PREA AUDIT REPORT ☒ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: December 13, 2016

Auditor Information			
Auditor name: Maureen G. Raquet			
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Telephone number: 484-366-7457			
Date of facility visit: July 11, 12, 13, 2016			
Facility Information			
Facility name: Hilltop Supervised Independent Living Program			
Facility physical address: 205 Fogel Street, Hollidaysburg, Pa. 16648			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 814-946-5256			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Nancy Kukovich			
Number of staff assigned to the facility in the last 12 months: 16			
Designed facility capacity: 15			
Current population of facility: 13			
Facility security levels/inmate custody levels: Supervised Independent Living			
Age range of the population: 16-20			
Name of PREA Compliance Manager: Kim Peck		**Title:** Program Supervisor/PREA Manager	
Email address: kim.peck@adelphoi.org		**Telephone number:** 814-946-5256	
Agency Information			
Name of agency: Adelphoi Village			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 1119 Village Way, Latrobe, Pa.15650			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 724-840-7000			
Agency Chief Executive Officer			
Name: Nancy Kukovich		**Title:** CEO	
Email address: nancy.kukovich@adelphoi.org		**Telephone number:** 724-804-7000	
Agency-Wide PREA Coordinator			
Name: Jennifer McClaren		**Title:** Quality Assurance Director/PREA Coordinator	
Email address: Jennifer.mcclaren@adelphoi.org		**Telephone number:** 724-804-7000	

AUDIT FINDINGS

NARRATIVE

Adelphoi Village came into existence in 1971 when Fr. Paschal Morlino, a Benedictine monk, set out with a plan to open a home for boys. This program, which he called Adelphoi, is Greek for "my brothers for whom I am concerned". In 1978, foster care was added, followed by a private academic school in 1981. Today, Adelphoi provides an extensive network of community-based programs and services to over 1,200 youth and families on a daily basis. Group homes, foster/adoptive care, a charter school, in-home services such as multisystemic therapy, education programs, mental health services, secure care and other services overlap to provide a complete continuum of care to children, youth and families. In 2015, Adelphoi served 2,347 youth and families. Anchored by a 20-acre campus in Latrobe that includes a school building, administration building, three secure units, a substance abuse residential facility, two sex offender group homes, and a multipurpose recreational center, Adelphoi has program sites in over 30 counties throughout Pennsylvania. Construction on the main campus is ongoing with the building of a new residential facility and a office building for Mental Health staff. The counselors, teachers, and therapists, along with administrative and supervisory staff, make up a workforce of nearly 650.

Adelphoi Village is a component of Adelphoi U.S.A. The juvenile residential component is comprised of 22 group homes of which 5 are female, and the rest are male. These units are located in Westmoreland, Blair, Fayette, Lycoming, Somerset and Armstrong Counties in Pennsylvania. A previous Audit of the 6 units on the main campus was conducted in August 2014. A subsequent Audit of four off campus units was conducted in April 2015, five units in June 2015 and three units in April 2016.

This Audit was conducted at Hilltop Supervised Independent Living Program, 205 Fogel Street, Hollidaysburg, Pa, about 5 minutes from the city of Altoona, Pa. Two other residential units were also audited at this time. Hilltop is a 15 bed male supervised independent living program, with ages ranging from 16-20, and licensed under the Pa. Dept. of Human Services 3800 regulations. In 2015, there were 13 admissions and the average length of stay was about 4 months. On the date of the Audit there were 12 residents in this unit; including residents who have "stepped down" from other more secure or structured Adelphoi facilities. This is an open residential unit. Most of the residents have jobs and earn unsupervised community time depending upon their levels. Residents without jobs, and those in need of school credits, attend school at the nearby Williams facility and are transported there by staff. These residents can be either dependent or delinquent and are committed by their respective Juvenile Courts or as mentioned above transitioned from other agency facilities. The residents cook their own meals as part of a life skills curriculum and for most boys there is no set meal time. There are 16 employees assigned to Hilltop, and the transitional livng program at nearby Williams. Staff at Hilltop consist of line staff who are full and part time and work first and second shifts. Third shift personnel work permanent 3rd, with rotating days off. There is also a Program Supervisor and a Caseworker.

Adelphoi contracts with 64 of the 67 Counties in Pa. and infrequently has had children committed from Delaware, West Virginia, Maryland, Nebraska, and Ohio. Because Adelphoi Village offers both foster care and adoption services, children from 0-21 are served. Adelphoi is considered a juvenile treatment facility and has a large sex offender population. Adelphoi Village has undergone training in the Sanctuary Model over the past three years and received their certification last year. Sanctuary is the Organizational Culture and Philosophy at Adelphoi. Hilltop, as are all Adelphoi homes, is JCAHO accredited.

DESCRIPTION OF FACILITY CHARACTERISTICS

Hilltop is located on the corner of a main thorofare in an older residential neighborhood in Hollidaysburg, Allegheny Township, Blair County in North Central Pennsylvania. The town is served by the Allegheny Township Police Department. This two story, 6200 square foot former funeral home is owned by Adelphoi and was completely renovated in 2009 and sits on about 2 acres. It is situated on a very large and well landscaped and maintained corner lot. It has a driveway, shed and basketball hoop in the back of the building that is accessed from the side street. Its exterior is sided and fits well into the residential neighborhood. There are many doors in and out of this building, including an original front door with side lights. As you enter the side door, directly ahead is a large living area, with upholstered couches and chairs, a staff desk and a television and phone area. Off this area is a dining room with large tables and wooden benches and double doors that slide together to close. This area is also used for visiting. The kitchen is off to the side of the living room and has a pantry area. There is also access to the outside from here. To the right of the main area is the staff/admin area with a door between. There are two bathrooms on the first floor, one for staff and one for residents. The first floor has an open layout, so that all areas can be supervised from the main living area, including the open kitchen. The basement is accessible to residents and has storage and some recreational items, such as a pool table. There are several small rooms with no doors and a furnace room. The older open stairway is behind the staff desk and accesses the second floor, where there are five bedrooms: one quad, three triples, and one double. The rooms are furnished with wooden bunk beds or wooden single beds. The closets do not have doors and the residents have many belongings in the rooms due their employment. All rooms have doors and windows that open. Because of the work schedule, some residents are sleeping during the day and the doors are closed for that reason. There are two single bathrooms with a sink, toilet and shower tub combo. There is no attic access. There are no cameras in the facility. There is a "Guard Tour System" for both room checks and checks of the outside of the building. However during the time of the onsite tour it had not yet been activated. Staff desks and midnight posts are in the second floor hallway. This facility has more of a home type atmosphere rather than a correctional one to fit into the neighborhood and to prepare the residents for independent living.

SUMMARY OF AUDIT FINDINGS

A notice of the onsite Audit was posted in Hilltop home on May 25, 2016. A picture of the posting in several common areas was emailed to me. The flash drive containing the completed Pre-Audit Questionnaire and required important documentation was received in my PO Box on May 31, 2016. Emails and Phone calls were conducted during this pre-audit period to clarify the information received. The on-site portion of the audit was conducted on July 11,12,13,2016, in conjunction with Audits of 2 other Units. An additional staff person, trained and contracted by the Auditor, was used to help conduct interviews of both residents and random staff. The Audit commenced with a brief entrance interview with the PREA Coordinator, Program Director, Program Supervisor and Caseworker. The tour of Hilltop took place on July 11, 2016, immediately after this preliminary meeting and the tour of Williams (another facility being audited diuring this time). Several residents were present in the living room and several were sleeping on the second floor having worked midnight shift.

During the tour, I saw several areas where the Audit itself was posted. I also saw postings for Reporting Sexual Abuse and Sexual Harrasment, Blackburn Center postings, Zero Tolerance Postings and First Responder Duty Postings. I spoke to residents and staff about Reporting and Unannounced Rounds. I toured all common areas that the residents have access to and all bathrooms, and bedrooms, although I refrained from entering bedrooms where residents were sleeping, instead viewing the room from the doorway. The area used for visitng is also the dining area and had reporting posters in both English and Spanish. Interviews of both staff and residents were conducted on both July 11 and 12 at both Williams and Hilltop homes. The residents who do not have jobs attend school at Williams and are transported there by staff. Accomodations were made to interview both third shift staff and residents who worked all three shifts. There is no common meal time because of the resident work schedule and the independent living aspect of the program.

Residents have several means to contact independent agencies to report instances of sexual abuse and/or sexual harassment. One is a "Hotline" to the Blackburn Center, a 24 hour hotline for crisis support and a Rape Crisis Center. There is a dedicated button on the phone that goes directly to a crisis counselor at the Blackburn Center. The phone is located in the living area and the Caseworker office. During the tour, a resident showed me how and where to use the phone and I spoke to the Blackburn Center on the other line. This information is included in the PREA Orientation resident handbooks and is given to the residents during Intake. There is also an age appropriate video watched by the residents during Intake. Also posted are the numbers for Child Line, another 24 hour reporting line run by DPW for any sort of alleged abuse. Additionally, addresses were posted for the Blackburn Center directly above the Phone. I spoke to a staff person at the Blackburn Center prior to the on-site Audit and they stated that they would offer phone services as described in the MOU,but because of the physical distance of this group home, they would not be able to accompany residents to the hospital, or accept reports. They provided Adelphoi staff with contact information for other PCARs that could offer these services. An MOU was in the process of being obtained from this other agency. When this is done, this information will be provided to me and I will contact them. The new reporting information will be disseminated and posted and follow up will be conducted to ensure that the residents and staff are aware. Copies of postings will be sent to the Auditor. Residents also have a grievance process for reporting.

As part of the on-site portion of the audit, ten residents were interviewed, this represents 83% of the total population on that date. There are 12 line staff and of those, three were not available so nine random staff from all three shifts were interviewed, including one phone interview. This represents 75% of the direct care staff. A teacher and dietary staff were also interviewed, because they serve both Hilltop and Williams residents, although they are physically located at Williams. Interviews were conducted by phone with the President of Residential Services, the Human Services Director, a volunteer for the agency and a contractor. In person interviews were conducted with the PREA Coordinator, Vice President of Residential Services, the Program Director, the Program Supervisor/PREA Manager, Caseworker, Director of Nursing and the Masters' Level Mental Health Therapist from another facility who conducts screens at Hilltop. The two and only staff assigned to the transistional living program at Williams, a program supervisor and caseworker were interviewed, because they are Hilltop employees. They conduct unannounced rounds and complete both PREA Education and the Vulnerability Assessment at the Transistional Living Program at Williams. This program was included in the Williams audit becausue it is physically located at Williams.

There are no Medical or Mental Health Staff in the facility. Physicals are conducted by a physician in the community. Medications are self administered and supervised by staff. Mental Health Screeenings are conducted by a community professional or Adelphoi staff from the main campus or another facility. Forensic Medical Exams are conducted at UPMC Altoona where there are SAFE/SANEs. The Director of Nursing for Adelphoi was interviewed to confirm all Medical and Mental Health arrangements. She confirms that the residents are offered forensic exams free of charge and that a SAFE/SANE in the above facility would conduct them.

There have been no allegations of sexual abuse or sexual harassment in the past 12 months.

Ten current resident files and two files of discharged residents were reviewed. Ten staff files were reviewed for documentation for various standards. There were no Transgender or Intersex resdients but there was one resident who identified as Bi-sexual and three who disclosed a prior sexual abuse in the population at Hilltop during the time of the on-site Audit. They were all interviewed.

Upon completion of the on-site portion of the Audit, on July 13, 2016, an exit interview was conducted with 10 Administrators and upper level staff in person and by conference call. Requested additional documentation for the following standards must be submitted to the Auditor for verification within 60 days of this Interim Report.

Standard #313 requires random unannounced rounds to be conducted on all shifts. A new supervisor has started to conduct these rounds, but there were not sufficient 3rd shift checks documented over a period of time to meet this standard.

On 10-10-16, I received logs of random unannounced rounds being consistently conducted on all three shifts. This log represents 60 days of rounds and meets the standard.

Standard #321 Evidence Protocol and Forensic Exams requires an MOU with a PCAR for a victim advocate or documentation of efforts to obtain one. This is an open time line and is currently being worked on by Adelphoi Staff. When obtained the Auditor will contact the PCAR and verify services.

On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Hilltop with the name and address of Family Services for reporting and

Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Hilltop and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports (Family Services) and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone. He did so and I could hear him and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met.

Standard #322 requires posting on the website of the policy ensuring that allegations of sexual abuse are referred to an agency with the legal authority to conduct such investigatons and shall describe the responsibilities of both the agency and the investigating entity. The website currently lists the Pa. State Police, which is the investigating entity for most of the Adelphoi facilities. It needs to be updated to include the Allegheny Township Police Department.

On 11-3-16, I received a copy of the updated website and it now includes the revised reporting information and which agencies to call. This has been verified and this standard has been met.

Standard #342 requires documentation of risk based housing decisions and although during the tour I was shown where residents who are identified as vulnerable or aggressive may be housed, there was insufficient documentation of such. Documentation of Risk based housing decisions for 60 days of new Admissions is required to meet this standard.

On 1 1-10-16, I received a log of four new admissions or transfers. All four of these residents scored in the "aggressive" range of the Vulnerability Assessments, because this is an independent living program or "step down unit" for other Adelphoi facilities that may house sex offenders. The four residents all had prior offenses that placed them in this category. On each of the VAIs, a risk based housing decision was noted, that this resident was aggressive due to a prior offense, so when considering housing, they were placed in bedrooms that did not include a resident who would match the victim profile. This information was documented and provided to me.

This standard has been met.

Standard #351, Resident Reporting allows for reports to Child Line which meets the requirement for an outside agency, but the "hotline" has been and will be the reporting method of choice. When the MOU with the new PCAR is obtained, both staff and residents must be advised of this change and postings must be changed. The dedicated phone button will also be re-programmed. The procedure will not be affected by this. The Auditor will contact the PCAR and will interview staff and residents to confirm. Pictures of the new postings will be provided to the Auditor. This is an open timeline based on the procuring of the MOU.

On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services, who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Hilltop with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Hilltop and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone. He did so and I could hear him and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met

Standard #354 Third Party Reporting requires public dissemination through the website on who to report to. This needs to be updated to include the Allegheny Township Police Department and the Local women against Rape.

On 11-3-16, I received an email with updated website information. It includes the revised information for Allegheny Township Police Department. Blackburn center is still accepting "hotline calls" and referring them to the local PCAR, because an MOU has not yet been obtained. This standard has been met. On 11-23-16, I received a copy of the MOU with Family Services of Altoona. They will receive reports and this information is listed on the website and verifired by the Auditor. This standard has been met.

All other Agency Policy and Procedure comply with standards.

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a PREA Coordinator and the facility has a PREA Manager. I interviewed both during the on site portion of the audit. They both state that they have the time and resources to fulfill their PREA responsibilities. There is a PREA policy that has been submitted and it includes the definitions of sexual abuse and sexual harassment as well as the agency's approach to preventing, detecting, reporting and responding to such. The position of PREA Coordinator is on the agency organizational chart and each of the facilities has a PREA Manager who is the supervisor of that facility.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Adelphoi Village does not contract with any other agencies to care for their residents. This standard does not apply.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy requires minimum staffing of 1:8 and 1:16 and must take into account all variables in the standard. I interviewed the President and Vice President of Residential Services, the PREA Coordinator and PREA Manager/Supervisor of Hilltop. All interviewed state that the PREA Requriement of a Ratio of 1:8 and 1:16 are always exceeded. This is a Supervised Independent Living Program and by Pennsylvania

3800 regulation does not require the above ratio, but does adhere to it. There are always two staff on midnight shift and three staff, not including the supervisor and caseworker, on the awake shifts. A schedule is prepared and posted for a two week period, but is reviewed daily to meet "one on one" supervision of residents, if needed, and other needs of the population, such as transportation to jobs and appointments, or to get a driver's license. A copy of this schedule was provided to me. A Facility Vulnerability Assessment is conducted yearly and this includes the physical plant as well as staffing needs. This Assessment was provided to me as an upload during the pre-Audit period. There have been no instances of not meeting ratio. Mandatory overtime is used if necessary according to the President of Residential Services. I reviewed the most recent Licensing and Inspection Summary from the Pa. Dept. of Human Services and there were no citations for not meeting ratio. These residents do not have a standard mealtime due to employment, but I did see 5 residents in the living room during the tour and there was one staff present in the room with them. There are no cameras in this facility. A Guard Tour system was in the process of being installed during the onsite Audit. Unannounced rounds are random and are conducted on all three shifts by the program director and the facility supervisor. The logs of these rounds were provided to me. The rounds are not consistent and had only three third shift checks in the past three months. A plan of correction requiring random, unannounced, logs of all three shifts for 60 days must be provided to comply with this standard. Onn 101-10-16, I received logs of random unannounced rounds being consistently conducted on all three shifts. This standard has now been met.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Search Policy prohibits any strip or body cavity searches. Cross gender pat down searches are also prohibited. Nine random staff were interviewed and they all stated that cross gender pat down searches are prohibited. They also stated they had been trained in the Transgender and Intersex Search policy, but had not yet had to utilize it. They could all answer affirmatively that they were aware of the policy prohibiting the search of a Transgender or Intersex resident for the sole purpose of determing that resident's genital status. There were no Transgender or Intersex residents in the population. All 10 residents interviewed stated that they had never been subject to a cross gender pat down search. They also stated that the one female staff person announces her presence when coming into the bedroom/bathroom area on the second floor and they are able to change clothes, shower and use the toilet without being viewed by a staff person of another sex. I saw during the tour that this female staff person knocked on a bedroom door and announced who she was before opening it. There is one toilet, sink and shower in each bathroom and all residents shower alone. The PREA Policy contains all necessary information and the random staff were able to answer questions about it during their interview.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There were no residents with disabilities, nor any residents who do not speak English. A non-English speaking child would not be admitted

because the child would be unable to participate in the program. It is more likely that parents may not speak English, and a contracted translator would be used to communicate with those parents. A copy of the contract was provided. Spanish and English PREA posters were throughout the house, including the dining room which is used for visiting. The Adelphoi Policy does make accomodations for residents with both physical and intellectual disabilities on a case by case basis. I confirmed this when I interviewed the President of Residential Services. Policy meets standard.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Director of Human Resources, by phone, having interviewed her less than two months before during a previous audit. She confirmed the Hiring and Promotion Policy that was provided to me. Both Adelphoi Policy and the Pa. Child Protective Services Law require a Child Abuse Clearance, a Criminal History Check, and a FBI clearance prior to employment. Adelphoi Policy requires that these be conducted every two years. Both the employment application and the personal interview ask whether the person applying has ever been arrested for any of the enumerated offenses listed in PREA Policy. The employee has an ongoing duty to report any such arrest after employment. I reviewed the files of 10 employees at Hilltop, including one recent promotion and two recent hires. All but one file had all clearances prior to employment. That one file had the Child Abuse Clearance and Pa. Criminal History Check, but did not have the FBI clearance until two months after beginning employment. The facility was cited by Pa. Bureau of Human Services Licensing for this omission during their annual inspection. Those staff who were employed longer than two years, all had additional clearances done in a timley manner. I saw a file for a contractor and volunteer and saw that both had the required clearances. During an interview with the HR director she stated she had just been asked to and did disclose an indciated sexual abuse against a former employee who was seeking employment. Although there was one exception, the majority (9/10) random files had all clearances conducted in a timely manner. This standard has been met.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no renovations or additions to this facility since 2009. A Guard Tour system is in the process of being added to the bedroom area. The software for this technology was received during the onsite portion of the Audit. This allows for 10 minute checks of each of the rooms. These checks are downloaded onto a computer and randomly checked by supervisors. I also interviewed both the President and Vice-president of residential services who discusssed the added security and safety that is paramount when considering any renovations.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Adelphoi is in the process of procuring a MOU with UPMC Altoona to perform forensic exams. SAFE/SANES are available at this ER and are also on call. I interviewed the Director of Nursing who confirms that forensic exams are provided at UPMC Altoona free of charge for the residents. Without the MOU, the requirement for SAFE/SANEs has been met and confirmed by the interview with the Director of Nursing. There is an MOU with the Allegheny Township Police Department to conduct Sexual Abuse Investigations and Adelphoi has requested that they follow the protocol outlined in this standard. This MOU was provided to me during the onsite portion of the Audit. There is also an MOU with the Blackburn Center, a PCAR, to provide victim support and crisis services. However, when I contacted Blackburn prior to the Audit, they stated that even though they had agreed to provide all services to all Adelphoi facilities, they would be unable to provide a victim advocate to accompany a resident to a forensic exam or during police interviews that is required in the standard because of the physical distance of the this facility. Blackburn gave to Adelphoi the name and contact of a local PCAR. Adelphoi is obtaining an MOU for all services and this will be submitted and then verified by the Auditor through a phone interview with the PCAR. This part of the corrective action plan has an open time line. Adelphoi staff are working on obtaining this. Although several upper level staff have received investigator training, they do not conduct investigations. They gather enough information to contact the Police and Child Line, and to keep the resident safe. They conduct an administrative incident review after the fact. I also interviewed the PREA Manager/Supervisor of Hilltop, who confirmed her knowledge of the MOUs and necessary procedure. Policy meets standard.
On 9-27-16, I received an MOU between Adelphoi and Altoona UPMC to conduct forensic examinations for th residents of Hilltop.
On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services, who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Hilltop with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Hilltop and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone. He did so and I could hear him and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

The PREA Policy and the Pa. CPSL require all staff with any knowledge or suspicion of Sexual Abuse or Sexual Harrassment to report to Child Line, under penalty of law, and the Adelphoi Policy requires also reporting to a supervisor and documenting the incident. All staff receive Mandated Reporter Training as part of their orientation. Interviews with 9 random staff confirm that they know both the policy and the law. One staff stated, "I would Child Line and then call my direct supervisor". Posted on the Adelphoi website is the Policy that all incidents will be referred to the State Police for investigation. This needs to be updated to include reporting to the Allegheny Township Police for this facility and also needs to include the new PCAR and its number to report. This revision should be completed once the new PCAR MOU is obtained, so this is an open ended timeline for the plan of correction. I interviewed the President of Residential Services and he confirms that the policy and procedure are followed. There have been no allegations of sexual abuse in the past 12 months at Hilltop. On 11-3-16, I received a copy of the updated website and it now includes the revised reporting information and which agencies to call, including the change to Allegheny Township. Also included on the website is the contact information for Family Services of Altoona, who will receive reprts. This has been verified by the Auditor. and this standard has been met.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The employees have all received the training required by the standard at orientation and then every year as a refresher. The refresher had just occurred in March 2016, four months prior to the Audit. The curriculum is a on line training and a power point that was provided to me. A review of the curriculum shows that it includes all 11 areas that PREA requires for employee training. The employees test out, demonstrating their understanding of the material. If they pass the test their name is added to the training log, if they don't, they are not included as having received training. A log of employee training was provided to me during the onsite. Nine random staff were interviewed and they could all discuss their first responder responsibilities, mandated reporting, and the agency's policy and procedure on preventing, detecting, reporting, and responding to incidents of sexual abuse and harassment. The policy indicates who must receive training, what the training will entail and when training will be received, both at orientation and refresher training.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed by phone both a HVAC contractor who does work at Hilltop and a church volunteer from the Main Campus. There are no

volunteers at Hilltop. When I interviewed them, they both stated they had received a pamphlet with information regarding the zero tolerance policy and mandated reporting. The brochure was provided to me. The amount of education is commensurate with the amount of time they spend with the residents. I saw sign offs in both a contractor and a volunteer file that they received and understood the training. When I interviewed them, they told me what information was in the training and how and who they could report to. The policy meets the standard.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Caseworker from Hilltop. He is responsible for conducting the Intake and providing information to the resident during the Intake. This information was in reference to the agency's zero tolerance policy on sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment. He is also responsible for conducting the education that must occur within 10 days of Intake. He detailed to me when and how they do this and all education is usually done at the same time at Intake. He showed me the information that is given to the resident at Intake, along with a Child's Rights' form and information on the grievance procedure. The video that is viewed by the residents was obtained from the Moss Group and is entitiled "Safeguarding your Sexual Safety". Ten residents were interviewed and all stated they received the appropriate information at Intake and then more comprehensive education within 10 days, but usually all of it at Intake. These cooperative residents were able to answer most of the questions candidly and were able to demonstrate that they not only received the education but understood it. Of the twelve files I reviewed, 10 active and twelve discharged, all residents had received all education on the same day as their Intake. Several of these residents were transfers from other Adelphoi facilities and per policy were educated again upon transfer to Hilltop. All resident files had a signed acknowledgement of receiving the necessary and timely education. Ongoing education was available through posters and pamphlets throughout the Hilltop home.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Adelphoi Staff do not conduct investigations. This is done by the Allegheny Township Police Department and Child Line. The law prohibits a facility to conduct an investigation prior to Child Line conducting one. Staff gather enough information to establish that a report is necessary and to provide a protective action plan for the resident. An Administrative investigation will be conducted after the police and Child Line conduct their investigation as part of a sexual incident review. Several administrators received investigator training as part of a "best practice" but do not conduct investigations. Policy confirms the staff role as described above. This standard does not apply.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There are no medical staff assigned to this facility. All Medical and Mental Health care is obtained in the community at a doctor's office. Emergency care is received at UPMC Altoona. I interviewed both the Director of Nursing and a Master's Level Mental Health Therapist from another facility. Both stated they received the PREA training that all employees receive, but also receive additional training as delineated in the PREA Standard through Adelphoi and through outside resources. All residents sign a consent form at Intake regarding mandated reporting, but both the nurse and therapist always advise a child of their mandated reporter roles prior to the initiation of services and then again if they have to report. Both state that they have reported incidents that have been disclosed to them, but have occurred either in the community or another institution. I saw training logs for all Medical and Mental Health staff. The PREA Policy outlines what training is necessary for any Medical and MH staff.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Caseworker for Hilltop who administers the Vulnerability Assessment during the Intake process. He states that he uses the questions on the instrument as well as information provided by the Probation Officer or Caseworker, information from previous placements, transfer information, a child's charges and a phone interview with the parents to complete the Vulnerability Assessment. He states that this is completed within 72 hours of Admission and most times is conducted right at Intake. Review of 10 current resident files and 2 discharged files show that this was done in a timely fashion in all cases. The file review showed that residents who are transferring to Hilltop from other Adelphoi facilities are having this done upon transfer and it is also being done at six month intervals for the three files I reviewed where the resident had been there over six months. The Vulnerability instrument itself is a commonly used one that takes into account prior victimization, prior aggressive sexual acts, physical factors, such as small stature, any disabilities, a problem with bullying in the past, prior institutionalizations and other important variables. The answers are scored to see if any or all of these factors identify a child as vulnerable or aggressive. The Policy states that this assessment must be conducted within 72 hours of intake and that the information is confidential. I saw where the resident files are kept. Only staff who supervise the residents have access to this information. The confidentiality was confirmed during the interview with the PREA Manager.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Use of isolation is prohibited by Adelphoi Policy and by the Pa. Department of Human Services 3800 Regulations. I observed no area during the tour where a child could be isolated. Interviews with both Medical and Mental Health staff, the PREA Coordinator, and PREA manager confirm that isolation is never used. I interviewed the Caseworker who administers the Vulnerability Assessment. He does this within 72 hours of Intake. He states that the information is used to determine housing assignments. I saw documentation for a resident who scored as vulnerable and it stated that "bedroom was to be in staff eye sight".I saw this room when I toured the facility. There was one resident who identified as bisexual and during the interviews and he answered "no" when asked if he was discriminated against or housed because of his sexual orientation . There were no transgender or intersex residents in the population during the Audit. However both the PREA Manager and PREA Coordinator state that there is no pre-determined housing for an LGBTI resident and that they would take into account that resident's concerns regarding their health and safety before assigning a room. All residents shower separately. I saw the single bathrooms during the tour. I reviewed 12 resident files for documentation of risk based housing decisions. Of the 12 files, 8 required documentation and only one file contained the required documentation. Discussions with the PREA Manager and the Caseworker revealed they do discuss room placement, but it is not documented anywhere. A plan of correction requires that sixty days of admissions be submitted with documentation of risk based housing decisions for those residents that require it.
Corrective Action:
On 10-10-16, I received a log of 4 new admissions/transfers who have been admitted to Hilltop since the date of the onsite portion of the Audit and the Vulnerability Assessment for all four. All of those residents had a Vulnerability Assessment conducted within 72 hours of admission. One resident was identified as both vulnerable and aggressive and consideration for his housing assignment was documented for both his protection and that of the other residents. The other three admissions also were identified as aggressive because of their prior offenses. Because all these residents have been through treatment and they are in a "step down" supervised independent living program, the consideration for their risk based housing was documented.
This standard has been met.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy dictates that a resident can report verbally, in writing, anonymously, and through third parties. The 10 residents that were interviewed were able to communicate that they understood this. They stated there was a phone in the staff office and the living area with a dedicated button that went directly to the Blackburn Center. There were also posters with addresses for the Blackurn Center and phone numbers for Child Line posted throughout the facility. Residents can use a grievance form to report and they receive and sign off on grievance information at Intake. This grievance sign off was in the 10 current resident files and the three discharged resident files that I reviewed. Residents also stated that they felt comfortable reporting to a staff person or could go to the caseworker or supervisor. They also have access to parents by visiting once a week, phone calls from parents or grandparents twice a week and confidential communication with their attorneys. These residents also have unfettered communication in the community when they are at their place of employment. They also earn unsupervised community time where they can go out into the neighborhood for one or two hours. All possible avenues for reporting have been made available to the residents and they know of them. Nine random staff were also interviewed as well as the PREA Manager. All had been trained on how to accept and document reports and how the residents could report. During the tour, I saw and used the Blackburn phone and also saw pencils available for written reports. Although Child Line is an outside agency that will accept reports, the "Blackburn Center" phone line is the one that is posted and the residents know. During the pre-audit period, I contacted the Blackburn

Center and they stated they do have an MOU with Adelphoi for all its facilities and will provide emotional support, education, training, etc, but because of the physical distance to Hilltop would not be able to provide a victim advocate and would have to either "pass on" a report or provide an phone number to the local PCAR. Blackburn has provided the name of a local agency and Adelphoi staff are in the process of procuring an MOU, so that the local agency can receive reports. When this is done, the postings and designated button will be changed. Both staff and residents will be educated and the Auditor will verify through interviews and documentation that this has been done. The timeline for this plan of correction is open ended and is determined by the ability to get the MOU.

On 11-23-16, I received an MOU with Family Services of Altoona, a member of the Pennsylvania Colalition Against Rape. I called and spoke to the Director of Family Services, who confirmed all services outlined in the MOU, including crisis services such as providing a victim advocate, providing information and referrals. On 11-30-16, I received pictures of the postings at Hilltop with the name and address of Family Services for reporting and Victim Support Services. I also received documentation of the training for staff and the education of the residents with the change in information. On 12-13-16, I called Hilltop and spoke to the Supervisor who advised me that the posters throughout the facility had been changed, the Hotline button re-programmed and the staff and residents educated as to the change from Blackburn Center to Family Services for receipt of reports and for victim's services. I interviewed two staff who could tell me who would receive reports and that they were educated as to the change at a staff meeting within the past two weeks. I also interviewed two residents, and both could tell me the posters had been changed, the "hotline" button re-programmed and labeled. They stated that they had been educated as to the change within the past two weeks. One resident read the poster to me in the office where he was being privately interviewed on the phone. Another resident also could tell me of the changes. I asked him to use the hotline while I was on the phone. He did so and I could hear him and he returned to the phone and he told me it went directly to Family Services.

After receiving the MOU, speaking to the Director of Family Services, reviewing documentation and re-interviewing two residents and two staff, the provisions of the standard have been met.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA policy provides for a grievance process to be used if desired to report Sexual Abuse and Sexual harassment. The Pa. Department of Human Services 3800 regulations requires a grievance process and notification to both the resident and their parents at Intake. There were sign offs of notification of the grievance process in the 12 resident files reviewed and no citations on the most recent BHSL Licensing and Inspection Summary for not providing this information. There is no requirement for a child to use this process to report. Reporting is more likely to utilize the many other means. The necessary timeline as well as the provision for an emergency grievance process is in policy. There have been no grievances reporting sexual abuse or sexual harassment in the past 12 months.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

I interviewed the Vice President for Residential Services and the PREA Manager/Supervisor for Hilltop. They both could tell me that the policy allowing parental visiting once a week, incoming parental phone calls twice a week and confidential calls or visits from attorneys was also practice. The 10 residents that were interviewed also stated they could and did receive visits and phone calls. They also stated they could contact their attorneys but most had not. The residents could talk about the posters with phone numbers and addresses for Victim Support throughout the Blackburn Center and where the phone was located in the living area and in the staff office and about the designated button to access the support. Some residents were clear about what kind of services these were, and some had to be cued during the interview to remember. While on the tour of the facility, I saw the posters with the information throughout the house, saw and used the phone. Prior to the on-site portion of the Audit, I received a copy of the MOU with the Blackburn Center outlining its services and I called and spoke to the Director, who verified that these emotional support services in the MOU were in effect, although they could not take a report or provide a victim advocate for the Hilltop residents. Blackburn has provided to the agency the name and contact information for a local Women Against Rape, who can and will provide a Victim Advocate. When a MOU is obtained the Auditor will verify the services contained in it with the PCAR. This is an open ended timeline for the plan of correction because of the outside agency. Residents are aware that these services are confidential, but there is a mandated reporter exception. There were no residents in the current population who had reported a sexual abuse.
On 11-23-16, I received an MOU with Family Services of Altoona. I called and spoke to the Director of Family Services, who confirmed the emotional support services outlined in the MOU. Although these services were offered through the Blackburn Center, they are now consolidated with the reporting services through Family Services of Altoona. All postings have been changed to include the new contact information. On 12-13-16, I interviewed by phone, the Hilltop supervisor, two random staff and two residents that I had previously interviewed. All confirmed their knowledge of this change. This standard has been met.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The policy states that the facility will provide a means to publicly disseminate information for third party reporting. The website, www.adelphoi.org contains the appropriate information, describing the Pa. State Police as the investigative agency and the appropriate contact person at Adelphoi to report to either by email or by phone. The website also lists the Blackburn Center with a phone number and address as a reporting resource. This website needs to be updated to include the Allegheny Township Police Department and the local PCAR.This is an open ended timeline for the plan of correction due to the need to obtain an MOU with an outside agency.
The website has been updated to include reporting information for the Allegheny Township Police Department and Family Services of Altoona with whom there is an MOU. This has been verified by the Auditor. This standard has been met.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Both the PREA Policy and the Pa. Child Protective Services Law require mandatory reporting. All staff receive Mandatory Reporting training as part of their orientation. All nine random staff interviewed were able to describe their responsibility, as were the Medical and Mental Health Staff that I spoke to. I interviewed the Vice President of Residential Services and the PREA Manager. They both could state that, in addition to Child Line, the facility would also notify the parents, legal guardians, Probation Officer, Caseworker, and the attorney of record, if there was one. This is a Pa. DHS requirement that requires notification via a HCSIS report. The agency only performs administrative investigations. However, a supervisor is always notified immediately as per policy. There have been no allegations of sexual abuse or sexual harassment in the past 12 months.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the President and Vice President of Residential Services and nine random staff. The Administrators state that the policy requires the immediate action by staff to protect a resident from imminent sexual abuse. This can be accomplished by moving the resident to another facility, placing the child in a different bedroom, always putting a safety plan into effect or suspending or transferring a staff person. The PREA policy requires immediate action. All staff interviewed could describe appropriate actions that they would take immediately. There have been no reports of immenent sexual abuse in the past 12 months.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PREA Policy requires that if Hilltop receives a report from a resident that he was sexually abused at another facility, Adelphoi will contact the head of that facility within 72 hours and will notify Child Line. If Hilltop receives a report from another facility that a child alleged sexual abuse while at Hilltop, a Child Line report will be made immediately and an investigation will commence. Both instances are reported to Child Line and documented. I interviewed both the President and Vice President of residential services who confirm that they would be the designated point of contact for a report from another agency. There have been no incidents of this in the past 12 months.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy and the Staff Training specifically delineate the staff first responder duties. Most of the 9 random staff could cite all responsibilities without being prompted. All staff could agree that they knew and understood the agency's protocol for collecting usable physical evidence, which is to secure the scene and to let the police gather that evidence and to provide medical services to the resident and not to let them shower or change clothes. The separation of the victim and his well being was cited as being of the utmost importance. The first responder duties are posted in the staff office. There have been no incidents in the past 12 months that have required staff to respond.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy and the Adelphoi Policy and Procedure manual describe a coordinated response for incidents of sexual abuse as well as other incidents. Nurses, line staff and administrators all play a role in this response. There have been no incidents in the past 12 months that have required a coordinated response. However, interviews with the Director and PREA Coordinator confirm that if there was an incident there would be a coordinated response as described in the policy.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There is no union representation or collective bargaining agreement. I interviewed both the Human Resources Director and the President of Residential Services, who stated that the Adelphoi Policy and the PREA Zero Tolerance Policy preserves the ability for the Agency to protect residents by being able to transfer or suspend abusers pending the outcome of the investigation.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the PREA Coordinator and the PREA Manager. The PREA Manager is the Hilltop Supervisor and she is present in the facility full time. She is responsible for protecting residents from retaliation and when interviewed she was able to tell me what signs she would look for and what actions she could take, including moving/transfering both staff and/or residents if need be. If a staff was involved she would include Human Resources and if a resident was involved, she would initiate contact and monitor for length of stay if need be. The policy states monitoring can continue for up to 90 days. I also interviewed both the President and Vice President of Residential Services and they also described actions that could be taken, including disciplinary acitons against staff up to and including termination. There have been no incidents of retaliation in the past 12 months.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Adelphoi Policy and the Pa. Department of Human Service 3800 regulations prohibits use of isolation. All administrators and Medical staff interviewed state that there is no use of isolation. A tour of the facility confirmed that there is no area where a child can be isolated. This standard does not apply.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

There is an MOU with the Allegheny Township Police Department and mandatory reporting to Pa. Child Line. Both of these agencies conduct an investigation of any allegation of sexual abuse. It is outlined in both PREA Policy and Adelphoi Polcy as to what the responsibilities are for agency staff in conjunction with an allegation of abuse or harassment. Although several staff have received investigator training, their role is limited to gathering enough information to report to Child Line and the PSP as well as ensuring the child's safety by implementing a protective action plan. Policy requires that they cannot interfere with a Child Line investigation. Interviews with the PREA Coordinator, the PREA Manager and the COO indicated that they would and do cooperate with the Police Department and Child Line for all investigations and perform administrative investigations after the fact that look at factors such as the physical plant, policy, etc, as a form of incident review. Most of the provisions of this standard are the jurisdiction of the Allegheny Township Police Department and the Blair County District Attorney's Office.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The evidentiary standard of preponderance of the evidence is in the PREA Policy and meets the standard . However, agency and/or facility staff do not make determinations of substantiation; this is the jurisdiction on Child Line and/or the District Attorney.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

PREA Policy contains all necessary procedures to meet this standard. I interviewed the President of Residential Services and he states the procedure is followed. In the event that Child Line completes an investigation, a letter to both the resident and the facility is sent advising them of the outcome of the investigation. If the police department is involved, an ongoing and cooperative relationship with the facility allows administrators to communicate with the police and obtain information regarding an investigation and they would notify the resident, parents and committing agency. There have been no incidents in the past 12 months that have required notification of a resident.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents in the past 12 months that have required any staff discipline. I interviewed both the President of Residential Services and the Director of Human Resources. Termination is the presumptive disciplinary sanction for a staff person who engages in sexual abuse. The Pa. CPSL prohibits a staff person to have contact with children if they are found to have engaged in sexual abuse. Other sanctions for lesser violations are commensurate with the action and are on a case by case basis taking into account an employee's disciplinary history. The Adelphoi Policy contains all verbiage required by the Standard and by Pa. CPSL.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents in the past 12 months involving contractors or volunteers. The Policy requires immediate removal of a contractor or volunteer from contact with children in the case of an allegation of sexual abuse or sexual harassment. The President of Residential Services states that they would not be permitted at any facility and that their parent agency and Child Line would be immediately notified. This would not be treated any differently than if it were a staff person. Pa. CPSL requires the same action. PREA Policy meets the standard.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents of disciplinary sanctions against residents who have falsely reported in the past 12 months. Both PREA Policy and the Pa. Child Protective Services Law does not allow for any disciplinary sanctions for a report made in good faith.
In the event that there was an incident, the child's mental health, intellectual level, and age would be taken into account, when determining what sanction would be appropriate. Previous sanctions for similar incidents by other residents are considered, so that discipline would be

consistent. Most times the Court and Probation Department would determine whether a resident would be permitted to stay in the facility according to an interview with the President of Residential Services. Agency policy and regulation does not permit consensual sexual activity between residents. In the case of sexual activity between a resident and a staff person, the resident would only be disciplined if the staff person did not consent.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All residents that have reported a previous sexual abuse or who have perpetrated a sexual abuse are offered medical and mental health assessments within 14 days of being identified. This in the PREA Policy. I interviewed the caseworker who completes the Vulnerability Assessment and he states that he ensures that follow- up is offered. I interviewed both the Director of Nursing and a Mental Health Therapist who stated that an assessment/physical is done on every child within 14 days and that a MH assessment can be completed by a therapist or a psychiatrist during that time frame. A signed consent is obtained from the resident at Intake and both the Medical and Mental Health care staff state that they advise the resident prior to the initiation of services and again if they have to report. I reviewed the files of 10 current residents and 2 discharged residents. Of those, three residents reported a previous sexual abuse. Although during the interviews they stated they declined the follow up that was offered, the file of one resident showed he did accept and received a Mental Health Assesment the day after Intake. Another resident, who had disclosed a prior sexual abuse, stated he was offered a Medical or Mental Health follow up but he declined it, because he had dealt with it at previous placements. Of the 12 files I reviewed, three did not warrant a Medical or Mental Health follow up, 6 residents declined and it was documented, one accepted as described above and two did not have documentation. There is enough evidence that this standard is routinely and consistently followed.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents that required emergency medical or mental health services. There were no residents to interview who reported a sexual assault. Alll emergency care, including forensic exams and emergency psychiatric evaluations would be received at UPMC Altoona. The Director of Nursing and the Mental Health Therapist both stated that they believe the level of care that the residents receive is better than if they were home, because of consistency and follow up and is free of charge for the residents. The nine random staff that were interviewed were able to discuss their first responder responsibilities regarding Medical and Mental Health emergency care. The Director of Nursing states that there is always a nurse on call. Any medical follow up regarding STDs is also provided. The PREA Policy meets the standard. All services would be free of charge for the residents.

On 9-27-16. I received an MOU between Adelphoi and UPMC Altoona describing services that would be received if needed, including but not limited to emergency services.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy contains the necessary procedure for this standard. Hilltop is a Supervised Independent Living Program and residents receive community care. Many residents also regularly see a psychiatrist for medication evaluations. Ongoing care is provided and follow up or aftercare planning also includes resources for both medical and mental health services upon discharge. There were no residents in the facility who had reported a sexual abuse.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no sexual abuse incident reviews at Hilltop because there have been no incidents in the past 12 months to review. However, an interview with the Program Director and the Director of Nursing, who are members of the Sexual Abuse Incident Review Team and a review of the policy show that there is a form that is used agency wide to formally document this review. All variables, including staffing, the physical plant, and whether the incident occurred due to gang or sexual status is considered. Appropriate action in the way of training, policy change or physical plant modification could be recommended and would be followed. The Nurse cited her participation in a review at another facility that resulted in the modification of the physical plant to reduce a blind spot in a stairwell. She stated that the Facilities Director in charge of the physical plant is a part of these reviews. This review would take place within 30 days of the completion of the investigation.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The PREA Policy outlines the Data Collection for this Standard. This Data is collected by the PREA Coordinator from the 22 facilities at Adelphoi. She aggregates this data for the agency rather than the individual facilities. This annual report was first published in November of 2015 and is posted on the website. It includes definitions, general information regarding the number of admissions, graphs and ongoing trainings and policies in response to any reports. The report has been viewed and verified by the Auditor.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Policy requires that data be reviewed in an ongoing manner and in an aggregated fashion as well. The ongoing review provides for immediate changes to be made if necessary, whereas the annual review shows the bigger picture comparing from year to year. I interviewed the COO and the PREA Coordinator. The PREA Coordinator prepares the report and presents it to the leadership team. It is approved by the COO before being publicly disseminated to the Board and on the website.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the COO, PREA Coordinator and PREA Manager and reviewed the PREA Policy which meets this standard. All personal identifiers for staff and residents are removed from any reports that are made public. All reports are kept for a minimum of 10 years or for whatever length of time required by law, whichever is longer. These reports are securely kept.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

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

Maureen G. Raquet December 13, 2016

Auditor Signature Date