



ACCREDITING COUNCIL FOR CONTINUING EDUCATION & TRAINING
1722 N. Street, N.W., Washington, D.C. 20036
Telephone : 202-955-1113 Fax: 202-955-1118
<http://www.accet.org>

December 21, 2018

VIA EMAIL & FEDERAL EXPRESS
(plenum@usa.com)

Dr. Geecee Pat, Director
Plenum Institute
3000 John F. Kennedy Blvd. #310
Jersey City, NJ 07306

***Re: Initial Accreditation Denied
(Appealable; Not a Final Action)***

ACCET ID #1553

Dear Dr. Pat,

At its December 2018 meeting, the Accrediting Commission of the Accrediting Council for Continuing Education & Training (ACCET) voted to deny initial accreditation to Plenum Institute located in Jersey City, New Jersey.

The decision was based upon a careful review and evaluation of the institution's record, including the institution's application for accreditation, Analytic Self-Evaluation Report (submitted July 10, 2018), on-site visit team report (visit conducted September 20-21, 2018), and the institution's response to the report (dated November 5, 2018). The team report cited the institution for weaknesses under 28 of ACCET's 33 Standards for Accreditation, with all 28 having ratings of 1 or 2. It is noted that two weaknesses cited in the team report (Standard VI-B Supervision of Instruction and Standard VII-A Recruitment), were adequately addressed in the institution's response and accepted by the Commission. However, the Commission determined that the institution has not adequately demonstrated compliance with respect to ACCET standards, policies, and procedures relative to the following findings:

1. Standard I-A: Mission

The institution failed to demonstrate that its mission provides a definitive basis upon which to deliver and assess its education and training programs. The institution did not demonstrate that it has established a systematically and effective procedure that utilizes specific criteria to measure whether it is achieving its mission.

The team report indicated that the institution's mission statement, "*To provide each student a diverse education in Healthcare, Management and Technology fields and to prepare today's communities to meet tomorrow's challenges through education, employment and opportunity,*"

was not consistently stated across policy documents, manuals, the ASER, and the website. Further, the mission was noted to be irrelevant and ineffective in assessing the education and training offered, since the institution does not offer management or technology programs. The institution's ESOL program was also not evident in the mission statement nor were the management personnel and staff familiar and well versed on the ESOL program offering. Additionally, the institution claims that it measures its success in meeting its mission by means of "various measurable factors," including student surveys, report cards, externship site supervisor reports, or placement in institutions of higher education in the U.S. However, with the sole exception of National Association of Certified Technicians (NACT) pass rates, these claims were not supported by any other relevant documentation.

In its response, the institution submitted the following documentation to evidence that it utilizes various processes and tools to measure its effectiveness in meeting its mission:

- *A brief needs analysis to justify its healthcare and ESOL program offerings.*
- *Individual transcripts for three students in three of its five healthcare programs.*
- *Student Feedback Forms for its Phlebotomy, ESOL, Advanced Patient Care Assistant (APCA), Medical Billing and Coding (MBC), EKG, and Medical Assistant (MA) programs.*
- *Externship Site Supervisor Surveys for three of its healthcare programs.*

The institution indicated that it has revised its mission as follows: "The mission of Plenum Institute is to provide each student with diverse educational opportunities by offering programs in both the Healthcare Field and English for Speakers of Other Languages (ESOL). We are committed to preparing our students to meet tomorrow's challenges through education, employment and opportunity."

*The institution further indicated that its Advisory Board received copies of the revised mission statement and the revisions "**will be**" inserted into all school-related documents and marketing materials. However, no evidence was provided to demonstrate that the advisory board reviewed the revised statement nor was evidence provided to demonstrate that the revised mission has been communicated to all stakeholder and published in the institution's policy documents and marketing materials.*

Additionally, as part of its needs analysis, the institution provided one example of a university acceptance letter for one student along with a Word document that listed college acceptances since 2016 in a chart format. However, the institution did not provide sufficient supporting documentation to verify that the data presented on the chart was accurate.

Therefore, the institution failed to demonstrate full compliance with this standard.

2. Standard I-B: Goals

The institution failed to demonstrate that it has established broad goals that support the institution's mission and are consistent with the Principles of Ethics for ACCET Institutions. Further, the institution failed to demonstrate that established overarching goals that guide the operations at the institution including: admissions, finances, education and training, management, and student services.

The goals outlined in the ASER were inconsistent and did not align with published information in the institution's catalog and on its website. The goals provided as an exhibit in the ASER did not align with actual operations at the institution, for example: "*creating and maintaining cross-training within the Division of HR*" and "*improving operational efficiency through automation and outsourcing.*" The team report noted that the institution had no HR Division and no evidence of a commitment to automation or outsourcing of its operations. The on-site team further noted that the institution's management could not articulate its goals nor evidence that they were published. Further, in its ASER, the institution describes its founding, its demographics, and general operations as institutional goals; however, such verbiage does not correspond to the establishment of broad goals that guide the operations of the institution in the key areas required by the standard.

In its response, the institution submitted a narrative with its version of restated goals in the following five areas: 1) Staying Current and Competitive; 2) Resources; 3) Credentials; 4) Growth; and 5) Career Pathways. However, there was no indication that these revised goals had been communicated to key personnel at the institution. Further, there was no evidence provided to indicate that these goals were published in any internal documents or on any institutional platform for sharing of information. Exhibits attached to the response included the personnel files of two employees and a list of books and instructional materials. It was not clear to the Commission what these exhibits were intended to illustrate.

Therefore, the institution failed to demonstrate compliance with this standard.

3. Standard I-C: Planning

The institution failed to demonstrate that it utilizes a and well-established planning process, consistent with its scope and size, to establish plans that support the institution's mission and goals. The institution failed to demonstrate that plans are reviewed at least annually, updated regularly, and implemented to improve the effectiveness of the institution. The institution failed to demonstrate that it has sound, written one-year and long-range plans that encompass both the educational and operational objectives of the institution and include specific and measurable objectives, along with corresponding operational strategies, projected time frames, required resources, and method(s) for subsequent evaluation, that are utilized to measure progress in achieving the established objectives, as required by the standard.

The team report indicated that the institution provided the team with a three-year plan covering objectives for the period 2017-2019. The majority of the objectives in this document were general, vague, and not measurable. Examples of some of these objectives were noted in the team report as follows: “finish all incomplete outlines;” “analyze marketing strategies;” or “prepare for new student enrollments in New Jersey.” There was no evidence that this planning document was utilized by the institution to improve and enhance the institution or its education and services. Additionally, the institution had not developed a short-term (one year) plan as required by the standard. Further, the institution did not have a policy and procedure for developing, reviewing, updating, or implementing business plans.

In its response, the institution submitted an exhibit entitled, “Policy for Planning and Development” outlining a procedure for planning to be implemented going forward. It submitted the revised plan within its narrative response. This narrative restated the overarching goals outlined under Standard I-B Goals in an attempt to demonstrate an alignment between overarching goals and plans. The plans included three brief sections entitled: “Plan Year 1 (2019),” “Plan Year 2 (2020)” and “Plan Year 3 (2021). In its response, the institution did not clearly specify if the plans submitted in the narrative represented a revised long-range plan for the institution or if it represented both long-range and short-term plans merged together. In each section, a brief outline is presented with each of the five overarching goals heading a bullet list of intentions. However, this response was inadequate in demonstrating that the institution has a solid understanding of appropriate business plans as required by this standard. The objectives outlined in the response remain general, vague, and not measurable. The plans did not incorporate all of the mandatory elements as required by the standard as follows: specific and measurable objectives, operational strategies, required resources, and method(s) for subsequent evaluation. There was no evidence that these plans had been communicated to key personnel and that they were circulated in any internal communications, nor that the plans had been implemented.

Therefore, the institution failed to demonstrate compliance with this standard.

4. Standard II-A: Governance

The institution failed to demonstrate that it has a clearly defined accountable governance structure which delineates authority for the approval of institutional policies and responsibilities for the overall direction effectiveness of the institution. Further, the institution did not demonstrate that its management structure ensures the integrity and capability of the institution and its compliance with statutory, regulatory, and accreditation requirements.

The team report indicated several inconsistencies and/or areas of concern relative to this standard. Specifically, the team report indicated that, during the on-site visit, the institution presented ownership information different from that which ACCET had on record. According to ACCET records, the institution’s ownership was divided between three individuals, P. Patel

(50%), P. Ullah (30%) and A. Patel (20%); however, according to the institution's Form I-17, the institution's sole owner was S. Parvin.

In its application to ACCET and in its ASER, the institution stated that it had never held, applied for, been denied or been withdrawn from previous accredited status. The team report however indicated that, under the institution's previous name (Institute for Health Education) its previously-held accreditation with ACCSC was withdrawn in 2015, that it was denied "continued initial accreditation" with CEA in 2015. Additionally, the institution indicated that it had applied for accreditation with ACICS but was no longer involved in that process, without providing confirmation from ACICS to verify whether the institution's failure to obtain accreditation with that agency was based on a voluntary withdrawal rather than institutional non-compliance.

The team report further indicated that, following its name change to Plenum Institute, and the accreditation denials/withdrawals, the institution continued to offer English language programs under its former name (IHE) and issued 263 Forms I-20 using an incorrect CIP code which referenced English Language and Literature rather than Language Learning. The team report also indicated that institution received a Notice of Withdrawal by SEVP in May 2018 for failure to notify SEVP of its loss of accreditation with CEA and ACCSC, contrary to federal requirements. However, the team report indicated that, during the on-site visit, the institution continued to advertise enrollment of F-1 students on its website, in promotional literature, and on its signage at the campus.

In its response the institution provided a narrative response stating that ownership had changed in January 2015 when Dr. S. Parvin took over the school from L. Chabria and S. Hiranandani, that the current ownership structure reflects ACCET's records of P. Patel (50%), R. Ullah (30%), and A. Patel (20%), and that the New Jersey Department of Education had accepted the change of ownership and location. The response further indicated that the institution submitted change of ownership to SEVP in January 2015, however, that no response was received and that changes were not made due to the I-17's locked status. Attached with the response was a copy of meeting minutes which confirms a discussion of the ACCET-approved ownership structure, and a copy of the I-17 dated 2015, which listed L. Chabria as the owner. No official ownership documentation was provided, such as articles of incorporation etc. to confirm the ownership structure on file with ACCET.

Regarding previous accreditation, the institution indicated that withdrawal of ACCSC accreditation in 2015 and the denial of continued initial accreditation by CEA in 2014, prior to the current owner's involvement, but provided no rationale for not disclosing that information to ACCET during the application process, or for excluding it from the ASER. Additionally, the institution's narrative response indicated that it began the initial accreditation process with ACICS midway through 2015 and that the application had not yet been accepted prior to the withdrawal of ACICS's recognition. The institution provided screenshots indicating an incomplete ACICS application, an email from ACICS staff communicating the schedule of an ACICS workshop, and information about ACICS' issues

with the Department of Education. Specific documentation demonstrating either voluntary withdrawal from the ACICS application process, or notification of rejection/withdrawal from ACICS, however, was not provided.

Finally, regarding the institution's I-17, as indicated in the team report, the institution received a Notice of Withdrawal by SEVP in May 2018 for failure to comply with SEVP following a loss of accreditation, and for issuing F-1 visas for ESOL students without accreditation. The institution provided in its response a copy of its I-17, dated in 2015, which recorded inconsistent ownership and CIP information. In its narrative response, the institution stated that it removed the former school name (Institute for Health Education) from the physical location and marketing materials; however, references to removal of advertising to international students was not included in the response. It was noted by the Commission, however that the website indicates that, "Plenum Institute do not offer I-20's for international students from August 2018;" however, no documented evidence of removal of signage advertising enrollment of F-1 students at the campus facility or in its promotional materials was provided in the response.

Therefore, the institution failed to demonstrate compliance with this standard.

5. Standard II-B: Institutional Management

The institution failed to demonstrate its management responsibly develops and effectively implements written policies and procedures within an organizational framework that is clearly defined, understood, and effective. The institution also failed to demonstrate that written policies and procedures guide the day-to-day operation of the institution.

The team report indicated that the ASER described a number of positions that comprise the senior management which did not appear on the organizational chart, and that during the on-site visit, the institution provided the team with an updated organizational chart, with several inconsistencies compared to the document provided with the ASER. Specifically, the organizational chart included with the ASER did not include the Board of Directors or the Assistant Director. At the time of the visit, the updated organizational chart also did not include the Board of Directors, and listed the Assistant Director as A. Rahman, who was recorded on the original organizational chart as Tech Support and Placement Officer. Additionally, the possible former owner, Dr. S. Parvin appeared on the original organizational chart as only a faculty member on the original organizational chart, but as both an instructor in a Career Services/Compliance position during the on-site visit.

Further, the team report indicated that the institution did not demonstrate clearly delegated responsibilities to specific individuals, nor did it demonstrate a defined management structure as evidenced by the institution's lack of responsiveness during the on-site visit in providing minimal information and documentation to the team, upon request, to demonstrate compliance with a number of ACCET standards, including: completion and placement documentation;

evidence of payroll taxes; samples of quizzes and exams; lesson plans; evidence that equipment had been calibrated; the institution's OSHA binder; and Safety Data Sheet (SDS).

In its response, the institution provided copies of several policy documents, including: a) Policy and Procedure for Developing, Planning, Implementing and Evaluating the Institutes [sic] Plan; b) Transfer of Credit/Advanced Standing policy; c) Policy for Financial Management; and d) Employer Satisfaction Survey. During review of these policy documents, it was noted that the planning policy references the Curriculum Director and Administrative Assistant, neither of whom appear on the institution's organizational chart; that the transfer of credit policy has several inconsistencies and areas of non-compliance as described in Standard VII-C: Transfer of Credit below; that the employer satisfaction provided a summary of the 2017 – 2018 survey collection and was not an over-arching policy document that outlined the persons responsible for conducting the survey and the process for collecting, reviewing and analyzing survey data, or how survey data is used to make improvements to the training offered; and that a policy relative to ensuring that instructional materials are up-to-date and readily available was not included with the response.

Additionally, the institution indicated that it had revised its organizational chart, including the addition of the Board of Directors, and that the institution added two Academic Director positions, one to oversee the allied health programs, and the other to oversee the language program. The updated organizational chart reflected the two new Academic Directors, and included the position of President, Vice President and CFO, and the names of the individuals holding those positions. Neither the narrative response nor the updated organizational chart specifically references which positions or individuals comprise the Board of Directors, and no job descriptions for the new positions were provided (Healthcare Academic Director, Language Academic Director, President, Vice President, and CFO) with the response to Standard II-B: Operational Management. Further, the updated organizational chart continues to indicate that the Admissions/Records professional, [REDACTED], is also the DSO, even though the institution no longer participates in SEVP.

The institution's narrative response clarified that A. Rahman has resumed full responsibilities as the Assistant Director and provided a copy of the job description detailing the breakdown of responsibilities into Assistant Director (20%), Tech Support (20%) and Placement Officer (60%); and clarified that Dr. Parvin continues to both teach and work in a Career Services/Compliance role as well. No job description for Dr. Parvin was attached, however.

Regarding management structure, the institution indicated that management of all accreditation-related issues are divided among three areas including the School Director, who oversees the accreditation process; Compliance and Curriculum overseen by Dr. Parvin; and Financial and Human Resources, overseen by A. Rahman, whose job description was provided. However, A. Rahman's job description makes no reference to specific tasks that support the accreditation process. Additionally, the institution did not submit job descriptions for Dr. Parvin or the School Director, or other documentation to demonstrate that the managerial responsibilities performed by these individuals support the institution's

accreditation and/or operational initiatives, nor did it provide clarification or supporting documentation describing the positions responsible for upholding a defined management structure.

While the team report had referenced missing documentation relative to completion and placement documentation, evidence of payroll taxes, samples of quizzes and exams, lesson plans, evidence of equipment calibration and the OSHA/MSDS binder. In its response, the institution indicated that the SDS and OSHA binder had been misplaced during the on-site visit, and that a copy of it was attached with the response. The institution also attached documentation that the bench top centrifuge had been calibrated and passed and provided a copy of the service agreement between the institution and the servicing company. The institution also provided blank copies of quizzes, exams and study materials for assessments in the Medical Assisting, EKG, Phlebotomy, PCT and LPN programs, as well as blank copies of verbal and reading comprehension assessments; however, no documentation was provided with this standard to demonstrate that these materials were in use at the institution. Further, the institution attached detailed program overview documents, labeled as syllabi, for the Advanced Patient Care Associate, Medical Assisting, Medical Billing and Coding, EKG, Phlebotomy, and a list of textbooks used in all programs; lesson plans, however, were not provided. Additionally, there was no documented evidence that payroll taxes had been paid as detailed in Standard III-B: Financial Procedures below. The institution failed to submit any documentation relative to completion and/or placement, as referenced in the weaknesses section of the team report. The institution failed to demonstrate that its policies/procedures guided the day-to-day operations of the institution in key areas including (but not limited to): business planning; transfer of credit; supervision of financial controls/management; orientation of instructional personnel; curriculum review and revision; and validation of employer satisfaction.

Therefore, the institution failed to demonstrate compliance with this standard.

6. Standard II-C: Human Resources Management

The institution failed to demonstrate that it develops and implements written human resource policies and procedures; that policies and procedures ensure that qualified and capable personnel, at appropriate staffing levels, are effectively utilized and evaluated at least annually; and that policies and procedures address the recruitment, selection, hiring, orientation, supervision, evaluation, retention, training, and professional development of all personnel.

The team report indicated that several of the institution's policies relative to governing personnel appeared to have been copied or adapted from other organizations, and that they did not accurately represent actual institutional operations.

Specifically, the institution provided a policy document on new employee orientation that appeared to have been copied from the Indiana University Human Resources Manual, and

contained several provisions, specific department contacts, a “buddy system, departmental goals, policies and unwritten rules or customs that are not part of the institution’s operations. Similarly, the institution’s performance appraisal policy appeared to be modeled on a human resources document published on monster.com, and although it had been somewhat adjusted to align with the institution’s operations, it contained a process for self-evaluation which was not in practice at the time of the on-site visit. The institution provided a third policy, specific to Employee Training and Development, that appeared to have been copied and pasted from workable.com without adaptation to reflect Plenum’s procedures as the policy document contained references to formal training sessions (individual and corporate), employee coaching and mentoring, conference and on-the-job training, job shadowing and job rotation that are not part of Plenum’s regular operations.

The team report further indicated that the institution did not demonstrate implementation of required personnel procedures, including performance evaluations for administrative staff, or an on-going schedule for employee training or professional development.

In its response, the institution indicated that it has over 35 policies for the benefit of employees and their welfare, contained in a green binder in the Director’s office, and that those policies include hiring new employees on various levels; managing and training newly-hired staff; new employee orientation; employee performance and appraisal; employee training and development, as well as “various internal policy for all staff member [sic].” With the response, the institution indicated that it had revised/rewritten all of the policies per the team’s suggestion, and submitted twenty attachments which included job descriptions, job responsibility documents, and policy documents.

Among the attachments provided with the response were copies of policy documents relative to new employee orientation, performance appraisal and employee training and development, as specifically reference in the weakness in the team report. The Performance Appraisal Policy attached with the response appeared to apply only to instructors, as the goal-setting agreement portion contained sections with “Instructor” in the heading without further reference to administrative employees. The Employee Training and Development Policy did not specify minimum training and professional development requirements for employees within a designated timeframe, and continued to reference coaching & mentoring, conferences and on-the-job training, job shadowing and job rotation, as referenced in the weaknesses section of the team report, and without providing documented evidence that these initiatives were in place.

Similarly, the institution did not provide documentation to evidence implementation of performance appraisals for administrative staff or documented evidence of on-going training and development for all faculty and administrative staff as cited in the team report. Additionally, in its response the institution indicated that policies and procedures had been rewritten/revised per the team’s suggestions; however, no documented evidence of review or revision of such as meeting minutes was provided, nor did the institution provide

documentation indicating that revisions had been communicated to staff and faculty, or that relevant staff and faculty received training on policy and procedure updates, as necessary.

Therefore, the institution failed to demonstrate compliance with this standard.

7. Standard II-D: Records

The institution failed to demonstrate that it has an organized record-keeping system that ensures all records are maintained in an accurate, orderly, and up-to-date manner. It was evident that the record-keeping system does not facilitate ready access and review by authorized third parties. Further, the institution failed to demonstrate sensitive records are protected from unauthorized access and undue risk of loss and that records are maintained for a period of time consistent with applicable statutes, regulations, and sound business and educational practices.

The team report indicated that the institution had several inconsistencies in its record-keeping policy, and multiple instances of incomplete records. Relative to the record-keeping policy, the team report indicated that, according to the ASER, student records were maintained by the school administrator, a position that did not appear on the organizational chart. The record-keeping policy also provided conflicting information relative to timeframes and formats for maintaining student records, specifically that “[t]he student folder hard copy and soft keep for 7 year [sic] according to the New Jersey State requirement and transcript keep for 21 years in cloud base electronic copy [sic];” however, the ASER also stated that student records would be maintained for five years, and that, up on graduation, records should be indefinitely maintained in the cloud.

The team report further indicated that, although the institution had a FERPA policy, hard-copies of student records were kept in unsecured filing cabinets stored in the campus’ main hallways and contained sensitive information such as copies of student IDs, documents with unredacted social security numbers, and academic records.

Additionally, the team report indicated that student ledger cards were incomplete and did not indicate when a refund had been requested, or when an administrative withdrawal had occurred, subsequently resulting in the institution’s inability to demonstrate accuracy and timeliness of refunds.

Lastly, the team report indicated that the institution did not demonstrate an effective record-keeping system conducive to third-party review as files requested were not consistently provided. By way of example, the team received only three refund calculation files out of the ten it requested during the on-site visit.

In its response, the institution provided a narrative describing the record retention policy, stating that “a hard copy of the student folders are kept for 7 years and clouds base [sic]

electronic data of the student folder is stored for 21 years.” The narrative continues to indicate that, following graduation, the student’s record will be archived in a cloud-based format, and that, “students should maintain their record indefinitely in their possession.” Attached with the response was a copy of the Student Records and Data Collection policy, which provided conflicting information on the record-keeping timeline and format as the policy document states, in the first line, that, “the school will maintain student records for a period of 7 years. Upon graduation, students will be given a copy of their records. The student should maintain these records indefinitely.” Further in the policy document, however, the institution indicates that electronic versions of transcripts will be kept for 21 years. Therefore, the institution did not demonstrate that it maintains a consistent, clearly-written record-keeping policy and procedure document.

The institution also provided a narrative description of the record-keeping policy, specifically clarifying that the “school administrator” referenced as the party responsible for maintaining student records is the Admin/Records professional, ██████████, and provided a copy of the organizational chart, which records ██████████ as a Placement Officer and lists ██████████ (DSO) as Admin/Records. The policy document also states that the “school administrator” maintains student records, which is a job title that does not appear on the organizational chart, and no other job title is referenced in the policy as responsible for overseeing or maintaining student records. The institution provided no additional documentation to demonstrate oversight, retention, and accessibility of student records.

Regarding FERPA and records kept in unsecured filing cabinets, the institution indicated that, at the time of the on-site visit, an instructor had taken a student folder from the Associate Director to confirm a student’s attendance record in order to prepare a transcript, and that the outside file cabinet was intended for instructor material, not FERPA-protected material; with the response the institution attached the Student Records and Data Collection policy which indicates that student files are kept in a locked cabinet in the admissions area. The narrative described disciplinary action taken for the violation of the record-keeping policy, including a warning letter issued to the instructor; however, no copy of the warning letter or other documented evidence of the conversation between the Instructor and the Assistant Director was provided. The institution did not address how its record keeping system ensured that files and confidential student information was kept secure such that removal of files by any employee could not occur. With the response the institution also provided photographs of locking file cabinets with stickers indicating “Office staff use only;” however, based on the photos, the filing cabinet key is in the lock, and not in the key box kept in the Assistant Director’s office, as described in the narrative, thus potentially affording uninhibited access to confidential information.

Further, the institution indicated that the “administrator who handles tuition collection and records” reviewed folders where refund request dates, refund processing time, copies of checks, and signatures were kept, and found that all refunds have been paid by check within the 45 days refund return requirement. The response references the specific job title/party responsible for performing refund file review as “administrator,” this title, however, is not

referenced on the organizational chart. Additionally, the response to this standard did not provide any reference to student ledgers, as cited in the team report, nor did it include copies of student refund files as evidence that the requisite refund calculation and financial information was recorded accurately and completely.

Lastly, the team report response indicated that “School admin” provided the team with eight refund files, that contained refund request documentation, refund calculation sheets, copies of refund checks and refund issue dates. The institution further indicated that it modified its refund policy and conducted refund re-calculations. The response, however, did not include names of the eight students whose refund files were provided to the team, nor did it provide copies of the eight refund files as supporting documentation. While the institution indicated that it revised its cancellation and refund policy, the revised policy continues to demonstrate areas on non-compliance with ACCET Document 31 – Cancellation and Refund Policy, as detailed in Standard III-B: Financial Procedures, and the institution provided no supporting documentation such as meeting minutes as evidence that revisions to the refund policy were discussed by and communicated to the relevant parties. Further, the institution’s response failed to address why files were not provided to the team during the visit.

Therefore, the institution failed to demonstrate compliance with this standard.

8. Standard II-F: Professional Relationships

The institution failed to demonstrate that its professional relationships are systematically maintained, utilized, and documented for the purpose of enhancing the quality of the education, training, and student services.

The team report indicated that during the on-site visit, the institution did not validate several of the professional relationships it had described in the ASER. Specifically, the team report indicated that, in the ASER, the institution stated it was a member of both the Private College and School Association of New Jersey (PCSANJ) and the Hudson County Chamber of Commerce. However, the institution was not listed on the PCSANJ website or the Hudson County Chambers of Commerce website.

In its response, the institution indicated that they are currently a member of the Hudson County Chamber of Commerce and included a screenshot as evidence. The institution further indicated that while they had been a member with PCSANJ, their membership had lapsed as the result of the employee leaving the organization. The institution stated that they planned to renew their membership in January for 2019; however, no supporting documentation was included to demonstrate that the institution has concrete plans to renew its membership with PCSANJ.

Therefore, the institution failed to demonstrate full compliance with this standard.

9. Standard III-B: Financial Procedures; and Standard II-C: Financial Assistance/Scholarships

The institution failed to demonstrate that systematic and effective written policies exist for proper financial controls and the supervision of financial management staff; Receipt of tuition payments and other monies is properly recorded and tracked; Cancellation and refund policies are written, fair, and equitable; are consistently administered; and comply with statutory, regulatory, and accreditation requirements. Further, the institution failed to demonstrate that institutional scholarships are responsibly administered and governed by written policies and procedures that ensure that student financial assistance is awarded in an effective, consistent, fair and equitable manner.

The team report indicated that the institution does not implement the following procedures in compliance with the requirements of this standard: (a) receipt of tuition payments and other monies is not properly recorded and tracked; (b) cancellation and refund policies, as written, are not fair and equitable; nor are they consistently administered; to comply with statutory, regulatory, and accreditation requirements; and (c) there was no documentation to verify that quarterly payroll taxes were paid for calendar year 2017 or year-to-date 2018.

The institution did not provide the team with its “cash receipts” binder for the six-month period prior to the on-site visit. Correspondingly, the institution could not demonstrate to the team adequate financial controls for the collection of student payments, issuance of receipts, the posting of payments to student accounts, and the accurate deposit of payments.

The institution’s refund policy is based on the New Jersey State policy requirements but is not compliant with ACCET requirements, as it does not incorporate ACCET Document 31 – Cancellation and Refund Policy or ACCET Document 31.ESOL – Cancellation and Refund Policy. For example, the institution retains 25% of total tuition if withdrawal occurs in the second or third week and 45% of the total tuition if withdrawal occurs after the third week but prior to completion of 25% of the course and 75% of the total tuition if withdrawal occurs after 25% but no more than 50% of the course. The institution, therefore, exceeds the pro rata portion of tuition for the training period completed through 50% of program completion, contrary to the requirements of ACCET policy documents. In addition, the institution charges non-refundable fees of \$100 (registration) and \$500 (“administrative cost for visa processing fee”) if an international nonimmigrant student visa is denied, which is not compliant with the maximum fees to be charged for cancellation prior to the start of the class in ACCET Document 31.ESOL. The institution further requires written notification of withdrawal, contrary to ACCET Documents 31 and 31.ESOL. Further, the team requested ten student files to review but was provided documentation for three students, each of which contained incomplete information; therefore, the team could not determine if refunds were accurately calculated and issued in a timely manner.

Upon its review of ACCET Document 50FR – On-Site Financial Review Checklist, the team found that the institution had not paid quarterly payroll taxes for calendar year 2017 or year-to-date 2018. The team reviewed an IRS Notice issued in February 2018 which indicated that

the institution had not submitted IRS Form 944, Employer's Annual Federal Tax Return for 2017 and, therefore, the IRS could not produce Forms 941, Employer's Quarterly Federal Tax Return, for that year. No 2018 forms were provided for the team's review.

The team report indicated that the institution's tuition was published in the school catalog, but that the fees reflected charges to students eligible to Title IV funding, and were inaccurate reflections of current tuition. For example, the published tuition fee was \$11,500 for its 900 clock hour allied health programs, when in fact, students were charged \$4,000 for these programs.

The team report indicated that the institution's enrollment agreement contains a "grant/scholarship" provision. The scholarship is not publicized in the catalog and the staff confirmed there were no scholarships or grants offered nor that policies, procedures, or criteria exist for scholarships. The staff informed the team that there is a tuition discount of \$7,500 from course fees of \$11,500. It was noted that no funds were available or transferred for either a grant or a scholarship at the institution.

In its response, the institution indicated that the receipt books were not available on-site as they were requested by the CPA. The response included pictures of the receipt books; however, the Commission noted that the institution's policy requires the assistant director to cross-verify receipts on a daily basis which cannot occur if the receipt book is not available on-site. Further, the pictures of receipt books did not resolve concerns regarding financial controls. The institution also included a copy of the Tuition Ledger. The ledger provided did not provide sufficient information to function as a ledger as it did not include date, amount, and purpose of a specific payment.

The institution's response also included a revised cancelation and refund policy; however, the institution failed to respond to the weakness cited regarding its noncompliant ESOL refund policy. The institution provided refund calculations for seven students. Four students refund calculations ([REDACTED], and [REDACTED]) were not calculated correctly as the tuition liability did not align with the weekly calculations.

In its response, the institution confirmed that it charges students a lower tuition amount than advertised and indicated that it is planning to do so until it receives eligibility to participate Title IV federal financial aid. The institution further stated that all students receive a \$7,500 discounted tuition but did not provide documentation that this was consistently applied to all students or how this discount was advertised and communicated to prospective students and the public. The response did not address why all documentation and marketing reflects a different amount than is actually charged. It provided blank enrollment agreements in its response to Standard III-C which replace the "grant/scholarship" provision with a provision for discounts. However, this revision does not demonstrate that the institution is applying its published tuition rates fairly and consistently, as required by the standard.

Further, in its response, the institution indicated that it modified its enrollment agreement,

removing the column “grants/scholarships” and replaced it with “discounts.” The institution stated that it gives all students a \$7,500 discounted tuition. The discount is unpublished, and it is not clear what the tuition rate is and if the tuition rates and/or the discount are being fairly and consistently applied to all students.

The institution provided copies of tax returns but failed to provide payment verification.

The institution failed to demonstrate responsible financial management, fair and consistent application of charges, systematic and effective implementation of an ACCET-compliant refund policy, and proper tracking and maintenance of student accounts as required. Further, the institution failed to demonstrate that it ensures that federal payroll taxes are paid in a timely manner, as required by ACCET and Federal law.

Therefore, the institution failed to demonstrate compliance with this standard.

10. Standard IV-A: Educational Goals and Objectives

The institution failed to demonstrate that its programs and courses have appropriate educational goals and objectives; that curriculum content and learning experiences are preplanned and present a sound, systematic, and sequential educational methodology; and that sufficient and appropriate knowledge and skill elements are included to meet the specific and measurable performance outcomes expected for the courses and programs.

The team report indicated that there were no lesson plans available for review for the ESL class that was running at the time of the on-site visit, and the syllabi provided did not reflect the class content observed. The course in session was a Level 1 class according to the institution’s catalog, “*designed for student[s] who score less than 41 on the entry exam*” and which focuses on the most basic language skills, grammar structures, and remedial vocabulary. However, the team observed that the class included students with a very broad range of English-language skills, ranging from beginner to advanced. The content covered did not adhere to any pre-planned course objectives for a Level 1 class. Correspondingly, the team found no evidence that the institution had implemented a sound, systematic, and sequential curriculum for its ESL program.

In its response, the institution submitted a narrative which stated that what the team observed was a group discussion. The institution claims that these “discussions” are held once a week and: “consist of two groups, (group A - students who have no experience with the English language and group B- students who can speak a little English but are unable to pass the all 3 components of the placement exam (reading, writing and speaking)).” The institution further stated that: “These discussions help explore the understanding of both groups through assigned group discussion, TV shows, ads, social media posts etc.” The institution indicated that it has updated its curriculum and syllabus to reflect these discussions. The institution submitted three exhibits as follows: 1) Intensive ESL Lesson Plan, 2) ESL Curriculum, and 3)

ESL Placement 2018. However, the Commission's review of these documents revealed that the institution's curriculum consisted only of a list of structures, topics, and functions. The curriculum lacked specific and measurable outcomes expected of learners for the English courses offered. The sample placement tests submitted demonstrated that students are only initially assessed on their knowledge of English grammar structure and did not demonstrate effective assessment of any of the four key language skills: listening, speaking, reading, and writing. The weekly lesson plans submitted for the various ESL levels, while sufficient as a lesson outline to guide instructors, were insufficient to replace appropriately constructed comprehensive syllabi for each language level.

The institution failed to demonstrate that its ESL program has appropriate educational goals and objectives. The institution did not demonstrate that its ESL curriculum content and learning experiences are sound and systematic, and based on comprehensive knowledge of language learning methodology. There was no evidence that sufficient and appropriate knowledge and skill elements are included to meet the specific and measurable performance outcomes expected for the courses and programs.

Therefore, the institution failed to demonstrate compliance with this standard.

11. Standard IV-B: Program and Instructional Materials

The institution failed to demonstrate that program materials, including syllabi, instructional guides, and texts demonstrate the appropriate scope, sequence, and depth of each program or course in relation to the stated goals and objectives. Additionally, the institution did not demonstrate that *all* materials are up-to-date, readily available, and facilitate positive learning outcomes.

The team report indicated that the syllabi for the Medical Assistant program did not align with the texts in use for the courses in this program. While the team found that the materials in use contained content relevant to the overall learning objectives of the courses in the Medical Assistant program, the textbooks were all older than five years and did not describe or facilitate training in updated technology used in current practice, updated federal guidelines, contemporary delivery techniques, and current privacy and safety regulations put forth by Centers for Disease Control Prevention (CDC), Health Insurance Portability and Accountability Act (HIPAA), and Occupational Safety and Health Administration (OSHA) requirements.

Additionally, it was observed during the on-site visit that none of the ESL students had a copy of the designated textbook for the single Level 1 class being offered at the time, *Future English for Results – Future Intro*, which the team noted would not have supported instruction in the class, since the class contained both beginner and advanced students. The class observed was conducted entirely of instructor-made materials with no clear supervision from the institution regarding whether or not these materials supported the published goals and objectives of the class.

In its response, the institution indicated that it has decided to change its current Medical Assistant textbook to the third edition published in 2016, and that this change was approved by the Advisory Board which consists of doctors. This third edition addresses current practice, up-to-date federal guidelines, contemporary delivery techniques, and relevant privacy, and safety regulations generated by Centers for Disease Control Prevention (CDC), Health Insurance Portability and Accountability Act (HIPAA), Material Safety Data Sheets (MSDS), and Occupational Safety and Health Administration (OSHA) requirements. However, the institution did not address the concern of the team that Medical Assistant program syllabi do not align with the textbook material. Further, the institution did not respond to the team's concern that the students did not have a copy of the text for the Level 1 ESL course offering. The institution simply stated that the task observed did not require the use of a textbook.

Therefore, the institution failed to demonstrate full compliance with this standard.

12. Standard IV-C: Externships/Internships

The institution failed to demonstrate that written policies and procedures for the supervision and evaluation of externships/internships are systematically and effectively implemented to ensure consistency and effectiveness in this training modality.

The team report indicated that in the institution's ASER, it provided a policy for the supervision of internship/externship sites. However, this document appeared to have been cut and pasted from Bergen Community College documentation entitled, *Student Course Syllabus Division of Health Professions –Medical Office Assistant Program's Medical Office Assistant Externship* (see <http://bergen.edu/wp-content/uploads/MOA-243.pdf>). During the on-site visit, no one at the institution could articulate a policy or procedure for the oversight of its externships; produce documentation to evidence that externships were monitored or evaluated; or demonstrate that externship students were appropriately evaluated during the course of their externship training. In addition, the institution provided the team with only a minimal set of learning objectives common for externships which did not establish clearly-stated learning outcomes relevant to the specific content of a student's chosen program and externship training at this institution.

In its response, the institution provided a blank competency checklist for the Medical Assistant program, but failed to provide any evidence that the new Competency Checklist had been systematically and effectively implemented. The institution did not address the lack of learning objectives for the Advance Patient Care Associate externship. The institution has not established a consistent pattern of conducting evaluations of students by the Externship Site Supervisor/Doctor since the only evidence provided consisted of one set of evaluations that was conducted over a two-day period. Additionally, there was no documentation submitted to demonstrate that the Internship Coordinator (Supervisor) has been informed of his/her new responsibilities and has begun completing such tasks as visiting and approving externship

sites, orienting students on the requirements for the training site, and outlining disciplinary policies/procedures, etc. The policy provided does not reference completion of the competency checklist by a qualified individual, and a review of the institution's organizational chart does not reflect the position "Internship Coordinator (Supervisor)" referred to in the internship/externship policy.

Therefore, the institution failed to demonstrate full compliance with this standard.

13. Standard IV-D: Curriculum Review/Revision

The institution failed to demonstrate that it has established effective written policies to continuously monitor and improve its curriculum. The institution did not evidence that it has established and regularly implements procedures that solicit and utilize feedback from relevant constituencies (e.g. faculty, students, graduates, employers, and advisory/certification boards) to inform improvements to its curriculum. Further, there is no evidence to indicate that there is a policy/procedure that ensures a comprehensive review of the curriculum as it relates to expected learning outcomes.

The team report indicated that while the institution's ASER stated that there was a Review Board to evaluate current programs and that it had developed new syllabi, curricula, and lesson plans to correspond to national standards, this was not evidenced during the team visit. There were no Board Meeting Minutes or other relevant documentation available to the team to verify this claim. Additionally, no member of the institution's staff could articulate the assignment of responsibility or authority for curriculum review and revision, and there was no evidence that this process took place. The team noted a concerning lack of awareness of the complexity of this process including key factors such as: consideration of current pedagogical trends, current theories, new texts/materials, and other crucial updates in the field that should be considered for incorporation into the institution's curricula. There was no evidence of any timeline of recent curricular changes or any schedule for review going forward. There was no evidence that feedback was solicited from relevant stakeholders (i.e. employers, students, instructors, or graduates), to inform curriculum review.

In addition, in interviews with instructors, the team was informed that faculty had requested updates to Allied Health texts to reflect current industry standards and the current regulatory environment, as well as updated equipment and supplies to more accurately reflect the current clinical environment, but that no progress had been made on these requests.

In its response, the institution provided a narrative that stated that: " Plenum Institute has yearly Advisory Board meeting for curriculum review. In between each year, if the institute needs to submit a curriculum update to the NJ Department of Education in New Jersey, the institute calls the subject matter Advisory Board meeting. (see the attached for the board meeting)." However, there was no attached documentation that evidenced an Advisory Board meeting. The institution submitted exhibits of updated (2018) syllabi for its Allied Health programs, a list of lab equipment and supplies, and several JPG picture files of updated

*equipment including such items as: a new Phlebotomy arm, a centrifuge (open and safety locked), an autoclave, a bio-hazard sharps container (open and closed), and a picture of signage indicating a Hazardous Waste Storage Area. However, aside from evidencing that it has responded to an **immediate** need for updated curriculum documents and equipment, the institution failed to demonstrate that it has systematically and effectively implemented a comprehensive Curriculum Review and Revision policy/procedure. The institution did not provide a written policy and procedure for curriculum review and revision which detailed the process for collecting and utilizing feedback for relevant stakeholders, considering and analyzing current educational trends and theories, and identifying updates in the field to inform the written, comprehensive curriculum renewal and revision process. Nor did it identify the party (or parties) responsible for overseeing and initiating this critical process.*

Therefore, the institution failed to demonstrate compliance with this standard.

14. Standard V-A: Instructional Methods

The institution failed to demonstrate that instructional methods encourage active and motivated responses from students. It did not demonstrate that there is consistency of application by all instructional staff. It was not evident that the instructional methodology employed is consistent with contemporary industry standards and appropriate of well-conceived educational goals and curricular objectives. The institution further failed to demonstrate that its methodology facilitates learning, and serves the individual learning needs and objectives of students. Instructional methods observed did not evidence that instructors take into consideration different learning abilities and styles as well as prior levels of achievement.

The team report indicated that despite the institution's stated teaching methodology which claims that it encourages the development of reciprocity, contact and cooperation among students in an active learning environment, this pedagogical practice was not observed during the visit. The team noted that the institution's principles of methodology appeared to have been cut and pasted from the University of Chattanooga's website (<https://www.utc.edu/walker-center-teaching-learning/teaching-resources/7-principles.php>) and many of these principles were noted by the team to be more pertinent to undergraduate education than to vocational ESL training. Class observations conducted by the team revealed high teacher talk time and minimal student talk time despite the fact that one of the activities observed included a speaking presentation on students' current careers. No pair or group work was observed. Further, the ESL class was supposedly a Level 1 class; however, it was composed of mixed levels including advanced students who seemed to take most of the teachers' attention, thereby demonstrating the lack of implementation of differentiated instruction. It was noted that students left the class at regular intervals throughout and a student was noted sleeping on two separate occasions. Observation of the Patient Care class revealed that the instructor taught to the test and did not employ effective illustration of lesson concepts nor did the instructor utilize comprehension check questions to effectively gauge student understanding of the content.

In its response, the institution submitted an internally developed document entitled: Policy for Teaching Methodology that attempted to outline the institution's philosophy and procedures relative to instructional methodology. This document was noted by the Commission to be of amateur quality with vague directives and poor language construction as exemplified by the following excerpt: "The curricula and instructional material aim to build knowledge acquisition for the students at the good quality, at advanced levels. The Institute has reviewed the current teaching techniques and student response to curricula that are designed to reach the latter's weaknesses. These curricula, teaching and learning style alterations are conducted as they are found necessary. [sic]" Further, the institution did not indicate how it would ensure systematic and effective implementation of this policy.

The institution indicated that the teacher of the Patient Care class was conducting a review session and that he was attempting to encourage cooperation and active participation from and among students. The institution stated that it had warned the teacher to engage the students in a meaningful way and to improve student participation in class discussions. The institution also stated that it had suggested to the instructor: "...to attend some course offered by the community college for how to improve teaching in vocational school (adult education) such as NJ DOE recommended for teachers license in 2018 as a refresher." However, there was no follow-up or documentation to indicate that any teacher training had occurred since the visit, nor what processes the institution was using to ensure that students received quality instruction.

The institution stated that the mixed level ESL class was comprised of a wide range of ages from 35 – 58 years old and that many of these students were new to the country and were shy to speak, and were probably confused. It was also stated that students felt more comfortable talking with those other students whom they knew in their own language. However, the Commission notes that this confusion, shyness, and the inclination to speak to others that share the same mother tongue is typical of all ESL classroom situations, thus the ESL teacher's inability to effectively manage such circumstances indicates poor instructional methods. In summary, the institution failed to demonstrate that there is consistency of application of effective methods implemented by its instructional staff and it further failed to demonstrate that the training methodology employed is consistent with contemporary industry standards to include effective implementation of techniques such as differentiated instruction.

Therefore, the institution failed to demonstrate compliance with this standard.

15. Standard V-B: Learning Resources, Equipment, and Supplies

The institution did not demonstrate that adequate, appropriate, up-to-date, and functional equipment, learning resources, supplies, and furnishings are readily available for instructor and student use and for the effective delivery of the institution's education and training.

The team report indicated that faculty in the allied health programs reported that they did not have access to essential equipment and supplies to teach all of the competencies in the courses

they were assigned to teach, including, for example, autoclaves to sterilize equipment. This was verified by the team during observations of the laboratory equipment available. Other equipment, including the centrifuge, was scarce in supply and also outdated. The team was informed by Phlebotomy instructors that they have to bring their own equipment to effectively teach the course. Much of the equipment that the institution utilized in its programs was not up-to-date and in good repair – for example, Phlebotomy arms were old, torn, and/or broken.

In its response, the institution submitted under Standard IV-D: Curriculum Review/Revision and under this Standard V-B: Learning Resources Equipment and Supplies a list of lab equipment and supplies, and several JPG picture files of updated equipment including items such as: a new Phlebotomy arm, a centrifuge (open and safety locked), an autoclave, a bio-hazard sharps container (open and closed), and a picture of signage indicating a Hazardous Waste Storage Area. However, aside from evidencing that it has some updated equipment, the institution did not provide purchase invoices for the new equipment, and evidence that instructors had been informed about and oriented on how to utilize and/or properly maintain the new equipment. There was no documentation or evidence to indicate that this additional updated equipment had been systematically and effectively integrated into appropriate program instruction and that the new equipment was adequate in quantity to fulfill the needs of the institution's program offerings. Additionally, the institution did not address the issue cited in the team report regarding Phlebotomy teachers having to bring their own equipment to effectively instruct the course.

Therefore, the institution failed to demonstrate full compliance with this standard.

16. Standard V-C: Facilities

The institution failed to demonstrate that the institution's facilities are appropriate for the education, training, and student services offered. Instruction is conducted in a safe, accessible, sanitary, and comfortable environment conducive to learning. The facilities meet all applicable local, state, and federal requirements.

The team report indicated that over the course of two days, the institution, despite repeated requests by the team, was unable to provide copies of its Safety Data Sheets (SDSs) to verify OSHA compliance, nor could it demonstrate availability of this essential information to staff and students in the labs. In addition, two classrooms contained sharps in an unsecured environment (i.e., in unlocked classrooms in open containers).

In its response, the institution indicated in its narrative that unfortunately at the time of the site visit, it had temporarily relocated the Phlebotomy lab and the MSDS/OSHA binder was temporarily misplaced and could not be located for the team. The institution did provide exhibits that included: 1) the OSHA Compliance E-book, 2) the OSHA White Paper, and 3) Plenum Institute's Materials Safety Data Sheet (MSDS). However, there is no evidence to indicate that this information is effectively distributed, communicated and available to

students. In its narrative, the institution attempted to clarify its internal safety policies with the following statements:

- *“After completion of the lab part waste container must be close by the student and supervised by the teacher and reviewed by admin then lock the class till next batch start.”*
- *“Management has informed the instructor and all attending students by notice to take care of medical waste seriously. Plenum Institute prohibits collecting real blood from other students or volunteers in the school premises to reduce bio-hazardous and infectious diseases also teacher may use consent from student and volunteer for venipuncture practice. Also, destroy all waste in the container and transported by the waste management company for proper disposal.”*

However, the institution did not provide documentation to demonstrate that these policies have been effectively communicated to faculty and students in any form (through meetings or internal published policy updates, etc.) since the visit.

Therefore, the institution failed to demonstrate full compliance with this standard.

17. Standard VI-C: Instructor Orientation and Training

The institution failed to demonstrate that it systematically and effectively implements written policies/procedures for the effective orientation and ongoing professional development training of its academic personnel to ensure a consistent, high level of instruction. The institution also failed to demonstrate that it consistently documents relevant in-service training activities that take place.

The team report indicated that while the institution has developed a basic policy and procedure for orientation and training of instructional personnel, the team found that the only orientation for newly-hired instructors is a basic human resources orientation, and that no orientation is conducted regarding methodology, curriculum, or classroom management to ensure a consistent high level of instruction at the institution. The institution stated in its ASER and in a policy document made available to the team that its instructors had been trained to adhere to the following principles: (1) encourage contact between students and faculty; (2) develop reciprocity and cooperation among students; (3) encourage active learning; (4) give prompt feedback; (5) emphasize time on task; and (6) and communicate high expectations. However, interviews with allied health instructors on-site acknowledged that no initial orientation or training had been conducted on curriculum, teaching methodology, or classroom management.

Further, the team noted that no ongoing training of instructors was documented to evidence ongoing professional development of faculty at the institution as required by this standard. The team found that the only professional development activities were those mandated by the state of New Jersey during licensure renewal.

In its response, the institution indicated that it has an Instructor Orientation Policy; however,

there was no documentation submitted to evidence the implementation of this policy. The institution included a policy document entitled: Policy for Teaching Methodology; however, this fails to outline the procedure for the orientation and training process of new faculty hires. The institution also stated that it utilizes peer coaching whereby its instructors meet monthly (every fourth Friday) to share strategies, best practices and relevant concerns. There was no documentation provided to evidence that these monthly coaching sessions occur.

The institution submitted evidence that two employees had signed up for and/or completed professional development: 1) a TESOL Certificate for [REDACTED] (completed October 24, 2018), and 2) a Medical Billing and Coding NACT Certification for [REDACTED] and evidence that this same employee had signed up for an “ed2go” workshop on Teaching Adult Learners (to be completed on December 12, 2018). However, this documentation is insufficient to demonstrate systematic and effective implementation of a Professional Development policy across all faculty and academic staff at the institution. Further, while the institution indicated that it has revised its Professional Development Policy going forward as follows: “The Institute will enforce from 2019 mandatory two (2) training for professional development to upgrade their skill about current industry and equipment/or educational credit about the interaction of teaching methodology. It will be financed by the school management, [sic].” The institution did not demonstrate that this policy has been communicated to all relevant faculty and staff, nor do future requirements demonstrate that the institution is currently ensuring professional development for instructors as required by ACCET.

Therefore, the institution failed to demonstrate full compliance with this standard.

18. Standard VII-C: Transfer of Credit

The institution failed to demonstrate that has written policies and procedures that ensure the fair and equitable treatment of students relative to the transfer of credit to and from the institution; and that it provides clear, complete, factual, and timely information regarding its transfer policies and practices.

The team report indicated that the institution, at the time of the visit, had not established a Transfer of Credit policy as required by this standard.

In its response, the institution provided a new Transfer of Credit policy, and indicated that this new policy is also published in an updated version of the catalog. While the new policy addresses some of the requirements of ACCET Document 16 -- Transfer of Credit Policy, it contains contradictory statements such as: “Student can request a transfer of credits from one program to another program (curriculum). Plenum Institute will transfer credits from one curriculum to another curriculum and both hours attempted and hours need to be completed [sic]” versus the statement “Transfer students from one program to another program are completely prohibited because of program content and duration...” Further, only a portion of the policy is included in the updated catalog. The catalog does not inform students of the

process to apply for transfer of credit, nor does it inform students of the necessary documents. Additionally, the institution failed to evidence that students and staff have been informed of the new policy in its entirety.

Therefore, the institution failed to demonstrate full compliance with this standard.

19. Standard VII-D: Student Services

The institution failed to demonstrate that student services are provided consistent with the mission and learning objectives of its programs to include such services as student orientation, academic and non-academic advising, tutoring, and job placement assistance.

The team report indicated that while the institution offers a basic range of student services, there was no documented evidence of counselling students, the benefits of its counseling, or extracurricular activities, including culturally-enriching experiences for its ESOL students as required by the Specific Field Criteria for ESOL programs.

In its response, the institution provided evidence of extra-curricular events with culturally enriching themes such as a Diversity Festival and an International Food Festival.

Additionally, the institution noted that each program has 60 hours of career development as a part of the curriculum, which covers resume and interview preparation. This is prescribed through the Personal Service Policy; however, the institution did not provide this policy in its response for Commission review. The institution also provided counseling notes that cover when students meet with administrators for personal or educational related issues, but the notes provided are brief and do not show any benefits of these sessions on the students' overall experience.

Therefore, the institution failed to demonstrate full compliance with this standard.

20. Standard VIII-A: Performance Measurements

The institution failed to demonstrate that performance measurements are written, periodically evaluated, and updated to ensure instructional effectiveness; that it has a sound, written assessment system that contains a set of defined elements, such as grading scale, weighting factors, tests, quizzes, reports, projects, attendance, and participation, that are appropriately related to the performance objectives of the program or course; and that the institution clearly and effectively communicates the assessment system to students at orientation and/or the beginning of the course/program.

The team report indicated that syllabi did not consistently contain complete grading information. For example, syllabi stated that there would be "frequent tests," but did not

provide detail regarding the frequency of testing. In addition, the Medical Terminology syllabus stated that grades will be based on (1) tests on selected chapters and (2) a final examination, with no further information on weighting of these components.

The institution indicated in its ASER, policies, and syllabi that student performance in all programs is based on regularly assigned homework, quizzes, hourly tests, mid-term and final examinations and either lab work or projects and presentations, and that grading is aligned to a uniform grading system. However, this grading system was not implemented at the institution, as confirmed by instructor and student interviews. For example, there was no indication that homework is assigned for any of the institution's courses, and the weights accorded to specific quizzes, participation, lab skills or presentations, and assignments vary from class to class, as verified by interviews with the institution's instructors and a review of academic files. Instructors indicated that some classes were graded pass/fail, which was not reflected in the course documentation, nor was there a structure in place to ensure consistent criteria for this pass/fail system in line with the learning objectives. Student academic records did not demonstrate implementation of the weighting system and performance assessments described by the institution's policies and curricular materials.

Further, while the institution claims to place students in the ESOL programs according to results obtained from the BEST Literacy test, the team found that the only ESOL program running at the time of the on-site visit (a Level 1 – Beginner class) contained students at all ranges of English language competence, from beginner to advanced, and that the placement test was not being used to place students into a class of the appropriate proficiency level.

In its response, the institution indicated that it had adopted the following evaluation scale for all programs:

Quiz/Homework 10%
Class participation 10%
Midterm Exam 40%
Final Exam 40%

The institution noted that for the healthcare programs there is no homework. It also noted that often there is no homework in other classes except reading assignments to better prepare for the next day's class. Most assignments are done in class. However, all syllabi provided in the institution's response included the Quiz/Homework grading category as 10% of the grade. The institution indicated that this universal grading scale is published in the school catalog, but upon review by the Commission, only the breakdown of letter grades is provided in the school catalog. Additionally, the institution did not address the Pass/Fail grading system communicated to the team during the on-site visit. Further, the institution did not provide examples of implementation of the new universal evaluation scale through course final grades/calculations.

The institution indicated that at the time of visit the Intensive English class Level I (Beginner - I) was running because the student scores were "below marks." Students scoring below 41

were to be placed in Level 1 (Beginner-I). The institution provided copies of the BEST Literacy tests given to 13 students; however, the institution did not provide documentation to verify that the student test results represented all of the students registered for the ESOL course the team observed during the visit.

Therefore, the institution failed to demonstrate full compliance with this standard.

21. Standard VIII-B: Attendance

The institution failed to demonstrate that it establishes and implements written policies and procedures for monitoring and documenting attendance; that the attendance policy ensures that student attendance and participation are consistent with: (1) the expected performance outcomes of the course or program and (2) statutory, regulatory, and accreditation requirements, including at a minimum the required student attendance rate established by the Accrediting Commission; and that it publishes a clear description of its attendance requirements and informs students of their attendance on a regular and timely basis.

The team report indicated that review of student attendance during the visit demonstrated that students did not consistently attend an entire class. Students arrived late and left early in all classes observed and this was not reflected on attendance documentation requested by the team after the classes had ended. While the team found that instructors reported students who were in attendance during the on-site visit, late arrivals and early departures (and, in the case of the ESOL class, students who left and re-joined the class on an arbitrary basis) were not reported to the administration.

The institution's attendance policy did not include any definition or consequences for tardies or early departures, as required by ACCET Document 35 – Policy on Attendance Requirements. The written policy did not outline any consequences for failure to maintain attendance standards, nor was there evidence of implementation of consequences.

The team found that the institution's management and faculty could not articulate how students were notified of their attendance performance or attendance issues. There was no clear and consistent understanding of attendance policy on the part of students or faculty. Further, the team noted that institution did not have a leave of absence policy consistent with ACCET Document 36 – Leave of Absence Policy.

In its response, the institution provided a new attendance policy, published in the school catalog, that defined a tardy as arriving more than 15 minutes late. Four tardies equal one hour absent and arriving more than 30 minutes late constitutes an absence. The policy indicates that an early dismissal requires approval from the School Director and that new students will be trained on the policy on day one of orientation and new faculty on day one of hiring. The policy does not outline the consequences for early departure. The institution provided no documentation to evidence training for current faculty and students on the new policy. No attendance sheets were

provided to evidence implementation of the tardy policy.

Upon review, the Commission noted that the revised attendance policy was not compliant with ACCET Document 35 in that the institution does not consider excused absences as counting toward the maximum allowed 20% absences as the policy states, "Missing more than 20 percent of instruction time that is recorded as unexcused absence." The policy does not indicate the maximum number of consecutive absences allowed before a student is automatically withdrawn. Although, the policy states that the institution has the right to terminate a student who remains on attendance probation for two consecutive terms, it does not provide a definitive course of action.

In addition, the institute has a probation policy in reference to attendance that is referred to in the student catalog, but not contained therein. This policy states a different policy than the required 80%. It states a student will be allowed six absences within a given term. On the seventh absence, the student is dismissed from the term and must repeat the course. It is not clear how this policy translates into the 80% attendance requirement and if it applies to ESOL students as well. It is also not clear when or if, under this policy, a student is placed on probation.

The institution provided a new Leave of Absence policy that is published in the school catalog and meets the requirements of ACCET Document 36; however, it does not provide a vacation policy for ESOL students as required by ACCET Document 36. ESOL - Leave of Absence, Medical Leave, and Vacation Policy.

Therefore, the institution failed to demonstrate full compliance with this standard.

22. Standard VIII-C: Student Progress

The institution failed to demonstrate that it effectively monitors, assesses, and records the progress of students utilizing the sound and clearly defined assessment system; that students are informed of their progress on a regular and timely basis; and that it publishes a clear description of its requirements for satisfactory student progress and utilizes sound written policies and procedures to determine student compliance with these requirements.

The team report indicated that the institution did not have a written satisfactory academic progress (SAP) policy in place at the time of the team visit. While the institution presented a written satisfactory academic progress policy to the team during the on-site visit, neither faculty nor staff could articulate SAP standards. In addition, the team found that the institution, which claims in its ASER to follow SAP policies "which are designed to monitor, assess, and record student progress in all avocational and vocational programs," and to monitor "all quizzes, hourly and mid-term evaluations" and discuss "solutions" with students, did not articulate a clear description of its requirements for academic progress or utilize sound written policies and procedures to determine student compliance with these requirements. In

interviews with the team, the Director indicated that a SAP policy had been created, but not implemented, and that the only indicator of “progress” was attendance in class (as noted under Standard VIII-A: Performance Measurements, instructors did not follow the institution’s grading policy). Indeed, the Director, and other members of senior staff, questioned the team on whether SAP was required to be monitored, assessed, and recorded for non-Title IV institutions. Of the 10 student files reviewed for the institution's ESOL programs, the institution could not demonstrate, that any of the reviewed students had met minimum academic requirements.

In its response, the institution provided a SAP Policy which includes both qualitative and quantitative measures. It states, "Students who are not making SAP will be notified in writing of the Evaluation results. If the student is not meeting SAP at the end of the course/program, the student will be placed on an Academic Development Status, and will be required to meet specific criteria of an improvement plan to assist them to meet SAP stander [sic]." The measurements are conducted at the end of each course to determine if the student is maintaining SAP. The institution stated that the reason instructors had not followed the established grading system was because there was confusion over the requirement for a SAP policy for non-Title IV schools but that now the instructors are better informed. Furthermore, the institution indicated that the reason the team was unable to validate whether students were meeting minimum academic requirements was because it was too early in the term and no assessments, with the exception of one quiz, had been administered to date and no progress reports were available for these students. However, no evidence was provided of notification or training on the SAP policy for students, staff, or faculty. The complete policy is not contained in the School Catalog and the written policy refers back to the School Catalog to get further information; therefore, the complete policy is not fully contained in any given location for easy reference and understanding. The institution did not provide any evidence of implementation of the SAP policy.

Therefore, the institution failed to demonstrate full compliance with this standard.

23. Standard IX-A: Student Satisfaction

The institution failed to demonstrate that establishes and implements written policies and procedures that provide an effective means to regularly assess, document, and validate student satisfaction relative to the quality of education, training, and student services provided; that open lines of communication with students exist and demonstrate responsiveness to student issues; that interim evaluations and a final evaluation upon completion of the term of enrollment are specified components of determining student satisfaction; and that student feedback is utilized to improve the education, training, and student services provided by the institution.

The team report indicated that while the institution conducts surveys, no survey results were provided to the on-site team during the visit. The institution attached five copies of ACCET

Document 19 – Instructor Evaluation to the ASER as evidence of collecting student satisfaction, which did not demonstrate student satisfaction with education, training, and student services. The sample survey that was provided to the team was an Excel sheet with numbers that cross referenced to classes offered but did not contain any verifiable data for the team to review. The institution had no policy or procedure in place to regularly document and assess student satisfaction, as required by this standard.

In its response, the institution noted that since 2015, over 200 students have been surveyed utilizing approximately five different methods and that feedback is compiled into a narrative summary report which is given to the management to address weaknesses and to implement corrective action. While the institution provided a sample of completed student surveys and figures per program to demonstrate overall satisfaction, the institution did not provide any documentation of the surveys used to create the summary figures, as the questions and topics did not align. The documentation did not evidence that students provided interim and final feedback upon completion of the program. Further, the institution did not demonstrate how it addressed students who were not satisfied with one or more areas of the institution, or any corrective actions taken to address the dissatisfaction, as none of the programs demonstrated 100% satisfaction. The institution stated that the reason for dissatisfaction was a lack of timeliness in career services. However, a review of the summary data provided indicated that over 20% of students were not satisfied with internships, for example. The institution's brief narrative does not address any other areas of dissatisfaction as reflected in the summary or the survey.

Further, the institution did not present a Student Satisfaction policy or procedure to guide the distribution, completion, and assessment of student surveys, as required by this standard.

Therefore, the institution failed to demonstrate full compliance with this standard.

24. Standard IX-B: Employer/Sponsor Satisfaction

The institution failed to demonstrate that it has policies and procedures to regularly assess, document, and validate employer/sponsor satisfaction relative to the quality of the training provided; or any feedback has been utilized to improve the training or services offered.

The team report indicated that a basic employer survey exists to collect feedback from employers. However, the institution could not demonstrate during the on-site visit that the survey was consistently distributed to all relevant employers, or that the feedback was analyzed for the improvement of the programs and services.

In its response, the institution stated that it has a policy to collect employer satisfaction and that an analysis is done every six months for managerial review. However, the institution did not provide a complete policy and procedure, nor did it provide analysis of any results. The institution submitted/attached "employer surveys" which consisted of ACCET Document 25.3

– *Employer Questionnaire and Program Overview*, which is to be utilized when an institution is justifying a new program offering, not to solicit information about employer satisfaction.

Therefore, the institution failed to demonstrate full compliance with this standard.

25. Standard IX-D: Completion and Job Placement

The institution failed to demonstrate that: (a) it establishes and implements written policies and procedures that provide effective means to regularly assess, document, and validate the quality of education and training services provided relative to completion and placement rates; (b) completion and placement rates meet ACCET’s benchmarks of 67% completion and the 70% placement; and (c) completion and placement are tracked in accordance with ACCET standards and policies.

The team report indicated that:

- a) The institution did not provide sufficient supporting documentation to validate its completion and placement rates. As noted in other standards, the grading system was inconsistently implemented, and documentation of externship completion was not provided. Therefore, completion rates could not be confirmed.
- b) The placement rate for the Medical Assistant program was below benchmark for the last two full calendar years, at 66.67% (9 eligible/6 placed) for 2016, and 66.67% (21 eligible/14 placed) for 2017.
- c) The institution indicated in its ASER that, “for English program [sic], completion rate is not calculated. The student for English program has to maintain the attendance and exit exam for completer or non-completer to maintain completion and according that the student receive the official transcript and unofficial transcript. student attendance and exit exam for level change exam maintain similar way [sic].”
- d) The institution provided 23 placement verification forms for 2018, although the institution had 38 claimed placements through April 2018. 13 placements were indicated as part-time, with no part-time attestations. Placement verification forms were not dated to evidence verification occurred after at least 30 days of employment. The institution provided 11 placement verification forms for 2017, although the institution had 41 claimed placements for the year. Two placements were indicated as part-time, with no part-time attestations available. One student, [REDACTED], was indicated as both part- and full-time. Further, the institution lacked documentation for waivers and part-time attestations to validate placement rates, and forms did not consistently include job titles, methods of verification, and dates.

- e) The institution's Career Services Notice Boards contained 20 job postings, 18 of which were from a single day in May 2018. While the institution updated the Career Services board between the first and second day of the visit, this did not evidence an ongoing commitment to career services.

In its response, the institution provided policy document "Job Placement and Follow-Up Plan"; however, the document did not contain internal completion and placement policies that include responsible parties, methods for tracking completion and placement, and appropriate timeframes.

The institution stated in its response that the placement rate for the 2017 Medical Assistant program increased to 71.43%; however, no corresponding Document 28.2 or other supporting documentation was provided to support that assertion, as it is unclear what placements provided in the team report response are updates, as they are not labeled for ease of review by a third party, and corresponding Document 28.2s were not submitted to verify the student cohort data. Further, the institution's response indicated that "Admin did not record students over three-month time of placement [sic]", but the institution did not provide any explanation as to the significance of the three-month period of time, nor why the administrator failed to record the placements, or how the institution has addressed this issue through policy document "Job Placement and Follow-Up Plan."

In its response, the institution also provided a Document 28.1 – Completion and Placement Statistics for the 2018 and 2019 Intensive English Programs. The Document 28.1 provided for the 2018 Intensive English Program evidenced a 92.31% completion rate. The Document 28.1 for the 2019 Intensive English Program indicated that all 22 gross starts scheduled to graduate in 2019 transferred out of the program; however, the institution provided no narrative explanation in its response for the transfer out of these students. Neither Document 28.1 for 2018 nor 2019 was labeled according to the proper calendar year, which is determined by graduating cohort, not by program start date. No updated policies and procedures related to the verification of completion rates for the Intensive English Program were provided in policy document "Job Placement and Follow-Up Plan."

The institution further provided two PDF files of placement documentation labeled 2017 and 2018 and indicated that it corrected all placement verifications and attestations; however, as noted earlier, corresponding updated Document 28.2s – On-Site Verification Forms were not provided in the response. The institution was unable to demonstrate alignment between Document 28.1s- Completion and Placement Statistics, and Document 28.2s – On-Site Verification Forms, and as such did not evidence that placements and waivers are tracked according to ACCET Document 28 – Completion and Placement Policy. Additionally, verification dates on numerous placement documents submitted in the institution's response to the team report remain blank; 30 day verification was in some cases undated or illegible, placements did not all demonstrate training related employment, and no supporting documentation was provide to validate all waivers. The institution did not demonstrate that its policies and procedures for monitoring, tracking, and recording placements are sufficiently

adequate to validate completion and placements.

Therefore, the institution failed to demonstrate compliance with this standard.

It is noted once again with gravity that the institution misled ACCET by making false statements on its initial accreditation application. As referenced under Standard II-A Governance, in the institution's initial application to ACCET, and in its Analytic Self-Evaluation Report (ASER), the institution stated that it had never held, applied for, been denied or been withdrawn from previous accredited status. However, it has been established that under the institution's previous name (Institute for Health Education) it's previously-held accreditation with ACCSC was withdrawn in 2015. Additionally, the institution was denied "continued initial accreditation" with CEA in 2015. Furthermore, the institution indicated that it had applied for accreditation with ACICS but was no longer involved in that process. The institution then failed to disclose the reason for its inability to obtain accreditation with ACICS, whether that action was based on the withdrawal of that agency's recognition or whether it was the result of the institution's non-compliance. Providing untruthful information, in itself, provides grounds for denial of accreditation based on ACCET Document 2.1 Principles of Ethics for ACCET Accredited Institutions which states: "*In the accreditation process, an institution must provide the Commission with accurate, complete, and pertinent information, including reports of other accrediting, licensing, and auditing agencies. An institution's failure to report honestly by providing false or misleading information, including misrepresentation by omission, will constitute a breach of integrity and seriously jeopardize the institution's accreditation status.*"

Since denial of initial accreditation is an adverse action by the Accrediting Commission, the institution may appeal the decision. The full procedures and guidelines for appealing the decision are outlined in Document 11 - Policies and Practices of the Accrediting Commission, which is available on our website at www.accet.org.

If the institution wishes to appeal the decision, the Commission must receive written notification no later than fifteen (15) calendar days from receipt of this letter, in addition to a certified or cashier's check in the amount of \$8,500.00, payable to ACCET, for an appeals hearing.

In the case of an appeal, a written statement, plus six (6) additional copies regarding the grounds for the appeal, saved as **PDF documents and copied to individual flash drives**, must be submitted to the ACCET office within sixty (60) calendar days from receipt of this letter. The appeal process allows for the institution to provide clarification of and/or new information regarding the conditions at the institution at the time the Accrediting Commission made its decision to deny accreditation. The appeal process does not allow for consideration of changes that have been made by or at the institution or new information created or obtained after the Commission's action to deny accreditation, except under such circumstances when the Commission's adverse action included a finding of non-compliance with Standard III-A, Financial Stability, whereupon the Appeals Panel may consider, on a one-time basis only, such financial information, provided that all of the following conditions are met:

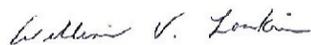
- The only remaining deficiency cited by the Commission in support of a final adverse action decision is the institution's failure to meet ACCET Standard III-A, Financial Stability, with the institution's non-compliance with Standard III-A the sole deficiency warranting a final adverse action.
- The financial information was unavailable to the institution until after the Commission's decision was made and is included in the written statement of the grounds for appeal submitted in accordance with the ACCET appeals process; and
- The financial information provided is significant and bears materially on the specified financial deficiencies identified by the Commission.

The Appeals Panel shall apply such criteria of significance and materiality as established by the Commission. Further, any determination made by the Appeals Panel relative to this new financial information shall not constitute a basis for further appeal.

Initial applicants are advised that, in the instance of an appeal following a denial of accreditation being initialized in accordance with ACCET policy, the institution may not make substantive changes to its operations, such as additional programs or sites, until a notice of final action is forwarded by the Commission.

It remains our hope that the accreditation evaluation process has served to strengthen your institution's commitment to and development of administrative and academic policies, procedures, and practices that inspire a high quality of education and training for your students.

Sincerely,



William V. Larkin, Ed.D.
Executive Director

WVL/cc/clr/mw/mcd/sb

CC: Mr. Herman Bounds, Chief, Accreditation Division, US ED (aslrecordsmanager@ed.gov)
Ms. Valerie Lefor, Accreditation Division, US ED (valerie.lefor@ed.gov)
Ms. Stephanie Zacniewski, School Approval Unit, NJ Department of Labor & Workforce
Development (stephanie.zacniewski@dol.nj.gov)
Ms. Rachel Canty, Director of External Operations, SEVP (rachel.e.canty@ice.dhs.gov)
Ms. Katherine H. Westerlund, Certification Chief, SEVP
(katherine.h.westerlund@ice.dhs.gov)