**PREA AUDIT REPORT ☐ INTERIM ☒ FINAL**

**JUVENILE FACILITIES**

**Date of Report: July 31, 2017**

| **Auditor Information** | | | |
|---|---|---|---|
| **Auditor Name:** Sharon G. Robertson | | | |
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| **Telephone number:** (828) 765-8180 | | | |
| **Date of facility visit:** July 20-21, 2017 | | | |
| **Facility Information** | | | |
| **Facility name:** Independent Living Program at George Street | | | |
| **Facility physical address:** 1298 North George Street, York, PA 17404 | | | |
| **Facility mailing address:** (*if different from above)* N/A | | | |
| **Facility telephone number:** (717) 846-8226 | | | |
| **The facility is:** | ☐ Federal<br>☐ Military<br>☒ Private not for profit | ☐ State<br>☐ Municipal | ☐ County<br>☐ Private for profit |
| **Facility type:** | ☐ Correctional | ☐ Detention | ☒ Other |
| **Name of facility's Chief Executive Officer:** Joseph Birli | | | |
| **Designed facility capacity:** 12 males | | | |
| **Current population of facility:** 9 males | | | |
| **Facility security levels/inmate custody levels:** N/A | | | |
| **Age range of population:** 16 – 21st birthday | | | |
| **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:** *(if applicable)* N/A | | | |
| **Physical address:** 77 Shoe House Road, York, PA 17406 | | | |
| **Mailing address:** (*if different from above)* N/A | | | |
| **Telephone number:** (717) 755-1033 | | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** Joseph Birli | | **Title:** Chief Executive Officer | |
| **Email address:** jbirli@choyork.org | | **Telephone number:** (717) 755-1033 | |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** Edward Watson | | **Title:** Director of Operations | |
| **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 Program at George Street (the facility) was conducted from April 24, 2017 to July 31, 2017. 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 audit consisted of a review of all PREA policies and procedures; a tour of facility; a review of documentation; and interviews with agency staff, facility staff, and residents. The Notice of the Audit was posted in various locations in the facility on May 24, 2017, and the Children's Home of York (the agency) main office located at 77 Shoe House Road, York, PA 17406. The on-site audit of Independent Living Program at George Street was conducted July 20-21, 2017.

During the on-site audit, an entrance meeting was held with the Agency PREA Coordinator to discuss the audit and schedule of activities. The Auditor toured the facility following the entrance meeting.

At the time of the audit the facility housed nine male residents, and seven of those residents were interviewed. At the time of the on-site audit there were no residents who had self-identified as being lesbian, bisexual, gay, transgender or intersex or disclosed prior sexual. At the time of the on-site audit, there were no residents who had communication disabilities or who were limited English proficient.

Interviews were conducted with Children's Home of York (the agency) President/CEO designee and the agency PREA Compliance Manager, the facility Supervisor, who is also the PREA Compliance Manager, supervisory and management staff. During a 30-day period prior to the on-site audit, the facility had received three staff resignations leaving a total of eight staff members working at the facility. Interviews were conducted with the staff member who monitors retaliation, a staff member who performs screening for risk victimization and abusiveness, an intake staff member, two members of the incident review team, two intermediate or higher level staff members, the agency's human resources staff member, one contractor, and six staff members. The facility does not have any contractors, volunteers, investigators, and medical and mental health staff. The facility does not perform any pat-down or strip searches at all, and they do not have any isolation areas. Staff was questioned regarding PREA training, the zero-tolerance policy, first responder responsibilities (including victim/perpetrator separation), reporting mechanisms and requirements, available interventions, conducting interviews, evidence collection, medical and mental health follow-up, and monitoring for retaliation.

Through interviews, the Auditor found the residents and staff to be very aware and knowledgeable of PREA. Staff was knowledgeable about the facility's zero-tolerance policy, their first responder responsibilities, mandated reporting responsibilities, and reporting/referral mechanisms to ensure a safe environment for residents and staff. Strip searches, body cavity searches, and pat-down searches are not allowed by the agency or the facility. The staff will call local police to perform pat-down searches of a resident when staff feels one is needed. Staff was aware of and followed the agency's prohibition of pat-down searches and strip searches. Resident interviews supported staff's compliance with the facility's prohibition of cross-gender viewing, pat-down searches and strip searches.

Staff received PREA related training as part of their initial orientation, annually as part of their cycle refresher training, and during roll calls. This was verified by the Auditor's review of nine randomly selected staff training records. Residents are provided information with reporting mechanisms, to include anonymous third-party sources for reporting. This was verified by the Auditor's review of four randomly selected resident records and observation of posters located throughout the facility. Residents are provided information with reporting

mechanisms, including anonymous third-party sources for reporting. The Auditor observed PREA information posted in every housing area, intake area, dining area, kitchen area, visitation area, and all hallways.

The facility does not provide on-site medical care. Telephone interviews were conducted with a SANE/SAFE Nurse with WellSpan York Hospital in York, PA and YWCA of York in York, PA.

At the completion of the on-site audit, the Auditor held an exit meeting with the Agency PREA Compliance Manager and facility Supervisor and Program Coordinator to discuss audit findings.

Throughout the pre-audit and on-site audit, open and positive communication was established between the Auditor and the facility's Supervisor/PREA Compliance Manager. The Independent Living Program at George Street was found to be fully compliant with PREA standards. Three standards were found to exceed requirements of the standard, and seven standards were not applicable. This finding is based on the Auditor's review of policies and procedures; a review of extensive and lengthy files and documentation provided to the Auditor during the pre-audit and the on-site audit; interviews with residents and staff during the on-site audit; interviews with the agency's Director designee and PREA Compliance Coordinator; and observations made during the tour of Independent Living Program of George Street during the on-site audit.

The Auditor wishes to thank the Supervisor/PREA Compliance Manager and the entire staff at Independent Living Program at George Street for their hard work and cooperation during the audit process and for their dedication to the elimination sexual harassment and sexual assault in their facility.

## DESCRIPTION OF FACILITY CHARACTERISTICS

Independent Living Program at George Street (the facility) is licensed by the Pennsylvania Department of Public Welfare and governed by the Children's Home of York (the agency). The agency's Mission Statement states: "the Children's Home of York empowers children to thrive, strengthens families and enriches communities."

The agency received Accreditation from the Council on Accreditation and is accredited through June 20, 2018, for achieving the Highest Standards of Professional Practice for the Services It Provides. The agency is also a Certified Sanctuary Programs by The Sanctuary Institute of the Andrus Center for Learning and innovation. The agency is also regulated by PA Code Title 55, Chapter 3800.

The agency 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 the agency has been evolving to care for children and families in need. The agency provides specialized residential programs to adolescents in need; and 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.

The Independent Living Program at George Street's Mission Statement is "Children's Home of York empowers children to thrive, strengthens families and enriches communities."

The facility 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. The agency will need to secure a waiver from the Pennsylvania licensing commission before the facility can house a 15 year old. The facility 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 the facility depends on their extended goals, and the average length of stay from July 1, 2016 thru June 30, 2017 was 243 days. The facility is a step-down facility from treatment programs and secured facilities. Referrals to the facility are made through Juvenile Probation (Probation Officer) or through Child Welfare (Social Worker). The agency receives funding from the County of York and federal reimbursement.

Individual service plans are developed for all residents utilizing Casey Life Skills Assessment beginning at the time of referral, and is continually updated throughout the resident's treatment. Upon entry to the facility, 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 the facility 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.

The facility is located at 1298 North George Street in York, Pennsylvania. The facility is housed in a 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 Program Supervisor's office, the Program Coordinator's office, staff bathroom, 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, game room, and hallways. Residents can be viewed while in the Youth Counselor's office. Residents who enter the Program Supervisor's and Program Coordinator's office are supervised by other staff and the doors are left open. The second floor consists of two single person bathrooms, an office for the 3rd shift staff located in the middle of the second floor, and four bedrooms with 2-3 beds per bedroom where up to 12 male residents reside. The third floor is storage area where residents do not have access and the door is kept locked. The basement is used for dry-food storage and freezers, cleaning and chemical supplies, and the boiler, all of which are kept behind locked doors. The washer and dryer are also located in the basement where residents do their own laundry, and staff monitors to allow only one resident at a time in the basement to do their laundry. All keys are retained in the supervisory staff office.

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 provides internet access. 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 personal cell phone at all times while on Level III.

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.

Residents are allowed to walk in and out of the facility at any time. Residents can sign out with a Youth Counselor for a "5" minute, unescorted walk in the community once a day when they first arrive in order to alleviate stress or tension. Residents then earn up to "15" minute sign-out walks the longer they stay at the facility. Staff members will start looking for the resident when they are late in returning from their walk in the community.

Food is prepared by staff and residents in the kitchen. The facility 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 on the first floor 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 remains downstairs for the remainder of the day unless he has a reason to go upstairs, and must ask permission from the Youth Counselor before being allowed to go back upstairs to their 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.

There is no camera or video monitoring system at the facility. The agency and facility management discuss every year when reviewing the staffing plans and discussing the budget the possibility of obtaining a video/camera system, and have concluded it is not feasible to install a camera/video monitoring system 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 agency's decision is to hire additional staff instead of installing a camera/video surveillance system.

First shift staff work from 7:00AM to 3:00PM, second shift from 3:00 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.

Facility staff does 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 any unusual. Staff does 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 Center at the YWCA of York in York, PA provide immediate, emergency mental health services.

The facility does not conduct any administrative or criminal investigations. Investigations are conducted 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. The facility uses the assistance of WellSpan Health Systems and the local Child Advocacy Center to secure a forensic medical examination in the event of an allegation of sexual abuse, and Victim Assistance Center of the YWCA of York for counseling 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: 32
Number of standards not met: 0
Number of standards not applicable: 6

**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 § 115.311
(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 Director of Operations.
(c) The PREA Compliance Manager is the Supervisor of Independent Living Services.

The facility has designated a PREA Coordinator and PREA Compliance Manager. Interview with the PREA Coordinator, who is also the agency's Director of Operations, 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 agency's 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.

Compliance with this standard was determined through policy reviews, interviews with specialized staff, and observations made during the on-site audit.

**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)
☒ Not Applicable

**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 is not applicable. Neither the agency nor the facility contracts with other entities for the confinement of residents.

**Standard 115.313 Supervision and monitoring.**

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

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

ILP@GeoSt PREA Policy, § 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 the facility dated June 1, 2017, which showed an operating capacity of 12, current capacity of 12, there was four staff on duty and a staffing ratio of 4:7. The staffing plan addressed all components of the facility's physical plant, the budget included allowances for over-time to ensure adequate staffing; specific staff conducting unannounced rounds, and interviews with staff and residents.

The Program Supervisor and Program Coordinator conduct unannounced rounds at a minimum of twice per month, once during first and second shift and once third shift, and staff is prohibited from alerting other staff members or residents that the rounds are or will be occurring. During the pre-audit, the Auditor was provided a copy of the facility's Unannounced Rounds Tracking form from July 5, 2016 through June 10, 2017 showing documented unannounced rounds s by the Independent Living Supervisor and Independent Living Coordinator at random times, on random dates, and during all three shifts. During the on-site audit the Auditor reviewed the Unannounced Rounds Tracking Logs from May 2016 to June 2017 for compliance with the policy.

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 that during the past 12 months the average daily number of residents was 11, and the staffing plan is based on a daily average of 12 residents. At no time in the past 12 months has the facility housed more than 12 residents. On the date of the on-site audit, there were nine residents.

There is no camera or video monitoring system at the facility. Facility supervisors and agency management discussed every year when reviewing the staffing plan and 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 physical 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 installing a camera/video surveillance system.

Interviews with Director of Operations 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.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

**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, § 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.

Policy prohibits all staff from conducting strip searches, pat-down searches, and visual body cavity searches. During the pre-audit, the facility reported none have been performed in the past 12 months.

During the on-site audit, the Auditor confirmed that staffs do not conduct pat-down and strip searches. Interviews with staff and residents confirmed that staffs 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. All staff also knocks on the doors of the resident bedrooms before entering the bedroom areas. 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.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

**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 § 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 can be reported, the grievance procedure, reporting retaliation, and the consequent of false reporting of sexual assault. During the on-site audit, the Auditor reviewed a sample of completed resident orientation forms.

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. The facility Supervisor reported to the Auditor that residents must be proficient in English to be accepted at the facility in order to meet the program's mission statement of seeking employment and independent living. At the time of the on-site audit, there were no residents housed at the facility that were limited English proficient or who had communication disabilities.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

**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, § 115.317 Hiring and Promotion Decisions.
See the agency Hiring Policies.

Section A.7, Revised October 2013, Pre-Employment

All new employees are required to complete the pre-employment process, which includes mandatory background screens in the following areas:

- PA Child Abuse History Clearance
- PA State Police Criminal Background Check
- FBI Fingerprint Background Check
- Motor Vehicle Records Check

Step 3: New Hire Offer Letter

- After the physical and pre-employment appointments have been scheduled, the Director of Human Resources will prepare and mail an officer letter to the newly hired employee. The offer letter introduces the employee to our Sanctuary principles, welcomes the employee to the agency, and provides the employee with their start date, position, the program at which they will be working, starting hourly rate or salary, as well as numerous instructions. The instructions pertain to the following:
    - Pennsylvania State Child Abuse History Clearance
    - FBI Clearance
    - Criminal Record Check
    - Motor Vehicle Record Check
    - Physical/TB/Drug Test
    - Orientation

Form – Children's Home of York Application for Employment

During the pre-audit, the Auditor was provided with a copy of the agency's 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 an Federal bureau of Investigations (FBI) Criminal Background Check." This page also lists offenses that prohibit employment in a child residential facility that include offenses as set forth in this Standard. The Auditor was also provided with a copy of Section A.7 Pre-Employment stating that all new employees are required to complete the pre-employment process which includes three mandatory background screens and FBI fingerprint 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 on-site audit, the Auditor verified that all facility employees who have contact with residents have had criminal background record checks and reviewed a sample of six employee files to verify completed and up-to-date background checks from the motor vehicle record, FBI and PA ChildLine were in the files.

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

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

**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)
☒ Not Applicable

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

The agency and facility reported they have not acquired a new facility or made a substantial expansion or modification to the existing facility since the last audit completed on August 4, 2016. The facility further reported they have not installed a video monitoring system, electronic surveillance system or other monitoring technology since the last PREA audit on July 18-19, 2016.

**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 § 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.
(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

The facility does not conduct any administrative or criminal investigations. Criminal investigations are conducted by the Northern York County Regional Police Department, who will be called in the event that a resident makes an allegation of sexual abuse or sexual harassment. The facility will use the assistance of Wellspan Health Systems and the local Child Advocacy Center to secure a forensic medical examination in the event of an allegation of sexual abuse, and Victim Assistance Center of the YWC York for counseling services.

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

The Auditor verified through telephone conversation with a SANE/SAFE Nurse from WellSpan York Hospital in York, PA, 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. The Auditor also verified through telephone conversation with YWCA York that their Victim Assistance Center will provide victim advocates, on-going counseling, and advocacy services.

During the audit, the Auditor verified through interview with a Detective from the Northern York County Regional Police Department that have received specialized training and they will 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.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

**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 § 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.

Policy requires all staff and contractors to report any unusual incident immediately to his/her immediate supervisor who will notify the Program Supervisor or Program Coordinator who will then direct staff to call the Northern York County Regional Police Department. Staff will then complete the Alleged Abuse and Sexual Assault Checklist. All staff are considered mandated reporters and are provided training on reporting any incident of child abuse or neglect to the PA ChildLine. The policies ensure that all allegations of sexual abuse or sexual harassment are thoroughly investigated. The facility 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, Children's Home of York Incident Report, and Sexual Abuse Incident Review Form.

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.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized 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.**

ILP@GeoSt PREA Policy § 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.

The facility provides extensive PREA standards training to all new employees during their pre-service training, annually during refresher training, and during bi-weekly refresher informational sessions. During the pre-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 agency's 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 an attributes of residents of juvenile facilities and to the gender of the residents at the facility.

During the on-site audit, the Auditor reviewed 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, had a good working knowledge of the standards, and received refresher training during annual training and during bi-weekly refresher informational sessions.

Compliance with this standard was determined through policy reviews, review of the PREA training course description, review of training files, observations made during the on-site audit, and interviews with staff.

**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 § 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.

The facility provides PREA training and training on the agency's zero tolerance policy relating to sexual abuse and sexual harassment to all volunteers and contractors who have contact with residents. During the pre-audit, the Auditor was provided and reviewed a copy of the following:
(1) A copy of the agency 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 contractors or volunteers. This was confirmed by the facility Supervisor during the on-site audit.

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

Compliance with this standard was determined through policy reviews, review of files, and interviews with specialized staff.

**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 § 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 showing where residents receive information at the time of intake explaining the facility's zero tolerance regarding sexual abuse and sexual harassment, information regarding reporting procedures, their right to be free from retaliation, and the availability of advocacy services: (1) End the Silence – Zero Tolerance for Sexual Abuse and Sexual Harassment: Prison Rape Elimination Act (PREA) pamphlet; (2) PREA Resident Education Training Log; (3) Juvenile PREA Intake Orientation; (4) Resident Orientation Notice of Understanding to be signed by the resident; and (5) George Street Program Rules, Expectations, Rewards, and Consequences

During the on-site audit, the Auditor viewed PREA posters in both English and Spanish located throughout the facility on the main floor on the bulletin board at the front door, the main bulletin board in the dining room; in the stairway to the second floor; and on the 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 random sampling of four resident files for completed and signed PREA Intake Orientation forms and the PREA Resident Education Training Logs. The Program Supervisor stated that residents who are visually impaired and with limited English proficiencies are not eligible for program due to facility's age and design.

The facility reported that in the past 12 months, 17 residents received comprehensive age-appropriate education on their rights to be free from sexual abuse and sexual harassment, from retaliation for reporting such incidents, and on agency policies and procedures for responding to such incidents during their first day of intake, and again within 10 days of intake.

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

Compliance with this standard was determined through policy review, review of documentation and files, observations made during the on-site audit, and interviews with staff and residents.

**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)
☒ Not Applicable

**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 § 115.334 Specialized training: Investigations.
N/A- Program staff do not conduct investigations of sexual abuse.

Sexual abuse administrative and criminal investigations for the facility are conducted by Northern York County Regional Police Department, an outside agency.

**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)
☒ Not Applicable

**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 § 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 employ or have any on-site medical or mental health workers. 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 Center from YWCA York.

**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 § 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.

The facility uses an objective screening instrument Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Violent Behavior to determine proper housing, bed assignment, education, and other programs assignments with the goal of keeping residents at high risk of being sexually abused and sexually harassed separate from residents who are at high risk of being sexually abusive. During the pre-audit, the auditor was provided with a copy of the 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 random sample of five resident files for completed 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 the facility, 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 Operations and create a Risk Management Plan outlining the conditions the prospective resident will have to meet while at the facility 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.

Interviews with residents also confirmed that during intake and classification they were asked questions about their prior incarceration history, sexual abuse history, sexual orientation identity, and whether they thought

they might be in danger of sexual abuse; and these questions were asked usually within 24 hours of their arrival at the facility.

As of the date of the audit, the facility reported in the past 12 months, 17 residents have been screened using the risk screening assessment instrument referred to above.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

**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 § 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.

The facility does not utilize isolation or protected custody.

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

The facility prohibits the placement of lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification. The facility also prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Interviews with the PREA Compliance Manager, PREA Coordinator, and Supervisor 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 the facility are provided an opportunity to shower and use the bathroom separately. Resident interviews confirmed they are allowed to shower and use the bathroom separately.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

**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 § 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.

All facility staff are considered mandatory reporters of child abuse under Pennsylvania law as stated on pages 7-9 in the agency's Employee Handbook Section 2.3 Mandatory Reporting of Suspected Abuse of Children. The facility has a policy requiring staff to document verbal reports they receive on the PREA Verbal Log. During the pre-audit to the Auditor reviewed a copy of 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.

Attachment A of the facility's Resident Handbook informs residents they should immediately inform a staff member they trust, fill out a grievance or call 911 if they or someone else has been abused or assaulted. 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 front entrance and 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, a local telephone number (which is the telephone number for the facility's Compliance Manager), and the YWCA 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 facility staff member, telephone calls to ChildLine (the Pennsylvania hotline), and make anonymous calls to Victim Assistance Center of YWCA York.

The facility does not accept residents detained solely for civil immigration purposes.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff, residents and advocacy services.

**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 § 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.

The facility has a means for exhausting administrative remedies through the agency's grievance process. During the pre-audit, the Auditor was provided and reviewed a copy of the following documents: (1) Children's Home of York (CHOY) Policy §300.14(a) Children's Home of York I.L. Program at George Street Residential Services Client Grievance Procedure; (2) CHOY Policy §300.14(b) Parent/Guardian Grievance Procedure; (3) Grievance Form; and (4) Grievance Investigation Form.

As of the date of the audit, the facility reported in the past 12 months they have not received any grievances alleging sexual abuse or 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.

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

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with residents.

**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 § 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 provides information on reporting sexual abuse or sexual harassment to staff by filing a grievance or by calling a toll-free number for the PA ChildLine and Abuse Registry, 911, and a local telephone number (which is the telephone number for the facility Compliance Manager).

During the pre-audit, the Auditor was also provided a copy of Attachment A to the facility's 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. The facility also provided a copy of the letter to the YWCA York and WellSpan regarding victim, medical counseling and support services, victim advocacy and forensic medical 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.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

**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 § 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.

The facility's also provides a way for third-party reporting by calling the ChildLine and Abuse Registry for the Commonwealth of Pennsylvania. The agency's website at www.childrenshomeofyork.org/about/about-zero-tolerance provides a way for residents, staff and third-party reporting by contacting the agency, notifying the PA Child Abuse Hotline and/or contacting local law enforcement. The agency at also provides a way for third-party reporting by calling into a specific telephone number and the address at the bottom of the page.

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.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

**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 § 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.

Agency policies requires all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility, retaliation against residents or staff who reported such incidents, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Policy states that apart from reporting to designated supervisors or officials, staff shall not reveal 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.

All staff are considered mandatory reporters and are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to designated State or local services agency where required by any mandatory reporting laws.

Through interview with the PREA Compliance Manager, the Auditor was informed that the facility must report any allegation of sexual abuse to PA ChildLine, the local police utilizing 911, HCSIS (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 PA ChildLine, calling 911, to their supervisor, to the facility if the incident happened at another location, and through HCSIS. The facility will also immediately report the incident to the Children's Youth Worker or the Probation Officer and victim's attorney. Staff is 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.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff.

**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 § 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 a random staff, it was determined that all staff were aware of their duties and responsibilities if they become aware of a resident that is subject to substantial risk of imminent sexual abuse. All staff interviewed stated they would take immediate action to protect the resident and report it to their supervisor.

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

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with staff and residents.

**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 § 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.

Policy requires the immediate reporting of any allegation of sexual abuse and/or sexual harassment by a resident that occurred at another facility to the facility's Program Supervisor. 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 Director of Operations 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 in the past 12 months they have not received any allegation that a resident was abused while confined at another facility, and has not received any allegation of sexual abuse from other facility.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with staff.

**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 § 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.

Agency policy requires the first security staff members to respond upon learning an allegation of sexual abuse on inmate and take action as set out in the above-stated policy. Through interviews with a random sample of staff it was determined that all staff are knowledgeable regarding their first responder duties upon first learning of any allegation of sexual abuse or sexual harassment. Staff stated they would immediately separate the residents; secure the scene as a possible crime scene and protect possible evidence; not allow the victim to bath, smoke, brush their teeth, defecate, urinate, eat, drink or change clothes; not allow other residents to destroy possible evidence; and call the police and PA ChildLine.

As of the date of the audit, the facility reported in the past 12 months they have not received any allegation that a resident had been sexually abused.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with staff.

**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 § 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 agency's Director of Operations 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 HCSIS. 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.

Interview with Program Supervisor stated she would coordinate with the custodial agency, provide evaluation through the Children Advocacy Center and Victim Assistance Center through YWCA York, and outpatient mental health services.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized staff.

**Standard 115.366 Preservation of ability to protect residents from contact with abusers.**

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

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

There is no collective bargaining agreement between the agency and employees. During the pre-audit, the Auditor was provided a copy of the Children's Home of York 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 § 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.

The policy prohibits any type of retaliation to any resident or staff who has reported sexual abuse or sexual harassment or who has cooperated in any PREA allegation investigation. The agency created 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 agency's Director of Operations, who is also the PREA Coordinator, as the agency's designated staff person for monitoring for possible staff and resident retaliation. The Director of Operations 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 Director of Operations and then talking with the agency's Human Resources Director. A supervisory meeting is held every two weeks. The Director of Operations 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 in the past 12 months there have been no incidents of retaliation.

Compliance with this standard was determined through policy reviews and interview with specialized staff.

**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)
☒ Not Applicable

**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 Director of Operations, the Auditor confirmed that the facility does not utilize isolation, 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 § 115.371 Criminal and administrative investigations.
The Organization does not conduct criminal investigations of sexual abuse reports.

ILP@GeoSt PREA Policy § 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 § 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.

The facility 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 administrative findings of resident-on-resident sexual abuse or criminal findings of guilt for resident-on-resident sexual abuse with the past 12 months.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

**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 § 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.

Policy states that administrative investigations are conducted by the agency's Compliance Office. During the on-site audit, the Auditor spoke with the agency's Director of Operations who confirmed that they do not impose a standard higher 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.

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 or criminal findings of guilt for resident-on-resident sexual abuse.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff.

**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 § 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 facility documents for review:
(1) PREA Notification Log 115.373 (Reporting to Residents) to be used when any residents makes an allegation of sexual abuse
(2) Substantiated Allegation/Complaint Notification form informing the resident of the outcome of the investigation.
(3) Unsubstantiated Allegation/Complaint Notification form informing the resident of the outcome of the investigation.

As of the date of the on-site audit, the facility reported in the past 12 months there has been no criminal and/or administrative investigations of alleged resident sexual abuse been completed by the agency at this facility. There were no investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months. There has not been any substantiated, unsubstantiated, or unfounded complaint of sexual abuse committed by a staff member against a resident in the past 12 months.

Compliance with this standard was determined through policy reviews, review of documentation, and observations made during the on-site audit.

**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 § 115.376 Disciplinary sanctions for staff.
See attached Discipline Policy.

Children's Home of York Employee Handbook, Section 5 – Employee Conduct
Section 5-4 Disciplinary Procedures
Disciplinary procedures may at times become necessary when performance or actions by an employee do not meet expectations. In those situations, the progressive disciplinary steps outlined below should be followed whenever possible and appropriate and documentation shall be placed in the employee's personnel file. During the orientation period or where, in the sole opinion of the Children's Home of York, the employee's conduct is willful, severe or otherwise egregious, the progressive disciplinary steps may be waived by the President or his/her designee and the employee be subject to immediate termination.
5-4-4 Step 4: Dismissal
Misconduct or continuous poor performance will result in the employee's dismissal. All terminations must be approved by the President of the Children's Home of York or his/her designee.
Resources will do an independent investigation and make a written response to the employee within ten (10) working days of the meeting.

The facility has a policy stating staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. This was confirmed by the Auditor during the interview with the Program Supervisor.

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.

Compliance with this standard was determined through policy reviews and interview with specialized staff.

**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)
☒ Not Applicable

**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 § 115.377 Corrective action for contractors and volunteers.
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/or volunteers. The Auditor verified this information during the on-site audit with the PREA Compliance Manager and PREA Coordinator.

**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 § 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 Independent Living Program at 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.

The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse which does not consider whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions.

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.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

**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 § 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.

Upon arrival all resident are screened and assessed by a qualified staff member for their risk of being sexually abused or sexually harassed by other residents, or for being sexually abusive towards other residents. During the pre-audit, the Auditor was provided with a copy of the Health and Safety Assessment/ILP@GeoSt that is completed by CHOY staff within 24 hours of admission that includes on page 2 questions regarding gender identity and sexual abuse history. A consent form is provided on page 3 for any resident 18 years of age or older. The Auditor also reviewed the PREA Medical/Mental Health Follow Up Appointment form which has a block asking for consent of treatment for resident 18 year of age or older.

During the on-site audit, the Auditor reviewed a random sample of three resident files with completed Health and Safety Assessments and other secondary materials.

Interview with the facility Supervisor confirmed the use of the screening tool and reassessment which is usually completed within the first day of the arrival of the resident.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

**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 § 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.

Policy requires that any time a resident makes an allegation of sexual abuse they resident will receive timely access to emergency medical treatment and crisis intervention. All staff are trained to preserve any on-site

evidence for criminal investigation. Residents are offered information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally acceptable standards of care, where medically appropriate. The treatment is offered at no financial costs to the resident irrespective of whether the victim/resident names the abuser or cooperates with any investigation arising from the incident.

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 Center at the YWCA York provide immediate, emergency mental health services.

Compliance with this standard was determined through policy reviews, review of documentation, and interviews with specialized staff and residents.

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

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

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

ILP@GeoSt PREA Policy § 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.

Policy states that residents who are victims of sexual abuse are offered ongoing medical and mental health care whether the abuse occurred prior to incarceration, at another facility, or at this facility. The evaluation and treatment includes follow-up services, treatment plans, and referrals for care in other facilities. The facility 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 Center at the YWCA York provide immediate, emergency mental health services.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized staff.

**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 § 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.

Policy states that the facility shall conduct a sexual abuse incident review of every sexual abuse investigation. During the pre-audit, the facility reported that all reviews will be conducted utilizing the agency's Serious/Critical Incident Debriefing process and is usually within 30 days of the conclusion of the investigation. Members of the review team are the PREA Coordinator, PREA Compliance Manager, and the agency's Director of Operations. Other agency staff members and the agency 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.

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.

During the on-site audit, the Auditor spoke with the agency's Director of Operations 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.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with specialized staff.

**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 § 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 agency's Director of Operations. The Director of Operations 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. This report is available on the Main Campus of the Children's Home of York at 77 Shoe House Road, York, PA.

The agency does not contract for the confinement of its residents.

The agency's Director of Operations and facility Supervisor stated that they would use any information revealed as a result of the review of any sexual assault or sexual harassment investigation to enhance or upgrade monitoring technology.

Compliance with this standard was determined through policy reviews, and interviews with specialized staff.

**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 § 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 copy of the PREA Report for the period July 1, 2016 to June 30, 2017 which showed there were no incidents of sexual abuse/assault during this time period. This report is approved by Children's Home of York President/Chief Executive Officer.

The facility reported that the agency's website indicates that the Annual PREA Report is available to the public at the Main Campus for Children's Home of York at 77 Shoe House Road, York, PA.

Compliance with this standard was determined through review of documentation.

**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 § 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 agency's Compliance Manager will be responsible for maintaining this information.

Compliance with this standard was determined through policy reviews, review of documentation, observations made during the on-site audit, and interviews with staff and residents.

## 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* **July 31, 2017**
**Sharon G. Robertson** **Date**