been no incidents.

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.

Data would be collected and aggregated as per policy by the PREA Manager anad submitted to the PREA Coordinator for an Agency Report. There is no data as of this time, because there have been no incidents.

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.

Aa per policy and interviews with Agency Vice President, PREA Coordinator and PREA Manager, data would be acted on in an ongoing manner and reviewed and compared on a yearly basis, and corrective actions would be made if necessary. The PREA Coordinator would write the report and it would be reviewed by the Agency Vice President befor dissemination and posting on website. All personal identifiers would be removed.

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.

According to policy and interviews, data would be stored securely and retained for the time required by law. It would be posted yearly on website after personal identifiers were redacted and noted in the report.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Maureen G. Raquet	October 14, 2015
Auditor Signature	Date