Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: Click or tap here to enter text. ☒ **N/A**

If no Interim Audit Report, select N/A

Date of Final Audit Report: **September 15, 2020**

Auditor Information

Name: Shirley L. Turner	**Email:** shirleyturner3199@comcast.net
Company Name: Correctional Management and Communications Group, LLC	
Mailing Address: P. O. Box 370003	**City, State, Zip:** Decatur, GA 30037
Telephone: 678-895-2829	**Date of Facility Visit:** August 17, 2020

Agency Information

Name of Agency: Perry Multi-County Juvenile Facility			
Governing Authority or Parent Agency *(If Applicable):*			
Address: 1625 Commerce Drive		**City, State, Zip:** New Lexington, OH 43764	
Mailing Address: Same as Above		**City, State, Zip:** Same as Above	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal
Agency Website with PREA Information: www.pmcjf.com			

Agency Chief Executive Officer

Name: Lea Ann Wells, Director	
Email: lea.ann.wells@pmcjf.com	**Telephone:** 740-342-9700

Agency-Wide PREA Coordinator

Name: Karen Brown, Compliance Coordinator	
Email: karen.brown@pmcjf.com	**Telephone:** 740-342-9700, ext. 104
PREA Coordinator Reports to: Lea Ann Wells, Director	**Number of Compliance Managers who report to the PREA Coordinator:** 0

Facility Information

Name of Facility: Perry Multi-County Juvenile Facility

Physical Address: 1625 Commerce Drive	**City, State, Zip:** New Lexington, OH 43764
Mailing Address: Same as Above	**City, State, Zip:** Same as Above

The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal

Facility Website with PREA Information: www.pmcjf.com

Has the facility been accredited within the past 3 years? ☒ Yes ☐ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☒ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:

Facility Administrator/Superintendent/Director

Name: Lea Ann Wells	
Email: lea.ann.wells@pmcjf.com	**Telephone:** 740-342-9700, ext. 106

Facility PREA Compliance Manager

Name: NA	
Email:	**Telephone:**

Facility Health Service Administrator ☐ N/A

Name: Angel Conrad, RN	
Email: angel.conrad@pmcjf.com	**Telephone:** 740-342-9700, ext. 111

Facility Characteristics

Designated Facility Capacity:	20

Current Population of Facility:	**8**
Average daily population for the past 12 months:	**17**
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	**12-20**
Average length of stay or time under supervision	**6 months**
Facility security levels/resident custody levels	**Medium**

Number of residents admitted to facility during the past 12 months	**29**
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	**29**
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	**29**
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A
Number of staff currently employed by the facility who may have contact with residents:	**30**
Number of staff hired by the facility during the past 12 months who may have contact with residents:	**9**
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	**1**
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	**1**
Number of volunteers who have contact with residents, currently authorized to enter the facility:	**8**

Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	**1**
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	**3**
Number of single resident cells, rooms, or other enclosures:	**20**
Number of multiple occupancy cells, rooms, or other enclosures:	**0**
Number of open bay/dorm housing units:	**0**
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	**1**
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe:)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	**0**
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☐ Local police department ☒ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	**1**
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: *Select all that apply*	☒ Facility investigators ☐ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Perry Multi-County Juvenile Facility is a community corrections residential facility located in New Lexington, Ohio. It houses medium security level juvenile offenders who would otherwise be committed to an Ohio Department of Youth Services (ODYS) correctional facility had they not be placed in this facility. The ODYS provides funding for the delivery of treatment services and programming to both female and male adolescents from 12 to 20 years old.

The Prison Rape Elimination Act (PREA) Audit was conducted by Shirley Turner, certified US Department of Justice PREA Auditor, assisted by Flora Boyd, Senior Vice President of Program Reviews and Audits for the Correctional Management and Communications Group, LLC (CMCG) and also a certified PREA Auditor. Due to COVID-19 concerns and out of an abundance of caution, the staff and resident interviews were conducted remotely including video calls. The interviews were conducted during the pre-onsite and post-onsite audit phases. The onsite audit phase was conducted on August 17, 2020. The facility was initially audited in 2014 and was last audited in 2017.

The audit was procured and assigned to the Auditor by CMCG located in Minneola, Florida. There were no known existing conflicts of interest regarding the completion of this audit. There were no barriers in completing any phase of the audit. The agency, ODYS, and facility ensured that the challenges of COVID-19 concerns would not eliminate the occurrence of the audit by supporting the use of alternative methods regarding the interviews. Limiting direct contact with residents and staff during the pandemic was instrumental in all attempts to complete a safe audit by reducing and preventing COVID-19 transmission.

General information and specific information about programs, services and activities conducted at the facility are detailed on the facility's website. PREA information, including staff contact information, is available on the facility's website and may be accessed by the general public, staff, contractors, and volunteers. The facility's website also contains reports, forms, PREA policy, and the 2017 PREA audit report.

Pre-Onsite Audit Phase
Key Processes and Methodology
The initial planning for the audit was conducted with the ODYS PREA Administrator and the CMCG Senior Vice President of Program Reviews and Audits. There was follow-up communication by the lead Auditor with the ODYS PREA Administrator and the facility's Director and Compliance Coordinator, who also serves as the facility's PREA Coordinator.

After the initial communication, PREA documents were provided to the Auditor. During the initial and follow-up conversations, the audit processes and logistics were discussed. The methodology and site visit itinerary were reviewed and the Auditor provided the opportunity for questions and clarification of information as needed. Direct communication was maintained with the ODYS PREA Administrator and the facility's Compliance Coordinator/PREA Coordinator. Audit dates were adjusted as agency restrictions and concerns related to COVID-19 were monitored.

All parties involved supported the use of the alternative method of remote interviewing to significantly reduce contact among residents, staff and the Auditors out of an abundance of caution in an effort to minimize anyone contracting or spreading the coronavirus. Final dates were agreed upon for the interviews and the site review. The interviews and comprehensive site review were conducted by both Auditors. Masks were worn by the Auditors and facility and agency staff members throughout the site review.

Effective communication was maintained with the Compliance Coordinator/PREA Coordinator regarding the virtual interviews; site review; access to the various staff members; and goals and expectations of the audit process. The facility staff members and residents were receptive to the alternative setting for the interviews. Staff members were familiar with the PREA audit process, having participated in and/or aware of the previous PREA audits. Many of the staff and residents previously interviewed were identified onsite by the Auditors during the site review. The residents that were encountered onsite were asked if they had any additional information to share and they related that they did not have any additional information to provide.

The PREA audit notice was copied in its original bright color and posted in various areas of the facility prior to the onsite audit, at least six weeks prior to the audit. The pictures of the notices were taken in their various locations and emailed to the Auditor by the Compliance Coordinator/PREA Coordinator. The audit notices were in a format that was easy to see and read and were posted at varying eye levels, easy to see. They were strategically posted, accessible to residents, staff, and any visitors if on campus during this time period; including the administrative and housing areas. The notices contained the Auditor's contact information and information regarding confidentiality of information. No correspondence was received during any phase of the audit and the facility has a process in place to ensure confidential communication. Further verification of the postings was made through observations during the comprehensive site review and as indicated through the interviews conducted with residents and staff.

The completed PREA Pre-Audit Questionnaire, policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the Auditor. The documentation on the flash drive was organized by each standard. This information was received by the Auditor prior to the comprehensive site review. An initial assessment was conducted of the information and the Auditor conducted a telephonic review with the facility Compliance Coordinator regarding additional information needed and followed-up with a documented request.

The lead Auditor provided a document to the PREA Coordinator that assisted in the completion of the interview schedule titled, “Information Requested to Determine Staff and Residents to be Interviewed During the On-Site PREA Audit.” The document which was completed and returned to the Auditor, requested shift assignments; identification of staff members who served and performed in specific PREA related specialized roles; and volunteers and contractors who have contact with residents. The additional information requested prior to the site review was provided to the Auditor.

Through the interview document, a request was made for a list of direct care staff and their scheduled shifts and the additional direct care staff, where applicable, and a current resident population roster. The written request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, bisexual and/or transgender residents; and residents housed in isolation. The information regarding the residents and staff was made available to the Auditor prior to the onsite audit phase of the audit.

Staff and residents were randomly selected by the Auditor based on the interview requirements. The interview schedule was developed by the Auditor with input through the PREA Coordinator. All interviews were conducted in private. When the residents were interviewed, the interviewer ensured that there was no staff in the room with the resident and understood that the residents were not coerced to be interviewed. The areas where interviews occurred were also observed during the comprehensive site review. The Auditor communicated with the PREA Coordinator to confirm schedules and to clarify specialized PREA roles and assistance in identifying residents in vulnerable categories. A resident roster was provided to the Auditor.

Based on the information and documents received, the Auditor completed the interview schedule of specialized and random staff and residents. The Auditor and PREA Coordinator worked together in resolving any conflicts in staff coverage and availability of staff and residents. The agenda and plans for the site review were discussed with the ODYS PREA Administrator and the facility’s PREA Coordinator, ensuring the Auditor would be as non-intrusive as possible where these actions did not interfere with the completion of a thorough sight review while also providing consideration for limited contact due to COVID-19 concerns.

The facility provided lists and documents that assisted with the following determinations and interview selections. The Auditor reviewed the documents provided and conferred with the PREA Coordinator for clarity information as needed.

Information	Comments
Resident Roster	Provided prior to site review.
Youthful Inmates/detainees	Youthful inmates/detainees are not housed in this facility.
Residents with Cognitive Disability	Three Identified
Residents who are Limited English Proficient	None Identified
LGBTI Residents	None Identified
Residents in segregated housing	None Identified

Information	Comments
Residents in Isolation	None Identified
Residents who reported sexual abuse	None Identified
Residents who reported sexual victimization during risk screening.	Two Identified
Resident with physical disability	None Identified
Staff Roster	Provided on interview document sent to the facility during pre-onsite phase of the audit.
Specialized Staff	Provided on interview document sent to the facility during pre-onsite phase of the audit.
Contractors/Volunteers that have contact with residents.	Provided on interview document sent to the facility during pre-onsite phase of the audit.
All grievances/allegations made in the 12 months preceding the audit.	Provided for allegations of sexual harassment. No allegations of sexual abuse for the 12 months preceding the audit.
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	There were no allegations of sexual abuse or sexual harassment reported for the 12 months preceding the audit.
Hotline calls made during the 12 months preceding the audit.	There were no hotline calls made during the 12 months preceding the audit.
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	Provided for allegations of sexual harassment; no allegations of sexual abuse for the 12 months preceding the audit.

Onsite Audit Phase

Key Processes and Methodology

The Auditors arrived in the early morning during the first shift and were greeted by the Director, Lea Ann Wells; Compliance Coordinator/PREA Coordinator, Karen Brown; and ODYS PREA Administrator, Alexander Stojsavljevic. The Auditors completed the sign-in sheet upon entry and temperatures were checked by the Compliance Coordinator. The Auditors, facility staff and ODYS PREA Administrator wore masks during the onsite phase of the audit. The comprehensive site review was facilitated by the Compliance Coordinator/PREA Coordinator and the ODYS PREA Administrator was also present during the site review.

The site review included visits to or observation of all areas of the facility which included the lobby; administrative area; clinic; classrooms; laundry room; gymnasium; offices; storage rooms; control room; outside weight room; conference room; kitchen; dining room; offices; housing units; and outside area that is also use for dining. The staff and residents were in preparations for the day's programming and activities.

Printed notifications of the PREA site visit were observed posted in the areas previously identified in the pictures sent to the Auditor, visible to residents, staff; and would be visible to contractors, volunteers and visitors during their visits. The notices contained large enough print to make them noticeable and easy to see and read and were observed in but not limited to the lobby and living area. Signs were posted that indicated where residents were not allowed or

allowed with staff supervision. Residents' files are maintained in a secure manner. The resident population on the day of the site review was eight.

There are signs posted throughout the facility regarding PREA information and materials are available and accessible that contains contact information of the assisting agencies for reporting allegations and seeking help regarding sexual abuse and sexual harassment. The posted information includes instructions on accessing assistance. Staff cannot deny a resident use of the telephone to access the reporting hotline. Residents are also provided contact information and information is posted regarding the hotline for reporting sexual abuse and sexual harassment and requesting advocacy services.

Victim advocacy services will be provided by the Family Health Services of East Central Ohio. The services to be provided were confirmed by the Victim Services Coordinator. Family Health Services of East Central Ohio may be used to report an allegation of sexual abuse or sexual harassment which will be reported to the facility Director or to the Perry County Sheriff's Department if the resident does not reveal their name. Family Health Services of East Central Ohio will also make a victim advocate available upon request. The assigned victim advocate will accompany the resident through the forensic medical examination and investigative interviews. Forensic medical services will be provided by a qualified medical practitioner at Genesis Hospital.

The Compliance Coordinator/PREA Coordinator answered questions regarding resident activities and staff duties as the site review progressed throughout the facility. The intake process was explained by the Nurse. Daily activities; treatment services; staff supervision; alternative methods of communication with parents/guardians; and other processes were discussed with the Compliance Coordinator/PREA Coordinator during the site review. The residents and staff interviewed revealed that staff members announce their presence when entering the housing unit of the opposite gender which was also observed during the site review.

Residents have access to writing materials as observed and determined from the interviews of the residents and staff. Signage was posted providing PREA reporting information. Cameras are strategically installed to supplement direct staff supervision. A dedicated phone for hotline use is located in each housing unit and access for assistance is also posted on the walls. There is a reasonable amount of privacy provided to residents when they use the toilet, change clothes and shower. The cameras were viewed from the control room and the views showed that the cameras do not infringe on the resident's privacy during the residents' personal hygiene time such as showers, using the toilet and changing clothes. Additional cameras have been added to blind spots in the mechanical room and conference room since the last PREA audit.

Interviews

Thirty staff members are currently employed at the facility that may have contact with residents. A total of eight residents were in the facility on the days of the interviews and site review. All residents were interviewed through the use of video controlled by the Auditor on July 24, 2020. Five were targeted interviews which considered information regarding the make-

up of the population and the information provided through the Compliance Coordinator/PREA Coordinator.

A total of 12 random staff members were interviewed, 10 on July 24 along with all the other interviews and two direct care staff members were interviewed during the post audit phase due to scheduling conflicts. Six individual specialized staff members were interviewed based on their job duties related to PREA roles, including a contractor and volunteer. Although six individuals were interviewed as specialized staff, the specialized protocols used totaled 11due to some staff filling more than one specialized role. The PREA Coordinator and Director were interviewed however their interviews in those roles were not counted as specialized staff. The interviews with the PREA Coordinator regarding investigations, PREA education and unannounced rounds were counted as specialized staff interviews. The additional interview with the Director regarding human resources was also counted as a specialized interview.

The Compliance Coordinator/PREA Coordinator ensured that all resident and staff interviews were conducted in private and residents were not coerced to participate in the interviews. The Auditor asked specific questions to the residents to confirm no one else was in the room with them and the description of where a staff member was posted outside of the room. During the comprehensive site review, the areas where the interviews were conducted were observed. There was no follow-up information provided to the Auditors by staff or residents during the site review however the Compliance Coordinator provided additional documents previously requested by the Auditor.

The interviews with residents, staff, visitor and contractor were conducted in private. The contractor interviewed provides hair care services to the residents and the volunteer serve s as the Chaplain for the facility. The PREA Coordinator managed the accessibility of staff and residents for the interviews during the pre-onsite and post onsite audit phases. She also ensured that no resident was threatened or coerced to participate in an interview. Eight random resident interviews were conducted and two of the eight were targeted interviews.

The Auditor conducted the following staff interviews:

Category of Staff	Number of Interviews
Medical Staff	1
Mental Health Staff	1
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff (Unannounced Rounds)	1
Contractors who have Contact with Residents	1
Volunteers who have Contact with Residents	1
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Intake Staff	1
Investigative Staff	1

Category of Staff	Number of Interviews
Number of Specialized Staff Interviews	11
Number of Random Staff Interviews	12
Total Random and Specialized Interviews	23
Total interviews including PREA Coordinator and the Director who was also interviewed in the role of Agency Head.	26

The community support interview was conducted by telephone during the post audit phase with the Victim Services Coordinator, Family Health Services of East Central Ohio, regarding the provision of reporting and victim advocacy services for alleged victims. The interview confirmed the accessibility of reporting and victim advocacy services to residents and verified that the written agreement for advocacy services to residents remains current. According to the Victim Services Coordinator, advocacy services for an alleged victim may be requested by the alleged victim, facility staff; hospital staff; and/or law enforcement.

Onsite Documentation Review

The Auditor received documentation for each standard as part of the pre-onsite audit phase data gathering process. Additional documentation was provided as requested prior to and on the day of the site review. The PREA Pre-Audit Questionnaire, facility policies and procedures and supporting documentation were reviewed prior to the site review. The supporting documentation reviewed included but was not limited to various forms; youth vulnerability assessments; facility vulnerability assessments; PREA education and training materials; training certificates; training logs; checklists; evidence of unannounced rounds; coordinated response plan; related written communication; annual staffing plan assessment; annual report; staff schedules; investigation reports; and facility organization chart. Staff PREA training was documented by training logs, acknowledgement statements; training certificates; and training materials.

During this audit period, there were five allegations of resident-on-resident sexual harassment. Four of the allegations were substantiated; and one was determined unfounded. Administrative investigations are completed by the Compliance Coordinator/PREA Coordinator. Allegations that are criminal in nature are investigated by the Perry County Sheriff's Department. There were no allegations of sexual abuse and none of the allegations of sexual harassment were criminal in nature.

Upon completion of the comprehensive site review, an exit meeting was held with the Director, Compliance Coordinator/PREA Coordinator, and ODYS PREA Administrator. The exit meeting served to review the onsite process, sharing of Auditors' notes, and the review of additional information needed. It was shared that a corrective action would be needed to address a PREA refresher session with residents, specifically reviewing the victim advocacy services. The need was identified as a result of the interviews with the residents during the pre-onsite audit phase. The plan for the education session was discussed and it was confirmed that documentation of the implementation of the corrective action would be provided to the Auditor. The timelines for audit reports were reviewed by the Auditor and staff was given the opportunity to ask additional questions about the audit process.

Post Onsite Audit Phase
Key Processes and Methodology
The Victim Services Coordinator with the Family Health Services of East Central Ohio confirmed advocacy services in a telephone interview. The services include but are not limited to accompaniment during the forensic medical examination and investigative interview; access to the 24-hour hotline; confidential support by telephone and in-person; information and referrals.

The PREA Training Log/Signature Sheet which also contained the refresher PREA education session course outline was provided to the Auditor confirming the implementation of the corrective action. The refresher PREA education session was conducted with the eight residents on August 19, 2020. The documentation contained the printed name and signature of each resident and the education session was conducted by the Compliance Coordinator/PREA Coordinator.

The aforementioned documentation; information provided during the audit phases; consideration of all interviews; and observations made during the site review, verified the standards were met. The Auditor maintained communication with the Compliance Coordinator/PREA Coordinator until all requested additional information was received. The final report was submitted to the ODYS PREA Administrator for subsequent delivery to the facility.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The program is located in one primary building and is located on five acres at the western end of the Appalachian plateau at the start of the Southern Ohio Hills. The building consists of three housing units are house male juvenile offenders. Each housing unit has a dayroom area. The building includes a lobby as the primary entrance where visitors sign-in/out. The building also contains classrooms; kitchen; dining room; gymnasium; clinic; conference room; storage rooms; laundry room; and offices.

The security camera system is located in the central control area and the cameras may also be viewed from the Director's office. Cameras are strategically placed inside and outside of the building and are constantly viewed and monitored. Direct supervision is provided by staff and all resident movement is monitored by staff and electronically through the camera system. There are no multiple occupancy cell housing units and no open bay/dormitory housing units. An isolation room or "Watch Room" is located across from the control room.

There are showers on each housing unit and the residents shower and use the toilet separately and a reasonable amount of privacy is provided. The lighting was adequate throughout the facility and the appearance of the facility was clean and orderly. During the comprehensive site review, posters and signs were observed in various areas regarding reporting allegations of sexual abuse or sexual harassment and for contacting the victim advocacy agency. The information is posted in English and Spanish.

Residents are provided with a wide variety of services during their stay at the facility based on individual needs including but not limited to the following:

1) Social Skills
2) Violence Prevention/Young Men's Work
3) Commitment to Change/Thinking Pattern Identification
4) Individual, group and family counseling
5) Life Skills/Career Development
6) Substance Abuse Treatment Programs
7) Anger Management/Aggression Replacement

The facility has a behavior management system which is also used to assist in changing a resident's behavior. The system rewards residents for making good choices and provides negative consequences for making poor choices. Each resident must progress through the individual level system, or a progressive phase system in order to gain additional privileges and complete the program. The phase system is designed to create a desire to improve behaviors and work toward rehabilitation. Expectations for each phase grow progressively higher. Each resident is expected to complete all phase assignments within a six week period unless otherwise noted by the treatment team. Failure to meet an expectation results in consequences up to and including suspension of privileges until the work is completed.

The observations during the comprehensive site review and discussions with staff confirmed that residents are afforded access to visitors, attorneys and court workers and visits may be conducted in private as needed. Visitation had been suspended due to COVID-19 concerns however residents can make video calls with family members two times per week. During the time of restricted visitation, residents are provided four stamped envelopes for communication on the outside instead of the usual two stamped envelopes per week. Residents have access to writing materials to make contact with parents, guardians, attorneys, court personnel, and other approved persons.

The third-party reporting information and form are available and accessible to visitors, residents, contractors, volunteers, and employees through the posting of the hotline numbers and the form. Information and the third-party reporting form are located on the facility's website. Administrative investigations are conducted by the facility-based investigator. When it is determined an allegation of sexual abuse or sexual harassment is criminal in nature, the case is referred to law enforcement. The Auditor observed postings within the facility that contain the information for reporting sexual abuse and sexual harassment and/or to request help regarding the occurrence of such. The PREA education materials were observed and

reviewed and the information is included in the Resident Handbook and helpful and related information is posted on the facility's website.

The Clinical Coordinator and counseling staff ensure clinical and counseling services. Each parent/guardian are required to attend two family counseling sessions a month. During these sessions, the family will address the juvenile's behaviors, parenting issues, and plans for the juvenile's return to the community. The resident has many opportunities to communicate with someone from the outside if they are hesitant to make a complaint within the facility regarding allegations of sexual abuse or sexual harassment. An individualized treatment plan is developed for each resident and individual and family counseling sessions are aligned with the plan. The mental health staff may assist with the PREA education for residents to ensure each resident understands the information provided. Supportive mental health services are provided by a local mental health agency. Volunteers through Narcotics Anonymous also provide support services.

Medical services are provided and coordinated by the Registered Nurse at the facility. Nursing assessments are conducted on each resident and sick call is also conducted. When needed, residents may be taken to the Genesis Medical Group to be seen by a physician or Nurse Practitioner. The Nurse Practitioner visits the facility at least quarterly and as needed and is continually accessible to the facility's Nurse. Residents have the opportunity to report all allegations to the Nurse through healthcare encounters or in writing.

All residents attend school and all teachers are certified in accordance with Ohio law. Residents with learning disabilities or other educational difficulties follow the IEP as designed by the home school of record. The classrooms are oriented to provide individual instructions to challenge each resident to proceed at his own pace. Residents will be evaluated upon their level of ability and effort. The education curriculum includes Mathematics; Science; Social Studies; English; Health; and Physical Education. The education staff members are equipped to assist with PREA education as needed to ensure the information is presented in a format understandable to all residents.

Direct care staff members are responsible for the daily and direct supervision of residents and manage them during daily activities. The staff to resident ratio was observed to be met during the comprehensive site review and from the review of work schedules and interviews. The PREA Coordinator reports there has not been a deviation from the staffing plan in the past 12 months. There is a host of staff members consisting of management, supervisory, support, volunteer and contract who provide oversite of or participation in processes and activities that contribute to the facility operations and the provision of services.

Documentation and staff and resident interviews confirmed the provision of the programs and services described. The residents indicated during the interviews, they could communicate with their parents/guardians and legal representatives. Communication is maintained through telephone calls, video calls currently, and visitation onsite when restrictions are lifted. Observations during the comprehensive site review revealed adequate space for conducting the programs and services described. Regular and special visitation can be accommodated at the facility.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: *No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded: Click or tap here to enter text.

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: Click or tap here to enter text.

PREVENTION PLANNING

Standard 115.311: Zero Tolerance of Sexual Abuse and Sexual Harassment; PREA Coordinator

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☐ Yes ☐ No ☒ NA

- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Policy 1.2
Facility PREA Policies, Chapter 6.0
Position Description
Organization Chart

Interviewed:
Compliance Coordinator/PREA Coordinator
Random Staff
Residents

Provision (a):
An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The Policies provide direction to staff regarding the facility's approach to preventing, detecting, and responding to conduct that violates the zero-tolerance approach regarding all forms of sexual abuse and sexual harassment. Policy addresses the definitions of prohibited behaviors of sexual abuse and sexual harassment. It also includes sanctions for those found to have participated in the prohibited behaviors. The facility has additional policies which support the PREA standards

Staff training, resident education, and intake screening assist in detecting sexual abuse and sexual harassment. The identified and other supporting policies include but are not limited to responding to sexual abuse and sexual harassment through prevention, responding, reporting, investigations, assessments, and disciplinary sanctions for residents and staff.

Provision (b):
An agency shall employ or designate an upper-level, agency-wide PREA Coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

The Compliance Coordinator, who serves as the facility's PREA Coordinator, is in an upper level management position and reports directly to the facility Director. The interview and conversations with the Compliance Coordinator confirmed her familiarity with PREA Standards and the audit process. The interview and observations revealed she has the time and authority to discharge the duties of the PREA Coordinator. The interviews revealed that the staff and residents are aware of the role of the Compliance Coordinator as the PREA Coordinator. The Position Description and Policy 1.2 provide for the appointment of the Compliance Coordinator who will also serve as the PREA Coordinator and have the time and authority to discharge the required duties.

Provision (c):
Where an agency operates more than one facility, each facility shall designate a PREA Compliance Manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

This is the sole facility and there are no other entities.

Conclusion:

Based upon the review and analysis of the available evidence, interviews and observing the interactions within the facility, the Auditor determined the facility is compliant with this standard maintaining a zero-tolerance policy toward sexual abuse and sexual harassment and the designation of a PREA Coordinator.

Standard 115.312: Contracting With Other Entities for the Confinement of Residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Interviewed:

Compliance Coordinator/PREA Coordinator
Director

Provision (a) and (b):
Provision (a): A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.
Provision (b): Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

There was no evidence that the facility contracts with other entities for the confinement of its residents. The interviews confirmed that the facility does not contract with other entities for the confinement of its residents.

Standard 115.313: Supervision and Monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☐ Yes ☒ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Supervision Policy
Facility General Administration Policy
Staffing Plan
Annual Review/Staffing, Supervision and Monitoring Review (annual staffing plan assessment)
Facility Vulnerability Assessments (unannounced rounds)
Video Review Forms
Work Schedules
PREA Pre-Audit Questionnaire

Interviews:
Director
Compliance Coordinator

Provision (a):
The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted juvenile detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.

Policy provides details for maintaining the internal staffing ratios. The facility's staffing plan, internal controls and management ensures that the PREA ratios of 1:8 during the waking hours and 1:16 during the sleeping hours will be maintained. Direct supervision is provided to residents during the daily activities and program services. In addition to the direct care staff, facility practice provides for additional supervision and support by the treatment and administrative staffs. Observations during the comprehensive site review indicated the staffing ratios are maintained.

The camera system is located in the control room beyond the administrative area and is routinely monitored. The provisions of the standard are taken into consideration regarding adequate staffing levels as confirmed through the interviews and review of Policy and the Staffing Plan which outline staffing requirements. The work schedules are based on the staffing plan and are aligned with the

Policy. Considerations for adequate staffing include but are not limited to standard security practices; composition of the resident population; activities and programming occurring on a particular shift; and the number of supervisory staff on duty at the time.

Provision (b):
The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.

The facility reports and there was no documentation of any deviation from the PREA staffing ratios of 1:8 and 1:16 in the past 12 months. According to the Director, the staffing plan and scheduling provide for adequate supervision and coverage. The facility is prepared to document any deviations from the PREA staffing requirements. The Director regularly conducts quality reviews of the schedules and time sheets. A staffing plan, aligned with policies and interviews, shows the requirements for shift coverage. The staffing plan provides for the staffing ratios to be met. The facility staff coverage includes varying shift hours for individual staff members based on the population number.

Provision (c):
Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

The internal staffing ratios for the facility provide for 1:8 during the waking hours and 1:16 during the sleeping hours. The staffing plan and population capacity ensures adherence to the PREA required ratios. The ratios were observed for and met during the comprehensive site review and review of documentation. Direct care staff members provide direct observation of residents. The staff to resident ratio was in compliance during the site visit as observed by the Auditors. Since the last PREA audit the average daily number of residents is 17. Since the last PREA audit, the average daily number of residents on which the staffing plan was predicated is 20. The facility is not involved in any lawsuits or consent decrees.

Provision (d):
Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA Compliance Manager required by §115.311, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

The Compliance Coordinator documents the assessment data in the form of the Annual Review/Staffing Supervision and Monitoring Review and confers with the Director. The document reviews but is not limited to the following areas: prevailing staffing patterns; review of staffing plan; electronic monitoring system; and allocation of resources. Policy requires that the review considers any adjustments that need to be made in the staffing plan, prevailing staffing patterns; deployment of monitoring technology; or the allocation of resources. The annual assessment documents the summarization of the review including the staffing plan, monitoring system and the process for conducting unannounced rounds. The individual unannounced rounds are documented on the Vulnerability Assessment.

Provision (e):
Each secure facility shall implement a policy and practice of having intermediate-level or higher level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

The facility Policy provides for the occurrence of unannounced rounds. This function is completed by the Compliance Coordinator through the completion of Vulnerability Assessments at various times and it details observations throughout the facility. The interviews confirmed that the unannounced rounds occur. The staff is not informed of when the rounds will occur and the visits are not conducted at scheduled times, according to the interview with the Compliance Coordinator who conducts unannounced rounds. The unannounced rounds are conducted throughout the facility to identify and deter sexual abuse and sexual harassment. Policy provides that staff not alert other staff when the rounds are occurring. Video Review Forms document the random review of camera footage which is also completed to identify and deter sexual abuse and sexual harassment and used for training and quality improvement opportunities.

Conclusion:
Based upon the review and analysis of the available evidence and the staff interview, the Auditor determined the facility is adhering to this standard regarding supervision and monitoring.

Standard 115.315: Limits to Cross-Gender Viewing and Searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Supervision Policy
Facility Training and Development Policy
Facility Juvenile Rights Policy
Training Curricula
Training Log/Signature Sheet
Strip Search Authorization Form
Intake Strip Search Form

Interviews
Random Staff
Residents
Compliance Coordinator/PREA Coordinator

Provision (a):
The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

Policy prohibits cross-gender strip searches and cross-gender visual body cavity searches. Cross-gender pat-down searches are not permitted, except in exigent circumstances. The interviews revealed that the practice is that cross-gender pat-down searches are not conducted. Documentation exists for regular pat-down searches and another dedicated form is used when intake strip searches are performed. There is no evidence of cross-gender searches of any type occurring at the facility in the last 12 months. Based on the review of the Pre-audit questionnaire and according to the interviews, no cross-gender searches were conducted at the facility during the past 12 months.

Provision (b):
The agency shall not conduct cross-gender pat-down searches except in exigent circumstances.

Policy provides for cross-gender searches only when there are exigent circumstances. The Policy requires that any exception to this premise must be documented. The training roster and materials show that staff receives training on how to conduct searches; staff participation in the training is documented. Staff interviews confirmed they are aware of the policy regarding searches. No residents or staff interviewed reported the occurrence of any cross-gender searches. The evidence shows cross-gender pat-down searches have not occurred at the facility during the last 12 months.

Provision (c):
The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

The Policy does not provide for cross-gender strip searches and cross-gender visual body cavity searches; and cross-gender pat-down searches only occur under exigent circumstances. The interviews revealed that no cross-gender searches are conducted. All searches are conducted utilizing the applicable dedicated forms. Staff members are instructed by Policy to document all searches and any cross-gender pat-down search must have prior approval of the Director.

Provision (d):
The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

Policy and practice provide that the facility enables residents to shower, perform bodily functions, and change clothes without staff of the opposite gender viewing them. This practice was confirmed through interviews with residents and staff. No residents interviewed reported ever having been naked in full view of the opposite gender staff while showering, changing clothing, and performing bodily functions. Observations during the comprehensive site review confirmed the practices for residents being provided reasonable privacy. Residents use the bathroom one at a time and a bell indicates when someone enters and leaves the bathroom.

The Auditors observed and the interviews support that staff members of the opposite gender announce their presence when entering the residents' living unit or an area in which residents may be showering or performing bodily functions. The evidence shows residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their buttocks or genitalia. Based on the review of the documentation, staff and resident interviews, and observations, the facility follows this provision of the standard. Viewing of the cameras and staff and resident interviews confirmed that residents are not directly viewed by staff when showering, using the toilet or changing clothes. Hygiene practices are performed with the expectations of reasonable privacy for each resident.

Provision (e):
The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

Policy prohibits the search of transgender or intersex residents solely for the purpose of determining the residents' genital status and staff interviews verified no such searches have occurred in the past 12 months. Staff received the training on conducting searches and searches of transgender and intersex youth. Staff interviews confirmed they are aware that Policy prohibits staff from conducting a physical examination of transgender or intersex youth solely for the purpose of determining the resident's genital status. When the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner in private.

Provision (f):
The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

The training curricula for staff training and practice provide that staff is not to search the resident's body for the sole purpose of determining the resident's genital status. The training stresses the sensitivity, professionalism and technique for the search process. The documentation and staff interviews support the training is conducted. The interviews revealed that an intersex or transgender youth will be asked

their gender preference for the staff that will conduct the search. The staff members are trained in how to conduct the searches in a professional and respectful manner for any resident admitted to the facility.

Conclusion:
Based on the reviewed documentation and interviews, the Auditor determined compliance with this standard.

Standard 115.316: Residents with Disabilities and Residents Who Are Limited English Proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Resident Screening and Housing Policy

Muskingum Valley Education Services Letter of Agreement
Vulnerability Assessment
Orientation Training Log
Individualized Education Program
Education Certification/License
PREA Education Video

Interviews:
Residents
Random Staff
Director

Provision (a):
The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

The Policy addresses the provision of support services for Limited English Proficient and disabled residents by providing these residents the equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Residents are not used as readers or interpreters and which was confirmed by staff interviews. The facility has a letter of agreement from the Regional Site Manager of the Muskingum Valley Education service Center verifying the provision of special accommodation services.

The letter states the Center has the means to provide an interpreter; hearing impaired specialist; vision impaired specialist; audiologist, English as a second language (ESL) specialist; equipment; and technology. Interpreters may also be provided by the referring court. The education staff onsite may provide immediate support services, especially for residents with cognitive disabilities. Assistance may also be provided by the treatment staff to ensure all residents' understanding of the PREA information. Posted and other PREA information is in English and Spanish.

Provision (b):
The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

The letter of agreement and staff interviews confirm the availability of professional services. The Vulnerability Assessments of residents, completed during the intake process, identifies any special

accommodations required by the resident and any problem areas he may have. The Policy and staff assistance provide that each resident has an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment.

PREA information is accessible to residents in English and Spanish and other languages as needed. The facility provides access to support services for preventing, detecting, and responding to sexual abuse and sexual harassment to residents who are Limited English Proficient, including taking steps to provide interpreters who can interpret effectively, accurately, and impartially.

Provision (c):
The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations.

The Policy prohibits the use of resident readers and interpreters except in limited circumstances where an extended delay in obtaining an interpreter could compromise a resident's safety; performance of first responder duties; or investigation of allegations of sexual abuse or sexual harassment. The interviews and documents are aligned with the Policy. The letter of agreement and staff members with the capabilities to provide support services ensure the Policy requirements are met and residents will receive the appropriate assistance.

Random staff interviews confirmed residents are not used to relate PREA information to or from other residents. Information regarding reporting allegations of sexual abuse and sexual harassment is posted throughout the facility and accessible in both English and Spanish. The facility has the resources available to get the PREA information translated and printed in the additional languages as needed. The Resident Handbook also contains information on how to report allegations of sexual abuse and sexual harassment.

Conclusion:
Based upon the review and analysis of the evidence, the Auditor determined the facility is compliant with this standard regarding residents with disabilities and residents who are Limited English Proficient.

Standard 115.317: Hiring and Promotion Decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local laws, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Personnel Policy
Facility General Administration Policy
Employment Application
Background Checks
Background Check Log

Interview:
Director

Provision (a) & (f):
Provision (a): The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—
(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.
Provision (f): The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

The collective Policies address hiring and promotion processes and decisions and background checks, including child abuse registries. The background checks occur initially and every five years thereafter, aligned with Policy and the Standard. The personnel packet includes the completed background check, including abuse registry check, and hiring documents. Background checks are conducted through the state Ohio Bureau of Criminal Investigation and the Federal Bureau of Investigation.

Through the employment application and interviews, prior to hire and promotion, employees are asked to verify if they:

- Have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
- Have been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or,
- Have been civilly or administratively adjudicated to have engaged in the activity described above.

The interview with the Director and a review of Policies provide details about the hiring process, completion of background checks, and grounds for termination. The forms completed and included in the personnel records are responsive to the above provisions of this standard. All applicants are asked about any prior misconduct involving any sexual activity. The documentation, interview and Policies support the facility does not hire anyone who has engaged in sexual abuse or anyone who has used or attempted to use force in the community to engage in sexual abuse. Policy informs employees that they provide continuing information for reporting arrests.

Provision (b):
The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The Policies support that the facility does not hire or promote anyone who has been civilly or administratively adjudicated or have been convicted of engaging in or attempted to engage in sexual activity by any means. The interview with the Director was aligned with the standard and the documentation shows the inquiry made during the application process regarding previous misconduct.

The Policies and interview collectively indicate that the facility considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor or volunteer, who may have contact with residents. Policy supports that no applicant will be considered for employment if a background check reveals any history of inappropriate sexual behavior or arrest for inappropriate sexual behavior.

Provisions (c) & (d):
Provision (c): Before hiring new employees who may have contact with residents, the agency shall:
(1) Perform a criminal background records check;
(2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and
(3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.
Provision (d): The agency shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with residents.

The background check process includes consulting a child abuse registry as confirmed during the interview and the review of personnel documents. Best efforts would be made to contact all prior institutional employers for information of incidents or allegations of sexual abuse.

Provision (e):
The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

Initial background checks are conducted and are conducted every five years thereafter, in accordance with Policy. The interview, review of documentation and a review of Policy provide details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard.

Provision (g):
Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

According to the interview and Policy, the omission of sexual misconduct information or providing false information is grounds for termination.

Provision (h):

Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

The interview revealed that when a former employee applies for work at another institution, upon request from that institution, information will be provided on substantiated allegations of sexual abuse or sexual harassment involving the former employee.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility meets the provisions of the standard regarding hiring and promotion decisions.

Standard 115.318: Upgrades to Facilities and Technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Fiscal Management Policy
Facility Vulnerability Assessment

Interviews:
Director

Provision (a):
If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse?

The Policy provides for consideration of the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. The agency has not acquired a new facility or made a substantial expansion to the existing building since the last PREA audit.

Provision (b):
If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, the agency considered how such technology may enhance the agency's ability to protect residents from sexual abuse.

The Policy provides for consideration of how the technology may enhance the agency's ability to protect residents from sexual abuse. Facility Vulnerability Assessments are completed which includes recommendations after an inspection, including for equipment and technologies that enhance the ability to protect residents from sexual abuse. The interviews and observations during the site review support actions taken such as the addition of cameras to blind spots in the mechanical room and conference room since the last PREA Audit.

RESPONSIVE PLANNING

Standard 115.321: Evidence Protocol and Forensic Medical Examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
  ☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Supervision Policy
Facility Response Policy
Ohio Revised Code
Plan for Coordinated Response
Memorandum of Understanding (MOU), Perry County Sheriff's Department
MOU, Family Health Services of East Central Ohio (FHSECO)
MOU, Nationwide Children's Hospital
Transfer Agreement, Genesis Healthcare System
Victim Advocate Instructions

Interviews:
Random Staff
Compliance Coordinator/Investigative Staff
Victim Services Coordinator, FHSECO

Provisions (a) & (b):
Provision (a): To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.
Provision (b): The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

The documentation and interviews provide the Policies will be followed regarding investigations of sexual abuse in accordance with the standard. Administrative investigations are conducted by the facility-based investigator and allegations that are criminal in nature are investigated by the Perry County Sheriff's Department. The facility-based investigator interviewed, Compliance Coordinator/PREA Coordinator is a member of the facility's management team.

The roles of the facility staff and the Sheriff's Department are outlined in the Memorandum of Understanding. The investigator's and random staff members' interviews confirmed awareness of protocol for obtaining usable physical evidence and knowledge of the entities responsible for conducting investigations. The Policy and MOU with the Perry County Sheriff's Department ensure that protocol for investigations is appropriate for youth.

Provision (c):
The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

The Policies, MOU and Transfer Agreement address the forensic services that would be provided to an alleged victim by a Sexual Assault Nurse Examiner at the hospital. Genesis Healthcare System would treat an alleged victim over 14 years old and the Nationwide Children's Hospital would treat alleged victims 14 years old and younger. The Victim Services Coordinator of Family Health Services of East Central Ohio revealed that the services in the MOU will be provided, including accompaniment through the forensic medical examination and accompaniment through the investigative interviews. A qualified medical practitioner will conduct the medical forensic examination at the hospital. Forensic examinations will be provided at no cost to the victim as stated by Policy and the written agreements. No forensic medical examinations have been conducted during this audit period.

Provisions (d) & (e):
Provision (d): The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

Provision (e): As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

There is a dedicated telephone for the use of residents reporting sexual abuse or sexual harassment or who may be requesting advocacy services. Victim advocacy services have been arranged and are documented through the MOU between the facility and Family Health Services of East Central Ohio. The MOU provides that the victim advocacy agency will follow all applicable laws and regulations with respect to confidentiality. The services that will be provided include:

- 24-hour hotline number
- Crisis Intervention;
- Emotional Support;
- Follow-up Services;
- Accompaniment through the Forensic Medical Examination;
- Accompaniment through the Investigatory Interview Processes; and
- Provide Information and Referrals

The MOU and Transfer Agreement provide that each hospital will also provide a victim advocate for the alleged victim. The MOU with Nationwide Children's Services state that upon the request from the alleged victim, the hospital will provide an advocate that will support the resident through the forensic medical examination. The Transfer Agreement with the Genesis Healthcare System will contact a victim advocate from a rape crisis center, upon the request from the alleged victim.

Information regarding victim advocacy services is provided to the residents, according to staff, and is posted. However, the resident interviews did not reveal clear and un-contradicted information regarding the advocacy services that will be provided if a resident needed them. A corrective action plan was implemented which provided a refresher PREA education session for all residents. The education session included a review of the advocacy services provided by the Family Health Services of East Central Ohio. The document, "Victim Advocates" was also reviewed with the residents.

Provisions (f) & (g):
Provision (f): To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section.
Provision (g): The requirements of paragraphs (a) through (f) of this section shall also apply to:
(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and
(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

The facility-based investigator conducts administrative investigations in accordance with facility Policy and the Standard. Investigations of allegations of sexual abuse or sexual harassment that are criminal in nature are conducted by law enforcement in accordance with the agency's Policies and the provisions of the Standard. A MOU exists with the Perry County Sheriff's Department which provides for the investigation for allegations that are criminal in nature. Facility Policy, interview and MOU collectively support that uniform evidence protocol will be used which maximizes the potential for obtaining usable physical evidence and which is developmentally appropriate.

Provision (h):
For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The facility has made arrangements for victim advocacy services with the Family Health Services of East Central Ohio, confirmed through the MOU and interviews. The hospitals also make victim advocates available upon request and in accordance with the MOU and Transfer Agreement, respectively.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with the provisions of this standard.

Standard 115.322: Policies to Ensure Referrals of Allegations for Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Response Policy
Memorandum of Understanding (MOU), Perry County Sheriff's Department
PREA Pre-Audit Questionnaire

Interviews:
Random Staff
Director
Compliance Coordinator/PREA Coordinator

Provision (a):
The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The Policy provides that staff report all allegations of sexual abuse and sexual harassment and to document reports. The facility reports there were five allegations of resident-on-resident sexual harassment during the past 12 months. A review of documentation show the allegations were investigated by the facility-based investigator and were not criminal in nature. There were no sexual abuse allegations or sexual harassment allegations that were criminal in nature reported during the past year and there was no indication of such through the interviews with residents and staff. The Policy, interviews and MOU provide for investigations of all allegations of sexual abuse and sexual harassment.

Provision (b) and (c):
Provision (b): The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.

Provision (c): If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

Policy and reporting information are located on the facility's website and within the facility. Policy, MOU and interviews confirmed allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by the trained facility-based investigator. Allegations that are criminal in nature are investigated by local law enforcement.

Provision (d):
Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The Perry County Sheriff's Department has policies governing investigations. Interviews and documentation confirmed that the facility has a trained facility-based investigator. The interview with the Compliance Coordinator, trained facility investigator, and review of documents confirmed administrative investigations are conducted and allegations that are criminal in nature will be investigated by the Perry County Sheriff's Department.

Provision (e):
Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The Department of Justice is not responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in this facility.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard regarding policies to ensure referrals of allegations for investigations.

TRAINING AND EDUCATION

Standard 115.331: Employee Training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Training and Development Policy
Training Curricula
Training Log/Signature Sheets
Training Certificates
PREA Pre-Audit Questionnaire

Interviews:
Random Staff
Compliance Coordinator/PREA Coordinator

Provisions (a) and (c):
Provision (a): The agency shall train all employees who may have contact with residents on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Residents' right to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;
(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;
(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
(8) How to avoid inappropriate relationships with residents;
(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and

(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
(11) Relevant laws regarding the applicable age of consent.
Provision (c): All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

The Policy address PREA related training for staff. Interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policies and Procedures; in-person training/meetings; and electronically. Staff interviews and documentation support that refresher training is conducted annually.

All random staff interviewed and the Compliance Coordinator/PREA Coordinator indicated training is provided as required. All random staff interviewed, Policy and training materials verified the general topics in this standard provision were included in the training. The facility reports all staff members that may have contact with residents, were trained or re-trained on the PREA requirements.

Provision (b):
Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses male juvenile offenders and the training considers the needs of the population served as indicated by the interviews. The Policy supports training being tailored to the needs and attributes of the population served.

Provision (d):
The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The PREA training reviewed was documented electronically and on dedicated sign-in training rosters (Training Log/Signature Sheet) and verified through staff interviews. Training acknowledgement statements and certificates also confirmed staff training.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with the provisions of this standard.

Standard 115.332: Volunteer and Contractor Training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Training and Staff Development Policy
Citizen Involvement Brochure
Citizen Involvement Agreement
Training Log/Signature Sheets
PREA Pre-Audit Questionnaire

Interviews:
Volunteer (Chaplain)
Contractor (Cosmetologist/Barber)
Compliance Coordinator/PREA Coordinator

Provision (a):

The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

The Policy requires volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual abuse prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of documents, the interviews and observation confirm the training occurs.

Provision (b):
The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

The interviews and review of documentation revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities regarding sexual abuse prevention, detection, and response to an allegation of sexual abuse or sexual harassment. The training is based on the services provided by the contractors and volunteers. The interviews with the contractor and volunteer revealed their familiarity with the zero-tolerance policy regarding sexual abuse and sexual harassment of residents, including how to report. The interviews confirmed that the review of the zero-tolerance policy is included in the PREA training.

Provision (c):
The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The training documentation and interviews confirmed the receipt and awareness of training by the contractor and volunteer.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with the provisions of this standard.

Standard 115.333: Resident Education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Screening and Housing Policy
Resident Handbook
Letter of Agreement
PREA Resident Orientation Training Logs
PREA Training Log/Signature Sheet
PREA Pamphlet (English and Spanish)
PREA Posters
PREA Pre-Audit Questionnaire

Interviews:
Residents
Compliance Coordinator

Provisions (a) and (b):
Provision (a): During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.
Provision (b): Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

The Policy provides that all residents admitted receive PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting, according to the documentation and interview with the Compliance Coordinator. The youth receive PREA information at intake and follow-up information is reviewed with the resident by the clinical staff; quarterly refresher education is also provided. A review of the education materials indicate the information provided to the residents is age-appropriate. The residents sign acknowledgement statements confirming receipt of information. A review of documentation indicates residents' participation in PREA education sessions however the interviews with residents revealed the need for PREA refresher training in the area of the type of available advocacy services to ensure clear and un-contradicted information.

Corrective Action: The Compliance Coordinator/PREA Coordinator implemented the corrective action to address the PREA education of residents. The Compliance Coordinator reviewed the refresher training

plan with the Auditor and the training was provided to all residents by the Compliance Coordinator during the post audit phase. The refresher education session was documented on a training log containing the residents' printed names and corresponding signatures. The training log acknowledged the refresher education date, educator, and contained the outline for the education session. The refresher included specific information about the victim advocacy agency and services. The documentation and affirmation of the refresher education session was provided to the Auditor by the Compliance Coordinator.

Provision (c):
Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.

Based on the evidence shown documenting the PREA education sessions in Provisions (a) and (b), and interviews, residents received PREA education. The facility reports that 29 youth were admitted to the facility during the past 12 months and all participated in PREA education sessions.

Provision (d):
The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; Deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. The letter from the Regional Site Manager of the Muskingum Valley Educational Service Center acknowledges the accessibility of special accommodations to address the special needs of residents. Interpreters may also be provided by referring courts.

The facility also has the education staff and mental health staff as resources to adapt the PREA information and delivery, as needed within their realm of education and experience, so that all residents will benefit from the PREA education sessions. The PREA information is accessible in English, Spanish and other languages as needed and accessible to residents, staff, contractors, and volunteers. Staff interviews confirmed a practice of residents not used as translators or readers for other residents and in accordance with Policy.

Provision (e):
The agency shall maintain documentation of resident participation in these education sessions.

Signed acknowledgement logs were reviewed which supported the residents' involvement in PREA education sessions. The residents lacked details regarding advocacy services, according to the interviews. The refresher training implemented as a corrective action was documented by the Compliance Coordinator and acknowledged by each resident's printed name and signature on the training log. The documentation and affirmation of the refresher training was provided to the Auditor by the Compliance Coordinator/PREA Coordinator.

Provision (f):
In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. PREA information is posted and provided to residents to assist in eliminating incidents of sexual abuse and sexual harassment. The printed materials, including Resident Handbook, provide sexual abuse and sexual harassment; steps victims may take; and reporting information. PREA information was observed posted and accessible; it was easy to see and read.

Conclusion:
Based upon the review and analysis of the available evidence, interviews, observations, and implementation of a corrective action plan, the Auditor has determined the facility is compliant with the provision of this standard.

Standard 115.334: Specialized Training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Prohibitions and Employee Education Policy
Training Certificates
Training Curriculum
Training Log/Signature Sheet

Interview:
Compliance Coordinator/Investigative Staff

Provision (a) & (b):
Provision (a): In addition to the general training provided to all employees pursuant to §115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. **Provision (b):** Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

According to the Policy, documentation and interview, general PREA training is required in addition to the specialized training regarding conducting administrative investigations. Allegations that are criminal in nature are investigated by law enforcement. The interview and review of documents confirmed administrative investigations are conducted by a trained facility-based investigator. According to the Compliance Coordinator, training curriculum and Policy, the specialized training includes but is not limited to interviewing techniques; proper use of Miranda and Garrity warnings; preserving evidence; and criteria for supporting a finding of substantiated, unsubstantiated or unfounded.

Provision (c):
The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

The facility maintains documentation of training certificates of the facility-based investigator. Allegations that are criminal in nature will be investigated by law enforcement, in accordance with Policy and the Memorandum of Understanding (MOU) with the Perry County Sheriff's Department. The specialized

training for the Compliance Coordinator was received online through the National Institute of Corrections and includes both the regular course for administrative investigations and the advanced course as evidenced by the training certificates.

Provision (d):
Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

The Perry County Sheriff's Department provides training to its investigators who will conduct criminal investigations at the facility which is confirmed by the interview and MOU.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

Standard 115.335: Specialized Training: Medical and Mental Health Care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?
  ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Training and Staff Development Policy
Training Certificates
Training Curriculum
Training Log/Signature Sheet

Interviews:
Registered Nurse
Clinical Coordinator

Provision (a):
The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

The Policy provides that medical and mental health staff members receive the regular PREA training as well as the specialized training. Training certificates, training logs and interviews document the general and specialized training.

Provision (b):
If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

Forensic examinations are not conducted at the facility.

Provision (c):
The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

Training certificates, training logs and interviews with medical and mental health staffs confirmed receipt of the regular and specialized training. Specialized training is through the National Institute of Corrections and is documented by the training certificates

Provision (d):
Medical and mental health care practitioners shall also receive the training mandated for employees under Standard 115.331 or for contractors and volunteers under Standard 115.332, depending upon the practitioner's status at the agency.

Medical and mental health staff completed the general training that is provided for all employees as indicated by training documentation and interviews. The standard PREA training is provided to all employees as indicated by the training logs and interviews.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for Risk of Victimization and Abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No
- Is this information ascertained: During classification assessments? ☒ Yes ☐ No

- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Resident Screening and Housing Policy
Youth Vulnerability Assessments
Youth Vulnerability Assessments Log
Referral Packet

Interviews:
Clinical Coordinator
Random Residents

Provision (a):
The Policy provides that upon arrival or within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

The Policy provides for a youth Vulnerability Assessment to occur within 24 hours of admission, conducted by mental health staff. According to the interviews, the screening assessment is generally completed within the same day of admission. According to the Clinical Coordinator, the approach in the administration of the screening instrument is through a conversation with the youth and she probes as needed. According to the Clinical Coordinator, the youth is made to feel comfortable she tells him how important it is to obtain the information. The youth is interviewed during the initial assessment and reassessment to obtain information about his personal history and behavior. The initial assessment

also includes a review of the case file; court records and other assessments available, in order to reduce the risk of sexual abuse by or upon a resident.

The facility reports that the number of youth admitted to the facility within the past 12 months who were screened during the admission process for risk of sexual victimization and the risk of sexually abusing other residents is 29. The youth Vulnerability Assessment instrument is used to obtain and record pertinent and personal information. The interviews revealed the practice of the risk screening being conducted as required. Screening instruments and interview with the Clinical Coordinator confirmed the information obtained includes but is not limited to the following:

- Prior sexual victimization or abusiveness;
- Resident's own perception of safety;
- History of psychiatric hospitalization;
- Self-identification of Resident;
- Level of emotional and cognitive development;
- Intellectual or developmental disabilities; and,
- Physical Disabilities
- Relationship with Other Youth
- Confirmation of Size
- Confirmation of Age

Provision (b):
Such assessments shall be conducted using an objective screening instrument.

The objective screening instrument, youth Vulnerability Assessment, is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his/her own safety. The instrument is scored based on the information received where a score can identify special needs. Assessments are conducted that collectively provide a presumptive determination of risk.

Provision (c):
At a minimum, the agency shall attempt to ascertain information about:
(1) Prior sexual victimization or abusiveness;
(2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
(3) Current charges and offense history;
(4) Age;
(5) Level of emotional and cognitive development;
(6) Physical size and stature;
(7) Mental illness or mental disabilities;
(8) Intellectual or developmental disabilities;
(9) Physical disabilities;
(10) The resident's own perception of vulnerability; and
(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Auditor reviewed the screening instrument and determined the items required by this provision of the standard are included. The interview with the Clinical Coordinator confirmed she is aware of the elements of the risk screening instrument. The resident interviews also confirmed the administration of

the screening instrument. The interviews revealed the practice is that the youth Vulnerability Assessment Instrument is administered the first day shortly after the youth's admission to the facility.

Provision (d):
This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

Information to complete screening instruments includes but not limited to review of court records, case files and assessments and information is obtained from parents/legal guardians. The interview with the Clinical Coordinator revealed that the information to complete the risk screening instrument is also gleaned from interviewing the youth. Additional classification assessments are completed when the youth is admitted to the facility and support the youth Vulnerability Assessment information.

Provision (e):
The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Appropriate controls are taken to ensure that sensitive information is protected and not exploited by maintaining the files securely in a locked cabinet in a locked office. The information on computers is password protected. The interviews with staff addressed the management of sensitive information and the expectation of confidentiality by staff. The evidence, including interviews and observations document the facility's adherence to the provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

Standard 115.342: Use of Screening Information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents

to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Resident and Housing Policy
Protection from Imminent Harm and Retaliation
Youth Vulnerability Assessments
PREA Pre-Audit Questionnaire

Interviews:
Clinical Coordinator
Residents
Nurse
Director
Compliance Coordinator
Random Staff

Provision (a):
The agency shall use all information obtained pursuant to §115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

Policy provides guidance to staff regarding the use of the information obtained from the screening instrument. The staff interviews and documentation indicate the screening information is used to inform staff of information based on the need to know and in housing assignments and the information may also affect program assignments.

Provision (b):
Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

A resident would only be placed in isolation as a last resort for protection and it would only be until other arrangements could be made to keep the resident safe and confirmed by the Clinical Coordinator. Policy also requires residents receive services which include education medical and mental health services. Interviews with the Nurse, Clinical Coordinator and Director were aligned with the Policy. Random staff interviews indicated that protective measures would be taken immediately when needed. There were not any residents at risk of sexual victimization placed in isolation in the 12 months preceding the audit.

Provision (c):
Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Policy support not placing lesbian, gay, bisexual, transgender, or intersex residents in specific housing solely based on how the residents identify or their status and there was no such housing identified during the comprehensive site review. The Policy prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. Housing assignments are made on a case-by-case basis as supported by the Policy and the interview with the Clinical Director. There were no residents in the facility that identified as gay, bisexual, transgender or intersex during the interview and site review dates.

Provision (d):
In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

Policy supports that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis which was evident from staff interviews and observations. There were no transgender or intersex residents identified in the facility during the pre-audit and onsite audit phases. The interviews with the Clinical Coordinator and Compliance Coordinator/PREA Coordinator confirmed the facility would consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

Provision (e):
Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

Policy provides placement and programming assignments for each transgender or intersex resident be reassessed twice per year to determine any threats to safety experienced by the resident. The Clinical Coordinator is aware of the facility policy.

Provision (f):
A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.
The resident's concern for his own safety is taken into account through the administration of the screening instrument and this applies to every resident as determined by review of Policy and the resident Vulnerability Assessments. The interviews were aligned with the Policy.

Provision (g):
Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Transgender or intersex residents will be given the opportunity to shower separately from other residents which is also supported by staff interviews and observations. All residents shower and use the bathroom separately. The interviews were aligned with Policy and the Standard.

Provision (h):
If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:
(1) The basis for the facility's concern for the resident's safety; and
(2) The reason why no alternative means of separation can be arranged.

Pursuant to paragraph (b), Policy requires that a resident would only be placed in isolation as a last resort for protection and it would only be until other arrangements could be made to keep the resident safe. The provisions of this standard would be provided in accordance with the Policies, which collectively are aligned with the standard. The interviews with the Nurse and Clinical Coordinator were aligned with the Policy. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit.

Provision (i):
Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

Pursuant to paragraph (h), Policy provides that every 30 days, staff will review the situation to determine whether there is a continuing need for separation from the general population. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard regarding use of screening information.

REPORTING

Standard 115.351: Resident Reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Reporting Policy
PREA Pamphlet
Resident Handbook
Facility Website
Grievances

MOU, Family Health Services of East Central Ohio (FHSECO)
PREA Pre-Audit Questionnaire

Interviews:
Random Staff
Residents
Compliance Coordinator/PREA Coordinator
Victim Services Coordinator, FHSECO

Provision (a):
The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The Policy and practice provide for internal ways a resident may report allegations of sexual abuse and sexual harassment, including how he can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to such. Residents may report allegations of sexual abuse or sexual harassment by telephone through 24-hour hotline numbers which includes Family Health Services of East Central Ohio. Telephones are accessible in each housing unit and residents are provided unimpeded access to the telephones to report allegations of sexual abuse, allegations of sexual harassment or to request advocacy services.

Policy, brochures, posters, and the Resident Handbook provide telephone numbers and instructions for reporting allegations and/or requesting assistance as a result of sexual abuse or sexual harassment. In addition to accessing a telephone, residents are also informed in the PREA education sessions, determined from the interviews, that they may tell staff; submit a grievance; or use the hotline regarding allegations of sexual abuse or sexual harassment. The residents interviewed identified someone who did not work at the facility that they could report to about sexual abuse or sexual harassment.

Random staff interviews collectively revealed residents may use the telephone, submit a grievance, or talk to staff. Residents may privately report sexual abuse and sexual harassment or request victim advocacy services by using the telephone or putting the complaint in writing. The telephones are dedicated for reporting abuse and requesting victim advocacy services and may be used by residents without staff assistance. Hotline numbers are provided on posters, in the Resident Handbook and are posted at the telephones. The Tip Line for the Ohio Department of Youth Services may also be used to report allegations of sexual abuse or sexual harassment.

Residents have access to writing materials, grievance forms and grievance boxes as observed and are accessible to all residents for reporting allegations. Written notes or letters may also be given to staff. If a grievance form is used to make a written allegation of sexual abuse, the reporting procedures will be implemented in accordance with Policy. PREA information is posted and each resident is provided a Resident Handbook which contains reporting and other PREA related information. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings.

Provision (b):
The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes

shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

Policy and interviews revealed residents and staff could use the hotlines to report allegations of sexual abuse and sexual harassment. The interviews revealed familiarity with the Policy and posted information on how to report allegations. Telephones are located in each living unit and telephones in offices may be used as needed. There have been no allegations of sexual abuse or sexual harassment during this audit period made through the hotline. The MOU provides for the resident to remain anonymous upon request. The Third-Party reporting form also allows for a resident to remain anonymous. The Reporting Policy provides that residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

Provision (c):
Staff shall accept reports made verbally, in writing, anonymously, and from third-parties and shall promptly document any verbal reports.

The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept reports made anonymously, third-party reports and to document verbal reports. The resident interviews collectively indicated awareness of the various ways of reporting allegations of sexual abuse and sexual harassment. All residents responded that the facility allows visits or telephone calls from lawyers and parents or someone else; there is the opportunity for reports to be made through those contacts.

Provision (d):
The facility shall provide residents with access to tools necessary to make a written report.

Policy supports and observations revealed writing materials are available for residents to complete Grievance Forms or write notes and indicated by the staff interviewed as well as residents. Each resident is provided a Resident Handbook which contains information regarding reporting through a Grievance Form.

Provision (e):
The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews collectively revealed that staff may privately report allegations of sexual abuse and sexual harassment through use of the hotlines; facility website; written note; written incident report; contact the Perry County Sheriff's Department; or verbally tell the Director.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

Standard 115.352: Exhaustion of Administrative Remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies

relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Facility Reporting Policy
Facility Juvenile Rights Policy
Resident Handbook
Grievance Forms

Interviews:
Random Staff
Residents

Provision (a):
An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

The facility is not exempt from this standard. Policy provides that an administrative process is used in dealing with grievances. Details are contained in the Reporting Policy that outlines the residents' grievance process; any third-party assistance to the resident; and appealing the initial decision in response to the grievance. The grievance process is described in the Resident Handbook. During this audit period, three Grievance Forms were submitted alleging sexual harassment and were investigated by the Compliance Coordinator/PREA Coordinator.

Provision (b):
(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

The Reporting Policy provides that there is no time limit for filing a grievance regarding allegations of sexual abuse and identifies the timelines contained in the grievance process. Residents are not required to use an informal process or give the grievance to any staff member regarding allegations of sexual abuse. The Policy does not restrict the facility's ability to defend against a lawsuit filed by a resident on the grounds that the applicable statute of limitations has expired.

Provision (c):
The agency shall ensure that—
(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

Policy provides that residents are not required to use an informal process or give the grievance to any staff member regarding allegations of sexual abuse. Such grievance is not referred to a staff member who is the subject of the complaint. To assist in the prompt handling of grievances alleging sexual abuse, the resident may check on the Grievance Form that it is PREA related and does not have to complete the remainder of the form. This action also makes the form easier and faster to complete for the alleged victim.

Provision (d):
(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.
(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.
(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.
(4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

The timelines of this standard provision are replicated in the Reporting Policy. The Policy provides for an extension if the normal time period for a response is insufficient to make an appropriate decision. Extensions were not required for the referenced grievances.

Provision (e):
(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.
(2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the

request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.
(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.
(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

Policy supports third-party assistance to a resident in filing grievances related to allegations of sexual abuse and a third-party may also file grievances on behalf of the resident. Attorneys are permitted to visit residents, providing the opportunity to assist with or file complaints alleging sexual abuse, if needed or requested by the resident. Parents or legal guardians will be provided the information to file a complaint on behalf of the resident, if needed, and the resident does not have to agree with the filing of the complaint. If a complaint is filed on behalf of the resident by someone other than the parent or legal guardian and the resident refuses the assistance, the reason will be documented as instructed by Policy.

Provision (f):
(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.
(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

Policy provides for emergency grievances to be responded to within 48 hours. A grievance alleging sexual abuse is received by the Director and the Compliance Coordinator. The review of the grievance will include measures to ensure safety and also include but not limited to determining an immediate corrective action that would be implemented within 48 hours. Grievances were not submitted alleging sexual abuse during this audit period.

Provision (g):
The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.
According to Policy, a resident may be disciplined for filing a grievance related to sexual abuse only when it has been determined that the resident filed the grievance in bad faith.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

Standard 115.353: Resident Access to Outside Confidential Support Services and Legal Representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Access to Care Policy
Resident Handbook
PREA Pamphlet
Resident Request Form
PREA Posters
MOU, Family Health Services of East Central Ohio

Interviews:
Residents
Compliance Coordinator/PREA Coordinator

Provision (a):
The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

Information is provided in the Resident Handbook and in the living units on the wall at the telephone. The resident interviews revealed they have access to call the hotline at any time and the information is posted. The MOU with Family Health Services for the provision of advocacy services and interview with the Victim Services Coordinator confirmed the availability of advocacy services. During the comprehensive site review, the dedicated telephones were checked and were found to be in working order. The MOU and the posted information address confidentiality. A corrective action was implemented for the current eight residents to specifically review the victim advocacy services to ensure the residents' clear understanding of the services that will be provided by Family Health Services of East Central Ohio.

Provision (b):
The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

The MOU and Policy provides there will be adherence to confidentiality measures. Posted at each telephone is a document which outlines what advocates can and cannot do. The refresher PREA education session included the review of confidentiality measures.

Provision (c):
The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support

services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

A MOU exists between the facility and Family Health Services of East Central Ohio for victim advocacy services. The MOU and the advocacy service agency's representative's interview document the provision of advocacy services including but not limited to emotional support; accompaniment through the forensic medical examination and investigative interview; and referrals. The facility is provided services through the 24-hour hotline number.

Provision (d):
The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

Residents have access to attorneys and court workers and reasonable access to their parents/legal guardians which is supported by the Resident Handbook, information on the internet and Policy. During the pandemic while visitation to the facility was suspended, youth have been provided the opportunity to conduct video calls with parents or guardians and with attorneys and court workers where requested.

The Resident Request Form may be submitted regarding any type request from the residents, including telephone calls to attorneys and other representatives of the court. Residents have also been provided additional envelopes and stamps for correspondence during the pandemic. All residents interviewed confirmed visitation and telephone calls occur.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility meets this standard.

Standard 115.354: Third-Party Reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Reporting Policy
Third-Party Reporting Form
Facility Website Information
PREA Posters and Brochure
Resident Handbook

Interviews:
Random Staff
Residents
Director

Standard 115.354:
The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

The staff members are aware third-party reporting of sexual abuse or sexual harassment can be done and that the information will be accepted and reported. Staff members reported that they are to document all verbal reports received. The interviews revealed that staff may report allegations privately and include but not limited to use of the abuse reporting hotline, facility website, and Sheriff's Department. The facility's website contains a Third-Party Reporting Form.

Information is posted in the facility accessible to staff, residents, contractors, volunteers, and visitors which support allegations being reported by a third-party. Information regarding reporting is contained in the Resident Handbook. All residents interviewed indicated knowing someone who did not work at the facility they could report to regarding allegations of sexual abuse. No third-party reports were received during this audit period.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is in compliance with this Standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and Agency Reporting Duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Reporting Policy
Facility Juvenile Rights Policy
Reports
PREA Resident Orientation Training Logs

Interviews:
Random Staff
Registered Nurse
Clinical Coordinator
Director
Compliance Coordinator

Provision (a) and (b):
Provision (a): The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.
Provision (b): The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

Policies support that all staff report any knowledge, suspicion, information, or receipt of information regarding an incident or allegation of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws. The facility-based trained investigator conduct administrative investigations and allegations that are criminal in nature are referred to the Perry County Sheriff Department. Staff members are deemed as mandated reporters by the State. Policy provides guidance to staff on reporting allegations of sexual abuse and sexual harassment.

Provision (c):
Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Policy addresses confidentiality of information and prohibits staff from revealing any information related to a sexual abuse report. Staff members are instructed to keep the information confidential regarding what was reported except when necessary regarding the investigation and treatment and management decisions.

Provision (d):
(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.
(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

Residents are informed at the initiation of services of the limitations of confidentiality and the duty of the staff members to report. Residents are also informed during orientation and it is recorded on the PREA Resident Orientation Training Log. The clinical staff interviewed revealed they are mandated reporters and required by the State to report allegations received regarding sexual abuse and sexual harassment which is also in accordance with facility Policies.

Provision (e):
(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified.
(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians.
(3) If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

The Reporting Policy and interviews provide that reports of allegations of sexual abuse will be made as soon as possible and complete written reports. The Director is notified and the Perry County Sheriff's Department will be notified by the Director or designee. The Compliance Coordinator who conducts administrative investigations is also notified. Additionally, the juvenile courts, parents/legal guardians and appropriate child welfare agency will be notified as soon as possible. The Policy and interview with the Director confirmed that a resident's case worker rather than a parent would be notified where indicated by the resident being under the guardianship of a child welfare agency. The resident's attorney would be notified by the Director or designee within 14 days, in accordance with the Policy.

Provision (f):
The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

The Compliance Coordinator, responsible for PREA investigations, is made aware of all allegations. Allegations that are criminal in nature are referred for investigation to the Perry County Sheriff's Department. Third-party and anonymous reports received must be reported and documented by staff as confirmed through staff interviews and Policy. The Director and Compliance Coordinator/PREA Coordinator confirmed that all allegations are reported to the investigative entities.

Conclusion:
The interviews with random staff, clinical staff and other staff revealed their awareness of the requirements regarding the reporting duties.

Standard 115.362: Agency Protection Duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Protection from Imminent Harm and Retaliation Policy
Grievance Forms

Interviews:
Director
Random Staff
Compliance Coordinator/PREA Coordinator

Provision (a):
When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

The staff is required to protect the residents through implementing protective measures. The Policy and interviews revealed that the expectation is that protective measures are implemented immediately. The interviews revealed that protective measures include separating the residents involved and alerting the Director and Compliance Coordinator. Administration of the youth Vulnerability Assessment, screening instrument, provides information that assists and guide staff in keeping residents safe through housing and program assignments.

During the intake process, residents are asked about how they feel about their safety as part of the inquiries by staff completing the youth Vulnerability Assessment. Additional assessment instruments provide information which offer additional information in determining the risk levels. No resident was identified to be at substantial risk of imminent sexual abuse in the past 12 months.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

Standard 115.363: Reporting to Other Confinement Facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Reporting Policy

Interview:
Director

Provisions (a) - (d):
Provision (a): Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency.
Provision (b): Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.
Provision (c): The agency shall document that it has provided such notification.
Provision (d): The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

Policy provides that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Director will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. The notification is to be made as soon as possible and within 72 hours and is to be documented, in accordance with Policy.

The Director will ensure that the allegations are investigated according to the PREA Standards as the Policy states. The interview supported that allegations of sexual abuse or sexual harassment from a resident regarding his/her stay in another facility will be reported and investigated as required. In the past 12 months, there were no allegations of sexual abuse occurring at another facility received by this facility.

Conclusion:
Based upon the information received and interviews, the Auditor determined the facility is compliant with this standard.

Standard 115.364: Staff First Responder Duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Response Policy
Facility Supervision Policy

Interviews:
Random Staff

Director

Provision (a):
Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to:
(1) Separate the alleged victim and abuser;
(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

The Policy and training provide that upon learning of an allegation a resident was sexually abused the staff response includes but is not limited to the following:

a. Separate the alleged victim and alleged abuser;
b. Call for assistance
c. Take appropriate steps for the preservation and collection of any evidence;
d. Preserve and protect the scene until appropriate steps can be taken to collect any evidence;
e. Request that the alleged victim not take any actions that could destroy physical evidence;
f. Ensure the alleged abuser does not take any actions that could destroy evidence.
g. Make the required notifications.

The interviews with staff confirmed general awareness of first responder duties and the training provided. There were no allegations or incidents where staff had to act as a first responder in the last 12 months.

Provision (b):
If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

The Policy instructs non-security staff who may act as a first responder to request that physical evidence be preserved and to contact direct care staff for assistance. There were no allegations or incidents where a non-security staff member had to act as a first responder in the last 12 months.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard and would respond accordingly, based on Policy, training documentation and interviews.

Standard 115.365: Coordinated Response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Response Policy
Plan for Coordinated Response to Sexual Abuse or Sexual Assault

Interviews:
Random Staff
Director

Provision (a):
The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The Policy provides guidance to staff regarding the actions to take when there is an alleged incident of sexual abuse and requires a written facility plan. The written institutional Plan formats the activities that must occur in response to an incident of sexual abuse. The institutional plan includes the involvement of identified staff members such as the first responder; mental health staff; medical staff; Director; Compliance Coordinator/PREA Coordinator; and outside agencies. The staff interviews indicated general familiarity regarding the response to an allegation or incident of sexual abuse.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility staff has the capability to implement the written Plan.

Standard 115.366: Preservation of Ability to Protect Residents from Contact with Abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Interviewed:
Director

Provision (a) and (b):
Provision (a): Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreements that limits the agency's ability to remove alleged staff sexual abusers form contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.
Provision (b): Nothing is this standard shall restrict the entering into on renewal of agreements that govern:
(1) The conduct of the disciplinary process, at long as such agreements are not inconsistent with the provisions of §§ 115.372 and 115.376; or
(2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.

Based on the interview, the facility is not involved in and does not maintain collective bargaining agreements and there is no evidence of such.

Standard 115.367: Agency Protection against Retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fears retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Protection from Imminent Harm and Retaliation Policy
Sexual Abuse and Sexual Harassment Retaliation Status Check Form

Interviews:
Clinical Coordinator
Director

Provision (a):
The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

The Policy supports protecting residents and staff who report sexual abuse or sexual harassment, or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents, or staff. The Clinical Coordinator, with support of the Compliance Coordinator, is responsible for ensuring retaliation monitoring occurs. The Form is used to document the monitoring activities. The interviews revealed familiarity with the role of the retaliation monitor.

Provision (b):
The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

Protective measures were identified during the interviews and aligned with Policy, including but not limited to random checks; random camera checks; housing changes; shift changes; personnel actions including termination; removal of resident from the facility. The review of the Monitoring Checklist and Policy and interviews confirmed the measures to detect and protect staff and residents from retaliation by others are in place. The staff interviews were aligned with the Policy and Checklist that would be used to document the required retaliation monitoring activities.

Provision (c):
For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The monitoring would occur for at least 90 days to see if there are any changes that may suggest possible retaliation is occurring. The Clinical Coordinator stated that the monitoring period could last longer if needed. The Policy and interviews identify items that would be monitored to assess retaliation include disciplinary reports; incident reports; grievances; housing changes; interactions; and point system documents. There have been no allegations of sexual abuse during this audit period. The PREA letter documented retaliation monitoring by the PREA Coordinator.

Provision (d):
In the case of residents, such monitoring shall also include periodic status checks.

The formal monitoring document and interview with the Clinical Coordinator indicate that status checks would occur as a part of retaliation monitoring. The residents who made the allegations were released from the facility within 30 days.

Provision (e):
If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

The Policy encompasses those who cooperate with an investigation if there is a concern regarding retaliation. The interviews indicated that the appropriate measures would be taken to protect any related individuals against retaliation.

Provision (f):
An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The obligation to monitor for retaliation terminates, if it is determined that the allegation is unfounded. The interviews determined familiarity with the Policy.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard. The facility has safeguards in place to identify and respond to retaliation if such occurs.

Standard 115.368: Post-Allegation Protective Custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Document Reviewed:
Protection from Imminent Harm and Retaliation Policy

Interviews:
Director
Registered Nurse
Clinical Coordinator

Provision (a):
The use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of §115.342.

The Policy provides that residents who may be placed in protective custody are only isolated as a last resort and until alternative measures can be arranged. The Policy states that while in isolation the resident will not be denied education, special education and daily large muscle exercise. The facility reports that there has not been any type segregation used for an alleged victim's protective custody.

The interviews provide that any use of isolation to protect a resident would not prevent them being afforded daily large muscle exercise, educational programming or special education services and daily visits from a medical or mental health clinician. If a resident is placed in protective custody, a review to determine whether there is a continuing need for the isolation will be conducted every 30 days, per Policy.

The facility reports that no residents alleged sexual abuse and were placed in protective custody in the past 12 months. The interviews supported that if a resident would be placed in protective custody, the required treatment and program services would be provided in accordance with the Policy.

Conclusion:
Based upon the review of Policy, interviews, and observations, the Auditor determined the facility is compliant with this standard.

INVESTIGATIONS

Standard 115.371: Criminal and Administrative Agency Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of

criminal OR administrative sexual abuse investigations. See 115.321(a).]
☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☐ Yes ☒ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Response Policy
MOU, Perry County Sheriff's Department
Investigation Reports

Interviews:
Compliance Coordinator/PREA Coordinator
Director

Provision (a):
When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

Based on the Policy and interview, the trained facility-based investigator conducts administrative investigations. The Perry County Sheriff's Department conducts investigations when the allegations are criminal in nature, in accordance with the Policy and MOU. Investigations are conducted promptly, thoroughly and objectively according to the review of documentation and interview with the Compliance Coordinator who conducts administrative investigations.

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Provision (b) and (c):
Provision (b): Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to §115.334. **Provision (c):** Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

The Auditor reviewed the investigator training certificates for the Compliance Coordinator and the interview was aligned with the training and the standard. The investigator has Certificates of Completion of the online courses with the National Institute of Corrections. Law enforcement is primarily responsible for collecting physical and DNA evidence.

Provision (d):
The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

The interview confirmed the provision in the Policy that an investigation is not terminated if the source recants the allegation.

Provision (e):
When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

The Response Policy provides that the Compliance Coordinator as the investigator may conduct compelled interviews only after consulting with the prosecutor's office and it will not jeopardize criminal

prosecution.

Provision (f):
The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

The credibility of an alleged victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as a resident or staff as supported by the interview and training, and in accordance with the Policy. According to the Policy, no resident who alleges sexual abuse will be subjected to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of an allegation.

Provisions (g) and (h):
Provision (g): Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse.
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.
Provision (h): Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

PREA investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. All investigations are completed with written reports that include a description of the evidence and investigative facts and findings.

Provision (i):
Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

The facility-based investigator does not conduct criminal investigations. It is the responsibility of law enforcement personnel to refer cases for prosecution which is indicated in the MOU.

Provision (j):
The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

The Policy provides that written investigative reports are maintained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.
Provision (k):
The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

Policy and the interview with the investigative staff confirmed that upon the start of an investigation, it will not end until the investigation has been completed. The departure of the alleged abuser or victim from the employment or control of the facility will not terminate the investigation.

Provision (l):

Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

The investigative agency is aware of the PREA standards requirements. There is a MOU with the Perry County Sheriff's Department. The MOU and Policy confirm a uniform evidence protocol will be used that maximizes the potential for obtaining usable physical evidence.

Provision (m):
When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

Facility Policy and interviews indicate that staff cooperates with investigators and that the facility is kept informed of the progress of an investigation and in accordance with the MOU.

Conclusion:
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

Standard 115.372: Evidentiary Standard for Administrative Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Document Reviewed:
Response Policy

Interview:
Compliance Coordinator/PREA Coordinator

Provision (a):
The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The Policy provides directions to staff regarding the administrative investigations and provides the evidentiary standard for administrative investigations. The Compliance Coordinator conduct administrative investigations and allegations that are criminal in nature are referred to the Perry County Sheriff's Department. According to the interview the standard of evidence required to substantiate allegations is a preponderance of the evidence.

Conclusion:
Based upon the review and analysis of the evidence, the Auditor determined the facility is compliant with this standard.

Standard 115.373: Reporting to Residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident

whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Response Policy
Resident Required Notifications

Interviews:
Compliance Coordinator
Director

Provision (a):
Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

The Policy addresses the resident being informed when the investigation is completed and the outcome of the investigation provided in writing. The facility has a dedicated form to be used for notification of completed investigations. The form provides responses to investigations conducted for sexual abuse and sexual harassment. The interviews revealed awareness of the Policy requirements.

Provision (b):
If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

The Director or designee will remain abreast of an investigation conducted by law enforcement and will be provided a copy of completed investigations and is supported by Policy and the MOU. The results of the investigation will be provided to the resident in writing by facility staff per Policy.

Provision (c):
Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:
(1) The staff member is no longer posted within the resident's unit;
(2) The staff member is no longer employed at the facility;
(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

The Policy requires that following a resident's allegation that a staff member committed sexual abuse against the resident, the resident will be informed, in writing, of the following, unless it has been determined that the allegation is unfounded, whenever:

a. The staff member is no longer posted within the resident's housing unit;
b. The staff member is no longer employed at the facility;
c. The staff member has been indicted on a charge related to sexual abuse in the facility; and/or
d. The staff member has been convicted on a charge related to sexual abuse in the facility.

Provision (d):
Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:
(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

The Policy provides that following a resident's allegation that he has been sexually abused by another resident the alleged victim shall be informed, in writing, whenever:

a. The alleged abuser is criminally charged related to the sexual abuse.
b. The alleged abuser is adjudicated on a charge related to sexual abuse within the facility.

Provision (e):
All such notifications or attempted notifications shall be documented.

The Policy provides that the notifications to the resident be documented.

Provision (f):
An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

The facility's obligation to report under this standard terminates if the resident is released from the facility and is no longer a part of Ohio Department of Youth Services, per the Policy.

Conclusion:
The interviews and review of Policy confirmed the requirements and staffs' knowledge of the process of reporting to a resident regarding the outcome of an investigation.

DISCIPLINE

Standard 115.376: Disciplinary Sanctions for Staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staffs subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff that would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Discipline Policy
PREA Pre-Audit Questionnaire

Interview:
Director

Provision (a):
Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

The Policy and interview support that staff be subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies. One employee was terminated regarding an arrest where the allegation was made outside of the facility. As a part of the investigation by the Perry County Sheriff's Department, residents were interviewed to determine if any issues were present during the staff member's working hours. No issues were identified and no charges resulted from employment.

Provision (b):
Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse.

The Policy states that termination is the presumptive disciplinary sanction for staff who has engaged in sexual abuse with a resident. The interview was aligned with Policy.

Provision (c):
Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Disciplinary sanctions for violations of policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) will be commensurate with the act committed, the staff member's disciplinary history, and the similar history of other staff. During this audit period, there were no allegations of staff-on-resident sexual abuse or sexual harassment.

Provision (d):
All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

The Policy provides that terminations for violations of the facility's sexual abuse or sexual harassment policies or resignations by staff by staff who would have been terminated if not for their resignation, will be reported to law enforcement, unless the activity is clearly not criminal. In addition, such will be reported to relevant licensing bodies.

Conclusion:
Based upon the review of Policies and the interview which was aligned with Policies, the Auditor determined the facility is compliant with this standard.

Standard 115.377: Corrective Action for Contractors and Volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Discipline Policy
Volunteer Handbook
PREA Pre-Audit Questionnaire

Interviews:
Director
Contractor
Volunteer

Provision (a):
Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

The Policy provides for contractors and volunteers who engage in sexual abuse with a resident to be reported to law enforcement and to relevant licensing bodies. Documentation and interviews with a contractor and volunteer confirm that the facility provides contractors and volunteers a clear understanding that sexual misconduct with a resident is prohibited. Any contractor or volunteer who violates the agency's sexual abuse or sexual harassment policies is prohibited from contact with residents and will be terminated. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

Provision (b):
The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.
Any contractor or volunteer who violates the agency's sexual abuse or sexual harassment policies will be prohibited from contact with residents and reported to law enforcement, unless the activity was clearly not criminal. In the past 12 months, no contractors or volunteers were reported for allegations of sexual abuse or sexual harassment.

Conclusion:
Based upon the review of the documentation and interviews, the Auditor determined the facility is compliant with this standard.

Standard 115.378: Interventions and Disciplinary Sanctions for Residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Discipline Policy
Juvenile Services Policy
PREA Pamphlet
Resident Handbook
Volunteer Handbook

Interviews:
Clinical Coordinator
Registered Nurse
Director

Provision (a):
A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

The Policy provides that residents may be subject to disciplinary sanctions only after formal proceedings regarding resident-on-resident sexual abuse. Residents found in violation of facility rules are subject to sanctions pursuant to the administrative process or following a criminal finding of guilt. The consequences will be administered in accordance with the Policy and the Resident Handbook and up to removal from the facility. There has not been an incident of sexual abuse during the past 12 months. Allegations of sexual abuse are referred for an investigation to the Perry County Sheriff's Department.

Provision (b):
Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

Disciplinary sanctions will be commensurate with the nature and circumstances of the offense committed; consider resident's disciplinary history; consider similar disciplinary history of other residents; and consider mental disabilities or mental illness contributing to the behavior. According to the Director, PREA related violations can result in the resident being removed from the facility. Allegations of sexual abuse are referred for an investigation to the appropriate investigative entity. Daily required visits would be made to residents if they are placed in isolation in accordance with Policy.

Provision (c):
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

Consideration of mental disabilities or mental illness is considered as to whether it contributed to the resident's behavior regarding the application of disciplinary measures. The interviews with the Director and Clinical Coordinator support this premise and Policy. There were no allegations of sexual abuse during this audit period.

Provision (d):
If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

The facility would consider whether to offer the offending resident intervention services designed to address and correct underlying reasons or motivations for the abuse participation, based on the interview with the Clinical Coordinator. The facility may require participation in such interventions as a condition for participation in the behavior management system but not to access general programming or education as determined from the Policy review.

Provision (e):
The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

The Policy provides that a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Provision (f):
For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The Policy supports that a report of sexual abuse made in good faith based on the belief that the alleged incident occurred does not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Provision (g):
An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

Policy and practice prohibit any sexual conduct between residents. Such contact is considered to constitute sexual abuse only if it is determined that the activity was coerced.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor determined the facility is compliant with this standard.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and Mental Health Screenings; History of Sexual Abuse

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Facility Resident Screening and Housing Policy
Facility Reporting Policy
PREA Resident Orientation Training Log

Interviews:
Registered Nurse
Clinical Coordinator
Compliance Coordinator

Provision (a) and (b):
Provision (a): If the screening pursuant to §115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.
Provision (b): If the screening pursuant to §115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

Policy and interviews provide that youth be referred to a mental health or medical clinician within 14 days if he is identified as at risk for sexual victimization of as previously having perpetrated sexual abuse. Targeted interviews and supporting documentation documented that a youth that discloses victimization or abusiveness during the screening is provided follow-up services with a clinician.

Provision (c):
Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

According to Policy, no information is to be shared with other staff unless it is required for security and management decisions regarding sexual abuse history. Information related to sexual victimization or abusiveness that occurred in an institutional setting will be strictly limited to the staff, as necessary, to inform security and make effective management decisions. The files maintained in a secure manner.

Provision (d):
Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

Informed consent is obtained for residents over 18 years old prior to clinical personnel reporting information disclosed about prior sexual victimization that did not occur in an institutional setting. The written information is provided on the PREA Resident Orientation Training Log and reviewed with the youth during the orientation process. Clinical staff members understand the practice of informed consent.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

Standard 115.382: Access to Emergency Medical and Mental Health Services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Response Policy
Plan for Coordinated Response to Sexual Abuse or Sexual Assault
MOUs

Interviews:
Registered Nurse
Clinical Coordinator

Provision (a):
Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

The written Plan and Policy support that the alleged victim will receive timely and unimpeded access to emergency medical treatment and crisis intervention services. The interviews were aligned with the Policy including that the nature and scope of there are services determined according to their professional judgment.

The victim would be transported to the hospital for a forensic medical examination by a Sexual Assault Nurse Examiner, at no cost to the victim and in accordance with Policy and the Plan for Coordinated Response to Sexual Abuse or Sexual Assault. Residents are informed of clinical services during the intake process. Observations revealed that medical and mental health staff members maintain secondary materials and documentation of resident encounters.

Provision (b):
If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners.

The interviews with clinical staff revealed residents have access to unimpeded access to emergency services. The Policies and Plan response plan provide guidance to staff in protecting residents and for contacting the appropriate staff and agencies regarding allegations or incidents of sexual abuse, including contacting treatment staff and/or arrangements for getting residents to the hospital. A review of the written Plan and Policy; observations; and the interviews indicate unimpeded medical and crisis intervention services will be available to a victim of sexual abuse.

Provision (c):
Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

Policy, MOU and interviews confirmed processes and services are in place for a victim to receive timely access to sexually transmitted infection prophylaxis at the hospital, where medically appropriate. Additionally, follow-up services as needed will be provided by the facility's treatment staff and/or transportation will be provided to support services coordinated by staff.

Provision (d):
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The Policy, MOU and interviews provide that treatment services will be provided to the victim without financial cost to the victim and regardless of whether the victim names the abuser, or cooperate with any investigation arising out of the incident.

Conclusion:
The Policy and interviews revealed emergency services will be provided by medical and mental health staffs. The interviews revealed knowledge of actions to take regarding an incident of sexual abuse. Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

Standard 115.383: Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Access to Care Policy
MOU

Interviews:
Registered Nurse
Clinical Coordinator

Provision (a):
The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

Medical and mental health evaluation and treatment will be offered to resident victims of sexual abuse. The interviews revealed that follow-up services will be provided that include but are not limited to additional counseling and emotional support and treatment of injuries and provision of other medical follow-up services.

Provision (b):
The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

The interviews with the clinical staff and documentation confirmed on-going medical and mental health care will be provided as appropriate and will include but not be limited to treatment planning; evaluations, and follow-up services and referrals as needed. Specialized treatment may also be provided by clinicians on site and through contracted services. Discharge instructions will be followed.

Provision (c):
The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Review of Policies, staff interviews and documentation revealed medical and mental health services are consistent with the community level of care. Treatment services may be provided by facility staff and contract providers. The interviews underscored that the treatment services at the facility are consistent with the community level of care.

Provision (d):
Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

Only males are housed at this facility.

Provision (e):
If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Only males are housed at this facility.

Provision (f):
Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The interviews and the Policy ensure that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate.

Provision (g):
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

All treatment services will be provided at no cost to the victim and whether or not the victim names the abuser of cooperates with the investigation, according to Policy, staff interviews and MOU.

Provision (h):
The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

An attempt for a mental health evaluation will be conducted on known resident-on-resident abusers within 60 days and treatment offered where appropriate, according to Policy.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor determined the facility is compliant with this standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual Abuse Incident Reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386 (d) (1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Incident Review Team Policy
Sexual Abuse and Sexual Assault Incident Review Checklist

Interviews:
Director
Assistant Director

Provision (a):
The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

The Policy requires the facility to conduct a sexual abuse incident review at the conclusion of an investigation, unless the allegation was unfounded. The staff understands the role of the incident review team. A review of the Policy and interview confirmed incident reviews will be conducted regarding the investigation of an allegation of sexual abuse, unless unfounded and in accordance with the Policy.

Provision (b):
Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

The Policy requires that the review occurs within 30 days of the conclusion of the investigation. The interviews confirmed incident reviews would occur within 30 days of the conclusion of an investigation in accordance with facility Policy and the standard. There were no allegations of sexual abuse during this audit period.

Provision (c):
The incident review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

The Policy and interviews identify the treatment team as the incident review team members and will also include other staff identified by the Director and the investigator from the Perry County Sheriff's Department. The additional staff members will attend the meeting as needed, related to the incident.

Provision (d):
The review team shall:
(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
(4) Assess the adequacy of staffing levels in that area during different shifts;

(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

The Policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The interviews and review of Policy confirmed the incident review team is charged with considering the factors identified in this standard provision regarding the results of the investigation. The Policy provides that written results of the meeting be prepared, including recommendations for improvement and the document be submitted to the Director.

Provision (e):
The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

The Policy directs the report be provided and the recommendations be implemented. The Policy also provides that the Director ensures that the recommendations of the incident review team be implemented and that when they are not, the reasons are documented. No incident review team meetings were held during this audit period due to there being no allegations of sexual abuse.

Conclusion:
Based upon the Policy and interviews, the Auditor has determined the facility is compliant with this standard.

Standard 115.387: Data Collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?
  ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
  ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Collection, Review, Public Report and Retention Policy
Facility Definitions Adopted from the Prison Rape Elimination Act Policy
Annual Data Report

Interviews:
Director
Compliance Coordinator

Provisions (a) & (c):
Provision (a): The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.
Provision (c): The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

The Policy provides that the facility will collect accurate and uniform data for every allegation of sexual abuse from incident-based documents necessary to answer all questions from the most recent version of the Survey of Sexual Victimization, formerly known as the Survey of Sexual, Violence. A review of documentation and interviews support the review of collected data of significant incidents occur.

Provision (b):
The agency shall aggregate the incident-based sexual abuse data at least annually.

The facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. The aggregated data is submitted to the ODYS PREA Administrator and contributes to the development of the overarching annual report which includes all of the state and local facilities under the auspices of ODYS.

Provision (d):
The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The facility collects and maintains identified data and related documents regarding PREA information as applicable. The facility collects and maintains data and aggregates the data which culminates into a report.

Provision (e):
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

The facility does not contract with other facilities for the confinement of its residents.

Provision (f):
Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

Policy provides that upon request, the facility completes all such data from the previous calendar year to the Department of Justice in a timely manner based on the year of the most recent version of the Survey of Sexual Victimization.

Conclusion:
Based upon the review and analysis of the documentation and the interviews, the Auditor has determined the facility is compliant with this standard.

Standard 115.388: Data Review for Corrective Action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response

policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Collection, Review, Public Report and Retention Policy
Annual Data Report

Interviews:
Compliance Coordinator
Director

Provision (a): The agency shall review data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:
(1) Identifying problem areas;
(2) Taking corrective action on an ongoing basis; and

(3) Preparing an annual report of its findings and corrective actions for each facility, as well as this agency as a whole.

The interviews support the review of data and that it will be used to improve the PREA efforts. The interviews and review of documentation revealed the collection of data. There is indication that data is reviewed to assess and improve the effectiveness of prevention, detection and response and for preparing annual reports based on the collected data.

Provisions (b)-(d):
Provision (b): Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.
Provision (c): The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.
Provision (d): The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

The annual data report is prepared by Compliance Coordinator, approved by the Director and submitted to the ODYS PREA Administrator. There are no personal identifiers in the report. The annual data report contains PREA related information that represents the last two calendar years allowing for comparison of data over the two-year period. The annual data report is posted on the facility's website.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor determined the facility is compliant with this standard.

Standard 115.389: Data Storage, Publication, and Destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Data Policy
Annual Data Report
Survey of Sexual Victimization

Interview:
Compliance Coordinator/PREA Coordinator

Provision (a)-(d):
Provision (a): The agency shall ensure that data collected pursuant to §115.387 are securely retained.
Provision (b): The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means.
Provision (c): Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.
Provision (d): The agency shall maintain sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.
The Policy provides that all data collected will be securely stored and maintained for at least 10 years unless a law requires otherwise. The Policy requires that personal identifiers be removed from aggregated data before making the data publicly available. The report of the Survey of Sexual Victimization is posted on the facility's website and the overarching annual report is posted on the ODYS website. A review of the report verified there are no personal identifiers. All facility records are securely stored per the Policy and as observed.
Conclusion:
Based upon the review and analysis of the documentation, interviews and observations, the Auditor determined the facility is compliant with this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and Scope of Audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The initial PREA audit was conducted in 2014 and there was a subsequent audit in 2017. The PREA Pre-Audit Questionnaire and supporting documentation was initially provided to the Auditor on a flash drive. The Auditor was provided additional information by email and in-person during the onsite audit phase, as requested. During the post audit phase, the Compliance Coordinator/PREA Coordinator provided the Auditor with evidence that the corrective action of refresher education for the residents was implemented.

During the onsite audit phase, a comprehensive site review was provided to the Auditors and there was full access to the facility. The Compliance Coordinator/PREA Coordinator, Director, other facility staff, and the Ohio Department of Youth Services' PREA Administrator were cooperative in providing information and participating in or facilitating the interviews.

The Compliance Coordinator ensured that the virtual interviews were conducted in private with the residents and staff. The posted notices regarding the audit were observed posted within the facility. The notices provided the general information and included instructions and Auditor contact information regarding how to provide confidential information to the Auditor. The facility has a process for confidential correspondence however no correspondence from staff or residents was received by the Auditor.

Standard 115.403: Audit Contents and Findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not

excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
2017 PREA Audit Report on Facility Website

Interviewed:
Compliance Coordinator/PREA Coordinator

Provision (f):
The agency shall ensure that the auditor's final report is published on the agency's website if it has one, or is otherwise made readily available to the public.

The posted audit report does not contain any personal identifying information other than names and job titles. The facility's policies and additional documentation, practices and interviews were reviewed regarding compliance with the standards and have been identified in the reports. The audit findings were based on a review of policies, procedures, supporting documentation, observations, and interviews. There were no conflicts of interest regarding the completion of this audit. This report does not contain any personal identifying information other than names and job titles of facility, community agency and State administrators and it will be posted.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Shirley L. Turner September 15, 2020

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.