**PREA AUDIT REPORT ☒ INTERIM ☒ FINAL**

**JUVENILE FACILITIES**

**Date of report:** April 7, 2016

| | | | |
|---|---|---|---|
| **Auditor Information** | | | |
| **Auditor name:** Maureen G. Raquet | | | |
| **Address:** PO Box 274, Saint Peters, Pa. 19470-274 | | | |
| **Email:** mraquet1764@comcast.net | | | |
| **Telephone number:** 484-366-7457 | | | |
| **Date of facility visit:** January 18,19,2016 | | | |
| **Facility Information** | | | |
| **Facility name:** Gateway Rehabilitation Liberty Station Youth Halfway House | | | |
| **Facility physical address:** 331 Hickory Grade Road, Bridgeville, Pa. 15017-1207 | | | |
| **Facility mailing address:** *(if different from above)* s/a | | | |
| **Facility telephone number:** 724-378-4461 | | | |
| **The facility is:** | ☐ Federal | ☐ State | ☐ County |
| | ☐ Military | ☐ Municipal | ☐ Private for profit |
| | ☒ Private not for profit | | |
| **Facility type:** | ☐ Correctional | ☐ Detention | ☒ Other |
| **Name of facility's Chief Executive Officer:** Dr. Richard A. Foster | | | |
| **Number of staff assigned to the facility in the last 12 months:** 14 | | | |
| **Designed facility capacity:** 24 | | | |
| **Current population of facility:** 5 | | | |
| **Facility security levels/inmate custody levels:** secure/halfway house | | | |
| **Age range of the population:** 13-21 | | | |
| **Name of PREA Compliance Manager:** Chris Ingram | | **Title:** Director of Extended Care Division | |
| **Email address:** chris.ingram@gatewayrehab.org | | **Telephone number:** 412-221-9480 x2661 | |
| **Agency Information** | | | |
| **Name of agency:** Gateway Rehabilitation | | | |
| **Governing authority or parent agency:** *(if applicable)* s/a | | | |
| **Physical address:** 311 Rouser Road,Moon Township,Pa.15108 | | | |
| **Mailing address:** *(if different from above)* s/a | | | |
| **Telephone number:** 412-604-8900 | | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** Dr. Richard A. Foster | | **Title:** Executive VP of Treatment Services | |
| **Email address:** Richard.foster@gatewayrehab.org | | **Telephone number:** 412-604-8900 x 1181 | |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** Dennis Rhodes | | **Title:** Corrections Division Director | |
| **Email address:** dennis.rhodes@gatewayrehab.org | | **Telephone number:** 724-378-5260 x2738 | |

## AUDIT FINDINGS

### NARRATIVE

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

Liberty Station is a Youth Halfway House located in Bridgeville, South Fayette Township, Allegheny County, Pa. This program is an all male facility with 24 beds, serving both delinquent residents and those who sign themselves in, who may also have court involvement but are not Court committed. The residents are between the ages of 13 and 21, and have a Drug and Alcohol Diagnosis. Many of the admissions come from the YES program or the Young Adult program on the main campus about 30 minutes away in Aliquippa. Liberty Station is a "step-down" or halfway house. The average stay is 86 days and in 2015 there were 52 admissions. During the time of the on-site portion of the Audit, there were 5 residents.

The staff consist of a Master's Level Therapist, Administrative Staff, a Life Skills/Career employee and Direct Care Staff referred to as Counselor Techs. There are both full and part time staff who work rotating shifts. Midnight staff work a permanent shift. There are a total of 12 staff currently assigned to this program. The medical staff consist of a contracted psychiatrist from Intercare, who is there two hours a week to do primarily medication evaluations and the Director of Nursing, who does the Medication Administration training for line staff and oversees the med room and the medical logs. She is also on-call, but because this is a halfway house, community medical resoureces are utilized.

The residents receive both Individual and Group Therapy. All residents also participate in ART groups. Residents can attend school on the main Gateway campus for credits or GED and the others have jobs in the surrounding community.The residents are transported by the line staff to school and are transported to and from their jobs. This program is operated as a Medical Model. It is licensed by both the Pa. Department of Human Services as a 3800 Regulation facility and also by the Pa. Department of Drug and Alcohol Programs (DDAP) . It is accredited by JCAHO. The per diem is paid by either Commercial Insurance, Medical Assistance or by the referring County. Gateway contracts with approximately 6 Western Pa. Counties, including Allegheny, Erie, Cambria, Mercer, Washington and Westmoreland.

## DESCRIPTION OF FACILITY CHARACTERISTICS

Liberty Station Youth Halfway House is located on a 15.53 acre campus in South Fayette Township, Allegheny County, southwest of Pittsburgh Pa. It is located off a busy Interstate, between the city of Pittsburgh and the Pittsburgh Airport. The campus itself is on the top of a hill separated from a residential housing development of single upper middle class homes by a large yard and a fence. There is an outside basketball court and a shed. On the same acreage there is another group home for MH adults. It is owned by the same landlord, but is not affiliated with Gateway.

This single story brick and siding ranch type home is approximately 3000 square feet. The building has a small parking lot for employees and visitors and a winding pavement to the front door. There are motion activated flood lights on the outside of the home. The driveway also goes down behind the house. As you enter the front door, there is a small foyer area with a bulletin board and table with PREA Postings in both Spanish and English and a table with PREA brochures for visitors and contractors. All along this corridor are offices and to either side of this hallway are sleeping units. The units are divided by age. The Eastside of the building is for those under 17 years of age and has 6 bedrooms: one single and five doubles. The bedrooms are sparsely furnished with wooden single beds, a bedside table, bulletin board above the bed and a wooden wardrobe in a recessed area of the room. There are also two bathrooms each with a separate sink outside and a bathroom with a door with a sink, toilet and shower stall. At the end of the hall is an alarmed door. Each bedroom has a large window that opens but is restricted from opening all the way.

On the Westside of the building is an identical living unit for those young adults, ages 18-21. There are 13 beds and 7 bedrooms. There is a triple room that has a bunk and a single bed, two single bedrooms and four doubles. The furnishings are the same as the Eastside bedrooms. Residents had personal belongings, including guitars, in their rooms. There are two bathrooms with an outer sink and an private bathroom with sink, toilet and shower.

In between the East and West sides is a corridor with a large staff office, Administrative Offices and Therapist offices. There are two more bathrooms, one for the staff and one with a "Dutch Door" next to the staff office that is used for taking urine samples.

Although this is a single story ranch style home, there is a lower level that is accessed by three stairways; a common stair in the middle and a stairway from each sleeping unit. The sleeping units are locked from 9:00-4:00 everyday and the lower level is used for programming. The lower level runs the length of the building with a kitchen/dining room at one end, recreational and tv rooms for the under 18 residents and the same for the over 18 residents. There is also a visiting room and a laundry room. At the other end of the building are "group therapy" rooms and a large room with a long table that can be used for remedial education or for those obtaining their GEDs. Along the back of the building are large windows to let in natural light that exit to grade, so it does not feel that you are in a basement area.

There are cameras throughout the building that are monitored and have a recording capability as well. They are used to supervise the residents as well as to review footage. Additional cameras were added to outside bathrooms and in blind spots within the last year. The resident rooms do not have cameras.

## SUMMARY OF AUDIT FINDINGS

Prior to the on-site portion of the Audit, the facility sent to me a flash drive with uploaded policy and procedure, as well as important documents. I received this flash drive in my Post Office Box on 12-4-15. I was also emailed pictures of the "posting" for the PREA Audit on 11-10-15. This posting was placed on the bulletin board in the foyer of the building as well as the living and common areas. I did not receive communication from anyone as a result of this posting. The on-site portion of the Audit was conducted on January 18 and 19, 2016. It commenced with an Introductory Meeting with the PREA Coordinator, Director of Extended Services/PREA Manager and the Clinical Manager. Immediatley following this meeting a tour was conducted of the facility. All common areas, including the kitchen, where residents prepare their own meals, the dining room, activity rooms, visiting room and group therapy room on the lower level were toured. Sleeping units and individual bedrooms were toured. The area that is used for visiting did not have posters for reporting, however prior to the end of the on-site portion of the Audit, they were posted . I saw the PREA Audit postings in the areas mentioned above. Throughout the rest of the facility there were large posters for reporting, victim support, and sexual abuse in both Spanish and English. The Admin office between the sleeping units contained a phone that all children and staff knew could be used to privately report sexual abuse to PAAR, Pittsburgh Action Against Rape. I called the posted number and it went directly to PAAR. On the large bulletin board in the hallway, near the front door, there was a poster regarding Victim Advocate Services and tear away phone numbers at the bottom.There is a signed MOU with PAAR and prior to the on-site on 12-7-15, I spoke to a staff person there who confirmed the services outlined in the MOU and was not aware of any ongoing problems or incidents at Liberty Station. During the tour, I spoke to staff, Counselor Techs, and all 5 residents regarding unannounced rounds and their PREA Education. They responded affirmatively regarding unannounced rounds and could spontaneously answer my inquiries regarding education. The residents had just completed breakfast and some were cleaning up, while another was going to school. While on the tour, I noticed cameras throughout and direct lines of sight. Liberty Station had a facility walk through conducted by the Pa. Bureau of Juvenile Justice Services PREA Coordinator while preparing to become PREA compliant. That person recommended several cameras be added outside of bathrooms as well as in the kitchen. This was done to improve supervision in those areas. Supervision of the residents throughout my time at the facility far exceeded the PREA and Pa. DPW 3800 regulation ratio. Due to the low number of residents during the time of the on-site, the number of staff exceeded the number of residents.
Subsequent to the tour, I interviewed Specialized Staff, Random Staff, and all 5 Residents of Liberty Station Youth Halfway House. Some Specialized staff were interviewed by phone. I had interviewed them in person less than 4 months ago during the Audit of the Gateway YES program. The Specialized Staff included: the Executive Vice President(by phone), PREA Coordinator, PREA Manager/Director of Extended Services, the Clinical Manager, a Master's Level therapist, who also does both Education and administers the Vulnerability Assessment , the Human Resources Director(by phone), the Director of Nursing(by phone), and the Psychiatrist, who is a contracted employee. There are no volunteers. As previously mentioned, there are 13 staff assigned to this program. Of these, 10 are direct care staff that are both full and part time. One was not available to be interviewed because it was her scheduled day off; another was out sick, but was interviewed by phone. I interviewed 9 direct care line staff and an administrative assistant. As noted above, I also interviewed 3 specialized staff assigned to this program, therefore interviewing all employees but one at Liberty Station. There were 5 residents in the population during the on-site and all were interviewed. Only one resident identified as LGBTI. None were identified as sexually vulnerable or aggressive, nor did any disclose prior sexual abuse. There have been no reports of Sexual Abuse or Sexual Harassment in the past 12 months.
I reviewed additional logs of unannounced rounds as well as training logs. I reviewed 15 staff files and all had sign offs that they received and understood their PREA training. They also contained the necessary child abuse and criminal history checks. Among these employee files were a newly hired employee and someone who had been promoted during the past 12 months. I reviewed the files of the 5 current residents and the files of 3 dishcarged residents. All contained Vulnerablity Assessments that were administered in a timely fashion. The education of all current and one discharged resident was timely, however two of the discharged residents received education, but not within the 10 day timeframe.
As mentioned above, there is a signed MOU with PAAR. There are also signed MOUs with South Fayette Township Police Department for Investigative Purposes and Saint Clair Hospital for Medical Services. The Director of Nursing, in her interview, stated that there is not always a SAFE/SANE on duty, but there is one on call.
At the conclusion of the onsite portion of the Audit an Exit interview was conducted with the PREA Coordinator, PREA Manager/Liberty Station Program Director and the Clinical Manager. Review of Policy, Documenation and Files, as well as personal iterviews of staff and residents show that the Liberty Station Youth Halfway House Program is compliant with most PREA standards. Additionally, one standard, #351, Resident Reporting has been exceeded. The following standards have not been met and will require corrective action: # 313 Supervision and Monitoring, #315 Limits to Cross Gender Viewing and Searches, and #331 Employee Training. Under #313, at least 60 days of documented random unannounced rounds must be submitted to show that they are being conducted on all shifts. Although they are being conducted and documented, the frequency of midnight shift rounds must be increased. Under #315, female staff are routinely conducting cross gender pat down searches of the male residents. This came to light during interviews of both staff and residents. A directive from the Program Director/PREA Manager was issued on 1-19-16, instructing staff to immediately cease this practice. Phone interviews of both residents and staff will be conducted prior to the 30 day report to ensure that this practice has ceased. Under #331, Employee Training, not all employees could discuss training regarding the search of Transgender and Intersex residents. Training will be conducted for all employees prior to the 30 day report and signed acknowledgements of the training will be provided to the Auditor. During telephone interviews, the staff will be asked to discuss their understanding of this training.
On Friday, February 12, 2016 from 7:30 AM to 9:00 AM, phone interviews were conducted with 8 residents, including 4, who I had originally interviewed on site, and 6 Staff: the clinical manager and 5 direct care staff. The early time was arranged to accommodate both midnight staff and those residents with jobs and who had school. All residents confirmed that the common practice of female staff performing pat down searches ceased on 1-19-16 and has not occurred since. They described the hands off searches that are now

conducted. All staff interviewed, including three female staff state they have not conducted any pat down searches of the male residents, since receiving the directive. I feel that this practice has stopped and the facility is now compliant in this area.
I also asked questions of the staff regarding their refresher training regarding Transgender and Intersex searches. A sign in log was uploaded and sent to me showing that this topic was covered at a staff meeting on 1-29-16. The five direct care staff and the Clinical Manager were all able to verbalize the procedure for searches of Transgender and Intersex residents. After conducting these phone interviews, I feel that the facility has met both Standard #315, Limits to Cross Gender Viewing and Searches and #331, Employee Training.
Additional logs for random unannounced rounds under Standard #313 Supervision and Monitoring must be submitted. It was agreed upon at the time of the exit interview that at least 60 days of rounds would be submitted as part of the corrective action plan. The due date for these logs is March 31,2016. That would include two full months, February and March, of midnight rounds.
On 3-30-16, I received 60 days of unannounced rounds logs. The random rounds are conducted once a week and throughout the month cover all shifts. They are conducted by upper and mid-level staff. The logs record the date, shift, and a short narrative as to what both staff and residents are doing and where they are in the facility. I feel that this additional documentation meets the requirement and therefore, Standard #313, Supervision and Monitoring has been met.

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

Number of standards exceeded: 1

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Zero Tolerance policy was submitted by flash drive on 12-4-15. I reviewed it during the pre-audit time period and it meets all standards. In this policy, there is an outline of how the facility will prevent, detect, and respond to sexual abuse and harassment. The policy also includes definitions of prohibited behaviors and sanctions for those who have participated in those behaviors. It was updated during the September 2015 Audit of the Gateway YES program. There is both a PREA Coordinator for the entire Gateway Agency and a PREA Manager for the Liberty Station Youth Halfway House program. These positions are on the Organizational Chart that was submitted during the pre-Audit period. I reviewed the policy and supporting documentation and interviewed both the Coordinator and the Manager. They both state that they have time to adequately perform their duties.

**Standard 115.312 Contracting with other entities for the confinement of residents**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.313 Supervision and monitoring**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Ratio of staff to residents exceeds both PREA and Pa. DHS 3800 regulations. The plan is based on 24 residents and the average daily number of residents was 14. On the date of the on-site portion of the Audit, there were 5 residents and there were more staff then residents. There were no reporrted deviations from this staffing plan. I reviewed a current staffing schedule, that is disseminated to staff and posted in the staff office. They are also filed and kept for review during the annual inspection by Pa. BHSL. I also reviewed the most recent licensing and inspection summary from Pa. DPW BHSL and there were no citations for not meeting ratio. Upper and mid level management conduct random unannounced rounds. I interviewed two Managers who conduct those rounds, saw a video of a round and documentation of such was submitted to me. However, there were not enough rounds being conducted on the midnight shift, even though in policy. Therefore, at least two months of documented random unannounced rounds with increased frequency on third shift need to be submitted. These additional logs were submitted and verified on 3-30-16. Random unannounced rounds are conducted once a week and cover all three shifts throughout the month. The log states the day, date, shift, manager signature and a short narrative of what both staff and residents are doing and where they are in the facility. There are cameras throughout the facility and additional cameras were added after a "PREA facility tour" to alleviate blind spots. This "tour" was conducted by a Pa. Bureau of Human Services Manager who attended PREA certification training and who provides technical assistance to any Pa. facility that requests it. Policy was reviewed and contains the necessary requirements for this standard. It includes that at least once every year, in collaboration with the PREA coordinator, staffing will be reviewed. Staff ratio is reviewed more frequently than once a year and the use of part time staff is utilized for intensive supervision if necessary. Interviews with the Vice President, Director and PREA Coordinator confirm policy Therapists as well as managers and the program director work on the "floor" when needed and the use of mandatory overtime is utilized if necessary. There were no deviations from mandated ratios.

### 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.**

I interviewed 9 direct care staff and all 5 residents in the population. Therre were no Transgeder or Intersex residents in the population, nor have there been any since PREA implementation. Both staff and residents interviewed confirmed that there is no cross gender viewing. Both residents and staff state that knock and announce is always used by female staff. I asked both staff and residents to demonstrate how a female staff announces herself before coming onto the living units, and they were able to do so. All residents shower separately in a bathroom with a door, which I saw during the tour. There is a policy in place for cross-gender pat down searches of transgender and intersex residents, however staff could not verbalize this policy. This training that staff receives was conducted again on 1-29-16 and documentation was submitted. Although policy prohibits any form of strip search, and interviews confirmed that they do not take place, the interviews with staff and residents show that female staff are routinely conducting cross gender pat down searches of the male residents. According to the interviews, when a female staff transports a resident, upon their return to the facility, she pats him down. This is prohibited in policy. This was immediately brought to the attention of the facility director and a directive was issued to staff to immediately cease this practice. A copy of this directive was sent to me. Re-interviews of both staff and residents will be conducted by telephone prior to the 30 day report to ensure that this practice has ceased. Phone interviews were conducted on Friday, February 12, 2016 from 7:30 AM to 9:00 AM. I spoke to all eight residents in the population, including residents that I had previously interviewed. I also interviewed 6 staff: 5 direct care staff and the Clinical Manager. All residents state they have not been patted down by a female staff since the PREA Audit. All female staff state they have not performed a cross-gender pat down search since the directive was issued on 1-19. Male staff state they now perform the pat down searches when a resident returns to the facility. I also asked staff about the Transgender and Intersex Search policy. Staff stated they received a refresher training on this policy at the Staff meeting on 1-29-16. They were able to discuss this policy adequately. This standard has now been met.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy was submitted prior to the on-site visit and reviewed by me. It contains established procedures to provide disabled residents with equal opportunity to participate in agency PREA efforts. There were no residents with any physical disabilities or who were not proficient in English. However, there is a contract that was provided to and reviewed by me. It provides for translators as needed and there are accomodations for any physical or mental disabilities through the Education Department. Interviews with the Vice President and Nine Random Staff confirm compliance. There were both English and Spanish posters throughout the facility that I saw while on the tour and they were added to the visiting area, at my request, prior to the end of the on-site visit. There are no residents who do not speak English and there never have been. However, it is more probable that a parent, rather than a child would be non-English Speaking and these resources would then be utilized.

**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.**

A phone interview with the Vice President of Human Resources showed that the HR policy includes all PREA verbiage and is part of the current procedure. I interviewed this HR employee in person 4 months prior to this Audit, during the YES program Audit. This policy was updated to include all necessary components during my September 2015 Audit of the Gateway YES program. There is an affirmative duty to report by the employee and the evaluation forms were revamped to include sexual harassment. A review of 15 staff files showed all child abuse clearances and criminal history checks were being conducted. These files included a staff person that was recently hired as well as a staff person that was promoted during the past 12 months. The policy and practice is also compliant with the updated Pa. Child Protective Services Law. This Law requires all staff to have Child Abuse Clearances, Pa. Criminal History Checks and FBI Clearances prior to working with children. This is also required of contractors and volunteers. These clearances must be conducted every five years. I also reviewed the file of a contractor, who also had the appropriate clearances. I reviewed the most recent Pa. Dept. of Human Services Licensing and Inspection summary and there were no citations for any late or missing Clearances of any kind.

**Standard 115.318 Upgrades to facilities and technologies**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion**

**must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

This building was built as a group living facility with separate sleeping units and separate activity areas. There have been no renovations since 2012. This facility has cameras throughout and during a PREA facility walk through by a Pa. DPW PREA Coordinator, several blind spots were pointed out and cameras were added to these areas to assist in supervision. This was done in the summer of 2015. The policy was reviewed and meets the standard. The cameras have both live and recording capability and are used to supplement supervision, because they are monitored by both staff and supervisors routinely throughout the shift. During the tour, I saw the cameras, including the new ones that were installed, and saw a direct care staff in the staff office actively monitoring the cameras. I interviewed the Vice President of Gateway by phone, having interviewed him in person 4 months earlier, and the Liberty Station Director, in person.

### Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the PREA Manager, nine random staff and the Director of Nursing by phone. There were no residents who had reported a sexual abuse, nor were there any allegations of sexual abuse or sexual harassment during the past 12 months at Liberty Station. There is a MOU with PAAR (Pittsburgh Action Against Rape) and the services were verified during a pre-onsite phone call to them om 12-7-15. Medical services, free of charge, are provided at Saint Clair Hospital. This MOU was provided to me. The Director of Nursing stated during the interview that a SAFE/SANE is not always on duty, but is on call. The Psychiatrist is contracted and does medication evaluations and there is a full time Master's Level Mental Health Therapist on Staff. All other medical services including physicals at admission are conducted in the community, because this is a halfway house. There are no forensic exams conducted here at Liberty Station. There are no criminal investigations conducted by Gateway staff. Any administrative investigation that is performed is done to gather only enough information to report to the South Fayette Police Department and to Pa. Child Line. The MOU with the PD was provided to me. An incident review is conducted after the criminal and/or Child Line investigtation. The Zero Tolerance Policy outlines the mandatory response by the agency, facility and by 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.**

I interviewed the agency head and reviewed the Policy. All allegations are reported to Child Line and there is a MOU with the South Fayette Township Police Department to investigate any and all allegations. There are no Investigative Staff. There have been no allegations of sexual abuse or harassment in the past 12 months. Pa. CPSL requires mandatory reporting by both the facility and staff. This is clearly

outlined in policy and all staff are trained in this and sign off on it to indicate that they have been trained and understand.

### Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I reviewed the Policy requiring all staff to have PREA training and refresher training. I interviewed 9 Direct care staff. The curriculum included all 11 areas that are required by the PREA Standard. I reviewed the curriculum that includes Cross Gender Searches of Transgender and Intersex Residents, however staff were unable to demonstrate an understanding of this during interviews. I saw logs of staff training and there was a signed declaration of understanding in the 15 staff files I reviewed. All staff interviewed confirmed they had been trained and demonstrated an understanding of this training except for the above. Refresher training must be conducted for cross gender searches of transgender and intersex residents and documentation of it must be submitted. A phone interview with staff will be conducted prior to the 30 day report for compliance. I conducted phone interviews of 5 staff on 2-12-16. They were able to discuss the policy regarding Transgender and Intersex searches. A sign in log was scanned and sent to me. This standard has now been met.

### Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There are no volunteers. All contractors have been trained. I interviewed the Psychiatrist, who stated she had been trained on the zero tolerance policy and knew her reporting duties. I saw the sign off that she had received this training. The training for contractors is commensurate with the amount of contact they have with residents. For example, a delivery man must sign into the visitor's log and is given a pamphlet that this is a PREA compliant facility that has a zero tolerance for Sexual Abuse and Sexual Harrassment. I saw these pamphlets and this sign in log in the foyer area during my tour. The PREA policy describes this training.

### Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed all 5 residents, who could anwer my questions readily and demonstrated understanding of their education. They stated they received it at the YES program and again at Liberty Station, when they "stepped down". I also saw resident logs that showed all residents have received education within hours of intake, since the inception of the education in March 2015. However, timely 10 day follow-up education was only evidenced in the current resident files. The review of three discharged resident files did not show timely 10 day education. During an interview, the PREA Manager stated that although implemented in March, subsequent review showed that staff were not conducting the follow-up, 10 day education in a timely manner. Change to procedure has resulted in all residents now receiving it in a timely manner. One of the current residents who has had timely education was admitted in July. All subsequent admissions were timely as well. Because this was corrected and has been ongoing for 7 months, this meets the criteria for timeliness. I interviewed a therapist, who conducts the education. There are no Intake staff. She stated that the education includes review of a power point presentation with the therapist, a checklist with definitions and conducting the risk-assessment. It is done both visually (Power Point), in written form, (pamphlets) and verbally (discussion with the therapist) to ensure that all residents can participate. The curricula was age appropriate. Throughout the facility there are posters describing sexual abuse and sexual harassment, as well as pamphlets in the foyer to meet ongoing education. Policy outlines the education, what it contains and when it is to be conducted.

### Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This facility does not conduct Forensic Medical Exams. That is done at Saint Clair Hospital. I interviewed the Director of Nursing who states that she completed the NIC online course as well as the PREA training for all employees. I saw the training logs and completion certificates. I also interviewed the Psychiatrist and the Mental Health Therapist. Both stated they have received specialized trainings. Age of Consent and Confidentiality were part of this training. Policy adequately describes what specialized training medical staff must receive.

**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.**

Policy requires that within 72 hours, a Vulnerability Assessment must be conducted. It is conducted by the therapist at Intake. I interviewed the therapist who states that, in addition to the assessment itself, interviews with residents, parents, probation officers, and other documentation are used to assess risk. I saw timely assessments for all current residents and three discharged residents, as well as a log of all VAs. Only the clinical and administrative staff have access to this information. All residents interviewed stated they had been asked the questions on the instrument. The instrument is a commonly used one that is objective and contains all necessary information. It takes into account prior victimization or sexual aggression, any gender nonconforming appearance or manner, identification as LGBTI, level of emotional and cognitive development, MH or MR concerns, physical size and stature and any other pertinent information. I also interviewed the PREA Manager and the PREA Coordinator

**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.**

Interviewed PREA Coordinator, PREA Managaer, and Therapist who administers Risk Assessment. I reviewed information in electronic files for risk based housing decisions. Although there were no residents that had been identified and needed risk based housing, the therapist showed me an example of documentation regarding a resident who needed to be placed in a single room. The same would be done if needed for a vulnerable or aggressive resident. There was one resident who identified as gay. He stated that he is not housed in a special room or unit, nor labeled in any way. Both policy and practice meet standard. There is no use of isolation by Pa. DPW regulations. Interviews confirm that isolation is never used and when I toured the facility there were no areas where a resident could be isolated. Housing assignments are by age(over 18 and under 18). There are separate wings for these age groups. The tour showed several single rooms, as well as multiple person rooms.

**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.**

I interviewed the PREA Manager, 9 random staff and the 5 residents in the population.There were no residents who had reported a sexual abuse. Residents can use the private phone in an administrator's office, can file a grievance, can tell staff, or their therapist. There are tear off phone numbers on the bulletin board in the central hallway. Reporting posters in both Spanish and English are throughout the facility as seen on the tour. Residents can report verbally, in writing, anonymously and through third parties. All avenues are provided and all residents and staff were aware of them. During the tour, I saw the tear off phone numbers, "blue phone" and residents using pencils and pens, as they are required to journal everyday. I used the blue phone to call the posted reporting number and it went directly to PAAR. Most residents leave the facility to work in the community. All residents have phone calls and visits as described in policy and confirmed in interviews. Access to lawyers by phone and in person is in policy and confirmed in interviews. Every avenue has been provided for reporting. This standard has been exceeded.

### Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The grievance policy is signed off on at Intake by both residents and parents. It is in every resident file that I checked. It is required by Pa. 3800 regulations and checked by them during the annual inspection. A review of the most recent Pa. DPW LIS reveals no citations for not advising residents and parents of the grievance policy. There have been no incidents of a grievance being filed regarding sexual abuse. If filed in good faith, there would be no discipline. Policy describes no timeline and that a parent can file a grievance on behalf of a resident.

### Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Vice President, PREA Manager, and all 5 residents in population. All could tell me that residents have access to visiting 2 times a week, phone calls 2 times a week and the ability to speak to their attorneys. Residents also earn home passes and probation officers and caseworkers visit. Most residents work at jobs in the community on a daily basis. There is a MOU with PAAR for Confidential Support Services and a phone number that is readily available. I spoke to PAAR prior to the on-site and they confirmed these services. Some of

these residents were able to describe what these services were. All stated that there was information given to them about these services. Review of Policy confirms access to phones and visiting.

### 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.**

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

### Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All administrators and all employees have a duty to report according to PREA Policy and also Pa. Child Protective Services Law. I interviewed the Vice President, PREA Coordinator, PREA Manager, Medical and Mental Health Staff and 9 random staff. All are mandated reporters and all know their responsibilities to include a report to Child Line and to the appropriate Police Agency. The Policy meets the standard. Education regarding this is part of new staff orientation and is signed off on and monitored by Pa. BHSL during their annual inspection.

### Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

**corrective actions taken by the facility.**

I interviewed the Vice President of Gateway, the Director of the Liberty Station Youth Halfway House Program and 9 direct care staff. All are aware of their responsibilities to protect a resident immediately. Policy was reviewed and meets standard. It requires immediate protection for a resident,

### Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

None of the staff have acted as first responders, because there have been no incidents in the past 12 months. However, all nine staff interviewed were able to enumerate their first responder duties for which they have received training. This is also contained in policy and the training curriculum that I reviewed . Some staff wore their first responder duties on a card on a lanyard with their keys. This enables them to be able to respond immediately to a situation that they have not encountered. They were able to describe protecting evidence and knew who to contact and in what sequence. They were particularly tuned in to separating and protecting the victim. There were no residents to interview who had reported a sexual abuse.

### Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There were no incidents in the past 12 months, so therefore no first responsders who have acted as such or residents who have reported a sexual abuse. The coordinated response is in policy and it outlines how the staff will respond. There is also check off sheet, that was provided to me, to facilitate the response. Interviews with both Agency administrators and line staff confirm this.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Agency Vice President, PREA Coordinator, Director of Liberty Station/PREA Manager. I also interviewed the Clinical Manager, who is always on site and who also monitors retaliation. There have been no incidents of such, but they would handle the situation properly, up to and including removing a resident from the facility and returning him to his County Detention facility. Staff could be moved to other facilities within the agency. The Policy outlines how often and for how long monitoring would occur. Staff could also tell me signs they would look for in residents, as well as staff, that may be suffering from retaliation. Policy also outlines that staff would be disciplined for retaliating and that HR would have a direct involvement in any staff retaliation. Although there were no residents who had reported a sexual abuse, the residents interviewed did not mention any fear of retaliation.

### Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy meets standard. There have been no incidents in the past 12 months. The facility would report all allegations and the investigating agency would determine the standard of proof.

### Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

### Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Vice President of Gateway as well as the Director of Human Resources. Discipline for staff is contained in both the PREA Zero Tolerance Policy and the HR policy. Termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Pa. CPSL requires that a staff person be immediately removed from contact with children. There have been no incidents in the past 12 months.

### Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Interviews with both the Vice President of Gateway and the HR Director confirm the policy for corrective action for contractors. There are no volunteers. Policy requires immediate removal of any contractor who is alleged to have engaged in any form of sexual abuse. There have been no incidents in the past 12 months.

**Standard 115.378 Disciplinary sanctions for residents**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There are no sanctions for a resident reporting in good faith according to the PREA Zero Tolerance Policy and also Pa. CPSL. Interviews with Agency Designee, and both Director of Nursing and Mental Health staff confirm that policy is practice. Other discipline would be consistent and would take into account mental health as well as other factors. There were no residents who reported sexual abuse or sexual harassment in the past 12 months.

**Standard 115.381 Medical and mental health screenings; history of sexual abuse**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Reviewed 5 files of current residents and 3 files of discharged residents. All residents have the vulnerability assessment completed at Intake and Physicals are completed within 14 days. This is a Pa. DPW requirement. There is a contract with a community medical provider to ensure timely follow up for any child who discloses sexual abuse or having perpetrated sexual abuse. I interviewed a therapist,who is responsible for the risk screening, the Director of Nursing, and the Psychiatrist. There were no identified residents. The policy contains the appropriate requirements. There were no residents who required follow up at this time, but the procedure is in place.

**Standard 115.382 Access to emergency medical and mental health services**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All residents have access to emergency medical and mental health services. There is a psychiatrist and a nurse on call. There is a MOU with

Saint Clair Hospital and a resident would be brought there for emergency treatment. Both Medical and Mental Health Staff confirm that there would be immediate access to Emergency care that would meet or exceed community level of care. The Policy outlines all requirements for emergency care that would be free of charge. There were no residents to interview that required ER care.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

**Standard 115.386 Sexual abuse incident reviews**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Clinical manager, who would participate on an incident review team, and the Agency Vice President and PREA Manager. This is already in practice for other incidents as part of regulations for an inpatient rehab. Policy meets standard and includes considering whether various factors, including identification as LGBTI may have contributed to an incident. There have been no incidents.

**Standard 115.387 Data collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

**corrective actions taken by the facility.**

Data is collected and aggregated as per policy by the PREA Manager and submitted to the PREA Coordinator for an Agency Report. The annual report has been completed and submitted. It will be published on the website. At the time of this writing, it is being reviewed by the PREA Coordinator. There is no data at this time for this facility because there have been no incidents. The Agency report will be broken down into Adult Facilities and Juvenile Facilities. The policy outlines who completes the report and what it contains. I interviewd the Vice President for Gateway, the PREA Coordinator and PREA Manager.

### Standard 115.388 Data review for corrective action

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

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

Aa per policy and interviews with Agency Vice President, PREA Coordinator and PREA Manager, data would be acted on in an ongoing manner and reviewed and compared on a yearly basis. Corrective actions would be made if necessary. The PREA Coordinator would write the report and it would be reviewed by the Agency Vice President before dissemination and posting on website. All personal identifiers would be removed. The PREA Coordinator stated during his interview that he will be doing separate annual reports for Juvenile and Adult Facilities. The Policy outlines the content and requirements.

### Standard 115.389 Data storage, publication, and destruction

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

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

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

### AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Maureen G. Raquet April 7, 2016

Auditor Signature Date