PREA Facility Audit Report: Final

Name of Facility: Community Transition Center Halfway House
Facility Type: Community Confinement
Date Interim Report Submitted: 05/06/2020
Date Final Report Submitted: 10/14/2020

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Ramona Wheeler	**Date of Signature:** 10/14/2020

AUDITOR INFORMATION	
Auditor name:	Wheeler, Ramona
Email:	ramona.wheeler@alvis180.org
Start Date of On-Site Audit:	02/13/2020
End Date of On-Site Audit:	02/14/2020

FACILITY INFORMATION	
Facility name:	Community Transition Center Halfway House
Facility physical address:	151 E. Hubert Ave, Lancaster, Ohio - 43130
Facility Phone	
Facility mailing address:	151 E. Hubert Avenue, Lancaster, - 43130

Primary Contact	
Name:	Mindy Lou Morrison
Email Address:	mindy@ctclancaster.com
Telephone Number:	7406891200

Facility Director	
Name:	Travis Mathes
Email Address:	travis@ctclancaster.com
Telephone Number:	7408080047

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Characteristics	
Designed facility capacity:	90
Current population of facility:	88
Average daily population for the past 12 months:	82
Has the facility been over capacity at any point in the past 12 months?	Yes
Which population(s) does the facility hold?	Males
Age range of population:	18-80
Facility security levels/resident custody levels:	low -
Number of staff currently employed at the facility who may have contact with residents:	29
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	5
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Community Transition Center, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	151 E. Hubert Ave, PO Box 11, Lancaster, Ohio - 43130
Mailing Address:	
Telephone number:	740-689-1200

Agency Chief Executive Officer Information:	
Name:	Jill Peck
Email Address:	jill@ctclancaster.com
Telephone Number:	740-808-0068

Agency-Wide PREA Coordinator Information			
Name:	Mindy Morrison	**Email Address:**	mindy@ctclancaster.com

AUDIT FINDINGS

Narrative:
The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-audit, on-site 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.

Background

the Community Transition Center (CTC) started in 1997 at its current location, 151 E. Hubert Ave., Lancaster, OH. CTC was founded by (the late) Jim Peck, who served in multiple capacities of law enforcement, including the Sheriff in the Lancaster, Ohio community, and State corrections. Jim decided to start a halfway house, as there was no community corrections entity in the area, and inmates had no post-release programming in the area. Jim's wife, Jill Peck became CEO in 2011, after Jim's passing, and is the current Executive Director.

The location identified is the only facility operated by CTC, and was the only site audited. This audit was the facility's second audit cycle. Prior PREA audits were conducted in 2015, and 2019 (the facility was not audited in 2018, which ended Cycle 1). The facility did not achieve full compliance with the PREA standards. This auditor conducted the facility's 2019 PREA compliance audit. Due to noncompliance, and corrective action not completed within the established 180-day period, the agency CEO requested to undergo a new audit in 2020. The PREA onsite visit at the Community Transition Center (CTC) was conducted on February 13 - 14, 2020.

Contract Procurement

On 10/2/2019, CTC Facility Director Travis Mathes contacted Ramona Wheeler via email regarding conducting a PREA audit, based on the outcome of noncompliance in its 2019 PREA audit. Director Mathes communicated that, since the 2019 PREA audit, the facility has been working on its Corrective Action Plan, and desires that a new audit be conducted. Several emails were exchanged to consider auditor and CTC schedules, and the requirement by the Ohio Department of Rehabilitation and Correction (ODRC) that all PREA audits in Ohio correctional facilities, be complected before March 1 of each year.

On 12/2/2019, CTC and Ramona Wheeler entered into an agreement for Wheeler to conduct a PREA audit February 13-14, 2020. A Memorandum of Understanding (MOU) between CTC and DOJ-certified PREA auditor Ramona Wheeler was submitted to the facility on 11/27/2019; the CEO, Jill Peck, signed the MOU on 11/29/2019. The signed MOU was emailed to the auditor on 12/2/2019. The MOU agrees that the Online Audit System (OAS) would be utilized for uploading pertinent documentation, and completion of the audit. The agreed upon review period for compliance was calendar year 2019 (i.e., January 1, 2019 through December 31, 2019).

On 12/3/2019, the auditor notified the PREA Resource Center assigned audit reviewer Scott Catey, that the audit dates changed, and needed to be updated in the Auditor Portal, Audit Initiation entry. Mr. Catey responded that he would update the information in the PREA Auditor Portal.

On 12/3/2019, the auditor submitted financial documentation, and the PREA Probationary Audit

notification letter. The letter explained the auditor's Provisional status, and that the CTC audit would be submitted to the assigned PREA Resource Center reviewer. The letter indicated the facility would receive the Interim, or Final audit report on April 14, 2020. The agency CEO requested that all correspondence be submitted to the facility director, in addition to the PREA coordinator.

The auditor conducted a practice-based PREA audit, relying on a triangultion of the evidence provided the the pre-audit, onsite audit, and post-audit phases. Triangulation of the evidence requires the auditor to analyze:

- Policies and procedures, and supportive documentation in the Pre-Audit Questionnaire (PAQ)
- Statements from random and targeted resident, and random and specialized staff interviews
- Facility site observations

PREA compliance audits seek to discover a facility's institutionalization of the PREA standards, thus, taking compliance of standards beyond the existence of policies and procedures, and measuring compliance on the demonstration of how established policies and procedures are followed on an ongoing, consistent basis. The auditor reviewed CTC polcies/procedures, documentation and information from calendar year 2019. Additional information was provided, upon request, when comparative data was required to demonstrate specific practices over more than a 12-month period (e.g., PREA training).

Pre-Onsite Phase/Notice of Audit Posting and Timeline

The CTC facility is accredited by the American Correctional Association. Under the Prison Rape Elimination Act (PREA), the facility is categorized as a community confinement facility. The compliance audit is based on national PREA standards for Community Confinement Facilities. The PREA audit was conducted in three phases:

1. Pre-onsite audit;
2. Onsite audit; and,
3. Post-onsite audit phase.

During the Pre-audit phase, the auditor communicated the auditing process via email. This included instructions for posting audit notices in conspicuous locations throughout the facility. The notice advises clients and staff that a PREA audit of the facility is scheduled, and provides contact information to reach the auditor for confidential communication, and reporting allegations of sexual abuse, sexual harassment, as well as client and staff retaliation for reporting, or cooperating in an investigation.

On 1/3/2020, the auditor notified the PREA coordinator to post Audit Notices in the facility, as part of the pre-audit phase. The auditor provided instructions, via email, and attached PREA Audit Notices, in English and Spanish. The PREA coordinator, and Facility director were instructed to:

- Post the notices in the facility no later than 1/6/2020;
- Print postings on bright-colored paper;
- Post in the Control Room area, and all areas where the notices would be visible to staff, visitors, and clients.

On 1/6/2020, the auditor received via email from CTC PREA coordinator Mindy Morrison, a photo of a PREA notice posted on the front door of the facility. On 1/7/2020, three additional PREA noticies were emailed to the auditor. The email indicated the notices were posted in the following locations:

- Counselor (case management) hallway;
- Client bulletin board in the Dorm hallway;
- Entrance door of the Dining area, where visitation take place.

On 1/9/2020, CTC PREA coordinator Mindy Morrison contacted the auditor via email indicating she was unable to access the OAS audit tool. The auditor advised, and provided contact information for the OAS Technical Support team. It is unknown exactly when access was achieved.

The facility has a maximum capacity of 94 beds, and is contracted to house 83 adult males, referred to as 'clients', who are transitioning from a prison institution, or are sanctioned to the facility by the Adult Parole Authority (APA) for probation/parole violations. The Ohio Department of Rehabilitation and Correction (ODRC) is the sole referral source. Client classifications range from Transitional Control (TC); Post-Release Control (PRC); and occasional County Probation. The facility does not receive referrals from municipal or common pleas court(s).

Pre-audit calls and communication occurred throughout the pre-audit phase. Purpose and topics of the calls included:

- introductions
- discussion of new PREA template forms (e.g., PREA Form 1.1)
- expectations of the upcoming onsite audit
- discuss issues, concerns with the PREA Online Audit System (OAS)
- discuss logistics regarding working space, internet access, interviewing room and work hurs
- discuss the auditor's need for unfettered access and unimpeded access to the facility to complete the onsite audit phase
- discuss the need to receive investigative, employee files, andn resident files upon the auditor's arrival.

On 2/8/2020, the auditor provided to the agency PREA Coordinator two forms via email attachment:

- PREA Form 1.1 - PREA Interviews: Specialized Staff, and Specialized Inmates
- Form 5H - PREA Audit Request for Information: Allegations and Investigations Overview

The auditor provided six PREA Interview Protocol forms from the national PREA Resource Center website, as reference and preparation material:

- Agency Head
- Random Staff
- Facility director
- PREA coordinator
- Residents (random, and targeted populations)
- Specialized staff

Request for Facility Lists

The auditor requested the following lists from the PREA coordinator, and PREA facility director:

- complete resident roster
- list of residents with disabilities

- list of residents who are lilmited English proficient
- any residents who identify as Lesbian, Gay, Bisexual, Transgener, or Intersex (LGBTI)
- residents who reported past sexual abuse during incarceration
- residents who reported sexual victimization during risk screening
- complete staff roster with specialized staff names
- all contractors and volunteers who have contact with residents
- all allegations of sexual abuse and sexual harassment
- all investigative reports of allegations of sexual abuse and sexual harassment
- all hotline calls for outside reporting of sexual abuse and sexual harassment allegations in the last 12 months.

Also requested was a list of youthful residents and residents in segregation and isolation. CTC responded that they do not house youthful residents and do not have anyone currently in segregated housing (Area 51).

External Contacts

On 2/12/2020 the auditor made contact via phone call with Family Health Services of East Central Ohio, a local sexual assault and domestic violence nonprofit organization in Fairfield County, Ohio, where CTC is located. The operator stated they are aware of PREA, and serves as a community resource for CTC. The operator stated she would provide contact information to local resoures, and offer to coordinate medical services at Fairfield Medical Center, if desired, including accompanying the victim through the forensic medical examination. Family Health Services will refer victims for counseling services, and will maintain relationships with a CTC client after they have completed the residential program.

The PREA coordinator uploaded in the OAS a signed Memorandum of Understanding (MOU) with Family Health Services of East Central Ohio, dated 12/3/19 (Travis Mathes, CTC facility director), and 12/4/19 (Family Health Services' Executive director). The operator would not confirm or deny whether calls have been received from CTC clients since the MOU was effective. The number the auditor called operates 24 hours a day, seven days per week, and is posted on CTC's website.

The auditor reached out to community resources via telephone to confirm scopes of services, as the facility currently has no established MOU's with community-based entities, which provide such services for those who have experienced sexual victimization. These community resources include:

- Fairfield Medical Center;
- Fairfield ADAMH;
- Light House;
- Crisis Center;
- ODRC PREA Hotline.

Research

The auditor researched information regarding CTC. The CTC website, https://www.communitytransitioncenter.com/, was reviewed. The PREA page of the website provides a way to report sexual abuse. There is no differentiation between reporting resources for clients, versus staff, relatives, or the public. The webside also states the last PREA audit, conducted in 2019, is available upon request. There is no live link to past PREA audit reports on the website.

The auditor conducted an internet search about CTC, which produced links to the agency, and the PREA

Report form, to report allegations of sexua abuse, or sexual harassment. there were not articls or finds specific to PREA, sexual abuse or sexual harassment at CTC. The auditor reviewed Mandatory Reporting laws, an it was found that Ohio does not defined confidential communications. Ohio mandatory reporting laws protect minor children, and elderly citizens who may be victims of any type of abuse, or neglect.

Onsite Audit Phase/Interviews

On 2/12/2020, the auditor communicated via email, with the PREA coordinator, requesting that 3rd Shift staff are made aware of the PREA auditor's arrival at approximately 5:30AM. Upon the facility director's arrival the auditor reviewed logistics for the audit, as well as the schedule and escorts for the onsite review later in the day. The facility director identified himself as the designee to accompany the auditor through the facility site review.

The PREA coordinator provided to the auditor a complete staff roster, dated February 2020, with the following information:

- employee name
- position status (i.e., full-time, part-time)
- work hours/shift
- position title

The PREA coordinator identified the Clinical Director, a part-time position, as a Contractor. The roster divided staff in the following categories:

- 1st shift
- 2nd shift
- 3rd shift
- Weekend shift 1st
- Weekend shift 2nd
- Transport Drivers (also classified as CCS')

The PREA coordinator stated the following do not exist at CTC:

- Volunteers
- Contract Administrator
- Staff who conduct strip searches (the facility prohibits strip searches)
- SAFE/SANE practitioner(s)
- Mental Health, medical practitioners

The auditor selected for interview the following 16 staff:

- nine (9) of 12 full-time security staff, representing 1st, 2nd, and 3rd shifts.
- four specialized staff
- two random non-security staff
- 1 contractor

Three security staff were not present during the onsite audit phase. Security staff are classified as Community Corrections Specialists (CCS). Security staff selection was not randomized, as the auditor interviewed all security staff who were present during the onsite audit. Random security staff represents

each shift - 1st, 2nd, and 3rd. Three of six non-security staff who have access to clients, were randomly selected for interview. The auditor chose the first three from the roster. One of three selected was absent during the onsite audit.

The auditor was able to interview the contractor and discuss the contractor's training, understanding of the facility's zero tolerance policy, and reporting procedures. The contractor received the same training as new staff during the hiring process, understood first responder duties (although mostly provides guidance to case management staff), and the requirement to report all allegations of sexual abuse and sexual harassment, and retaliation.

The auditor interviewed the following specialized staff:

- Agency Head
- PREA Coordinator
- Facility director (also HR director)
- PREA Investigator (also Intake staff)

The Security Director was identified as designated staff charged with 'Retaliation Monitoring'. The staff was absent during the onsite audit. The methodology of selecting random staff was for a diverse cross section of staff. the following staff were selected and interviewed:

- direct line and supervisory staff of varying positions, posts and rank

The auditor was able to ask staff questions on:

- the agency's zero tolerance policy;
- training;
- reporting protocols;
- first responder duties, coordinated response plan;
- grievance procedures;
- investigation protocols;
- confidentiality;
- retaliation monitoring;
- risk screening;
- client protection from abuse;
- LGBTI policies and procedures;
- data collection, annual reports;
- staffing plans, client monitoring;
- reporting to other confinement facilities;
- disciplinary procedures;
- searches;
- opposite gender announcements, cross-gender supervision policies.

On Day 1 of the onsite audit, the facility Coverage Log form identified a total headcount of 80 clients. The log reported 67 clients in-house; 13 were out working, or other approved activities. The PREA coordinator identified two targeted population clients:

- one client who identifies as LGBTI (Bisexual)

- one client who reported sexual harassment (unfounded)

Based upon the resident population of 80 at the facility on Day 1 of the onsite audit, the PREA Auditor Handbook specifies that a minimum of 16 resident interviews must be conducted; a minimum of eight (8) random resident and eight (8) targeted resident interview are required. The auditor utilized the PREA investigator's office as a private location for conducting client interviews. The auditor selected the clients to interview, and conducted the following number of resident interview during the onsite phase of the audit:

- Random clients = 14
- Targeted clients = 2

The breakdown of targeted client interviews:

- one client who identifies as LGBTI (Bisexual)
- one client who reported sexual harassment (unfounded)

The auditor was informed that in 2019, the facility investigated one reported allegation of sexual abuse, which was substantiated. There was one allegation of sexual harassment in 2020 (unfounded); no client or staff retaliation for reporting and allegation, or cooperating in an investigation.

The facility did not house the following client populations:

- who identified as transgender or intersex;
- who are blind, deaf, or hard of hearing;
- who are limited English proficient, or have a cognitive disability.

On Day 2 of the onsite audit, the facility director provided to the auditor a Coverage Log form for the day. The form provided did not indicate the number of clients in-house. He stated the count was the same as the previous day. Clients not in-house were working in the community, or attending other approved activities or programs.

The auditor conducted the interviews in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook for effective strategies for interviewing staff and clients. Clients were asked to discuss their experience with:

- PREA-related education;
- allegation reporting requirements;
- communication with staff;
- knock and announcements
- grievance procedures;
- searches, including pat, strip, cross-gender, and body cavity;
- housing unit concerns
- limits to confidentiality;
- outside supportive services;
- client safety;
- retaliation, and disciplinary sanctions.

At the beginning of the onsite audit, the auditor was led by the facility director on a facility site review,

including outer perimeter areas. The site review observations included:

- the housing units (including the Briar Patch area);
- main control room;
- client TV room/lounge area;
- kitchen, dining room (which connects to the TV room);
- staff offices;
- laundry area;
- property storage areas;
- bathrooms;
- pantry;
- inactive file/equipment storage rooms;
- semi-private area for group sessions (Area 51), and;
- outdoor recreation area.

During the onsite audit, the auditor engaged informally in conversations with staff, including kitchen staff, and clients. The facility has 22 surveillance cameras throughout the facility. Clients have the ability to move freely in the facility unaccompanied, except for areas designated with signage as restricted, and/or authorized personnel. The auditor observed no client phone(s) in the facility, as clients are permitted to have cellphones. The auditor was provided a private office to conduct confidential interviews with clients, and staff.

The facility has a total of 24 full-time staff members including a Facility Director who is the operational head of the facility, and whom reports to the CEO. The auditor was able to engage formally, and informally with agency leadership during the onsite visit, which includes:

- Jill Peck, Chief Executive Officer (CEO)
- Travis Mathes, Facility Director (and Human Resources head)

Six part-time staff provide a variety of tasks, including:

- case management
- security (CCS)
- clerical, and administrative support
- investigations

Part-time staff were not interviewed due to absence on the onsite audit dates, or not having regular contact with clients.

Processes and Areas Observed

The Intake process for newly admitted clients begins with an an assessement, including PREA-specific assessment, and orientation. Assessments and orientation are conducted by the PREA Investigator, who also serves as the facility Intake staff. There was one client to complete the process during the onsite audit. The auditor observed the Intake, and orientation, which was conducted in the staff's office. The auditor introduced herself to the client, and explained that a PREA audit was underway. The client was asked if he was comfortable with the auditor observing the process. The auditor observed the Intake staff utilized a PREA Screening tool to conduct the PREA assessment. The screening tool is divided into four sections:

- Identifying data - client demographic information
- Risk Indicators - 10 weighted questions, which determine client status (non-victim; potential victim; known victim) related to being sexually victimized. Clients who disclose prior sexual victimization during incarceration, are automatically classified as a Known Victim in the relevant category. Clients who express fear for their own safety, or are perceived as vulnerable, may be housed in the Briar Patch section of the client dorm.
- Behavior Indications - 10 weighted questions, which determine client status (non-abuser; potential abuser; known abuser) related to being sexually abusive. Clients who disclose prior sexual abusiveness during incarceration, are automatically classified as a Known Abuser may be housed in Area 51 of the facility, away from the general population.

The fourth section is to be completed during the 30-day re-screening. The PREA coordinator is required to approve recommended special accommodations. The Intake staff stated she conducts both screenings. Clients are provided the CTC Client Handbook, and asked to review it prior to completing orientation. Information received during orientation is entered into a state-wide CCIS Web system. The Ohio Department of Rehabilitation and Correction (ODRC) oversees the system, and has access for state-wide data collection, and reporting across all correctional agencies. Intake documentation is maintained in the client's individual file, which is retained in the Intake staff's office.

The client dorm area is divided into three sections (A-C), and a small area with six beds, known as the Briar Patch. The auditor observed female staff announce themselves when entering specific dorm sections. One female staff was observed announcing herself as, "Female entering B Street". Clients are required to dress/undress in the restroom, and must be fully dressed in the dorm area at all times. During client interviews, all clients stated they are only permitted to change clothes inside the restroom/shower area.

The auditor observed in the dorm main hallway, vending machines for snacks, beverages. There is a locked, glassed-in bulletin board with a variety of announcements, information. The auditor observed PREA Audit Notices posted in English, and Spanish, printed on brightly-colored green paper. Large, laminated PREA posters provide information regarding ways clients can report, community-based resources. Posters provide phone numbers, email addresses, and mailing addresses for internal, and external reporting. There were no phones in the dorm to test, as clients are permitted to have cellphones. The facility director stated during the site review that cellphones are considered a privilege, which may be taken away if clients violate program rules, and/or other policies and procedures.

The auditor observed in the Client Handbook, a breakdown of violations and resulting sanctions. Violation no. 15 of the Client Handbook states clients who engage in sexual conduct with an employee is consider a High-level violation. The auditor observed a documented violation issued to a client related to a substantiated allegation of sexual abuse by an employee.

The Client Handbook discusses the process for filing grievances. The process does not include reporting allegations of sexual abuse, sexual harassment, or retaliation via the grievance process. One client stated during his interview that he reported an employee's comment to him as Sexual Harassment. The client did not mention utilizing the grievance process; he stated he reported the allegation to his case manager. During random client interviews, 16 of 16 clients were able to articulate ways they could report PREA allegation; none identified the grievance process as a method for reporting. No client knew of a standardized process for reporting an 'emergency grievance'. Clients stated if an imminent risk of sexual abuse existed, they would report to the facility director, or call the Lancaster Police on their own. All clients articulated that the facility director and/or PREA coordinator investigates allegations of sexual

abuse, sexual harassment, or retaliation. Three clients also named the PREA investigator/Intake staff as someone they would report a PREA-related allegation. One client stated he would not report to the PREA investigator/Intake staff, that she is rude, and not helpful to clients, and comes across as judgmental.

Clients were asked if they were aware of how a client with limited English Proficiency (LEP) would report an allegation of sexual abuse. No client articulated that they were aware of interpreter services, should there be such a need. The PREA coordinator stated a MOU is in place, but has not been utilized. The facility director stated if someone was very limited in communicating in English, they would likely not be accepted in the program.

Specific Area Observations

The housing area has a large, divided area for watching television, or exercising. Dividing walls are painted red throughout the dorm. The TV/lounge area contains an inside door, which leads to the dining area. Visitation occurs in the Dining area during specific hours. The auditor observed cameras on both sides of the door, which can be monitored from the control room, and facility director's office. Clients have unimpeded access to recreation, and TV/lounge areas while in-house, until 10:00pm. The exercise area contains nautilus equipment, weights, treadmills, and textured rubber-type tiled floor conducive for floor exercises.

All areas of the dorm have mounted cameras, and can be monitored from the control room, and facility director's office. During the site review the facility director stated that clients have unimpeded access to their bed area, known as their 'Rack', and locker. The auditor observed clients reading, engaging in casual conversation in their Rack area. Each Rack contains four twin-sized beds. Each section contains 28 beds. The facility director described the sections as:

- A Dorm - primarily houses clients with disciplinary issues, or classified as High Risk
- B, C Dorms - primarily houses clients who work; clients in C Dorm have few, or no violations, and progressing well in their program.

Onsite Documentation Review/Conclusion

During the onsite audit phase, the auditor reviewed 31 files:

- 17 Client files reviewed for risk screening records, disciplinary records; history of sexual victimization or abusiveness, and the facility's response to such reports (if such exists)
- 13 Employee files (including one contractor), including training records, completed criminal background checks
- 1 administrative investigation file related to client sexual abuse (2019)

There were no medical, or mental health records to review, as the facility does not provide such services in-house. Staff training records were reviewed to confirm staff received required PREA training.

On 2/14/2020, the auditor met with the PREA coordinator, and facility director to thank the facility staff for being welcoming, cooperative, and courteous during the onsite audit. The auditor expressed that improvement efforts (since the 2019 PREA audit) were noticeable, and visible. Many of the clients speak highly of facility staff, who show care and concern for their wellbeing. Clients trust that they can reach out to a staff member, should there be a concern for their sexual safety, and staff would help them through the situation.

A subsequent discussion was held with the PREA coordinator, and agency CEO. The CEO asked the auditor if the facility "passed" the PREA compliance audit. The auditor stated all documentation needed to be reviewed, and analyzed before a determination of compliance could be provided. The CEO expressed concern that the audit outcome will impact their continued funding from ODRC, due to their 2019 non-compliance PREA audit outcome. The auditor reminded her of the 180-day Corrective Action period, and the opportunity it affords to achieve full compliance. The CEO expressed doubt as to whether the ODRC will extend to CTC the full 180 days to achieve full compliance before determining if funding the program will continue.The auditor concluded the discussion with a recommendation to seek advisement from the national PREA Resource Center, should there be an issue regarding the 180-day Corrective Action period.

Post-Audit Report

On 2/26/2020, the auditor received a third-party report alleging a client was retaliated against (i.e., removed from the program and arrested) for reporting sexual abuse by a staff. The reporting individual stated the incident allegedly occurred on, or about 2/17/2020. The reporting individual stated a second incident occurred on, or about 2/24/2020. The report was that a client complained about the way a staff conducts urine testss. The client perceived the response from management was retaliatory, and he was threatened with violations for reporting.

The auditor forwarded the report to ODRC's PREA Liaison Cynthia Ali. It was noted that during the onsite audit at CTC, three clients named the same staff as someone who is “not right”, and mentioned how he conducts urine tests. One client stated during the random client interviews he refuses to urine "drop" for him and complained to the facility director. He was unsure of the outcome but noted the staff doesn’t approach him to drop anymore, and that he was approved to work right after he made the allegation.

The third-party reporter stated all PREA notices at the facility were taken down the day after the onsite audit. The auditor contacted the PREA coordinator, who stated she was aware of the allegations, and the report(s) were in the Intelligrants system. Intelligrants is an online tool for state-funded correctional facilities to submit documentation, and various types of investigative reports, including PREA investigative reports. The auditor does not have access to information from other agencies, so the outcome of these allegations is unknown.

AUDIT FINDINGS

Facility Characteristics:
The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate or resident 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 Community Transition Center (CTC) is a halfway house facility in Lancaster, Ohio. The building is a one-floor open warehouse plan, renovated in 1997 by the founding Executive Director. The facility currently shares the building with an adjacent Dollar General Store. There is no access to the facility from the retail store. There has been no new construction of the facility, nor is there an opportunity for growth, due to enacted legislation to prevent any expansion of halfway house beds in the city of Lancaster, Ohio.

CTC serves an adult male population. The facility has a physical capacity of ninety-four (94) beds. The current contract with the Ohio Department of Rehabilitation and Correction (ODRC) is 83 open-bay style beds, divided by free-standing partitions. Residents, identified as "clients", are referred to the facility by ODRC, and classified as:

- **Transitional Control (TC)** - still classified by ODRC as 'inmates', who are completing the last 120-180 days of their sentence; programming is based on standardized assesment score. The program focus is employment and housing;
- **Post-Release Control (PRC)** - sentence has been completed, but the offender as no home, of record, or has violated terms of parole. ODRC institutions are not permitted to release an inmate homeless, so will refer to a halfway house to obtain employment and housing.

The facility site review was conducted on 2/13/2020, Day 1 of the PREA Onsite Audit. The facility director, Travis Mathes, escorted the auditor through the facility site review. The following is a description of the areas that were observed:

Front entrance:

- The front entrance of the facility is locked from the outside. Clients and visitors are required to ring a doorbell, and announce themselves before the doors are opened electronically from the inside Control Room. Clients sign in/out at the control room; medication passing is performed, and medications stored under lock and key. A security camera allows persons to be identified from the Control Room, and facility director's office. All other exits are locked from the outside at all times, unless unlocked by staff for a specific purpose or use. There is full view of the main client dorm entrance from the control room front window. PREA notices are posted in the control room.

Inside front area: cameras at each end of the hall capture full length of the main hallway;

Control room: the primary check point for clients entering and exiting the facility. Staff in the control room monitor the facility via surveillance cameras mounted in the room. Visitors, clients ring an outside doorbell, which alerts control room staff that someone is at the main entrance. Access is provided by electronic door lock system. An external camera provides a line of sight at the main front entrance. Inside the control room is general office equipment - a copier, client medication records, over-the-counter (OTC) medications are logged and secured in locked cabinets. A locked bulletin board contains chore

lists, PREA contact list, medication schedule. Other observations in the control room include:

- Client mail - checked daily by staff;
- Routine, client-related information, forms are filed in the control room file drawers;
- One camera monitor is not working on Day 1 of the onsite audit - the facility director stated a replacement is due soon. The DVR still captures footage, which can be viewed inside the facility director's office which has access to all camers. The cameras throughout the facillilty have no audio capacity. On Day 2 of the onsite audit, the auditor observed that the camera monitor was replaced, and in working order.

Intake staff/PREA Investigator office: located next to the control room, has a solid door entrance. The auditor observed individual clients inside, with the door open. The office contains multiple file cabinets containing client files, which were observed locked. One client was admitted at the time of the onsite audit. The auditor observed a client intake, and orientation, which was conducted in the Intake staff's office. The Intake staff stated client intake sessions may be conducted in her office individually, or small groups. The auditor conducted client file reviews, and random client interviews in this office.

Executive Director/CEO office: located next to the Intake office, the office is occupied by Jill Peck the CTC Chief Executive Office (CEO)/Executive Director. The auditor conducted the specialized staff (Agency Head) interview in her office. The office is locked when not occupied.

Back area, off '*Area 51'*: primarily used as storage space, the area is kept locked unless in use. The facility director stated during the facility site tour that only management has keys, so it would not be difficult to determine how a client accessed the area. Laundry supplies, inventory for facility bedding (e.g., sheets), cleaning supplies are organized in sections near the washer/dryer. The facility director stated that clients are assigned laundry chores as a 'detail', to be completed on an established daily schedule. HVAC (heating, cooling) equipment is inside the area, in a locked room, with ‘Employee Only” signage on the door. The auditor observed a camera at the area’s entrance, facing inside toward the rear of the area. The facility director showed the auditor, via video monitor in his office, the view span of the cameras in this area.

A Second section inside has donated clothes, followed by a private shower area with four single-person showers. All showers have solid white curtains, which provide no line of sight as to who is inside. The auditor observed an large area nearby, where inactive files are stored on shelves; a 360-degree camera at the rear exit door provides a line of sight of the storage, shower, and file areas. The auditor tested the rear exit door, which triggered an audible alarm when opened. The external camera provides a line of sight from outside the facility, to the street; a fenced-in smoking/ Recreational area is also visible.

Restroom for urine drops: a large, single-person restroom located at the end of the main hall, past the client dorm, across from the Group area, called *“Area 51”*. The restroom is locked when not in use. During the facility site review, the facility director stated male staff use the the same restroom.

Group area:

- *'Area 51'* sign (client artwork with an Alien drawing) is on the wall outside the area, walled off from the facility main hallway; the auditor obsereved staff announce on intercom a Group session was beginning in Area 51. A two-way mirror faces a camera at end of the hallway and provides a view of who is going inside the rear storage area, just beyond Area 51. The auditor observed tables, chairs, and flip chart on an easel in the space. At the conclusion of reviewing the rear storage area,

the auditor observed a group session taking place in Area 51.

- The staff Ladies restroom is a single-person restroom at the rear of Area 51. The door is marked with a placard that says “Employees Only", and is locked; all staff have a key. The PREA coordinator provided the auditor a restroom key for unimpeded access during the onsite audit.

Main Dorm area: The auditor observed the client TV room has a clear door; a side door provides access to the client dining area. The facility director stated the door is unlocked, but pointed to a camera in the dining room, which provides a line of sight of entering and exiting from the area. The Client restroom/shower area has solid curtains, and 8 shower stalls. the auditor observed separate restroom, without showers. The auditor observed 14 sinks (seven on opposite sides).

Client Dorms:

There are three dorm sections: A, B, and C, with 28 beds in each, divided into pods of four beds. A-dorm primarily houses clients with discipline issues; B, and C are further from the dorm entrance, and assigned to clients who work, or do not have behavior issues. Staff refer to each section as Streets: A Street; B Street; C Street. Some female staff announce themselves as, "Female on B Street".

Laundry:

The client laundry room has 3 washers, and 3 dryers, an ironing board, and no door. Clients may request an iron at the Control Room. Laundry hours are 6a-10p daily. An exit door to a client smoking/recreation area is accessible near the laundry room. The laundry room camera captures entry and exits. Clients have unlimited access to do laundry during waking hours, then locked by security staff. A second door outside the laundry room leads to an outside area, which is open from the faclity to the street. the auditor tested the door and an alarm sounded when opened.

The client restroom has no showers: eight toilets; 14 sinks, seven on each side of a dividing center wall. Toilets (4) are divided by half walls, with 4 toilets opposite a dividing wall; tall walls face sinks for extra privacy.

Offices:

Facility director office: contains camera monitors of all areas of the facility, for a total of 22 cameras, no audio. Currently, staff has to ask to review cameras. Mathes’ office is adjacent to M. Morrison’s (PREA coordinator/Accreditation manager) office, with a shared, inside door. Each office has an outer door that is locked to the main hallway. During the onsite audit, the PREA coordinator provided to the auditor a key to the office for use after she left for the day. Employee (including contractor) files are locked in her office.

Case Management: The case management area, including the clinical director’s (contractor) office, is a dedicated area, behind a closed door, across the hall from the facility director’s office. Upon entering, the auditor observed posted information related to resources for sexual abuse (PREA posters); suicide text lines, and crisis line (to Fairfield ADAMH). There is a small break room inside the area, which can be used by any staff. The entrance is not locked, but clients must ask at the Control Room to see their case manager unless they have an appointment. If so, the case manager meets the client at the door.

Investigator's office: The position is part-time. The office contains a drug-testing system, which is managed in-house for client urine tests. The auditor observed information regarding proper use. The facility director stated they do not send urine samples to an external company (e.g., Quest, LabCorp.); they have experienced few challeges as to the accuracy of the system. The auditor utilized the office

during the onsite audit, to conduct random staff interviews.

Kitchen: The auduitor observed, and tested that the main pantry door was locked. Lines of sight in the operational is provided by two cameras, which access the entrance and view of kitchen prep area. A camera is in the walk-in fridge, which is locked at night, along with all cabinets, drawers. The rear outside exit is not accessible to clients, unless supervised. The exit is used as a fire exit in an emergency. Such was verified on evacuation posting.

Food is prepared in-house by food service staff and clients who are approved to work in the kitchen. The chemical room contains a mounted mop water system, which stays locked. A hallway door (locked) next to kitchen stores mop heads, mops, switches to ceiling fans, and other miscellaneous cleaning, maintenance supplies.

AUDIT FINDINGS

Summary of Audit Findings:
The OAS will automatically calculate the number of standards exceeded, number of standards met, and the number of standards not met based on the auditor's compliance determinations. If relevant, the auditor should provide the list of standards exceeded and/or the list of standards not met (e.g. Standards Exceeded: 115.xx, 115.xx..., Standards Not Met: 115.yy, 115.yy). Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	0
Number of standards met:	41
Number of standards not met:	0

At the conclusion of the audit, based on evidence provided, the auditor determined the facility to be non-compliant with the following 16 PREA standards:

- 115.213
- 115.217
- 115.221
- 115.222
- 115.231
- 115.232
- 115.234
- 115.263
- 115.264
- 115.265
- 115.267
- 115.271
- 115.273
- 115.276
- 115.278
- 115.286

The auditor communicated with the facility PREA coordinator, Agency Head, and Facility Director during the Corrective Action period. The facility provided updated policies and procedures, and ensured staff were trained on updated practices. Clients were informed of changes via Resident meetings, and documentation was provided to indicate new information has been institutionalized in practice.

Based on evidence provided, the identified non-compliant standards haave been met. This report has been revised as a Final Report.

Standards

Auditor Overall Determination Definitions

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

Auditor Discussion Instructions

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

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA and Zero Tolerance 2. Agency Table of Organization Interviews: 1. PREA Coordinator 2. Contractor Findings: 115.211(a) The facility provided in the pre-Audit Questionnaire (PAQ) policy 800-50 PREA and Zero Tolerance. The policy mandates zero tolerance against sexual abuse, and sexual harassment. Policy Section IV. 5., A-E includes five procedural areas of focus to implement the agency's approach: 1. Zero Tolerance 2. Staffing Issues 3. Employee Training 4. Client Education 5. Prevention Policy Section III includes definitions of prohibited behaviors, which coincide with PREA standards. The policy states a PREA Binder is retained in two CTC locations: a) Control Room; b) PREA Coordinator's office. The PREA Binder is accessible to all staff, clients, interns, contractors, and volunteers who have access to, and engage with clients. During the onsite visit, the auditor observed the PREA Binder on a file cabinet, inside the Control Room. The PREA coordinator displayed a second binder, which she stated is retained in her office. The PREA Binder contains a hard copy of the National PREA Standards for Community Confinement facilities, agency policies and procedures, and first responder duties. Policy 800-50 Section IV. 1. A-E (Zero Tolerance) describes the facility's zero tolerance toward client sexual abuse and sexual harassment. The policy outlines consequences for prohibited acts, including staff, contractors, volunteers, interns, and clients. The policy states termination as an automatic, and immdiate outcome for substantiated allegations of sexual abuse, sexual harassment. Based on the evidence provided, the facility meets this provision. 115.211(b) The facility indicates in the PAQ that a PREA coordinator has been appointed to oversee compliance with PREA standards. Policy 800-50 Section Iv. 1. D. requires a PREA Coordinator be appointed to oversee the agency's compliance with PREA standards, and that the position is an "upper-level" position with the appropriate authority to carry out the appointed duties.

	The facility provided in the PAQ a facilityTable of Organization for management positions in the agency. The PREA coordinator position reports to the facility director, which is second to the CEO/Executive Director (Agency Head). The PREA coordinator has a dual role in the agency, and also serves as the Accreditation Manager. During the pre-audit phase, the Facility director was the designated point-of-contact (POC) who reached out to the PREA auditor, and coordinated with the CEO on the audit schedule. The facility director, and PREA coordinator were designees to complete the PAQ, and upload documentation. During the onsite audit phase, the PREA coordinator and facility director greeted the auditor. The facility director was the auditor's primary contact while onsite. This person led the auditor on the onsite facility review, answered questions, and provided requested information. The PREA coordinator's office is adjacent to the facility director, and is where employee files are located. The auditor was provided a workspace inside the PREA coordinator's office, and a key for entry, as the office stays locked. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action recommended.

115.212	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) Interviews: 1. Agency Head Findings: 115.212(a) The facility does not contract with other facilities for the confinement of their clients. The facility indicated on the PAQ that N/A is the applicable response to this standard. The facility PAQ states there are two contracts for the housing of individuals. During the onsite audit, the agency CEO confirmed during interview that the organization does not contract with an outside entity for the confinement of residents. She stated CTC is contracted with the Ohio Department of Rehabilitation and Correction (ODRC) to provide residential programming and services for adudlt males. ODRC is the sole referral source for housing residents at the CTC facility. CTC does not own, or operate other locations, nor were any contracts for residential services provided. The auditor determined that the PAQ response is zero, and the response stating two contracts exist for housing residents on behalf of CTC is an errof. Based on the evidence provided, the facility meets this provision. 115.212(b) The facility PAQ indicates CTC does not contract with other facilities for the confinement of their clients. The Agency Head explained in her interview that if CTC maximized their bed/population capacity they would not accept new admissions until space became available. CTC has been contracted by the ODRC to house state-referred residential clients. Based on the evidence provided, the facililty meets this provision. Corrective Action: No corrective action is recommended.

115.213	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 200-03-04: Staff Coverage 2. Staff Coverage Memo for PREA 2020 Interviews: 1. Facility director 2. PREA coordinator Site Review Observations: 1. Physical layout of the facility Findings: 115.213(a) The facility PAQ affirms there is a staffing plan is in place. Policy 200-03-04 was provided in the PAQ as supportive documentation to indicate compliance with this provision. The policy indicates an established staffing minimum, to ensure the sexual safety of clients. PREA policy 800-50, Sec. IV, 2. A-C references the existence of, and processes for utilizing, the facility PREA staffing plan. During the onsite audit the auditor requested the facility staffing plan. The PREA coordinator stated Policy 200-03-04, uploaded in the PAQ, is the staffing plan. Policy 800-50, Section IV. 2. A. lists eight considerations documented in the PREA Staffing Plan for calculating staffing levels, and the need for video technology. No supportive documentation was provided, which outlines how the facility considers any of the stated considerations. The facility director stated during his interview that the facility has a PREA Staffing Plan. He described it as, "...the work schedule that covers how many people should be working in the facility. There's a minimum staffing level of two CCS'(security staff) per shift, and is how shifts are scheduled, including weekends. Assessing adequate staffing levels and the need for video is based on the facility layout, and number of incidents in the past 12 months. Two staff per shift was determined to be the baseline for shift schedules. There is an on-call list, in case someone calls off. If no coverage if found, the security director will cover the shift. Compliance with the staffing plan is checked by verifying time cards, security camera footage of who is in the facility. The leave request form is submitted in advance for vacation, or sick (advance or call-off), so deviations can be tracked...." The facility director stated in PREA protocol questions 1-4 that a staffing plan exists. However, Policy 200-03-04 does not contain the detailed documentation referenced in policy 800-50. Policy 200-03-04 is specific to shift schedules and facility coverage. It states the minimum client to staff ratio is 90:1, or one security staff for the facility; the preferred ratio is 45:1, or two security staff. During the facility site review, the PREA coordinator provided to the auditor a facility Employee Roster for February 2020. The Roster lists three operational shifts:

- 1st shift: 7:00AM - 3:00PM
- 2nd shift: 2:00PM - 12:00AM
- 3rd shift: 10:00PM - 8:00AM
- Weekend 1st shift: 7:00AM - 7:00PM
- Weekend 2nd shift: 7:00PM - 7:00AM

The roster reflects two security staff on each shift. During 1st shift, one Community Corrections Specialist (CCS) shift schedule as 6:00AM - 2:00PM. During the pre-audit phase, the PREA coordinator provided to the auditor via email, PREA form 1.1, which identifies shifts, agency specialized staff, and specialized resident population(s). The facility indicates the same operational schedule as what the auditor received onsite via Employee Roster, with the exception of one CCS who works 6:00AM - 2:00PM.

The standard provision states:

(a) For each facility, the agency shall develop 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, agencies shall take into consideration:

(1) The physical layout of each facility;
(2) The composition of the resident population;
(3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(4) Any other relevant factors.

A PREA-compliant Staffing Plan goes beyond the number of staff per shift, and how employees request time off. Policy 200-03-04 does not identify how components 1-4 are considered. The explanation of the staffing plan by the facility director indicates physical elements of the facility are considered (e.g., blind spots), but offers no explanation as to how such occurs, and how it relates to the staffing plan. Based on the evidence provided, the facility does not meet this provision.

115.213(b)

The standard provision states:

b) In circumstances where the staffing plan is not complied with, the facility shall document and justify all deviations from the plan.

The CTC Staffing Plan indicates that employee leave request forms serve as documentation of deviations from the plan. It references an "on-call" list of staff is utilized to cover employee absences, and that the security director will cover if no staff are available. If the staffing levels are maintained, replacing an absent employee, whether pre-approved, or call-off, is not a deviation of the staffing plan. The facility director did not provide during his interview circumstances where the staffing plan was not complied with, or actions taken. Based on the evidence provided, the facility does not meet this provision.

115.213(c):

The standard provision states:

(c) Whenever necessary, but no less frequently than once each year, the facility 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 adequate staffing levels.

The facilitiy provided in the PAQ a "Coverage Memo" document as supportive documentation of compliance. The document states that on 1/16/2020, the facility director, and PREA coordinator reviewed the facility staffing plan, and determined no changes were required. The document contains no signature, or other verification of what it states.The review period for the audit is 1/1/2019 - 12/31/2019. No documentation was provided to determine if the staffing plan was reviewed in 2019, or if the review on 1/16/2020 was a review of the 2019 plan. The document does not indicate the four components of 115.213(c) were assessed, or the existence of a final determination, based on an assessment. Based on the evidence provided, the facility does not meet this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:

1. Include in section IV. of policy 200-03-04 how all components identified in sections (a) - (c) of this provision, are considered.

2. Create a formal, documented annual staffing plan review procedure.

3. Review the staffing plan with all employees, at least annually, and document all components reviewed, and any recommended changes.

FACILITY RESPONSE:

The facility submitted an updated PREA Staffing Plan, which provides a detailed outline of how the Plan considers:

- The physical layout of each facility;
- The composition of the resident population;
- The prevalence of substantiated and unsubstantiated incidents of sexual abuse;
- Any other relevant factors.

The facility developed a Staffing Plan Deviation form, which describes the reason for the identified staffing deviation, and a documented plan of resolution. The form requires signature by facility leadership:

- Program Director
- Agency PREA coordinator
- Security Director

Policy 200-03-04 was updated to include Section IV., which requires annual staff review the agency's Staffing plan, as well as:

	• Uniform evidence protocol • Sexual abuse/sexual harassment policies (880-50/800-51) • Staff participation is documented via signed attendance sheets. Based on the evidence provided, the facility is compliant with this standard. **Review**: Policies 800-50, 800-51; 200-03-04 PREA Staffing Plan Staffing Plan Deviation form

115.215	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: Staff files: 1. CTC Policy 800-50: PREA and Zero Tolerance 2. CTC Policy 800-51: PREA Report Response 3. CTC Policy 200-05: Female Offenders 4. Staff meeting notes dated 1/3/2020 Interviews: 1. Non-Medical Random Staff Site Review Observations: 1. Auditor site observations of Operational Procedures Finding: 115.215(a), (b) The facility PAQ response indicates staff do not conduct manual or instrument inspection of client body cavities. The PAQ response also states that facility staff do not conduct strip searches of clients. CTC policy 800-50, Section IV. 3. C. states staff are training on how to properly conduct cross-gender pat-down searches and searches of transgender and intersex clients. Staff training record were reviewed onsite. The auditor reviewed 13 staff training records of those staff who were interviewed during the onsite audit, with the following results: • 11 of 13 files reflected staff were trained on how to conduct cross-gender pat searches, or searches of transgender/intersex clients • The agency PREA policy, which states staff are to be trained on how to conduct client crossgender, and transgender/intersex searches, was reviewed by staff on 6/28/19. The training included appropriate transgender searches, and first responder duties • During interviews with eight (8) random non-medical staff, all stated they participated in a PREA refresher training, which included conducting client pat-searches. When asked about searches of transgender or intersex clients, all 8 staff stated the training on 1/3/2020 included training for conducting pat-searches on transgender or intersex clients. Staff unanimously stated the facility doesn't allow client body cavity searches. During the facility review, the auditor had informal discussions with staff and clients regarding transgender pat-searches. The auditor asked staff to describe what would be the process for conducting a pat-search on a transgender female client who had fully

developed breasts, and wore a bra. All staff indicated they would know what to do. One male staff stated he would have a female staff conduct such a search. The auditor asked staff what exigent circumstance would require them to conduct a cross-gender strip, or cross-gender visual body cavity search; staff could articulate what would constitute an exigent circumstance.

- During the onsite facility review, the auditor observed clients being searched who were returning from work. Searches were conducted in view of security cameras, in the front of the control room. In all cases, a male staff conducted the pat-search, even though there was a female staff working in the area. No staff was observed strip searching any client.
- CTC is an adult male facility. There are no female clients in the facility.

Based on the evidence provided, the facility meets this provision.

115.215(c)
The facility indicated in the PAQ that it does not conduct cross-gender strip searches and cross-gender visual body cavity searches, and that there are no female clients at the facility. During the site review there were no female clients observed in the facility. Based on the evidence provided, the facility meets this provision.

115.215(d)
The facility indicated in the PAQ that policies and procedures are in place, which enable clients to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances. Policy 800-50, IV. 5. B. re-affirms the language in the provision.

Policy 800-51 Section IV. 5. C. requires female security staff to announce themselves ("Female in the facility for the shift") when entering the client dorm area at the beginning of their assigned shift. No subsequent announcements are required. Non-security female staff are required to announce themselves each time they enter the housing unit ("Female in dorm unit"). During the facility review, the facility director lead the auditor into the dorm unit, and announced our presence. The auditor did not observe other female staff, both security and non security, enter the client dorm without announcing themselves. During informal conversations with random security staff, the auditor questioned the practice of female staff not announcing themselves. Of the eight (8) CCS' interviewed, all stated female staff announce themselves when entering the client dorm area. Two male staff stated if restroom/shower areas are searched, they would trade with the female staff, so she could cover the Control Room, while they check client restrooms/showers.

During client interviews, 16 of 16 clients stated female staff do not enter the shower room, or restroom. They all corroborated staff statements that they are given privacy to take care of personal hygiene needs, and dress/undress. All clients stated that they are required to be dressed when in the restroom, which has no door, and sinks are visible. Clients stated they dress in the shower area, or at their bedside. Three clients stated the facility staff are very strict, and will write a violation if they exit the restroom partially undressed (e.g., undershirt without an outer shirt).

During the facility review, the auditor observed the dorm unit, which consists of three aisles, each divided by an approximate six-foot wall. Beds are coupled, and separated by two short end tables and lockers, referred to as a 'Rack'; a wall separates each Rack, which provides

privacy between each. The front of each aisle is open. Each aisle contains 28 beds. There are six beds in one area just inside the dorm entrance, identified by staff as the 'Briar Patch', which houses clients whom are being more closely monitored, mainly due to failed drug tests. Based on the evidence provided, the facility meets this provision.

115.215(e)
The facility PAQ indicates it meets this provision, although it houses no transgender clients. Policy 800-50 Section IV. 3. C. states, *"All staff shall be trained on how to conduct cross-gender pat-down searches and searches of transgender and intersex clients to ensure professionalism and to utilize the least intrusive manner possible consistent with security needs."* During random staff interviews, all staff stated training is provided on how to properly conduct a pat-search of a transgender or intersex client. The PREA coordinator stated the facility has not had a transgender or intersex client.

During a review of 17 client files, documentation indicated that no clients were transgender or men. Client demographic information contains check boxes for the client to self-identify as a transgender male or female. There is a check box for sexual orientation. During interview with the PREA coordinator, no clients self-identified as transgender or intersex. Based on the evidence provided, the facility meets this provision.

115.215(f)
The facility PAQ indicates 100 percent of staff are trained on how to conduct cross-gender pat-down searches in a professional and respectful manner. Training attendance sheets, dated 6/28/19, and 1/3/2020, were provided as supportive documentation. Policy 800-50 states staff are trained on how to conduct cross-gender pat-down searches and searched of transgender and intersex clients to ensure professionalism and to utilize the least intrusive manner possible consistent
with security needs. The PREA coordinator stated during interview that there have been no transgender clients. Based on the evidence provided, the facility meets
this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.216	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA and Zero Tolerance 2. CTC MOU for interpretive services 3. Staff Coverage Memo 2020 Interviews: 1. Agency Head 2. Random Staff Site Review Observations: 1. Housing unit common areas, control room, case management office area, common areas, public entrance to building, and visitation 2. Posted materials, English only 3. CTC Client Handbook, English only Findings: 115.216(a) The facility indicates in the PAQ that it complies with this provision. A document titled 'Staff Coverage Memo for PREA 2020' was provided as supportive documentation. The content of the memo is related to the facility Staffing Plan. This provision is not related to the review of the staffing plan. The document appears to have been uploaded in this standard, in error. CTC Policy 800-50 Section IV. 4. F. states the agency will provide the necessary provisions for disabled clients, or those with limited English proficiency. The agency CEO stated in her interview that the facility director, and PREA coordinator are designees for coordinating and providing needed support services to vulnerable client populations. During random staff interviews, staff stated the facility director or PREA coordinator would decide on the appropriate resources for clients with any type of special need. The PREA coordinator provided to the auditor a documented Memorandum of Understanding (MOU) with and individual to provide assistance with client interpretation needs. The MOU is dated 12/31/19, and is effective until, or unless the agreement is terminated, or changed. The auditor was not provided with information that describes how other services would be provided (i.e., hearing, literacy, vision assistance). The CTC website states clients will be referred to a Deaf Services Center for those who are hearing impaired. The website states the agency uses "translate.google.com" for translating written information. The auditor searched this website, which offers 100+ languages in which documents may be translated. It offers a mobile App, which provides a voice-generated

interpretive option. During the onsite facility review, two 'Break the Silence' posters, in English and Spanish, with ODRC hotline information, was observed in the client dorm area, next to the shadow box bulletin board. No information was observed related to speech or hearing assistance in the same area, case management office bulletin board or in any common area of the facility.

During the onsite audit, the auditor observed a client intake, and orientation. The Intake staff asked questions related to the need for assistance in order to effectively communicate, or understand written information. During an informal discussion with the PREA coordinator, she stated the facility would not likely accept a referral for a client who could not speak any English, or whose disability was beyond the facility's current ADA compliance. The facility does not accept individuals with severe mental, or developmental disability. Questions were asked related to physical, or mental disability, including cognitive limitations. Based on the evidence provided, the facility meets this provision.

115.216(b)
The facility PAQ indicates that there are steps in place to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to clients who are limited English proficient. Policy 800-50 Section IV. 4. F. states, *"Staff shall make appropriate provisions for clients not fluent in English, those with low literacy levels, and those with disabilities that hinder their ability to understand the information in the manner provided. The Agency PREA coordinator shall ensure that all clients with disabilities have an equal opportunity to participate in or benefit from all aspects of the CTC's efforts to prevent, detect ad respond to sexual misconduct. A client interpreter, client reader, or other client assistant shall not be used except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the client's safety, the performance of first-response duties, or the investigation of the client's allegation."* The PREA coordinator provided to the auditor a MOU signed 12/31/19, with an individual to provide interpretive services, upon request. Based on the evidence provided, the facility meets this provision.

115.216(c)
CTC policy 800-50 states it will not rely upon clients as interpreters, readers, or other types of assistants except in limited circumstances that could impact a client's safety. The facility PAQ indicates the facility does not comply with this standard. During the onsite facility review, notices as to how clients could receive interpreter, or language assistance, in Spanish, or other language, were observed posted in the client dorm area, and case management office area. During random staff interviews, staff stated that there is a process in place to ensure the facility doesn't rely on other clients to interpret when a client has a need. Based on the evidence provided the facility meets this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.217	Hiring and promotion decisions

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making the compliance determination:

Documents:

1. CTC Policy 700-06: Hiring and Promotions
2. 13 Staff files
3. MOU for PREA 2020

Interviews:

1. Human Resources (also the Facility Head)
2. PREA coordinator

115.217(a)
The facility PAQ indicates it does not comply with all sections within this provision. A MOU between CTC and Family Health Services of East Central Ohio was provided as supportive documentation. The MOU is related to the entity's service as a crisis center for client reports of alleged sexual abuse. The MOU is not related to compliance with this standard provision, and was likely uploaded in error.

Policy 700-06 Section II. C. 1-3 re-states the language from the PREA standard for this provision. The policy indicates it does not hire, promote or contract with anyone with access to, or who engages with clients, with substantiated allegation(s) of sexual abuse or sexual harassment in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. § 1997); it does not hire, promote, or contract for services anyone 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; it does not hire, promote or contract for services anyone who has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) of this section.

The facility director serves in a dual capacity, and also has human resources oversight. In addition to interview questions for the Facility Head, the Human Resources interview protocol was followed for this position. The facility director stated, as it relates to hiring, the CTC employment application is not specific to an applicant's past involvement in allegations of sexual abuse in a correctional facility, or other institution (as defined in 42 U.S.C. 1997). He stated that PREA-related questions is part of the interview process. The auditor reviewed CTC's employment application, and observed the application asks applicants to respond to two questions:

1. *"Do you have any pending criminal charges?"*
2. *"Have you been convicted of a felony?"*

The facility director stated during his interview that no contracted services would be enlisted to someone who may have contact with clients 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). Such would be discovered through background checks, references, or interviews. The same was stated as it relates to actual, or attempted sexual abuse allegations in the community.

Policy 700-06 states it prohibits the hiring and promotion of anyone who may have contact with client who has engaged in sexual abuse. The auditor reviewed 13 employee files during the onsite audit. Of the 13 files reviewed, nine (9) contained the agency's Client Rights document, which covers client abuse, and neglect; client sexual harassment, and sexual abuse; their right to be free from:

- staff abuse;
- client-on-client abuse;
- guest/visitor abuse;
- adolescent abuse/neglect.

The document states staff are prohibited from:

- sexual proposition of, or sexual relations with a client;
- sexual prejudice.

Based on the evidence provide, the facility meets this provision.

115.217(b)
The facility PAQ indicates it complies with this provision. Policy 700-06 was provided as supportive documentation of its compliance with this provision. Policy 700-06, section II. C. b., states the facility will 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 clients. The Agency employment application does not inquire about an applicant's involvement with a prior allegation(s) of sexual harassment. The PREA coordinator provided to the auditor a "Required Criminal History and PREA Interview Questions" document. Question #5 asks, *"Have you ever been accused of sexual harassment? If yes, indicate date, employer, or city/state, outcome."* The PREA coordinator stated the document was created in 2020, and is new to the hiring process. The auditor was not provided with any signed interview forms as evidence of it being institutionalized in the hiring, or promotion process. The facility director stated an allegation of sexual harassment wouldn't be an immediate barrier to an employment, or promotional opportunity, if the allegation wasn't substantiated. Based on the evidence provided, the facility does not meet this provision.

115.217(c)
The facility PAQ indicates criminal background checks are required for new hires who may have contact with clients. Policy 700-06, section II. B. requires all job candidates to submit to and pass a criminal background check. The facility director stated during his interview that the Fairfield County Sheriff department conducts a standard BCI (state of Ohio, Bureau of Criminal Investigations) pre-employment criminal background checks for CTC.

Policy 700-06, section D., states the facility will make it best efforts to contact all prior

institutional employers for information on substantiated allegation of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The PAQ indicates there were seven (7) new hires in the past 12 months. The auditor reviewed 13 staff files. None reflected new hires in the past 12 months. The PREA coordinator provided a "Required Criminal History and PREA Interview Questions" form. She stated the form was created in 2020. The onsite audit was February 13-14, 2020. The auditor was not provided any interview forms signed by new hires. There was no evidence of PREA-related questions being asked as a part of reference checks to previous correctional/institutional employers. Based on the evidence provided, the facility does not meet this provision.

115.217(d)
The facility PAQ indicates criminal background checks are required of those hired as contractors, who engage with clients. Policy 700-06 Section II. C. requires all job candidates, including contractors, to submit to and pass a criminal background check. The facility director stated during his interview that
the Fairfield County Sheriff department conducts a standard BCI (state of Ohio, Bureau of Criminal Investigations) background checks for CTC, including contractors who may have contact with clients. The auditor's review of a contractor file confirmed that a BCI background check was conducted at the time of hire. Based on the evidence provided, the facility meets this provision.

115.217(e)

The facility PAQ indicates criminal background checks are updated every five years. Policy 700-06 was provided as supportive documentation. Policy section II. E. states all employees and contractors whom have access to clients will have a criminal background check updated every five years, or will have a system in place to obtain such information. The facililty director, who also oversees the Human Resources (HR) function of the agency, stated in his interview that the Employee Census is reviewed monthly to determine when five-year criminal background check updates are due. He stated the Fairfield County Sheriff's Office conducts the background checks, at CTC's expense.

The auditor reviewed 13 employee files while onsite. Of the 13 files reviewed, four (4) contained background check documents five years apart, including one (1) contractor; seven (7) of 13 files were inside five years of employment, and did not contain a follow-up criminal background check; two (2) of 13 files contained an updated criminal background check in 2020, but were beyond five years from the date of the previous background check. No files were missing a background check within the past five years. Based on the evidence provided, the facility meets this provision.

115.217(f)

The facility PAQ indicates compliance with this provision. No documentation was provided to support the assertion of compliance. The auditor reviewed the CTC employment application, available on the agency's website. The application form does not ask, or require applicants to affirm the required information in section (a) of this standard. The application form asks if an applicant has ever been convicted of any violation, including traffic violations. There is no mention of sexual abuse, or sexual harassment allegations, convictions, or the administrative adjudication of such. No documentation was provided to indicate if, or how questions are asked of internal promotional candidates.

The facility director stated during his interview (human resources protocol questions) that questions related to sexual abuse, and sexual harassment have been added to the interview process. He stated a continuing affirmative duty to disclose past allegations of sexual abuse, or sexual harassment is addressed in the performance evaluation process. Policy 700-06 section II. F. supports this assertion. During the onsite audit, the PREA coordinator provided to the auditor a document titled " Criminal History Interview Panel Instructions" as evidentiary documentation. The document instruction is an explanation of the agency's requirement to obtain criminal history information, including sexual misconduct, as required by the Prison Rape Elimination Act of 2003. The document, titled "Required Criminal History and PREA Interview Questions contains six questions related to past charges and convictions. Questions 3-6 ask:

- *"Have you event been accused of an inappropriate or unauthorized relationship in a prison, jail, lockup, community confinement facility, juvenile facility or other institution? If yes, indicate the employer, dates of employment allegation, and outcome."*
- *"Have you ever been accused of sexual abuse or resigned from employment during a pending investigation of an allegation of sexual abuse? If yes, plealse indicate the employer, dates of employment, allegation, and outcome."*
- *"Have you ever been accused of sexual harassment? If yes, indicate date, employer or city/state, outcome."*
- *Have you ever been civily or administratively adjudicated or convicted of engaging or attempting to engage in sexual activity in the community faclitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? If yes, indicate the location of adjudication or conviction, date of adjudication and/or conviction, allegation, and outcome."*

The criminal history interview document contains no date to indicate when it became effective. There is no indication if it is utilized only in the hiring process, or if the document is utilized in the performance evaluation process as current employees' continuing affirmation duty to report prior allegations. The auditor asked the PREA coordinator if there were any signed documents to demonstrate the form's institutionalization into the hiring process. The PREA coordinator stated the form was developed in 2020, and had not been utilized. Of the 13 employee files reviewed, the auditor identified three (3) whereby the employee hire dates were in the year 2017, or 2018. No files were provided of hires in 2019, or 2020. No staff were identified on the Employee Roster, dated February 2020, as new hires. The auditor observed performance evaluations in employee files; none contained documented employee affirmation of duty to report prior allegations of sexual abuse or sexual harassment. There is no evidence that the form has been implemented into the hiring, or promotion process. Based on the evidence provided, the facility does not meet this provision.

115.217(g)

The facility PAQ indicates material omissions, or falsification of information related to prior allegations of sexual abuse, or sexual harassment, is grounds for termination. Policy 700-06 was provided as supportive documentation. Policy section II. G., re-states this provision. The auditor was not provided files of terminated employees for review. The PREA coordinator stated during informal conversation that no employees were terminated in the past 12 months for material omissions, or falsification of information related to prior allegations of sexual abuse, or sexual harassment. She stated that an employee would be immediately terminated

if the facility director found such to have occurred. Based on the evidence provided, the facility meets this provision.

115.217(h)

The facility indicates in Policy 700-06, section II. H. that, unless prohibited by law, it provides to institutional employers information related to a substantiated allegation involving a former employee applying to work at the institution. The facility director stated in his interview that there have been no requests from institutional employers on information related to substantiated allegations of sexual abuse against a former employee. Theh auditor was not provided with terminated files, whereby the facility received a request for information related to a former employee's substantiated allegation of sexual abuse while employed at CTC. Based on the evidence provided, the facility, by default, meets this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:

1. Institutionalize in the hiring process for employees, and contractors, the newly-created 'Required Criminal History and PREA Interview Questions' form, ensuring proper signature and date by interviewer(s).
2. Institutionalize in the promotion process for current employees, the newly-created 'Required Criminal History and PREA Interview Questions' form, ensuring proper signature and date by interviewer(s) .
3. Develop a documented Employee Reference Check form, which contains the required three components in standard 115.217(a) for prior institutional employers, and which identifies the institution, dates of employment, and outcome of any disclosed allegation(s) of sexual abuse, or sexual harassment.
4. Develop a standardized form to document as part of performance evaluations for current employees, the employees' continuing affirmative duty to disclose prior allegations of sexual abuse, or sexual harassment. Ensure the form is signed and dated, and included in the employees' file.
5. Document what factor(s) were considered in determining whether to hire, promote or contract with candidates, who disclose prior sexual harassment allegations, and whose role, or position at CTC provides access to, or engagement with clients.

FACILITY RESPONSE:

The facility has re-vamped the hiring process, and developed new forms to capture the required information from previous institutional employers. The following (new) forms were provided as supportive documentation:

- PREA Applicant Questionnaire - this form asks about prior criminal history, and four questions from this standard regarding prior allegations of sexual abuse, or sexual harassment. The form is explicit in that a response of "N/A" is not an option. Applicants are required to sign, and date the form.
- New Hire Questionnaire Reference Check - this form is used by agency hiring staff who conduct applicant reference checks from previous employers. The form asks previous employers the three questions required in 115.217(a). If yes, a follow-up question seeks

details of the situation.

- Annual PREA Acknowledgement form - this form is provided to current employees during their performance evaluation process, and requires a continuous affirmation to report any involvlement with an incident of sexual abuse or sexual harassment.

Policy 700-06 (Hiring and Promotions) was updated to include explicit language that the agency does not hire, or promote employees, volunteers, or contract with anyone who engages with, or has access to residents, and whom have been involved in allegations of sexual abuse, or sexual harassment. The policy clarifies that it shall consider and evaluate a candidate's previous involvement in resident/inmate sexual harassment on a case-by-case basis, as it relates to hiring, and promotions.

The facility provided as supportive documentation, completed new hire forms, which are signed, and dated. Training documentation dated 8/7/2020 on the new hire process, and policy (700-06) update was provided, which includes confirmation that attendees understand the information provided. The training form is also signed by the agency PREA coordinator.

Based on the evidence provided, the facility is in compliance with this standard.

Review:

Policy 700-06

Annual PREA Acknowledgement and Review form

PREA Applicant Questionnaire

New Hire Questionnaire Reference Check

Training documentation

Completed New Hire documentation

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) Interviews: 1. Agency Head 2. Facility Head Site Review Observations (not an all-inclusive list; see the report Narrative for more information): • Housing dorm • housing unit common areas • Main security/control room • main hallway/lobby (in front of the control room) • facility main entrance • outdoor recreation area • 'Area 51' • cafeteria Findings: 115.218(a) The facility PAQ indicates there have been no upgrades to the facility since the last PREA audit. During the onsite audit, the facility director was able to show the video monitoring system, and how footage can be captured onto a flash drive. The control room monitor covers 14 cameras (***note***: one monitor was not working on Day 1 of the onsite audit, and replaced on Day 2), including views on the outside perimeter, kitchen pantry, laundry, group room (known as Area 51) near the ladies (staff) restroom; rear storage room entrance, and full view of the designated smoking area; inside dorm entrances. There is full view of the main dorm entrance from the control room front window. Clients sign in/out, and receive medications (locked inside a cabinet) at the control room counter, which can be viewed on a monitor in the facility director's office. There is a PREA Binder in the control room, which contains PREA standards, policies, and forms. Clients may access the Binder upon request. Based on the evidence provided, the facility meets this provision. 115.218(b) The Agency Head stated that when she considers the facility layout, and physical aspects, a major consideration is the security staff's ability to monitor client movement in, and around the facility, and the use of technology to monitor the entire facility. She stated the facility director

	has remote access to the video surveillance system, and routinely reviews random video footage in the facility. She stated she trusts that he stays on top of the technology, and that the facility is effectively monitored inside, and out. The facility director stated during his interview that there have been no expansions or modifications of the facility in the last 12 months. In 2018, higher resolution cameras were installed, which provided the capability to download video footage onto a USB/flash drive. During the onsite audit the auditor observed the facility director's office, which houses video monitors for 22 security cameras, including the control room. No cameras have audio capacity. The control room houses 14 cameras, with views of the outside perimeter, kitchen pantry, laundry room, group room near the ladies (staff) restroom, known as "Area 51"; rear storage room, entrance to, and full view of, client designated smoking area, and inside client dorm entrances. Footage from one monitor in the control room has to be reviewed in the facility director's office, until the monitor is replaced. Theh auditor observed the monitor was in working order prior to the end of the onsite audit. There is a full view of the main dorm entrance from the control room front window. The auditor observed clients signing in/out at the control room, or receiving medication, which is locked inside the control room. Based on the evidence provided, the facility meets this standard.

115.221	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA Zero Tolerance 2. CTC Policy 800-51: PREA Report Response 3. CTC Policy 800-52: Uniform Evidence Protocol 4. PREA Victim Support Person training certificates 5. MOU for PREA 2020 Interviews: 1. PREA coordinator 2. Random Staff Site Review Observations: Finding: 115.221(a) The facility PAQ indicates the facility conducts administrative investigations of reported allegations of client sexual abuse. CTC does not conduct criminal investigations. The PAQ indicates the facility follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Policy 800-52 is provided as supportive documentation for compliance with this provision. The policy header indicates it became effective in January 2020. The policy is divided into four sections (I. - IV.): • Section I., *Policy*, states a written procedure will be established as it relates to Evidence protocol and Forensic Medical Examinations. • Section II., *Applicability*, states the policy applies to all CTC staff, volunteers, interns, and contractors. • Section III., *Implementation*, states CTC will utilize the National Protocol for Sexual Assault Forensics Medical Examinations for Adults/Adolescents (April 2013) in order to develop a Uniform Evidence Protocol Plan. The section states newly hired staff, within 30 days of hire, will be trained on the Evidence Protocol; current staff will receive refresher training annually. The section outlines five (5) steps for immediate respond to sexual abuse: 1. Separate the abuser and victim(s) 2. Secure and protect the crime scene 3. Notify the facility director and PREA coordinator 4. Follow Uniform Evidence Protocol procedures

5. Contact Lancaster (local) Police and request a criminal investigation

- Section IV., *Procedure*, lists 18 detailed action steps, including victim emotional support, ensuring potential evidence is not contaminated, and separately transporting the allege abuser, and victim.

During the onsite audit, the auditor interviewed 13 random staff. All staff were able to articulate the five protocol steps outlined in policy 800-52. All staff identified the facility director, and PREA coordinator as points of contact, if a sexual abuse is reported, or observed. During the onsite audit, the PREA coordinator provided attendance sheets dated 6/28/19 from staff training on first responder duties. No staff training records on policy 800-52 were provided as evidence that policy 800-52 has been implemented. None of the 13 employee files the auditor reviewed contained documentation of training on policy 800-52. Based on the evidence provided, the facility does not meet this provision.

115.221(b)
The facility PAQ indicates it does not house youth, and the provision is not applicable. Auditor observation indicates there are no youth housed at this facility. The PAQ indicates a Uniform Evidence Protocol is utilized, which is 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. Policy 800-52 was provided as supportive documentation. Based on the evidence provided, the facility, by default, meets this provision.

115.221(c)

The facility PAQ indicates clients who allege sexual abuse will receive forensic examinations by a Sexual Abuse Nurse Examiner (SANE), or Sexual Abuse Forensic Examiner (SAFE). The facility PAQ indicates in Policy 800-51, Section IV. 2. B. (1-4)., that CTC will offer to clients unimpeded access to health care and mental health services. Clients will be referred to Fairfield Medical Center, during regular, and non-business hours. The facility PAQ indicates forensic examinations are conducted by SAFE/SANE where possible. The MOU with Family Health Services was provided as supportive documentation.

The facility PAQ indicates there has been one allegation of client sexual abuse in the past 12 months. The allegation involved a sexual relationship between a female staff, and male client. Sexual encounters occurred in the community, arranged by the staff. The alegation was substantiated, and the employee was terminated; the client successfully completed his program. According to investigative documentation, the client did not request, or receive medical services related to sexual encounters with the identified staff. Policy 800-51, Section IV. 2. B. 3 states if a client/victim of sexual abuse refuses to be transported to Fairfield County Medical Center, a Refusal of Treatment form is completed. The investigative documentation did not indicate whether the client was offered SANE/SAFE medical treatment, or if such was received, or refused.

The investigative report indicates law enforcement was not notified; the named staff admitted having a sexual relationship with the client. CTC Policy 800-51, section IV., 3 (Investigations) A., states, in part, *"...All allegations of sexual abuse/harassment that may be violations of local, state, and/or federal law shall be reported to the Lancaster Police department for further*

investigation...". The Prison Rape Elimination Act (PREA) standard 115.6(4) describes Sexual Abuse, in part, as *"...Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer includes any of the following acts, with or without consent of the inmate, detainee, or resident:..."*. Ohio Revised Code (ORC) section 2907.03 prohibits sexual conduct with inmates, or those under correctional supervision. Such is deemed as Sexual Battery, and a third degree felony. Willingness on the part of the client to engage in sexual activity with the identified employee, does not constitute consent, due to an imbalance of power between the client and employee. Based on the evidence provided, the facility does not meet this provision.

115.221(d), (e)
The facility PAQ indicates it attempts to make available to the victim a victim advocate from a rape crisis center, either in person or by other means. The facility uploaded an MOU between CTC and Family Health Service of East Central Ohio, as supportive documentation. The PREA coordinator stated during her interview that two employees are designated as PREA Victim Support Persons. Training certificates of specialized training by the ODRC was provided as evidence. Policy 800-51 IV. 3. B supports the PAQ, stating, *"The facility victim support person shall consult with the investigator on the case and offer assistance as is appropriate based on their training..."*. The auditor interviewed one of the two Victim Support Persons, who was able to articulate their role with respect to providing client victims of sexual abuse emotional support, including accompanying the client victim to the hospital, and referrals for services not provided by CTC. Based on the
evidence provided, the facility meets this provision.

115.221(f)
The facility PAQ indicates it complies with this provision. The facility does not conduct administrative AND criminal sexual abuse investigations. Policy
800-51 states if the alleged sexual abuse is deemed to be criminal, the Lancaster Police department will be contacted for further investigation. The Uniform Evidence Protocol 800-52 states in section III. 5. that staff will immediately contact the Lancaster Police and request that they conduct a criminal investigation. The facility director stated during his interview that local law enforcement will be contacted in the event a sexual abuse allegation is considered to be criminal.

The auditor reviewed one investigation of reported sexual abuse in 2019. There was no evidence that the Lancaster Police department was contacted to conduct a criminal investigation. During review of the investigative documentation, the PREA coordinator stated to the auditor that law enforcement was not notified, since the identified employee admitted to the sexual relationship. The employee was terminated. Based on the evidence provided, the facility does not meet this provision.

115.221(g)
The auditor is not required to audit this provision.

115.221(h)
The facility PAQ response is that it complies with this provision. Policy 800-51 states the designated victim support person shall consult with the investigator
on the case and offer assistance as is appropriate based on their training. Two staff were identified as PREA Victim Support Persons. Each received training in 2018 for this role. Training was provided by the Ohio Department of Rehabilitation and Corrections (ODRC), and

the content has been accepted for meeting this provision. During the onsite audit, the auditor reviewed training records in 13 employee files. The auditor observed in the identified employees' files that each have a signed, dated certificate of completion of the training. Staff files verify that the identified employees in the PAQ are appropriate to serve in this capacity. Based on the evidence provided, the facility meets this provision.

Based on the overall evidence provided, the facility does not meet this standard.

Corrective Action:

1. Train all staff on Policy 800-52: Uniform Evidence Protocol.
2. Institutionalize the Uniform Evidence Protocol.
3. Train PREA investigator(s) on all requirements of Policy 800-52: Uniform Evidence Protocol; and Policy 800-51: PREA Report Response.
4. Ensure allegations of sexual abuse referred to the Lancaster Police department.

FACILITY RESPONSE:

The documentation provided in the PAQ was newly created in January 2020. There was no evidence that the documented processes were institutionalized, or that staff had been trained on the updated forms, and information. During the Corrective Action period, the facility provided training documentation, which was signed by staff attendees, and dated. Policy 800-52 was updated to clarify that allegations of staff sexual abuse will be referred to the Lancaster Police department. The facility PREA coordinator indicated there have been no new allegations of resident sexual abuse, or sexual harassment. Therefore, no documentation was provided regarding actual referrals to the Lancaster Police department.

Based on the evidence provided, the facility meets this standard.

Review:

Policies 800-51, 800-52

Staff training documentation

115.222	Policies to ensure referrals of allegations for investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making the compliance determination:

Documents:

1. Pre-Audit Questionnaire
2. CTC Policy 800-51: PREA Report Response
3. CTC Website: https://www.communitytransitioncenter.com/
4. CTC Policy 800-52: Uniform Evidence Protocol

Interviews:

1. Agency Head
2. Investigative staff (PREA Coordinator)

Finding:

115.222(a)
The facility PAQ indicates all allegations of sexual abuse, and sexual harassment are administratively investigated, unless such is deemed to be criminal. Policy 800-51, provided as supportive documentation, states criminal investigations are conducted by the Lancaster Police Department. The facility director stated during his interview that the facility works closely with local law enforcement, which will respond to an allegation of sexual abuse, or sexual harassment, should there be an imminent threat to the alleged victim, or if it is clear a crime has been commited. The PAQ indicates there has been one allegation of sexual abuse in the past 12 months. The auditor reviewed the administrative investigation documentation. The auditor found no evidence that policies 800-51, or 800-52 were followed, as law enforcement was not contacted for a potential criminal investigation. The PREA coordinator stated Lancaster Police department was not contacted since the identified employee admitted to being sexually involved with a client. The Agency Head stated in her interview that there was an allegation of sexual abuse of a client by a female staff, but it was concluded to be fraternization, not sexual abuse. She stated the employee was still terminated.

The agency website lists two contacts to report client sexual abuse and harassment - the PREA coordinator, and PREA investigator. The website provides a single phone number for both individuals. The auditor observed that neither the PREA coordinator, or PREA investigator conducted the 2019 administrative investigation. The auditor reviewed 13 employee files, including the file for the individual who conducted the administrative investigation for the 2019 case. The auditor did not observe evidence that the employee received specialized training for conducting investigations of cases involving sexual victimization. The employee's file contained a signed certificate for training received as a Victim Support Person, dated 2/9/18. Based on the evidence provided, the facility does not meet this provision.

115.222(b)

The facility PAQ indicates sexual abuse criminal investigations are referred to local law enforcement (i.e., Lancaster Police department). It states local law enforcement has the legal authority to conduct criminal investigations. Policy 800-51 supports the PAQ, and lists Lancaster Police department as the primary entity for conducting criminal investigations.

The PREA coordinator stated during her interview that she contacts Lancaster Police to launch a criminal investigation. The facility director stated during
his interview that, should there be an emergency situation, local law enforcement will be contacted, and that the agency has a good rapport with the local police. The Auditor reviewed the facility website, and located contact information for the PREA investigator, and PREA coordinator. The auditor observed a live link to Policy 800-51: Response Reporting, related to reporting allegations of sexual abuse and harassment. The PAQ provides policy 800-52 as additional supportive documentation to demonstrate the process for making such referrals. The PREA coordinator stated during her interview she, or the facility director would call Lancaster Police. Based on the evidence provided, the facility meets this provision.

115.222(c)
The facility PAQ indicates Lancaster Police conducts criminal investigations related to allegations of sexual abuse. Policy 800-51 is provided as supportive documentation of how this process is carried out. Policy 800-51, section 3. A., states the facility PREA coordinator is to maintain the written investigative report. The policy does not describe the responsibilities of the Lancaster Police, and CTC in relation to how criminal investigations are carried out. The auditor reviewed one administrative investigation file from 2019. The allegation was of sexual abuse of a client by a female employee.There was no evidence that the facility contacted Lancaster Police to request a criminal investigation. The PREA coordinator did not state during her interview that there is a structured, or documented process for the facility's engagement with lancaster Police other than an initial contact via phone. Based on the evidence provided, the facility does not meet this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:

1. Revise policy 800-51 to reflect the role CTC and Lancaster each has to ensure criminal investigations are conducted in accordance with this standard.
2. Include in policy 800-51 who is the official designee for notifying Lancaster Police, and ensuring investigation protocols are documented.
3. Train staff on the content of the policy.
4. Publish the updated policy 800-51 on the agency website or make the policy available through other means.

FACILITY RESPONSE:

The facility submitted as supportive documentation an updated policy 800-51, which contains a procedure for contacting the Lancaster Police to determine if a criminal investigation is warranted related to allegations of resident sexual abuse. Proof documentation was provided as verification of staff training on the updated policy and procedure.

The auditor reviewed the CTC website, and located a link to the agency's policy 800-51.

	Based on the evidence provided, the facility meets this standard. **Review**: CTC website Staff training documents Policy 800-51

115.231	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA and Zero Tolerance 2. Staff training records Interviews: 1. Intake Staff (PREA investigator) 2. Random Staff Site Review Observations: 1. PREA Signage through the facility Findings: 115.231(a) The facility PAQ indicates that they provide staff training on the zero tolerance policy for sexual abuse and sexual harassment during new employee orientation. Policy 800-50 PREA and Zero Tolerance was provided as supportive documentation. Policy 800-50, section IV. 3. (Employee Training) A., states PREA-specific training during orientation includes the agency's zero-tolerance policy on sexual abuse and sexual harassment. Policy section I. states CTC *"...provides a safe, humane, and appropriately secure environment, free from the threat of sexual misconduct for all clients by maintaining a program of prevention, detection, response investigation and tracking...".* It further states that sexual abuse and/or sexual harassment by staff toward clients is strictly prohibited. Policy section III. Definitions defines *Sexual Abuse, Voyuerism,* and *Sexual Harassment,* as defined in the PREA standards. The facility provided in the PAQ staff meeting notes dated 1/3/2020 as evidence that such was reviewed with staff. The document details the definitions reviewed, requirement for female staff to announce themselves when entering the client dorm area. During the onsite audit, the PREA coordinator provided an updated copy of the 1/3/2020 meeting notes, which contained 'Exigent Circumstances', as an added term, and the PREA standard definition. She stated it was added after the document was created, and was included in the meeting. The auditor reviewed 13 employee files during the onsite audit. Six (6) of 13 files contained PREA refresher training dated 6/28/19, which covered first responder duties, and searches of transgender and intersex clients. The training on 1/3/2020 was documented in nine (9) of 13 files, and covered PREA definitions, transgender and intersex searches, and announcement requirements of female staff entering the client dorm area; three (3) files reflected a general PREA refresher training dated 2/7/2020. Training files contain a copy of the PREA policy 800-50 review from previous years.Three of 13 employee training files reviewed contained a 2017 LGBTQ culture training, provided by the Alcohol, Drug and Mental Health Board of Franklin County (ADAMH). Eight (8) of 13 training files contained the agency rules and regulation of client rights. This document includes client rights to be free

from sexual harassment and sexual abuse.

The policy 800-50 Section IV. 3. A. a-i. states employee are trained on the components of PREA employee training:

1. zero tolerance
2. employee's responsibilities regarding sexual prevention, detection, reporting, and response policies and procedures
3. client rights to be free from sexual harassment, and sexual abuse,
4. client and staff right to be free from retaliation for reporting sexual abuse,
5. dynamics of sexual misconduct in confinement
6. common reactions of sexual misconduct victims,
7. how to avoid inappropriate relationships with clients,
8. effective and professional communication with clients including LGBTI, or gender nonconforming clients,
9. how to comply with relevant laws for mandatory reporting of sexual abuse to outside authorities.

Policy section B. states the facility will provide refresher training annually. The policy doesn't include *How to detect and respond to signs of threatened and actual sexual abuse,* also a component of this provision. Based on the evidence provided, the facility does not meet this provision.

115.231(b)
The facility PAQ states the training provided to staff is gender-specific for an adult-male population. During the onsite review, there were no observed female clients in the facility. Client files supported that there are no female clients at CTC. The auditor observed in staff training records that employees participated in training related to transgender and intersex searches, and effectively engaging with LGBTI populations. Based on the evidence provided, the facility, by default, meets this provision.

115. 231(c)
The facility PAQ indicates all employees who have contact with clients receive training on the agency's zero-tolerance policy. The policy 800-52 was provided as documentation of this requirement. The policy states all new hires who engage with clients are trained on the agency's zero tolerance policy withing 30 days of hire. The facility provides annual PREA refreshers. During random staff interviews, all employees stated they completed PREA training on the agency's zero-tolerance policy. Staff stated they had training in 2019 and/or 2020.

During the onsite review, the Auditor reviewed 13 employee training records. The PREA and Zero Tolerance policy was reviewed during the time of hire for all employees. There was evidence of subsequent policy review periods. Specifically, 10 of 13 files reflected training in 2020; seven (7) files reflected training in 2019. Based on the evidence provided, the facility meets this provision.

115.231(d)
The facility PAQ indicates there is documentation that employees understand the content of training received. No supportive documentation is provided. During the onsite audit, the PREA coordinator provided an attendance sheet from PREA training on 1/3/2020. The attendance sheet contains a typed list of employee names, and a signature line for participants. There is

no qualifying statement on the attendance sheet indicating employees understood the training they received. The auditor reviewed 13 employee files. Of 13 files reviewed, one file contained a record of Relias (online) PREA training, which includes a post-test to complete a given training. Of the remaining 12 training records, none contained documentation that employees understood the training provided.
Based on the evidence provided, the facility does not meet this provision.

Based on the overall evidence provided, the facility does not meet this standard.

Corrective Action:

1. Include in current training curriculum for employee PREA training how to: f) how to detect and respond to signs of threatened and actual sexual abuse.
2. Create a detailed training verification document/form, which indicates the specific PREA topic(s) covered, length of training session, date, attendee signatures, and job titles. Include a clause, or other means (i.e., pre/post-test) to document that employees understand the training received.

FACILITY RESPONSE:

The facility provided as supportive documentation training records of staff PREA training on updated policy 800-51 Training documentation indicates 22 employees attended training on 3/6/2020, four (4) attended on 3/9/2020; 19 employees attended training on 9/11/2020, and one staff attended on 9/14/2020. The policy update includes 115.231(f) how to detect and respond to signs of threatened and actual sexual abuse. Training documents were signed by participating employees, and confirmed that they understood the information provided. The facility included a training agenda, which indicates review of the agency's PREA policy, and procedure.

Based on the evidence provided, the facility meets this standard.

Review:

Staff traiing documents

Policy 800-51

115.232	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. CTC Policy 800-50: PREA and Zero Tolerance 3. CTC Policy 800-52: Uniform Evidence Protocol 4. Staff Meeting Notes 1/3/2020 Interviews: 1. PREA coordinator 2. Human Resources Representative (Facility Director) 3. Formal and informal interviews with staff and contractor Findings: 115.232(a) The facility PAQ indicates it provides PREA training for volunteers and contractors. The PAQ indicates the facility has one contractor who has access to clients. Staff meeting notes dated January 3, 2020 was provided as supportive documentation. Policy 800-50, also uploaded as supportive documentation, states volunteers and contractors receive training on the agency's zero tolerance policy. Policy 800-50, section IV. 3. E. states all interns, volunteers and contractors who have contact with clients shall be notified of the facility's zero-tolerance regarding sexual misconduct and how to report such incidents. Policy 800-52 was uploaded as supportive documentation. The policy states in Section II. that the protocol guidelines apply to employees, volunteers, interns, and independent contractors. The clinical director (contractor) stated in his interview that he participated in PREA training on 1/3/2020. He stated he attended PREA training in 2019, as well. He was able to articulate the agecy's zero-tolerance policy, first responder duties, including reporting to the PREA coordinator or facility director. He stated he does not have ongoing contact with clients, but advises case managers on how to effectively engage with clients in various situations. He stated it is not likely that a client would report an allegation to him, but would to a case manager. The auditor reviewed training records of 13 employee files. The facility director stated during informal conversation that the clinical director is the only contract person at the facility. A file for the position was provided to the auditor during the onsite audit. Training records indicate the contractor received PREA training on 6/28/19, 1/3/2020, and 2/7/2020. No volunteers were present during the onsite audit. Based on the evidence provided, the facility meets this provision. 115.232(b)

The facility PAQ indicates volunteers and contractors receive PREA training on the agency's zero-tolerance policy. Policy 800-50, and 800-52 were provided as supportive documentation. The facility provided an attendance training sheet signed by the contractor, as evidence that policy implementation includes independent contractors. The clinical director (contractor) stated in his interview that he received PREA refresher training in 2019, and 2020. The auditor identified in training records, documentation of PREA training on 6/28/19, and 2/7/2020. Based on the evidence provided, the facility meets this provision.

115.232(c)
The facility PAQ indicates training documentation that confirms volunteers and contractors understand the training they receive related to the facility's zero-tolerance policy against sexual abuse and sexual harassment. The facility provided policy 800-50 as supportive documentation. Policy section E. states volunteers, interns, and contractors will receive PREA zero-tolerance training. The policy does not indicate a requirement to document that volunteers, interns, and contractors understand the training they receive. The clinical director (contractor) stated during his interview that he understands the PREA training he received, but did not recall signing an actual document to attest to such. Based on the evidence provided, the facility does not meet
this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:

1. Develop proof documentation (i.e., post-test), or add to existing PREA training attendance forms for volunteers, interns, and contractors PREA training, a statement to affirm trainees' understood the training received.

FACILITY RESPONSE:

The facility provided as supportive documentation PREA Memorandum of Understanding for Contractors, Interns, and Volunteers. The form is required for all contractors, volunteers, including student interns, who engage with, or have access to CTC residents. The document includes review of policy 800-50, and 800-51, and requires signature and affirmation that the information provided is understood.

No signed documents were provided, as there are no contractors, or volunteers at the facility.

Based on the evidence provided, the facility meets this standard.

Review:

Staff (contractors, volunteers, interns) training document

Policy 800-50, 800-51

115.233	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA and Zero Tolerance 2. Client files Interviews: 1. Intake Staff (PREA investigator) 2. Random clients Site Review Observations: 1. PREA signage through the facility Findings: 115.233(a) The facility PAQ indicates the agency's zero-tolerance policy against client sexual abuse and sexual harassment is reviewed with incoming clients during the intake process. Intake procedures includes reviews with clients on: • how to report incidents or suspicions of sexual abuse or sexual harassment; • their rights to be free from sexual abuse and sexual harassment; • their rights to be free from retaliation for reporting such incidents; • agency policies and procedures for responding to such incidents. The facility PAQ provided policy 800-50 as supportive documentation, which states in section IV., 4. (A), that information provided during intake must include: • Prevention • Self-protection • Reporting • Treatment and counseling During the facility site review, the auditor observed client information, announcements, posted inside a locked bulletin board, located in the client main dorm hallway. The auditor observed the following PREA information: • PREA reporting instructions • Contact persons within the facility, and community-based resources • Community-based resource (Family Health Services of East Central Ohio) • External entity for reporting allegations of sexual abuse During random client interviews, 17 of 17 clients identifed Intake staff Carol Combs as the person, with whom PREA information was reviewed. All were aware that PREA-related

information was posted inside the dorm, on the bulletin board. A review of client files showed PREA documentation in Section 9 of the client file, which contained the signed form acknowledging receipt of their resident handbook, and PREA policy 800-50 as part of the intake process. Based on the evidence provided, the facility meets this provision.

115.233(b)
The facility PAQ indicates 310 clients were admitted to the facility during the past 12 months. Policy 800-50 section IV. 4. A. states all clients, upon arrival, will receive PREA information in oral and written form. The auditor observed a new client intake, and an orientation session during the onsite audit. The Intake staff conducted each meeting in her office. The auditor introduced herself to the client, and explained why she was present. The client stated he had no issue with the auditor observing his intake. The intake consisted of a series of questions regarding the client's history related to past sexual victimization, or sexual abusiveness; client medical and mental health history; highest level of education completed. The client was informed of community-based resources for reporting allegations externally. The client was provided a copy of the 'No Means No' poster, and the information included on the poster. The client was informed of medical and mental health resources. The Intake staff reviewed the three possible outcomes of a PREA allegation (unfounded, unsubstantiated, substantiated), and the definition of each. The client received instructions regarding staying on (surveillance) camera; no name-calling. She advised the client that all staff are trained on PREA compliance. At the end of the session, the client was asked to review all information reviewed, and sign-off on the agency's zero-tolerance statement.

The auditor observed an orientation session with a client. The auditor introduced herself and explained why she was observing. The client stated he had no issue with the auditor's observation.. He stated his orientation was delayed because he had not read his Client Handbook. The Intake staff stated such is a prerequisite for completing orientation. Client information collectedwas entered in a statewide system, CCIS Web. The system captures client demographic information, assessment information. The Intake staff entered information during the orientation session.

During random client interviews, 17 of 17 clients were able to articulate that they received the agency's zero-tolerance policy regarding client sexual abuse and sexual harassment either upon entering the facility, or within 1-2 days of arrival.One client commented the PREA intake process began before he unpacked his belongings. They all recalled a second assessment, conducted by their case manager. Two clients stated the reassessment was approximately two weeks after their arrival, and was conducted by their assigned case manager.

During the facility onsite review, the Auditor reviewed 17 client files. All files reviewed contained evidence of an initial PREA intake screening and orientation within 1-2 days of the clients' arrival. Files included a follow-up screening, which was conducted two weeks after their arrival. Both documents are dated, and signed by the client and staff who conducted the screening. The auditor observed the PREA re-screening was consistently completed two weeks after the initial screening. Based on the evidence provided, the facility, by default meets this provision.

115.233(c)
The facility PAQ indicates it provides to all clients education in formats accessible to those who are: limited English proficient, deaf, visually impaired, have limited reading skills, or otherwise disabled. Policy 800-50, section IV. 4. F. affirms the facility provides assistance needed to

ensure clients receive information in a way they can understand, and will offer disabled clients tools and resources to effectively receive PREA-related information, or to report allegations of sexual abuse, and sexual harassment. The Intake/PREA investigator is identified as the position responsible for ensuring such is provided. The PREA investigator is the person assigned to conduct client intakes. During her interview, the PREA investigator stated she conducts client intakes within the first 24 hours of their arrival. If a client had a need for any type of assistance, or if they knew prior to the client's arrival they had some type of physical disability, she would meet with the facility director
and/or PREA coordinator to arrange for the appropriate accommodation.

During the Auditor's review of client files, no clients were identified as having a physical disability. During review of the client roster, the PREA coordinator did not identify any cllients as disabled. During the auditor's review of 17 client files, no files contained information identifying a client as disabled, physically, or mentally.
Based on the evidence provided, the facility meets this provision.

115.233(d)
The facility PAQ indicates that the documents assistance or accommodation(s) provided to clients. No supportive documentation was provided in the PAQ. The PREA investigator stated in her interview that she has a conversation with clients during intake about any special needs or accommodation they may
have. She stated most clients do not request anything special, so there isn't usually anything to document. Of the client files the Auditor reviewed, 17 of 17 did not contain client requests for any type of accommodation, or to receive information in a special format (e.g., Spanish, braille). Based on the evidence provided, the
facility meets this provision.

115.233(e)
The facility PAQ indicates key information is readily available and accessible to all clients through posters, resident handbooks, or other written formats. The facility provided in the PAQ a document of PREA posters, which the auditor observed during the facility site review. A ***"No Means No"*** poster contains three sections of information:

- Right to Report - includes the facility's commitment to keep clients free from sexual victimization
- How to Report - includes internal options to report sexual abuse and sexual harassment
- Victim Support Services - includes Family Health Services of East Central Ohio as a rape crisis center

A ***"Break the Silence"*** poster was provided, which contains the toll-free hotline number, email, and mailing address for reporting sexual abuse or sexual harassment allegations outside the CTC. The auditor tested the number, which connects callers to the Ohio Department of Rehabilitation and Correction's (ODRC) PREA voicemail line. The caller can leave a message, and will be contacted within 24 hours. The auditor observed English, and Spanish versions of this poster.

During the onsite audit, the PREA coordinator provided to the auditor a hard copy of the CTC Client Handbook. Page 30 of 30 provides the facility's zero-tolerance statement, "...against any form of Sexual Abuse and/or Sexual Harassment...". The page includes client and staff

rights to report retaliation. The page lists three available resources, and affirms clients' right to report anonymously. The resources listed are:

- ***Family Health Services of East Central Ohio*** toll-free number: 800-688-3266 or 740-653-6338
- ***ODRC PREA hotline***: 614-728-3399 or email: DRC.ReportSexualMisconduct@odrc.state.oh.us
- ***CTC PREA coordinator***: 740-689-1200, ext. 102 or email mindy@ctclancaster.com

During random client interviews, 17 of 17 clients were able to articulate where pertinent information is located in the facility, or to whom they go to obtain key information. Clients stated during random interviews that they knew important information is in their intake folder, which is provided by the PREA investigator/Intake staff, when they first arrive, should they have a need to report sexual abuse or sexual harassment, or retaliation. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility meets this provision.

Corrective Action:
No corrective action is recommended.

115.234	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50; PREA and Zero Tolerance 2. Employee training records Interviews: 1. PREA coordinator Findings: 115.234(a) The facility PAQ indicates that those who conduct administrative investigations received training in conducting such investigations in confinement settings. The PAQ indicates two staff received specialized training to conduct PREA investigations related to reported allegations of sexual abuse. Policy 800-50 section IV. 3. D. states, in part, "...All investigators shall receive specialized training which shall include, but not be limited to, conducting investigations in confinement settings...". The PAQ included two uploaded training certificates of specialized PREA investigations training completed March 12-13, 2018 by the PREA coordinator, and PREA investigator (Intake staff). The certificates indicate the training was facilitated by The Moss Group. The auditor reviewed one PREA allegation investigation file from 2019. The facility PAQ indicated one allegation was received in the last 12 months. The PREA coordinator or PREA investigation were not identified as who conducted the investigation. Documentation indicates the facility investigator conducted the investigation. During informal conversation with the PREA coordinator, the auditor inquired as to why she, or the named PREA investigator, did not conduct the PREA investigation. The PREA coordinator stated the facility director instructed the facility investigator to conduct the investigation, since he has a law enforcement background. The auditor reviewed 13 employee files during the onsite audit. The auditor verified the two uploaded training certificates for specialized PREA investigations training was contained in the identified employees' files. The security directorTraining records confirmed their attendance, as a certificate of completion, signed by The Moss Group (who facilitated the specialized training), is contained in their training file. A curriculum was provided, which reflects all provisions of this standard are met. The Two-day training included a half-day "Train-the-trainer" session. One of the employee files the auditor reviewed was the facility investigator. Training records reflect PREA training during new employee orientation on 11/6/17; Victim Support Person training (and certificate of completion by ODRC) on 2/9/18. There is no evidence of training or experience in dealing with sexual trauma, or sexual

victimization. the employee has not completed PREA specialized training for PREA investigations. The PREA coordinator stated the employee is not designated to conduct PREA investigations. Based on the evidence provided, the facility does not meet this provision.

115.234(b)
The facility PAQ indiates that the specialized investigations training meets all requirements of this provision: techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Policy 800-50 section IV. 3. D. supports the indication in the PAQ. The training curriculum was made available in hard copy. The Auditor verified the training to be comprehensive and thorough. The PREA investigator, and PREA coordinator were able to articulate the content of the specialized investigations training. The facility investigator, who conducted the administrative investigation in 2019 had no specialized training in his file. The PREA coordinator confirmed the facility investigator is not a designee for PREA-related investigations. Based on the evidence provided, the facility does not meet this provision.

115.234(c)
The facility PAQ indicates specialized training documentation of agency investigators is maintained. Two training certificates were provided as supportive documentation to verify such training has been received. During the onsite audit, the auditor observed the same documents in the PREA investigator
and PREA coordinator training records. The auditor reviewed the investigative file of a 2019 PREA allegation. The employee identified as the investigator is not one of the trained employees identifed to conduct PREA investigations. The auditor observed no evidence in the employee's training records that indicates completion of specialized training in sexual victimization, or sexual trauma. Based on the evidence provided, the facility does not meet this provision.

115.234(d)
The Auditor is not required to audit this provision.

Based on the overall evidence provided, the facility does not meet this standard.

Corrective Action:

1. Ensure all staff who conduct administrative, or participate in criminal investigations of sexual abuse receive specialized training dealing with sexual trauma, sexual victimization, or other sexual abuse training, which satisfies the requirements of this standard.
2. Document the training received, and curriculum of training related to sexual trauma, sexual victimization, to ensure such meets the requirements of this standard.

FACILITY RESPONSE:

The facility provided as supportive documentation an updated policy 800-51, which explicitly states in Section 3. (Investigations), A., that the PREA coordinator is the primary designee to conduct administrative investigations. The PREA coordinator may designate another person to

	participate in, or conduct the investigation, as long as the designated staff has completed PREA investigations specialized training. The facility PREA coordinator has completed investigations Train-the-trainer training, and may train staff to conduct, or assist with, PREA investigations. No additional specialized investigations training documentation was provided, as no additional staff have been designated to conduct PREA investigations. Based on the evidence provided, the facility meets this standards. **Review**: Policy 800-51, Section 3.A.

115.235	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. CTC Policy 800-51: PREA Report Response 3. Employee Roster Site Review Observations: 1. No medical or mental health practitioners at CTC Findings: 115.235(a) The facility PAQ indicates it does not have medical and mental health practitioners who work regularly in the facility. The facility did not provide supportive documentation related to medical and/or mental health services offered onsite to clients. Policy 800-51, section IV. 2. C. 1. states clients referred to mental health by medical services following an allegation of sexual abuse shall be seen by a mental health professional that shall complete further screenings or assessments. During the onsite audit, the facility provided to the Auditor an Employee Roster dated February 2020. The census did not list any medical or mental health practitioners as employees, or contracted staff at the facility. During the onsite audit, the Auditor did not observe any medical or mental health practitioners in the facility. Direct medical and mental health services are not offered at this facility. Clients are referred to the Fairfield Medical Center, or CMC (Correctional Medical Center), depending on status (classification), and urgency of the situation. Based on the evidence provided, the facility, by default, meets this provision. 115.235(b) The facility PAQ indicates this provision is not applicable (N/A), as medical and/or mental health services are not provided at this facility. The agency policy states clients will be referred to Fairfield County Medical Center for medical services. During the onsite audit, there was no evidence of direct medical or mental health services being provided at CTC. Based on the evidence provided, the facility, by default, meets this provision. 115.235(c) The facility PAQ indicates it does not employ in-house medical or mental health practitioners. Policy 800-51, section IV. 2. C. Mental Health Responsibilities states clients are referred to medical and mental health professionals for services. Policy section IV. 2. B. 4. identifies Fairfield Medical Center as the entity where clients are referred for medical and/or mental health services, assessment. Based on the evidence provided, the facility meets this provision.

	115.235(d) The facility PAQ indicates there are no medical or mental health care practitioners employed at CTC, and that the provision requirement is not applicable (N/A). Policy 800-51, section IV. B. states clients are referred to external entities for medical or mental heath services. The Employee Roster does not list medical or mental health practitioners who volunteer or are contracted to provide medical or mental health services. During the onsite audit, there were no staff, volunteers, or contractor(s) identified as employed, or contracted to provide medical or mental health services for clients at CTC. Based on the evidence provided, this provision is not applicable to this facility. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.241	Screening for risk of victimization and abusiveness
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response 2. Client files Interviews: 1. Intake staff (PREA coordinator) 2. Staff that conduct risk assessments (PREA coordinator) 3. Random clients Findings: 115.241(a) The facility PAQ indicates that all clients are assessed during intake for their risk of sexual victimization, or sexual abusiveness. Policy 800-51 was provided as supportive documentation, which states in section IV. 5. A., that all clients shall be screened and assessed upon admission for their risk of being a victim of sexual abuse or their likelihood of committing sexual abuse. During the onsite audit, the auditor reviewed 17 client files. Of the 17 clients interviewed, all, or 100 percent stated they received an initial risk screening within the first 24 hours of arrival at the facility. One client stated he went through a PREA screening before he put away his belongings. The auditor reviewed 17 client files during the onsite audit. All files reviewed contained records of completed intake screenings. Based on the evidence provided, the facility meets this provision. 115.241(b) The facility PAQ indicates intake screenings are ordinarily completed within 72 hours of arrival. Policy 800-51 is uploaded as supportive documentation. The policy states in section IV. 4. A. that PREA screenings are conducted with 24 hours of the client's arrival at CTC. During random client interviews, 17 of 17 clients stated they completed their PREA intake when they first arrived at CTC. The auditor reviewed 17 client files during the onsite audit. All files reviewed contained signed intake screening documentation, dated within 24 hours of the client's arrival at CTC. Based on the evidence provided, the facility meets this provision. 115.241(c) The facility PAQ indicates it uses an objective screening instrument for screening clients for sexual victimization, or past sexual abusiveness. Policy 800-50 states in section IV. 5. A. that clients will be screened and assessed upon arrival. The policy does not indicate the facility uses an objective screening tool. The PREA screening tool was uploaded as supportive documentation. The tool contains 12 questions that determine if a client is: a) known victim; b) potential victim, or c) not a victim of sexual abuse. Section II contains 10 questions that determine if a client is: a) high risk; b) potential risk; c) no risk of being sexually abusive. The auditor reviewed 17 client files during the onsite audit. All files reviewed contained a completed screening document. Based on the evidence provided, the facility meets this provision. 115.241(d) The facility PAQ indicates clients receive a risk assessment upon admission. The facility

Screening for Risk Indicators tool is uploaded as supportive documentation. The screening tool contains the nine criterion this provision requires to assess whether a client is one of three designated types of sexual victim or sexual abuser. The PREA Intake staff stated during her interview that If they are designated as a known victim, and appears particularly fearful, they are placed in the 'Briar Patch' section. This is an area just inside the dorm entrance, containing six beds. This would place a vulnerable client closest to the control room, just outside the door. Clients who fail a drug screen may also be placed in the Briar Patch.

The screening form asks about prior sexual abuse, and whether such occurred during incarceration, or prior to incarceration. The form asks about the client's history of being sexually abusive. During the interview, the PREA Intake staff stated no intakes, so far, have identified a client as sexually abusive. If such were identified, they would likely be placed in general population, if a high risk (for sexual victimization) person was already assigned to the Briar Patch section. Based on the evidence provided, the facility meets this provision.

115.241(e)
The PREA Intake Screening form provided as supportive documentation indicates the screening considers, when known, prior acts of sexual abuse, or history of institutional violence or sexual abuse, or if such has been experienced, in general. The instrument considers whether a client has been convicted of a
sex offense. The form asks the client about prior convictions of violent offenses. Based on the evidence provided, the facility meets this provision.

115.241(f)
The facility PAQ indicates clients are re-screened in no more than 30 days from the client's arrival at the facility. The PAQ provided policy 800-50 as supportive documentation. Policy section IV. 5. A. states that all new admissions will be screened upon arrival (within 72 hours). The policy does not reference a re-screening within 30 calendar days of arrival. The screening tool allows the screener three options for conducting the PREA screening:

- New admission
- New information
- PREA allegation

The form does not reference whether the PREA risk screening is a 30-day re-screening. Seventeen (17) of 17 files the auditor reviewed contained an initial, and re-screening within 30 days of the client's arrival date. Based on the evidence provided, the facility meets this provision.

115.241(g)
The facility PAQ indicates it conducts client risk screenings due to:

- a referral
- a request
- an incident of sexual abuse
- or receipt of additional information that bears on the client's risk of sexual victimization or abusiveness.

No supportive documentation was provided to indicate risk assessments are conducted under these circumstances. The Intake staff did not state any other reason for conducting client risk screenings, outside of the initial screening, and re-screening, within 30 days of arrival. The Auditor reviewed 17 client files. None indicated clients had been re-screened for any reason, beyond the 30-day re-screening. Based on the evidence provided, the facility meets this provision.

115.241(h)
The facility PAQ indicates it does not discipline clients for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section. Policy 800-50 section IV. 1. C. states clients shall be subject to disciplinary sanctions following an administrative and/or criminal finding that the client engaged n client-on-client sexual misconduct.

The PREA Intake staff stated during her interview that clients are not disciplined for refusing to answer risk screening questions. During the Auditor's review of client files, none indicated a sanction or other violation for not responding to screening questions. Based on the evidence provided, the facility meets this
provision.

115.241(l)
The facility PAQ indicates appropriate controls are in place to control 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.

During the onsite interview with the PREA coordinator, and PREA investigator, both stated there is limited access to client risk assessment information. During the onsite audit, client files were observed locked inside the PREA coordinator's office, in metal filing cabinets, each of which were locked. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.242	Use of screening information
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA and Zero Tolerance 2. CTC Policy 800-51: Report Response 3. Client risk assessments 4. Client files Interviews: 1. PREA coordinator 2. Staff that conduct risk assessment (PREA investigator) 3. Random clients Site Review Observations: 1. Housing area 2. Program area Findings: 115.242(a) The facility indicates in the PAQ that risk screening information is used for the five purposes outlined in this provision. Policy 800-50 states housing determinations are based on the risk screening results. The facility uploaded in the PAQ the Risk screening tool as supportive documentation. The screening tool documents the initial (within 72 hours of arrival) PREA screening, and 30-day re-screening. The screening tool documents how screening information informs housing assignments, bed assignments, work assignments, education assignments, or program assignments. The PREA coordinator is required to authorize the accommodations via signature on the form. The Intake staff stated in her interview that no special accommodations have been required based on PREA screening results. The auditor reviewed 17 client files during the onsite audit. There was no evidence that special accommodations were made for clients due to the PREA risk screening result. The auditor interviewed 17 clients during the onsite audit. No client stated a need was identified for housing assignments, bed assignments, work assignments, education assignments, or program assignments, based on the risk screening result. Based on the evidence provided, the facility meets this provision. 115.242(b) The facility PAQ indicates individualized determinations are made about how to ensure the safety of each resident. The policy 800-51 section IV. 5. A., B. states determination is based on an assigned PREA Classification, using a PREA Accommodation Strategy (PAS). The policy

section III. Definitions, defines the PAS as a strategy plan prepared by the Program Director and PREA coordinator, and will comply with PREA Community Confinement Standards. The PREA Risk Screening tool requires the PREA coordinator to document, and authorize individual accommodations provided to a client, based on risk assessment results. The document is maintained in the client file. The Intake staff stated in her interview that no client assessment has warranted accommodation outside the standard placement process, based on the client's risk screening results. The auditor reviewed 17 client files. The auditor did not observe evidence of a PAS for a client.
Based on the evidence provided, the facility meets this provision.

115.242(c)
The facility PAQ indicates housing assignment decisions for transgender or intersex clients are made on a case-by-case basis. The PAQ provided the PREA Risk Assessment as supportive documentation as to how placements are made. The PREA coordinator stated during her interview that housing assignments for transgender or intersex clients would be made based on the client's need, or request She stated if a transgender or intersex client were referred, they would likely be housed in the Briar Patch section of the facility if the risk assessment determined the client was a known, or potential, victim. She stated a client who was identified as an Abuser would likely be assigned among the general population, particularly if there were a client identified as a known, or potential victim, already assigned to the Briar Patch section during the same period. She stated she didn't know for sure, but is not aware of the facility having housed a transgender client. Of the 17 clients the auditor interviewed, none self-identified as transgender or intersex. The auditor reviewed 17 client files. PREA risk screening documents contain client sexual orientation, and gender identity, including perceived orientation. No screening assessment identified a client as transgender or intersex. Based on the evidence provided, the facility meets this provision.

115.242(d)
The facility PAQ indicates housing placements and programming assignments for transgender or intersex clients are based on the clients' own views with respect to his or her own safety. The PREA screening assessment tool was provided as supportive documentation. The PREA investigator, who also conducts intakes, and risk screenings, stated the facility hasn't had this type of situation (i.e., a transgender or intersex client). The auditor's review of client files, and random informal interviews did not result in identifying that any client self-identifies as transgender or intersex. Based on the evidence provided, the facility meets this provision.

115.242(e)
The facility PAQ indicates that provisions are in place for transgender or intersex clients to shower separately from other residents. Policy 800-50 states CTC will make provisions to ensure transgender or intersex may shower separately from other residents. Policy 800-51 states the same as a prevention measure. The policy includes a procedure for how a transgender or intersex client would be allowed to shower separately from other clients. The facility did not have any clients during the time of the onsite audit, who self-identified as transgender or intersex. Based on the information provided, the facility meets this provision.

115.242(f)
The facility PAQ indicates that it refrains from placing LGBTI clients in dedicated facilities solely on the basis of the client's gender identity or sexual orientation.
The PAQ provided the PREA screening tool as supportive documentation. The screening tool

	requires the PREA coordinator to document how screening results inform housing, programming, and other decisions. The PREA coordinator stated during her interview that LGBTI clients are not housed solely on the basis of the client's gender identity, or sexual orientation. During the process of selecting clients for interviews, the PREA coordinator identified one client as LGBTI. During client interviews, the auditor interviewed said client, utilizing both random resident, and targeted populations interview protocols. The client stated during his interview he self-identifies as LGBTI during intake screening. He stated he was not assigned to housing dedicated to LGBTI clients, nor did he perceive his bed assignment was based on his sexual orientation. He stated his schedule is the same as other clients, and staff, nor clients have treated him differently because of his sexual orientation. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.251	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. CTC Policy 800-50 PREA and Zero Tolerance 2. CTC Policy 8800-51 Report Response 3. Sexual Abuse Emergency Reporting Contact Information on CTC website 4. CTC Client Handbook 5. No Means No postings in client dorm 6. Break the Silence postings in case manager office area 7. Fairfield ADAMH web site 8. Client files 9. Employee files Interviews: 1. Random clients (one targeted client identified) 2. Random staff 3. PREA coordinator Site Review Observations: 1. PREA signage throughout the facility Findings: 115.251.(a) The facility PAQ indicates clients have multiple internal ways for clients to report: sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse; sexual harassment; staff neglect or violation of responsibilities that may have contributed to such incidents. The PAQ provided policy 800-51 as supportive documentation. Policy section IV. 1. A. 1. states, *"...clients may report allegations of sexual abuse/harassment, or retaliation by other* *clients or staff verbally, or in writing. In addition, clients may report staff neglect or violations of responsibilities that may have contributed to incidents of sexual misconduct. Allegations may be reported to any staff member."* The policy states clients may report to any staff, verbally or in writing. The facility provided the Client Handbook as evidence. The handbook provides as an internal reporting source for PREA allegations, phone, and email contact information for the agency PREA coordinator. During the facility site review, the auditor observed posters throughout the facility, including client dorm area, and case management area. The auditor observed a poster titled 'No Means No'. The poster outlines the following internal steps for reporting allegations

of sexual abuse, sexual harassment, and retaliation:

- Anonymously
- Internal grievance process for reporting allegations of sexual abuse, sexual harassment, or retaliation
- Sick call slip
- Verbally, to any staff, volunteer, or contractor
- Report to the agency PREA coordinator

During the onsite audit, the Auditor reviewed the grievance form in client files. The form is generic, and may be used to address any issue a client has at the facility. During random client interviews, 17 of 17 clients stated they could report to the PREA coordinator, or facility director an allegation of sexual abuse, sexual harassment, or retaliation. All clients articulated their knowledge of PREA posters throughout the facility. No client stated he didn't know of any way to report an allegation of sexual abuse, sexual harassment, or retaliation.

During random staff interviews, 13 of 13 staff stated clients could report PREA allegations to them, and they would report it to the PREA coordinator, or facility director. All staff were aware of information on the client dorm bulletin board. Based on the evidence provided, the facility meets this provision.

115.251(b)
The facility PAQ indicates it provides at least one way for clients to report sexual abuse or sexual harassment to a public entity or office that is not part of the agency; that such entity or office is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials; and that such entity or office allow clients to remain anonymous upon request. During the facility site review, the auditor observed posters titled, 'Break the Silence', and listed external reporting information for allegations of sexual abuse, sexual harassment, and retaliation. The poster lists the ODRC PREA hotline, email, and phone contact. The auditor observed English and Spanish versions of the poster. The poster was observed in the client dorm bulletin board area, and case management office area.

Policy 800-51 section IV. 1. A. 2. states that clients will have the opportunity to report PREA allegations to an entity outside ODRC, or CTC, by using the phone number and address provided. The auditor reviewed the CTC website during the pre-audit phase. The website identifies as an external PREA resource the Alcohol, Drug and Mental Health Board of Fairfield County (Fairfield ADAMH). The auditor called the hotline number 800-825-0541, and spoke with a live operator. The auditor identified herself, and the purpose for the call. The operator verified that CTC clients may call them for referral services, emotional support resulting from sexual abuse. The operator stated clients have the option of confidentiality, and that they will not notify the CTC of the client's identity, if the client requests such.

During random client interviews, clients knew they could obtain information for outside allegation reporting in the client dorm bulletin board, or in their folder of information, which they stated is provided to them during orientation. The facility provided in the PAQ a MOU with Family Health Services of East Central Ohio. The MOU agrees that the entity will receive client reports of sexual abuse, and assist them through referral services, including forensic medical examinations (SAFE/SANE) at Fairfield Medical Center. The entity will notify CTC of a report of

client sexual abuse, unless the client requests confidentiality. Based on evidence provided, the facility meets this provision.

115.251(c)
The facility PAQ indicates that staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties, and that such are promptly documented. Policy 800-51 section IV. 1. A. 1. states allegations may be reported to any staff member. Section IV. C. 5. states such notifications will be provided as soon as possible, but no later than 72 hours after receiving the allegation. The auditor reviewed an investigation file from a sexual abuse allegation CTC received in 2019. The investigative report indicates the source of the allegation is unknown. The allegation information states the report was received on 7/3/19, and the alleged sexual abuse incident occured on 7/2/19. Based on the evidence provided, the facility meets this provision.

115.251(d)
The facility PAQ indicates that staff may privately report client sexual abuse and sexual harassment. Policy 800-51 section IV. 2. B. 2. states staff private reporting is made by completing an Incident Report marked confidential and submitting it directly to the agency PREA coordinator. During random staff interviews, all staff were articulate on first responder duties. All staff stated if a client alleged sexual abuse, the first priority would be to identify the abuser, and ensure the safety of the alleged victim. Staff indicated they would immediately contact the PREA coordinator, whether the report was received on a weekend, or at night. The Auditor observed during the facility site review that the PREA coordinator contact phone number and email are included on the posting of Emergency Phone Numbers for Reporting Sexual abuse, sexual harassment, and retaliation. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:

No corrective action is recommended.

115.252	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. Client files Interviews: None Findings: 115.252(a) - (g) The facility PAQ indicates it does not have administrative procedures to address resident grievances regarding sexual abuse. No supportive documentation was provided, which indicates an administrative procedure exists. During review of client files, the Auditor observed that the client grievance form is generic, and makes no mention of utilizing the form for reporting allegations of sexual abuse. Policy 800-50 or 800-51 does not acknowledge grievances as an option for clients to report allegations of sexual abuse. The PREA investigator stated during informal conversation that CTC does not conduct grievance hearings, or administrative hearings related to client reports of sexual abuse. Based on the evidence provided, the facility, by default, meets this standard. Corrective Action: No corrective action is recommended.

115.253	Resident access to outside confidential support services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response Interviews: 1. Random clients Findings: 115.253(a) The facility PAQ indicates clients are provided access to outside victim advocates for emotional support services related to sexual abuse by giving clients mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. Policy 800-51, section IV. 1. A. 1-4., states clients will have access to external entities, other than ODRC's hotline, and CTC, to report allegations of sexual abuse, sexual harassment, or retaliation. CTC provides on the facility website direct links to community-based resources for reporting sexual abuse/harassment, and retaliation, not operated by CTC. During the onsite facility review, the Auditor observed information posted with contact information to outside entities where clients could contact for emotional support, and advocacy. The Auditor contacted the phone numbers listed, with the following results: • ***Family Health Services of East Central Ohio*** (740-653-6338): spoke with a live person, who verified they provide emotional support services, and referrals to victims of sexual abuse. The operator was familiar with CTC, and stated they would assist a client who reported sexual abuse. CTC has a signed MOU with this entity. • ***Crisis Center*** (740-687-8255): spoke with a live person, who verified they assist those who have been sexually victimized. • ***Crisis Hotline*** (800-825-0541): A recorded messaged offered roadside assistance for purchase. When opted out, call was disconnected. The same happened when tested a second time. • ***Light House*** (740-687-4423): A live person answered, who explained a resident may request assistance related to sexual abuse. An intake will be conducted over the phone, and options discussed, including available residential programs. Nonresidential programs are available through the organization's recovery center. • Outside reporting number (614-728-3399): Received a recorded message from the ***Ohio Department of Rehabilitation and Corrections' Division of Parole and Community Services.*** The message states there will be a call back within 24 hours. The Auditor observed clients using personal cell phones in the facility. The PREA coordinator stated during informal conversation that cell phones are permitted. The Auditor did not observe pay phones in the facility. Based on the evidence provided, the facility meets this

	provision. 115.253(b) The facility PAQ indicates clients are informed of any communication monitoring. During the facility review, the Auditor observed several clients in their 'Rack', TV room, and hallway, using cell phones without any interruption from staff. The Auditor did not observe phones in the facility, which the facility controls or monitors. Based on the evidence provided, the facility, by default, meets this provision. 115.253(c) The facility PAQ indicates there is a Memorandum of Understanding (MOU) with a community service providers that are able to provide clients with confidential emotional support services related to sexual abuse. The PAQ provided a signed MOU between CTC and family Health Services of East Central Ohio as supportive documentation. The Auditor spoke with entities listed on facility postings, which provide such services, and verified clients have access outside more than one community resource, even though an MOU agreement exists. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommeneded.

115.254	Third party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. Agency website 2. PREA Hotline (614-728-3399) Interviews: 1. Random clients 2. Random staff Findings: 115.254(a) The facility PAQ indicates it provides third-party reporting options for reporting PREA allegations. The agency website provides email access, and direct links to report PREA allegations. Contact phone numbers for Family Health Services of East Central Ohio, ADAMH of Fairfield County Crisis hotline; Light house crisis line, are posted on the agency website. The auditor interviewed 17 random clients. All clients stated during random interviews they were aware that posted hotline numbers were to an outside, third-party, to which they could report an allegation of sexual abuse/harassment, or retaliation. Clients commented that they are comfortable reporting internally. The Auditor observed a posted an external PREA hotline number in the main hallway of the facility. Based on the evidence provided, the facility meets this provision, and standard. Corrective Action: No corrective action recommended.

115.261	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response Interviews: 1. Facility director 2. PREA coordinator 3. Random staff Findings: 115.261(a) The facility PAQ indicates all staff are required to report any knowledge of client sexual abuse or harassment, retaliation, or regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation. The PAQ provided policy 800-51 as supportive documentation. Section IV. 1. B. 2. affirms such is the case, and that staff are to report any knowledge of client sexual abuse or harassment, retaliation, or regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation, whether or not the alleged PREA violation occurred at CTC. All random staff respondents named the facility PREA coordinator, and/or facility director as individuals, to whom they would report a PREA allegation, regardless of whether the alleged incidosRverified there are no medical or mental health staff at the facility. Based on the evidence provided, the facility meets this provision. 115.261(b) The facility PAQ states it requires staff to always refrain from revealing an 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 800-51 section IV. 1. C. 2. re-states the affirmative to this requirement. Nine of nine random security staff stated during interviews that the facility director and/or PREA coordinator is who they would direct reports, and information, and that such is not to be shared with anyone. The facility Employee Roster does not identify medical or mental health staff at the facility. PREA form 1.1 PREA Interviews - Specialized STAFF, provided to the auditor during the pre-audit phase, did not identify any names in section 4.c., Medical and Mental Health Staff. During the onsite facility review, the auditor did not observe, nor were any persons identified as medical or mental health staff. Based on the evidence provided, the facility meets this provision. 115.261(c) The facility PAQ indicates it complies with this provision. The policy 800-51, section IV. 1. B. 2, states medical and mental health practitioners are required to report client sexual abuse, inform the client of their duty to report, and limitations to confidentiality. The Employee

Roster indicates there are no medical or mental health staff at the facility. The MOU between CTC and Family Health Services of East Central Ohio states Family Services will report to CTC that an allegation of sexual abuse has been received. Based on the facility not having medical and mental health staff at the facility to report sexual abuse allegations, the auditor determines that the facility meets this provision.

115.261(d)
The facility PAQ states there are no clients at CTC under age 18. The facility website states it is an adult facility. During the onsite audit, no clients on the Resident Coverage Log were identified by the facility director as under age 18. Based on the evidence provided, the facility meets this provision.

115.261(e)
The facility PAQ indicates all allegations are reported to designated staff, including third-party reports. Policy 800-51 section IV. 1. C. 1. states the PREA coordinator is the facility's designated staff to receive allegations of sexual abuse, sexual harassment, and retaliation. The facility provided one investigative file from a 2019 allegation of sexual abuse as evidence. Case documentation indicates the facility director, to whom the PREA coordinator reports, received information regarding the alleged sexual abuse. Random staff and random clients stated they would report allegations of sexual abuse to the facility director and/or PREA coordinator. Based on the evidence provided, the facility meets this provision.

Based on the overall evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response Interviews: 1. PREA coordinator 2. PREA investigator 3. Random staff Findings: 115.262(a) The facility PAQ indicates the facility will take immediate action to protect a client at risk of imminent sexual abuse. Policy 800-51 was provided in the PAQ as supportive documentation. Policy section IV., 2., A. 1. (iv.), states staff will take immediate action, should a client report an imminent threat of sexual abuse. Policy section IV. 3. A. identifies the Lancaster Police department as the primary contact for allegations that may be criminal. During random staff interviews, nine (9) of nine (9) security staff stated if there was a clear threat to a client's safety, they would call the police, and notify their immediate supervisor, facility director, and/or PREA coordinator. Staff consistently articulated appropriate first responder duties to ensure the safety of the alleged victim (i.e., separate the alleged victim from an abuser, or prevent access from an identified abuser). Two security staff stated they would re-locate the alleged victim to Area 51, while an investigation is completed. During the onsite facility review, Area 51 was observed, which is located at the end of the main hall, beyond the control room. There are two single-person restrooms in, or near the area, which allows clients in the space to remain separate from the general population. The Auditor observed that this area can be monitored from the control room, to ensure client safety, and facility security. The door opposite Area 51, on the inside, leads to a large area, priarily used for storing recreation equipment, holiday decorations, washer/dryer, terminated client files (boxed), and terminated personnel files (boxed, past seven years), as well as client personal items that were left behind. There are four single shower stalls, each with a solid white shower curtain, to the rear of this area. There are locked double-doors outside the showers. The facility director stated there is limited key access, so there would be no situation when a client is in this area without someone providing access. An alleged client could be placed in Area 51 until an investigation is concluded. Based on the evidence provided, the facility meets this standard. Based on the evidence provided, the facility meets this standard. Recommendation: 1. Replace solid white shower curtains with curtains that provide a line of sight above the

	shoulder, and below the knee.

115.263	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response 2. Notification to another facility of PREA allegation Interviews: 1. Agency head 2. PREA coordinator Findings: 115.263(a), (b) The facility PAQ indicates if a client reports having been sexually abused while confined at another facility, the head of the facility will be notified within 72 hours of CTC receiving the allegation. Policy 800-51 was provided as supportive documentation. Policy 800-51 section IV. 1. C. 4. states the PREA coordinator will notify the facility/institution managing officer/designee where an alleged sexual abuse occured. During an interview with the agency head (CEO), she stated the facility director, or PREA coordinator will, as her designee(s), notify the facility/institution's designee where the alleged sexual abuse occured. She stated she is kept abreast by the facility director. Policy section IV., 1.C.5., states the facility will notify the facility/institution where the alleged sexual abuse occured within 72 hours of receiving the allegation. The facility uploaded in the PAQ a notification to an institution where a client disclosed during intake, that he was sexually abused. The auditor observed the notice states CTC was made aware of the allegation within 72 hours of the client's admission to the facility. The named institution submitted a written response to CTC the same day. The response indicates the allegation was made in 2018, and was unfounded. The CTC PREA coordinator was carbon copied (cc'd) on the institution's response. The auditor noted the CTC file on the client identified him as having disclosed prior sexual abuse while incarcerated. Based on the evidence provided, the facility meets this provision. 115.263(c) The facility PAQ indicates it documents if another facility is notified (within 72 hours) that a client alleged previous sexual abuse during incarceration. Policy 800-51 section IV. 1. C. 5 affirms this assertion, and states such notification shall be documented. The facility provided in the PAQ a documented notice in 2019 to an institution that a client alleged sexual abuse while at that institution. The auditor verified in the client's file that the notice to the institution was within 72 hours of the client's arrival at CTC. The institution responded to the notification the same day. Based on the evidence provided, the facility meets this provision.

115.263(d)
The facility PAQ indicates the facility head or agency office that receives such notification will ensure that the allegation is investigated in accordance with these standards. The PAQ referenced policy 800-51 section IV. 1.C. 5. as supportive documentation. This section reflects the process when a client reports to the facility of sexual abuse while housed at another facility/institution. The policy does not support what action steps CTC's facility head or agency head will take, should a report be received from another facility that their resident/inmate/detainee reported sexual abuse at CTC. The policy does not provide information on how such a notice would be handled. The facility director stated during his interview that, should the facility receive a report from another facility that a former client alleged being sexually abused while at CTC, they would fully investigate the allegation, based on the information available. Based on the evidence provided, the facility does not meet this provision.

Based on the overall evidence provided, the facility does not substantially meet this standard.

Corrective Action:

1. Include in policy 800-51, whom is responsible for receiving reports from another facility/institution, that a former CTC client reported being sexually abused while a resident at CTC.
2. Ensure receipt of such reports are documented
3. Establish, in accordance with this standard, a documented procedure of the agency's response, and investigation of, alleged sexual abuse reported by a former CTC client.
4. Ensure the policy and procedure for documenting and investigating reported allegations from another facility/institution, regarding a former CTC client, is institutionalized in practice.

FACILITY RESPONSE:

The facility provided as supportive documentation updated policy 800-51, which states in Section IV., 1. C. 5., the facility program director will respond to an external facility or institution to acknowledge receipt of their report, and notify the PREA coordinator, should the agency be notified that a former resident reported being sexually abused while at CTC. Staff training has been conducted to ensure employees understand the communication flow, and agency practice. The facility provided training documentation to verify such has occurred, and staff signatures were required to affirm they understand the information provided.

No documentation regarding externally-reported allegations were provided, as none have been received during the corrective action period.

Based on the evidence provided, the facility meets this standard.

Review:

Staff training documents

Policy 800-51

115.264	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-audit Questionnaire (PAQ) 2. CTC Policy 800-51: PREA Report Response 3. CTC Policy 800-52: Uniform Evidence Protocol 4. Client files 5. Staff training records 6. Appendix D: Sexual Abuse - First Responder Checklist Interviews: 1. Security staff who are first responders 2. Non-security staff Findings: 115.264(a) The facility PAQ indicates that it has a first responder policy for allegations of sexual abuse. The PAQ references policy 800-52 as supportive documentation. Policy section III. states, *"...Upon receiving a report of Sexual Assault, the staff shall immediately:* • *separate the alleged victim(s) and abuser(s);* • *preserve and protect the crime scene(s);* • *notify the PREA coordinator or facility director;* • *follow the procedure as outlined by the Uniform Evidence Protocol plan. See procedure below;* • *contact Lancaster Police Dept., and request that they conduct a criminal investigation."* The procedure cites 17 steps involved in the Uniform Evidence Protocol plan. The steps include requesting the alleged victim to not do anything, which may contaminate physical evidence (e.g., eat, drink, urinate, deficate, wash clothes, shower, etc.), which may still exist at the scene, or on the alleged victim's body. The procedure does not instruct first responders on steps to take so the alleged **abuser** (bolded for emphasis) does not destroy, or contaminate evidence. The PREA coordinator provided to the auditor during the onsite audit, a form identified as 'Appendix D: Sexual Abuse - First Responder Checklist'. The form is divided into two sections: one for non-security first responders, and one for security staff first responders. The security first responder section includes steps to request the victim not take action to destroy or contaminate evidence. It includes a second row to document steps to ensure the abuser does not destroy, or contaminate evidence. The auditor observed this document in the PREA Binder. There is no date indicating when the form became effective. The form was not included in the 2019 sexual abuse investigative file.

During staff interviews, nine of nine security first responder staff were able to articulate the core four first responder steps related to an allegation of sexual abuse, as required in this provision. No staff were familiar with the steps outlined in policy 800-52, section IV. (Procedure). The auditor noted in the policy section procedural references, and pages, do not coincide with the structure of the policy itself. The steps include considerations for alcohol, or drug-facilitated sexual assault, and other more clinical modalities and training. The staff did not know of any detailed procedures, and stated that the content has not been part of the training they have received. Based on the evidence provided, the facility does not meet this provision.

115.264(b)
The facility PAQ indicates if a first responder is a non-security staff, they are required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. Policy 800-52 is uploaded as supportive documentation. The policy does not reference an established procedure for non-security staff who may be a first responder in a sexual abuse allegation. The auditor interviewed two non-security staff during the onsite audit. One non-security staff stated a sexual abuse allegation would be reported to the director and PREA coordinator; one of the victim advocates (i.e., Victim Support Persons) would be brought in to assist the alleged victim. A second non-security staff stated the agency has created, and updated PREA policies and procedures two weeks prior to the onsite PREA audit; everything has been "drilled" into everyone's mind from the January 2020 staff meeting, which was called a "PREA training". Both non-security staff were able to articulate first responder duties. The additional 15 components listed as part of the 'Procedure' in policy 800-52, were unknown to non-security, and security staff. Based on the evidence provided, the facility does not meet this provision.

Based on the overall evidence, the facility does not meet this standard.

Corrective Action:

1. Establish, in policy 800-52, a non-security staff protocol, should they be a first responder in a sexual abuse allegation.
2. Develop a training plan for all staff, which covers newly developed PREA forms, policies and procedures (i.e., 800-52), and ensure all staff are knowledgeable on how/where to access, and/or review such information.
3. Ensure client education includes newly developed PREA policies and procedures, and/or updates to current PREA policies and procedures; the protocol to access PREA information not included in the most current Client Handbook.
4. Include in first responder training, steps to ensure the alleged abuser does not take any action to destroy evidence.

FACILITY RESPONSE:

The facility has updated policy 800-52, which outlines in Section III. (Implementation), a nine-point procedure for first responders in a sexual abuse allegation. Step 4 of the procedure instructs to ensure the alleged abuser does not take any action to destroy evidence. The facility provided signed, and dated staff training attendance sheets, and identifies first responder duties as an agenda item. The policy itself contains an added signature for

	employees, and the agency PREA coordinator, and date. Signed policies were provided to the auditor as evidence of the institutionalization of the updated review process. The facility provided as supportive documentation an updated Client Orientation Packet, which is provided, and reviewed during the initial Intake. The updated packet contains policy 800-52, which residents read and review during Intake. The packet requires residents to initial that the policy was review, or read to, that clients have received education on the agency's zero-tolerance policy, and ways to report allegations of sexual abuse, sexual harassment, and retaliation. Based on the evidence provided, the facility meets this standard. **Review**: Policy 800-52 CTC Client Orientation Packet Staff training documentation

115.265	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-audit Questionnaire (PAQ) 2. CTC Policy 800-52: Uniform Evidence Protocol Interviews: 1. Facility director Findings: 115.265(a) The facility PAQ indicates there is a coordinated response, and there is a facility staffing plan, which demonstrates the institutionalization of PREA-related procedures and protocols as part of the overall safety of the facility, and clients' sexual safety. During his interview, the facility director described the facility coordinated response as: 1) the first responder separates the victim from the abuser; 2) secure any physical evidence; 3) contact the facility director, and/or PREA coordinator; 4) ensure the victim does not take any action that would destroy or contaminate evidence (e.g., do not eat, drink; urinate, deficate; shower, brush teeth; wash clothes); 5) contact Lancaster Police Department; 6) transport the alleged victim to Fairfield Medical Center for SAFE/SANE medical examination, if necessary.. Policy 800-52 was uploaded as supported documentation. The Uniform Evidence Protocol includes in section III. that staff will ensure the alleged victim does not take any action, which will destroy or contaminate evidence. The policy does not include actions staff will take to ensure the alleged abuser does not destroy or contaminate evidence. Policy section III. (Procedures) includes 15 additional steps required for first responders. During random staff interviews, nine of nine staff stated they were not aware of the 15 steps they're expected to take, as outlined in policy 800-52. The policy was established in January 2020. There is no evidence the Procedure, documented in policy section III., has been reviewed with staff, or has been institutionalized in practice. Policy 800-52 was established on 1/8/2020. Based on the evidence provided, the facility does not meet this provision. Based on the evidence provided, the facility does not meet this standard. Corrective Action: 1. Develop a written institutional plan, which includes coordination of law enforcement procedures (e.g., forensic evidence collection), and meeting client medical needs (i.e., SAFE/SANE examinations) related to reported allegations of client sexual abuse. 2. Ensure all staff are trained on the institutional plan, and their role in its execution. 3. Ensure policy 800-52 contains procedural steps staff are trained to carry out, and

formatted to not include page, and section references outside the policy itself, or other CTC policies and procedures.

4. Ensure procedures in policy 800-52 are within first responders' job description(s), and decision-making authority.

FACILITY RESPONSE:

The facility provided as supportive documentation policy 800-52, which was updated to include in Section IV. (Procedures) the facility's institutional plan. The Section lists 16 steps, which cover coordination with law enforcement, meeting resident medical needs, and staff roles related to carrying out each step. First responder duties coincide with, and identify what positions are to communicate information internally, and externally.

The facility provided training documentation, which verifies staff have been trained on the updated policy and procedures, and understand the information presented.

Based on the evidence provided, the facility meets this standard.

Review:

Policy 800-52

Staff training documents

115.266	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: 1. CTC 800-50 PREA and Zero Tolerance 2. CTC 800-51 PREA Report Response 3. CTC 700-06 Hiring policy Interviews: 1. Agency head Findings: 115.266 (a) The PAQ indicated that neither the agency nor facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Thus, they are not restricted in the disciplinary process of staff members that have violated sexual abuse/sexual harassment policy or limited in their ability to remove staff sexual abusers. There was no documentation for this standard uploaded in the PAQ. The Agency head corroborated during her onsite interview that there is no collective bargaining agreement or other agreement between CTC and any entity. Interviews with random staff also supported this information. Based on the evidence provided, agency, by default, meets this pirovision. 116.266(b) The auditor is not required to audit this provision. Corrective Action: No corrective action is recommended.

115.267	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: 1. CTC 800-50 PREA Zero Tolerance 2. CTC Policy 800-51 Report Response 3. Facility physical layout Interviews: 1. Agency head 2. Director or Designee 3. Designated Staff Member Charges with Monitoring Retaliation 4. PREA coordinator Findings: 115.267 (a) The facility PAQ indicates there is a policy which will protect clients and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigation from retaliation. The facility uploaded policy 800-50 as supportive documentation. Policy section IV. 4. B. states within seven (7) days of arrival, clients will be educated on their right to be free from sexual abuse, sexual harassment. The education will include their right to be free from retaliation for reporting such incidents, and must include agency policies and procedures for responding to such incidents. During the pre-audit phase, the PREA coordinator provided to the auditor PREA form 1.1. Section 4.k. identifies the Security Director as the designee for client and staff retaliation monitoring. The auditor reviewed Policy 800-51, also provided in the PAQ. The policy states in section I., that retaliation against persons who report sexual abuse/harassment is strictly prohibited. The policy states that reports of sexual abuse/harassment and/or retaliation will be administrative and/or criminally investigated. Section IV. 1. B. 1. identifies the security director as the designee to ensure there is no retaliation of clients or staff who report sexual abuse/harassment. Policy sections IV. 1. C. 1, 3, state that reports of sexual abuse/harassment, or retaliation are to be documented on an Incident Report form, and submitted to the PREA coordinator. The PAQ indicates there was one allegation of sexual abuse in the past 12 months. The auditor reviewed an investigative file of a sexual abuse allegation from 2019. The documentation does not indicate if retaliation monitoring for the client was conducted. the auditor was provided a form titled, "Sexual Abuse Incident Follow-up Care. The form was not included in the investigative file from 2019. There is no date on the form. The auditor did not review evidence related to the 2019 allegation, that retaliation monitoring occured. The auditor did not identify evidence that the Sexual Abuse Incident Follow-up Care form has been

implemented, or institutionalized, in practice.

During random client interviews, one client stated he reported an allegation of sexual harassment against a staff person. He stated the PREA investigator commented to him that the agency doesn't have to respond because of what a client says. The client stated he elevated his report to the facility director, who stated he would address the situation. The client stated he felt he was retaliated against, as the staff whom he complained about imposed to him a violation after the client reported the allegation about the employee's conduct. He stated he felt the facility director said something to the staff, as he hasn't said anything to him since. The auditor inquired about the issue during an informal discussion with the faciity director. He acknowledged the client's complaint, but stated the client may have misinterpreted the employee's comment, that it wasn't necessarily a PREA issue. He stated he verbally addressed the employee, but the complaint was not documented as a PREA allegation. The PREA coordinator stated she did not receive an incident report of a sexual harassment allegation in the past 30 days. Based on the evidence provided, the facility does not meet this provision.

115.267(b)
The facility PAQ indicates it provides a policy which entitles clients to a safe environment and that all allegations are administratively, or criminally investigated. Policy 800-52 outlines five core action steps for first responders who receive an allegation of client sexual abuse, the first of which is to separate the alleged victim from the abuser. During the facility site review, the facility director (who guided the auditor) described an area, to the rear of the main hallway. The area entrance has signage identifying the space as Area 51. The facility director stated it's primary use is for client programming, groups. The auditor observed a group in session during the site review. The facility director stated the space would be used if a client alleged sexual abuse. The area can be monitored from control room surveillance cameras, as well as from the facility director's office. The area provides acces to a private, one-person restroom, and separate shower area, which is only accessible if a staff person unlocks the entry door.

During random staff interviews, seven (7) of nine (9) security staff stated they would separate the victim from the abuser; one staff specified placing an alleged victim in Area 51. During a review of the facility layout, and onsite facility review, a section consisting of six beds, just inside the client dorm entrance, was identified by the facility director as the "Briar Patch". This section was identified as where a client would likely be placed, should he be fearful of sexual abuse due to prior sexual abuse (while incarcerated); threatened or actual sexual abuse, or retaliation. Clients who fail a urine test for drugs are also temporarily placed in the Briar Patch section. He stated if the alleged harasser/abuser were in the facility, he would likely place the victim in Area 51, to maximize the distance between the victim and abuser.

the Agency Head stated during her interview that she would first consider the source(s) of allegation(s). She would have an alleged abuser removed during the investigation. The facility director stated a client abuser would likely be sent to the local jail. The PAQ reflects there has been one
allegations of sexual abuse, or sexual harassment in the past 12 months. The auditor reviewed the investigative documentation, which indicates the identified abuser (employee) was terminated. Based on the evidence provided, the facility meets this provision.

115.267(c)
The facility PAQ indicates that it conducts PREA retaliation monitoring. CTC Policy 800-51 is

uploaded as supportive documentation. The PAQ cites policy section IV. B. 2 as evidence of the facility's procedure, which requires staff to report client or staff retaliation for reporting allegations of sexual abuse, or any staff neglect or violation that may contribute to an incident of retaliation (paraphrased). The facility identifies the Security Director as the person responsible for retaliation monitoring. The policy states retaliation monitoring will be conducted during facility walk-throughs, and headcounts, when client wellness checks will be conducted for any client who may be a target of retaliation. The security director was not in the facility during the onsite audit, and so was not interviewed.

During random client interviews, one client stated he reported sexual harassment by a staff person. He stated the facility director addressed the situation. He did not state anyone had checked on him regarding possible retaliation. He stated he felt a violation he received after reporting sexual harassment was retaliatory. No documentation regarding the allegation was provided to the auditor as evidence of action steps that were taken, and how the matter was resolved. Policy 800-51 identifies a staff person responsible for retaliation monitoring; it does not indicate a timeframe (i.e., minimum of 90 days), in which retaliation monitoring will continue. Based on the evidence provided, the facility does not meet this provision.

115.267(d)
The facility PAQ indicates the facility conducts periodic status checks, and documents if periodic status check are conducted, as required by standard 115.267. Policy 800-51 was provided as supportive documentation. The facility indicated during the onsite audit, and request for files, that there was one reported case of sexual abuse in the past 12 months. The auditor reviewed the investigation file during the onsite audit. The staff identified as the abuser was terminated. There was no evidence in the file that retaliation monitoring occured during the client's remaining time in the facility. During an informal conversation with the PREA auditor, the auditor inquired about retaliation monitoring. The PREA coordinator responded that retaliation monitoring did not occur because the employee was terminated. Based on the evidence provided, the facility does not meet this provision.

115.267(e)
The standard requires the facility to take appropriate action for any other person who may have cooperated and fears retaliation. The PAQ states there was one sexual abuse allegation in the past 12 months, but that no retaliation monitoring occured. Policy 800-51 provides a procedure as to how client retaliation monitoring is to occur. The policy does not outline a procedure as to how staff retaliation monitoring is to occur. The policy does not outline a procedure for keeping others who may cooperate during an investigation safe from retaliation. The facility director stated during his interview that, should a staff person fear retaliation, the person's supervisor would be monitored to ensure such is not happening. The PREA coordinator stated during her interview that there have been no employees in the past 12 months, who reported fear of retaliation, related to a PREA allegation. The auditor reviewed 13 employee files, and 17 client files. The auditor did not observe any evidence of employee retaliation, or client retaliation. Based on the evidence provided, the facility does not meet this provision.

115.267(f)
The Auditor is not required to audit this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:

1. Revise policy 800-51 to include a procedure for keeping staff who report an allegation, or cooperate in an investigation, safe from retaliation.
2. Document the retaliation monitoring process, the timeline to be followed (e.g., 30-60-90 days), and ensuring monitoring continues beyond 90 days, if monitoring is needed; include such in investiative files.
3. Include in staff training the procedure to ensure the protection of others who cooperate in an investigation, from retaliation.
4. Develop a procedure whereby client and staff disciplinary reports, client program changes or negative staff performance reviews or staff reassignments, post-PREA allegation, are monitored.
5. Include retaliation monitoring procedures, and reporting protocols, in the Client Handbook.

Recommendation:

1. Add a retaliation monitoring procedure, including date(s) each monitoring occurs, to the 'Sexual Abuse Incident Follow-up Care' form. Structure the form so it is applicable for client, and/or staff retaliation monitoring, as well as others who cooperate in a PREA allegation investigation.

FACILITY RESPONSE:

The facility has developed a standardized retaliation monitoring procedure, which has been incorporated in policy 800-51, Section B. 7. The policy states the Program Director, and PREA coordinator are designees for responding to reports of retaliation by residents, or staff. A Retaliation Monitoring Sheet was developed to document action steps during the 90-day retaliation monitoring period. The form allows for extending the monitoring beyond 90 days, if deemed necessary. The form requires an explanation of how monitoring will occur, and is signed by:

- Staff
- Resident
- Retaliation Monitor
- Program Director

The form is reviewed, and maintained by the agency PREA coordinator. The facility provided no completed retaliation sheets, as there havae been no reported allegations of sexual abuse, sexual harassment, or retaliation.

Based on the evidence provided, the facility meets this standard.

115.271	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51 PREA Report Response 2. CTC Policy 800-52 Uniform Evidence Protocol 3. Facility layout document 4. Staff training records Interviews: 1. PREA Investigator 2. PREA coordinator 3. Facility director Onsite facility review Findings: 115.271(a) The facility PAQ indicates it has a policy related to PREA administrative, and criminal investigations. Policy 800-51 Section IV. 3. A. states, *"All reports of sexual abuse/harassment, and retaliation shall be invesitgated, and the findings documented in writing."* The PREA investigator stated in her interview that an internal investigation would begin immediately upon receiving a report of client sexual abuse, sexual harassment, or retaliation. In addition to her, the PREA coordinator, facility director, and/or security director may participate in an administrative investigation, based on their area of primary responsibility. The facility director determines the outcomes of internal investigations, and confers with the CEO on such. Allegations, which appear to be criminal would be referred to the Lancaster Police Department to begin a criminal investigation. The facility director stated during interview that he would contact the state's Adult Parole Authority (APA), depending on the clien'ts status. The PAQ indicates ther was one reported allegation of sexual abuse in the past 12 months. The auditor reviewed the investigative file during the onsite audit. The PREA coordinator confirmed there were no investigative files to review for sexual harassment, or retaliation in the past 12 months, including third-party, or anonymous reports. During random client interviews, one client disclosed having reported an allegation of sexual harassment against a staff person "approximately a month ago". The facility director stated in his interview that a staff person made an inappropriate comment to the client, but was not considered as sexual, so not treated as a PREA allegation. He stated he verbally addressed the staff, and the client was satisfied with the outcome. During the facility site review, the facility director identified an area, known as Area 51, as where an alleged victim would be placed to separate him from an alleged abuser. The area

can be monitored via surveillance cameras in the control room, and the facility director's office. The auditor observed a one-person restroom just outside Area 51; separate shower facilities are also available in a a secure area next to Area 51. According to the facility director, who also oversees the human resource function for the agency, if the identified abuser is a staff member, they would be placed on administrative leave with pay until the investigation is complete. If the alleged abuser is a client, he would be temporarily removed, and housed in the local jail, until the investigation is complete.

Although policy 800-51 outlines investigation procedures, it does not include in procedures that staff named in an allegation of sexual abuse, harassment, or retaliation, will be placed on administrative leave with pay, until the investigation is concluded. Based on the evidence provided, the facility does not meet this provision.

115.271(b)
The facility PAQ indicates internal investigators received specialized training related to sexual abuse investigations, as per standard 115.234. Training for facility investigators was verified through supporting documentation provided by the facility. The PREA investigator, and PREA coordinator files contained certificates dated 3/12-13/18 from PREA Investigator specialized training, facilitated by The Moss Group. The curriculum of the two-day training was provided, and meets all aspects required of specialized training for PREA investigations. The training included a half-day Train-the-trainer training,
which qualifies the PREA investigator and PREA coordinator to provide PREA investigations training to internal staff who may participate in the investigation process. The PREA coordinator's file also contained a certificate for completing PREA administrative investigations training on 6/4/16.

The auditor reviewed one investigative file from a 2019 allegation of staff sexual abuse. The auditor observed that the staff identified as having conducted the administrative investigation is not the PREA coordinator, or PREA investigator. The auditor's review of the employee's personnel file did not identify evidence of specialized training related to sexual abuse allegations. The employee's job title is Investigator. PREA Form 1.1, submitted to the auditor during the pre-audit phase, does not list the Investigator as a specialized staff related to allegations of sexual abuse, sexual harassment, or retaliation. The auditor inquired to the PREA coordinator why staff was permitted to conduct a PREA administrative investigation, having no specialized training for investigative allegations of sexual abuse. The PREA coordinator stated the person's prior law enforcement background is considered appropriate for conducting a PREA investigation.

Policy 800-51 Section IV. 3. A. states PREA investigations are conducted by the agency PREA coordinator, or program (facility) director. Based on the evidence provided, the facility does not meets this provision.

115.271(c)
The facility PAQ indicates, and documents in policy 800-51, section IV. 3. G., investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data. It further states that the facility will review prior complaints and reports of sexual abuse involving suspected perpetrator. Policy 800-51 Section IV. 3. A. states allegations in violation of local, State, or federal law are referred to the Lancaster Police Department to conduct a criminal

investigation. Policy 800-52 states in section III.2. that first responders are to *"preserve, and protect the crime scene",* not collect evidence. The auditor reviewed a 2019 PREA investigation file. The file did not contain information regarding evidence collection, as the alleged sexual conduct did not occur in the facility. The file does not document whether it reviewed prior complaints and reports of sexual abuse involving suspected perpetrator. The investigative report indicates the alleged victim and abuser were interviewed.

During interviews, the facility director demonstrated how video technology can be utilized as part of an investigation. During the onsite facility review, the auditor observed 22 cameras in the facility director's office, which covered internal and external areas throughout the facility. A facility layout document was provided, which reflected camera locations, and the view span of each camera, to identify blindspots in, or around, the facility. The PREA coordinator stated in her interview that physical or circumstantial evidence would be collected by Lancaster Police, as part of a criminal investigation. Staff are trained to preserve, and protect physical evidence in an investigation until law enforcement takes over. Based on the evidence provided, the facility meets this provision.

115.271(d)
The facility PAQ indicates compelled interviews will be conducted, if an allegation rises to criminal. Policy 800-51 IV. 3. A. states the Lancaster Police Department will conduct criminal investigations. The policy states in section IV. 3. H. that compelled interviews may be conducted after consulting with Lancaster Police. The PAQ indicates there have been one allegation (sexual abuse) in the past 12 months. The auditor reviewed a 2019 PREA investigative file. There was no evidence that the interviews with the alleged victim, or abuser were compelled to answer questions. There is no evidence that the facility requested Lancaster Police to conduct a criminal investigation. Documentation reviewed indicates law enforcement was not notified, as the conduct was not deemed as criminal. Evidence provided indicates administrative action was taken, resulting in staff's terrmination. Based on the evidence provided, the facility meets this provision.

115.171(e)
The facility PAQ indicates Policy 800-51 Section IV. 3. I. states, *"The credibility of an alleged victim, suspect, or witness shall be assessed on an individual bases and shall not be determined by the person's status as inmate, client, or staff, and that no institution shall require a client 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 facility provided one investigation file for review in the past 12 months."* During interviews, the facility director, and PREA coordinator stated the agency does not conduct polygraph tests, nor does it use any other truth-telling device during PREA investigations. During client interviews, none of the 17 clients interviewed expressed ever being asked to take a polygraph test; none of the 17 clients interviewed stated they experienced sexual abuse while incarcerated, or while at CTC. Based on the evidence provided, the facility meets this provision.

115.271(f)
The facility PAQ indicates administrative investigations: (1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (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. Policy 800-51, is provided as supported documentation. Policy section IV. 3. J. states, *"Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse and shall be documented in written reports that include a description of the physical and testimonial evidence, the reason behind credibility assessments, and investigative facts and findings."*

During interviews, the PREA investigator, facility director, and PREA coordinator all stated CTC has had no criminal investigations in the past 12 months. The facility director stated criminal investigations are conducted by local law enforcement, or APA. The facility director stated the facility has a good relationship with local law enforcement, in the event they're contacted related to a PREA violation. Based on the evidence provided, the facility meets this provision.

115.271(g)
The facility PAQ indicates all criminal investigations shall be documented in a written report that contains thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Policy section IV. 3. K. states *"All criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence. Copies of documentary evidence shall be attached when feasible."* One investigative file was reviewed to corroborate what is stated in policy, as the facility has had one reported allegation in the past 12 months. The auditor observed the case was investigated administratively, and not referred to Lancaster Police, as it was not deemed to be criminal. During interviews with the agency head, facility director, PREA investigator, and PREA coordinator, all stated there have been no allegations of sexual abuse and/or harassment, or retaliation in the past 12 months, which were deemed as criminal. Policy 800-51 identifies the Lancaster Police Department as the entity responsible for criminal investigations, and that such would be conducted in accordance with PREA standards.

Of the 17 client files reviewed onsite, none contained documentation related to allegations of sexual abuse and/or sexual harassment, or retaliation, which were referred to law enforcement as a criminal case. Client intake screenings did not indicate there have been reported allegations at CTC, nor were there any reports of prior sexual victimization. Review of 13 staff human resources files resulted in no finding of disciplinary action, or other legal action against staff for client sexual abuse and/or sexual harassment, or retaliation, or evidence of any criminal charges for past sexual abuse, sexual harassment, or retaliation. The auditor reviewed on file from 2019, which contained a staff termination for sexually abusing a (male) client. Based on the evidence provided, the facility meets this provision.

115.271(h)
The facility PAQ indicates substantiated allegation of conduct that appears to be criminal shall be referred for prosecution. Policy 800-51, section IV. 3. L. states, *"Substantiated allegation of conduct that appears to be criminal shall be referred for prosecution."* During the onsite audit, no criminal investigation files were reviewed, as the facility has had no allegations in the past 12 months, which were deemed as criminal. There were no records in client files of court cases stemming from allegations of sexual abuse and /or harassment, or retaliation. The facility director stated during interviews that there have been no PREA-related allegations, which were deemed to be criminal, and referred for prosecution. The PREA investigator, and

PREA coordinator both stated in interviews there have been no allegations, which appeared to be criminal in nature. The agency head stated the facility has had one allegation of sexual abuse and/or harassment, or retaliation in the past 12 months. Based on the evidence provided, the facility meets this provision.

115.271(i)
The facility PAQ indicates all case records associated with allegations of sexual misconduct or retaliation shall be securely retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Policy 800-51 Section IV. 6. E. states that all case records associated with allegations of sexual misconduct or retaliation shall be securely retained in accordance with 'DRC' (i.e., Ohio Department of Rehabilitation and Correction) Records Retention Schedule. No information was provided in the PAQ, or during the onsite review indicating the timeframe associated with ODRC's records retention schedule. Policy section IV. 6. F. states all case records associated with sexual misconduct shall be retained for a minimum of 10 years after the date of initial collection. The PREA standard requires records be retained for "...as long as the alleged abuser is incarcerated or employed by the agency, plus five years". During the onsite audit, no records retention documentation was provided for review. No records retention documentation was provided in the PAQ. The facility director, PREA coordinator, and PREA investigator all stated there has been one allegation reported in the past 12 months.
The policy's assertion that records are retained for a minimum of 10 years after the date of initial collection, does not provide a retention maximum. Therefore, the policy does not clearly define the facility's records retention period. Based on the evidence provided, the facility does not meet this provision.

115.271(j)
The facility PAQ indicates it ensures that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation. Policy 800-51 is provided as supportive documentation. Policy section IV. 3. M. states, *"The departure of the alleged Abuser or Victim from the employment or control of the institution or Department shall not provide a basis for terminating an investigation."* The auditor reviewed one investigation file from 2019. According to the documentation, the alleged victim successfully completed the program, and the staff was terminated. Based on the evidence provided, the facility meets this provision.

115.271(k)
The auditor is not required to audit this provision.

115.271(l)
The facility PAQ indicates 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. Policy 800-51 is provided as supportive documentation. Policy section IV. 3. O. states 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. During the onsite audit, the auditor reviewed one investigation file, as there was one reported allegation of sexual abuse and/or harassment, or retaliation in the past 12 months. The file contained no evidence of communication between the facility and an outside entity regarding the investigation. No supportive documentation regarding investigations conducted by an outside entity was provided in the PAQ.

The facility director stated during interviews that there would be ongoing communication with the Lancaster Police, if they were investigating a PREA allegation. The PREA coordinator stated investigatory documentation would be submitted to ODRC/BCS via their Intelligrants online reporting tool. T
Based on the evidence provided, the facility meets this provision.

Corrective Action:
1. Include in policy 800-51 administrative action taken when an employee is named in an allegation of sexual abuse, sexual harassment, or retaliation.
2. Include in investigative documentation protocols followed to ensure investigators review prior complaints and reports of sexual abuse involving the suspected perpetrator.
3. Ensure all staff involved in an investigation have received specialized training related to investigating allegations of sexual abuse. Document evidence of training in employee training records.
4. Implement a protocol to ensure investigative reports are retained for as long as the alleged abuser is incarcerated or staff is employed by the agency, plus five years.

FACILITY RESPONSE:

The facility provided as supportive documentation policy 800-51, which was updated on 9/14/2020 to include in Section 3. (Investigations) A. explicit language that identifies the Program Director, and PREA coordinator as leads in administrative investigations. The section states other staff designated to participate in PREA investigations will have completed specialized PREA investigations training. The auditor observed during the initial onsite audit training documentation verifying that the PREA coordinator, and program director have received specialized PREA investigations training.

Policy 800-51 states in Section 6. (Data Collection and Monitoring) F. states PREA investigative reports are retained for as long as the alleged abuser is incarcerated or staff is employed by the agency, plus five years.

The facility provided documented, signed training attendance sheets dated 3/6/2020, 3/9/2020, 9/11/2020, and 9/14/2020, and a training agenda that identifies policy 800-51 to be reviewed.

Based on the evidence provided, the facility meets this standard.

Review:

Policy 800-51

Staff training documentation

115.272	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51 PREA Report Response Interviews: 1. Investigative staff Findings: 115.272(a) The facility PAQ indicates it imposes a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment can be substantiated. Policy 800-51, in section IV. 3. N. affirms the language in this provision. The policy was provided as supportive documentation. The facility PAQ states there has been one allegation of sexual abuse in the past 12 months. The auditor reviewed an investigative file provided from 2019; the allegation was substantiated based on the abuser's own admission of sexual abuse. There was no evidence that a standard higher than a preponderance of evidence was used to substantiate the allegation. Based on evidence provided, the facility meets this standard.

115.273	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: 1. CTC Policy 800-51 PREA Report Response 2. 17 client files Interviews: 1. Facility head 2. Investigative staff 3.17 Random client interviews Findings: 115.273(a) The facility PAQ indicates the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. Policy 800-51 was provided as supportive documentation. Policy section IV. 3.B. c. states that following an investigation into an inmate's allegation that he or she suffered sexual abuse in an institution, the institution investigator shall inform the inmate as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Although the language in this section references an "institution", the context is within the context of this provision. The PAQ response indicates there has been one reported allegation of sexual abuse in the past 12 months that have been administratively and/or criminally investigated. The auditor reviewed an investigative file from a 2019 sexual abuse allegation. The investigative documentation indicates the client was verbally informed of the outcome. No documented responses to clients regarding the outcome of an investigation was provided, or found in the 17 client files reviewed. None of the 17 clients interviewed stated they have reported an allegation of sexual abuse, and none stated they were aware of reports of alleged sexual abuse in the facility. One client interviewed stated about a month ago" he alleged sexual harassment against a staff person at CTC. He stated the facility director took care of the situation, and informed him he would address the named staff. The facility director corroborated the client's statement. However, the facility director stated the issue was not documented as a PREA allegation, as the staff's comment, albeit inappropriate, was not sexual. Based on evidence provided, the facility meets this provision. 115.273(b) The facility PAQ indicates if the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, the agency requests the relevant information from the investigative agency in order to inform the resident. Policy 800-51 was provided as supportive documentation. Policy section IV. 3. B. d. states, *"If CTC did not conduct the*

investigation, it shall request the relevant information from the outside investigaing agency in order to inform the client." The facility PAQ indicates there are no investigative files to review, where outside agencies conducted an investigation regarding alleged client sexual abuse. Policy 800-51 states Lancaster Police Department will investigate sexual abuse allegations deemed to be criminal. The facility director stated during his interview that there have been no sexual abuse allegations, which were investigated by Lancaster Police. Based on the evidence provided, the facility meets this provision.

115.273(c)
The facility PAQ indicates upon completion of an inmate sexual abuse allegation against a staff member (unless unfounded) the PREA coordinator shall inform the inmate of the following:

- The staff member is no longer posted within the inmate's unit;
- The staff member is no longer employed at the facility;
- The institution learns that the staff member has been indicted on a charge related to sexual abuse within the institution;
- The agency learned that the staff member was convicted on a charge related to sexual abuse within the facility.

Policy 800-51 was uploaded as supportive documentation. Policy section IV. 3. B. e. 1-3, states three of the four listed components of this provision. The policy section does not include the component, which states that facility informs the client victim whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. The facility PAQ indicates there has been one sexual abuse allegation in the past 12 months, which involved a staff. The auditor reviewed the investigative file during the onsite audit. The Sexual Abuse Incident Review indicates the client was notified verbally of the investigation's outcome. There was no evidence in the investigative file indicating that the client was notified of the employee's status (no longer employed at the facility), when the investigation was concluded.

The PREA coordinator stated during her interview that she did not conduct the investigation, that a part-time staff Investigator was assigned (by the facility director) to conduct the sexual abuse investigation. She provided to the auditor a Acknowledgement of PREA Investigation Findings form. She stated the form is used to notify clients of the outcome of an allegation of sexual abuse, sexual harassment. The form is not dated, so it is unknown when it was implemented. There was no completed version of the form in the investigative file the auditor reviewed. Based on the evidence provided, the facility does not meet this provision.

115.273(d)
The facility PAQ indicates that 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. All such notifications or attempted notifications shall be documented. Policy 800-51 is provided as supportive documentation. Policy section IV. 3. C.1-3. states the PREA coordinator shall inform the client

victim of: 1) when the alleged abuser has been indicted on a charge related to the sexual abuse within the facility; 2) the alleged abuser has been convicted on a charge within the facility; 3) the client abuser has been convicted on a charge related to sexual abuse within the agency. The provision does not require notification if the alleged abuser is convicted of an offense not related to a PREA-related allegation (e.g., sexual abuse). There were no investigation files to review of client sexual abuse against another client within the facility. The PAQ does not indicate any reported allegations of client sexual abuse against another client in the facility have been received in the past 12 months. The facility head, PREA investigator, PREA coordinator all stated during interviews that the facility has received no reported allegations of client-on-client sexual abuse and/or harassment, or retaliation in the past 12 months. Based on the evidence provided, the facility, by default, meets this provision.

115.273(e)
The facility PAQ indicates the agency has a policy that all notifications to residents described under this standard are documented. Policy 800-51 is uploaded as supportive documentation. Policy section IV. 4. D. is not the section referenced in the PAQ, but is the section that coincides with this provision. The policy section states, *"All such client notifications, or attempted notifications shall be issued in writing and documented."* The facility PAQ indicates the facility received one client allegation of sexual abuse by a staff in 2019. The PREA coordinator provided to the auditor the investigative file, during the onsite audit. The auditor observed documented reference that the client victim was verbally notified of the investigation outcome. The auditor was provided a form titled 'Acknowledgement of PREA Investigation Findings'. There was no evidence of the document in the 2019 investigative file. The form contains no effective date, to indicate when it was implemented. Based on the evidence provided, the facility does not meet this provision.

115.273(f)
The Auditor is not required to audit this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:

1. Implement the Acknowledgement of PREA Investigation Findings form; including a completed, signed document in all PREA investigative files.
2. Include in policy 800-51 that a client victim will be notified of the employee's status (in cases where an employee is the abuser), when the investigation is concluded.
3. Update policy 800-51 to include informing client sexual abuse victims (by a staff member) when the agency learns that the staff member has been convicted on charges related to sexual abuse within the facility.

FACILITY RESPONSE:

The facility provided as supportive documentation updated polilcy 800-51 (dated 9/14/2020), which specifies in Section 3. (Investigations) B., e. 1-4. how residents will be notified in cases involving employees. Section 3., B., f. 1-3 specifies how residents will be notified in cases involving other residents.The PREA Investigation Findings form has been updated to require signature by the PREA coordinator, and affected resident.

	The facility provided signed training documentation, which verifies staff have been trained on the updated policy and procedures. Based on the evidence provided, the facility meets this standard. **Review**: Policy 800-51 Staff training documentation PREA Investigation Findings form

115.276	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-50: PREA and Zero-Tolerance 2. Employee Roster: February 2020 3. 13 Employee files Interviews: 1. Facility director/Human Resources Findings: 115.276(a) The facility PAQ indicates all staff shall be subject to disciplinary sanctions up to, and including termination for violating agency sexual misconduct policies. Policy 800-50 is uploaded as supportive documetation. Policy section IV. 1. A. states all staff shall be subject to disciplinary sanctions up to, and including termination for violating agency sexual misconduct policies. It further states that a substantiated allegation against a staff shall result in immediate termination. Section IV. 1. B. states any contractor, intern or volunteer who engages in sexual misconduct is prohibited from contact with clients and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and also to relevant licensing bodies. The facility director is also responsible for overseeing the human resources function for the agency. He stated during his interview that CTC terminated an employee in the past 12 months, due to alleged sexual abuse with a client. The auditor reviewed an investigative file during the onsite audit. The file, provided to the auditor by the PREA coordinator, involved a staff in an inappropriate relationship with a client in 2019. The auditor reviewed documented evidence that the alleged staff abuser was terminated. No files for volunteers were provided for review. During the onsite audit, the Employee Roster provided, from which the auditor made random and specialized staff interview selections, identified one person as a contractor. The contractor's file reflected PREA refresher training on 2/7/2020. Based on the evidence provided, the facility meets this provision. 115.276(b) The facility PAQ indicates that termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Policy 800-50, which serves as the facility's Zero-tolerance policy, was provided as supportive documentation. Policy section IV. 1. A. states all substantiated allegations result in termination, as the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Section IV. 1. A. states all staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual misconduct policies. The auditor observed in the provided 2019 investigative file, documentation for

discplinary action (termination) against the employee named in the sexual abuse allegation. The PREA coordinator stated during her interview that immediate termination would be imposed, should it be substantiated that a staff engaged in sexual abuse, while on the clock (actively working). Based on the evidence provided, the facility meets this provision.

115.276(c)
The facility PAQ indicates that disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed. Policy 800-50 states, *"All staff shall receive disciplinary sanctions up to and including termination for violating facility sexual misconduct policies."* The PAQ indicates there has been one PREA allegation in the past 12 months. The auditor reviewed the investigation file of the sexual abuse allegation from 2019. The investigation resulted in the identified employee's termination. During his interview, the facility director stated there have been no other allegations in the past 12 months, whereby an employee was disciplined. The auditor reviewed 13 employee files. None contained evidence of disciplinary action for violating the agency's zero tolerance policy. Based on the evidence provided, the facility meets this provision.

115.276(d)
The facility PAQ indicates 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, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies. Policy 800-50 was provided as supportive documentation. Policy section IV. 1. A., states, *"...All terminations for violations of agency zero tolerance policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies unless the activity was clearly not criminal, and also reported to any relevant licensing bodies."*

The PAQ indicates no terminations for violating the agency's zero tolerance policies were reported to law enforcement, unless the activity was clearly not criminal. Ohio Revised Code 2907.03(A)(11) states sexual conduct between a person in a detention facility and an employee of that facility, is sexual battery (paraphrased). Section (B) of the same, states violations of the Code is a felony of the third degree. The auditor reviewed one sexual abuse investigation file, from 2019, during the onsite audit. The investigation documentation did not contain evidence that the facility reported to Lancaster Police that an employee was terminated for allegations of sexual abuse. Based on the evidence provided, the facililty does not meet this provision.

Corrective Action:

1. Implement, and document, the requirement in policy 800-50, section IV. 1. A., that all terminations for violations of agency zero tolerance policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies unless activity was clearly not criminal.

FACILITY RESPONSE:

The facility provided policy 800-50, which indicates in Section IV. 1. A. that law enforcement is to be notified when a substantiated sexual abuse allegation involves an employee, unless the activity was clearly not criminal.

	No documentation was provided to verify the implementation of the policy, as there have been no sexual abuse allegations during the corrective action period. Based on the evidence provided, the facility, by default, meets this standard. **Review**: Policy 800-50

115.277	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC policy 800-50 PREA and Zero Tolerance Interviews: 1. Facility director Findings: 115.277(a) The facility PAQ indicates agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies.agency's response on the PAQ indicated that Agency policy does not require that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. It further indicates that agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. Policy 800-50,provided as supportive documentation, states in Section IV. 1. B., that any contractor, intern, or volunteer who engages in sexual abuse/harassment is prohibited from contact with clients and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and also to relevant licensing bodies. The PREA coordinator stated during her interview that there are no files for volunteers. During the auditor's review of the Employee Roster, no volunteers were identified. One contractor was identified. A personnel file review determined the clinical director (contractor) completed PREA refresher training on 2/7/2020; PREA training was also verified in 2019. Based on the evidence provided, the facility meets this provision. 115.277(b) The facilitiy PAQ indicates the facility takes appropriate remedial measures and considers 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. Policy 800-50, uploaded as supportive documentation, states in section IV. 1.B., *"The agency shall take appropriate remedial measures, and terminate the contract, intern arrangement, or volunteer arrangement with independent contractors, interns, or volunteers, or shall demand that the offending employee of a contractor be excluded from providing services under the contract."* The facility provided no volunteer files to review for compliance with the agency's policy. The facility director stated in his interview that there were no volunteers providing services at CTC. One contractor file contained evidence of completed PREA Zero Tolerance policy training, and PREA refresher training. No volunteers were observed in the facility during the onsite audit. Based on the evidence provided, the facility meets this provision.

	Based on evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.278	Disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC policy 800-50: PREA and Zero Tolerance 2. CTC Client Handbook 3. Client files 4. Agency Table of Organization 5. Client Sanction Receipt (2019 investigation) Interviews: 1. Facility Director Findings: 115.278(a) The facility PAQ indicates residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse; residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. The PAQ further states there have been no administrative findings of resident-on-resident sexual abuse that have occurred at the facility in the past 12 months; there have been no criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility in the past 12 months. Policy 800-50 was provided in the PAQ as supportive documentation. The policy indicates in section IV. 1. C. that "clients shall be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative and/or finding that a client engaged in client-on- client sexual abuse/harassment." During the last 12 months, there were no allegations with an administrative finding of client-on-client sexual abuse that occurred at the facility, and there were no criminal findings of guilt for client-on-client sexual abuse that have occurred at the facility. During the onsite audit, the PRE coordinator provided to the auditor a copy of the CTC Client Handbook, as documentation of client accountability. On Handbook pages 11-17, violations and sanctions are addressed and coincide with a violation code table. There are six violation codes: 1. Automatic referral to Behavioral Review Committee (A) 2. High (H) 3. Moderate High (MH) 4. Moderate (M) 5. Low Moderate (LM)

6. Low (L)

The Handbook states on page 11, *"The Behavioral Review Committee will determine the sanctions to be applied to the violations and/or referral to the Bureau of Community Sanctions. Sanctions can range from internal restrictions to removal from the program..."*. Sexual Misconduct is listed as a category of unacceptable behavior. There are three general types of prohibited sexual misconduct, each tagged with the applicable Violation Code:

1. Non-consensual sexual conduct or contactwith another whether compelled:
    1. By force (A)
    2. By threat of force (A)
    3. B intimidation other than threat of force (A)
    4. By any other circimstances evidencing a lack of consent by the victim (A)
2. Consensual physical contact for the purpose of sexually arousing or gratifying either person (MH)
3. Seductive or obscene acts including indecent exposure or masturbation; including, but not limited to any word, action, gesture, or other behavior that is sexual in nature and would be offensive to a reasonable person (MH)

Consequences for non-consensual client-on-client sexual conduct is documented, and communicated with facility clients. Each client receives a Client Handbook during Intake. The facility has a formal Behavioral Review Committee, which reviews client violations, and determines the level of sanction. During the auditor's review of 17 client files, no sanctions were identified for client-on-client sexual misconduct. The PREA coordinator stated in her interview that there have been no allegations of client-on-client PREA allegations in the past 12 months. Based on the evidence provided, the facility meets this provision.

115.278(b)
The facility PAQ indicates 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. Policy 800-50 is provided as supportive documentation. Section IV. 1. C., states, *"Clients shall be subject to disciplinary sanctions following an administrative and/or criminal finding that the client engaged on client-on-client sexual misconduct. When determining the appropriate disciplinary sanction, CTC shall take into consideration any Mental Health diagnosis of the abuser."*

The facility Behavioral Review Committee reviews client violations, and determines the level of sanction.The facility director stated during his interview that a substantiated allegation of sexual abuse would result in the client's termination from the CTC program, and possible new charges. Lesser violations may result in a client being placed in Area 51, or the Briar Patch, or both, depending on the situation. Sanctions are not determined by one person, but the Committee; the client's history, prior violations, are considered when determining appropriate sanctions. Based on the evidence provided, the facility meets this provision.

115.278(c)
The facility PAQ indicates when determining what types of sanction, if any, should be imposed, the disciplinary process considers whether a resident’s mental disabilities or mental illness contributed to his or her behavior. Policy 800-50 was provided as supportive documentation. Policy section IV. 1. C., states, in part, *"...When determining the appropriate disciplinary*

sanction, CTC shall take into consideration any Mental Health diagnosis of the abuser." The facility director stated during his interview that a client's mental disability would be considered as it relates to the type of sanction to be imposed. Based on the evidence provided, the facility meets this provision.

115.278(d)
The facility PAQ indicates the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The auditor was provided a copy of the agency's table of organization as supportive documentation. According to the agency Table of Organization, the facility does not provide mental health services, such as therapy, counseling, or other interventions. One case manager is assigned clients with known mental health issues; interventions would be determined by the facility's referral source, ODRC, where clients have access to mental health services. The case manager facilitates linkages to services such as Tele-Med conferences between clients and mental health practitioners at a correctional institution, with which the client it connected.

The Employee Roster, from which the auditor selected random and specialized staff interview selections, did not list mental health therapists, or counselors. PREA Form 1.1 does not list medical, or mental health practitioners. The facility director stated during his interview that the agency does not provide in-house medical, or mental health services to clients. Based on the evidence provided, the facility meets this provision.

115.278(e)
The facility PAQ indicates a 'no' response to this provision. The PAQ asks if the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. Policy 800-50 is uploaded as supportive documentation. The policy addresses client accountability for client-on-client sexual abuse, sexual harassment. The policy does not indicate whether clients receive disciplinary sanctions for sexual conduct with staff only upon finding that the staff member did not consent to such contact. The Client Handbook does not specify if violations for sexual misconduct apply to sexual conduct with staff.

The facility entered in the PAQ Comment Box for this provision, "General House Rule". The auditor reviewed the Client Handbook. Rule no.15 states, as a violation, *"Establishing or attempting to establish a personal relationship with an employee, contractor, or volunteer."* Sub-section (d) states, *"Engaging in or sosliciting sexual conduct, sexual contact, or any act of a sexual nature with an employee (H)."* The auditor reviewed one sexual abuse investigative file from a 2019 allegation. The file indicates the client successfully completed the CTC program after the investigation was closed. The facility uploaded a 'Sanction Recipt' document from the investigation, signed by the client, his case manager, the staff Investigator (who conducted the PREA investigation), and the facility director. The document indicates the client in the sexual abuse allegation received disciplinary sanction for violating Rule 15. The disciplinary sanction(s) imposed were:

- 30 days in-house (no work, itinerary, free-time, or passes)
- 20 hours extra duty
- Phase reduction from Phase 3 to Phase 2
- No visits for 30 days
- No phone contract for the remainder of the client's program

- Weekly allowance reduced to $30/week

Based on the evidence provided, the facility does not meet this provision.

115.278(f)
The facility PAQ indicates the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation response affirms that client reports of sexual abuse made in good faith are not considered false reports, or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Policy 800-50 Section IV. 1. C. states, *"...Clients are only subject to disciplinary sanction if an administrative and/or criminal finding that the client engaged in client-on-client sexual misconduct."*

The 2019 investigation file reviewed by the auditor indicates the employee involved was terminated, and the client successfully completed the program. The report indicates the source of the allegation is 'unknown'. The PREA coordinator stated to the auditor that the (female) staff admitted to a sexual relationship with the client. While the client involved did not report the sexual conduct, such was substantiated. Of the 17 client files reviewed, none contained evidence of disciplinary action imposed on a client based on an unsubstantiated allegation of sexual abuse. Based on the evidence provided, the facility meets this provision.

115.278(g)
The facility PAQ indicates the agency always refrains from considering non-coercive sexual activity between residents to be sexual abuse. Rule 9, in the Client Handbook prohibits *"Consensual physical contact for the purpose of sexually arousing or gratifying either person (MH)"*. Non-coercive sexual behavior does not constitute sexual abuse, but is considered a 'Moderate High' program violation. There were no violations of sexual misconduct in any of the 17 client files reviewed. There were no allegations of client-on-client sexual abuse in any of the 17 client files reviewed. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility does not substantially meet this standard.

Corrective Action:

1. Add a qualifying statement to Client Handbook, Rule 15 (Unauthorized Relationships and Disrespect), which states client disciplinary sanctions for sexual conduct with staff is imposed only if there is evidence that the staff did not consent to such contact.

FACILITY RESPONSE:

The facility has updated the Client Handbook, Rule 15, adding in Section d. that client disciplinary sanctions for sexual conduct with staff is imposed only if there is evidence that the staff did not consent to such contact. Staff training documentation, dated 8/7/2020, was provided as verification that staff were trained on the updated language. Training documentation is dated, and includes staff signatures.

Based on the evidence provided, the facility meets this standard.

Review:

	Policy 800-50 Staff training documentation CTC Client Handbook

115.282	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51 PREA Report Response 2. CTC Policy 402-15 Mental Health Interviews: 1. Security Staff First Responder Review Observations: 1. PREA resource posters in client dorm bulletin board 2. PREA resource posters in case management office area bulletin board Findings: 115.282(a) The facility PAQ indicates resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The PAQ affirms that the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. It indicates further that medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. The PAQ states, related to the latter affirmation that case managers are responsible for documenting appointments and services clients receive related to sexual abuse. Policy 800-51 Section IV. 2. B. 2. states, *"CTC will offer unimpeded access to health care and mental health services. During business hours, clients can request to be seen by a contracted physician or be referred to Fairfield Medical Center. During non-business hours, clients may be referred to Fairfield Medical Center."* The same policy states in section IV. 2. C. 6., *"All clients who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility shall be offered medical and mental health evaluations, and treatment as appropriate."* The auditor reviewed policy 402-15. The policy statement, in section I. states, in part, *"...In an instant where a client is a victim of sexual abuse, they shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and health practitioners, according to their professional judgment."* During the auditor's review of 17 client files, no evidence was found of allegations of sexual abuse, or emergency medical treatment or crisis intervention services having been received.

The auditor reviewed a sexual abuse investigation file from a 2019 allegation. There was no evidence the client requested medical or mental health services. The PREA coordinator stated the client declined any services, as he was a willing participant in sexual conduct with the identified staff. The PREA coordinator, and PREA investigator both stated during interviews that the facility has received no allegations of sexual abuse in the past 12 months, which warranted access to medical, or mental health services. Based on the evidence provided, the facility meet this provision.

115.282(b)
The facility PAQ indicates if no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders (CCS') shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners. Policy 800-50 was provided as supportive documentation. Policy section IV. 3. F. states, *"...CTC shall have at least one victim support person."* Section IV. 3. G. states, *"All full-time and part-time victim support staff shall receive specialized training, to include, but not limited to:*

- *How to detect and assess signs of sexual misconduct;*
- *How to preserve physical evidence of sexual abuse;*
- *How to respond respectfully and professionally to victims of sexual misconduct; and*
- *How, and to whom to report allegations of sexual misconduct."*

The auditor reviewed 13 employee files during the onsite audit. The auditor identifed two employees (one full-time, one part-time) whose file contained training a certificate to serve as a Victim Support Person. One certificate is dated February 9, 2018; the second on January 17, 2017. The training was facilitated by ODRC's Training Academy. The training is approved for seven (7) training hours.Neither employee was present for interview during the time of the onsite audit.

The facility PREA coordinator provided to the auditor a signed Memorandum of Understanding (MOU) between CTC and Family Health Services of East Central Ohio. The MOU stated the entity will assist clients who contact them with emotional support, and referral services related to sexual abuse. Referral services includes mental, and medical services (Fairfield Medical Center). The date of the MOU is 12/4/19, and is signed by the CTC facility director, and Family Health Services' Executive Director. Family Health Services of East Central Ohio is listed on the CTC website as a community resource to report sexual abuse.

During the onsite audit site review, the auditor identified posters related to sexual abuse victim resources, including 24-hour hotline, and Crisis Centers. The auditor identified and tested the following entities:

- Crisis Line of Fairfield County: 740-687-8255; called and spoke with a live person who verified they will provide assistance to victims of sexual abuse.
- Lighthouse: 740-687-4423; A live person answered the call and explained that a CTC client may request assistance related to sexual abuse. An intake would be taken over the phone, and options discussed, including residential programs. Nonresidential programs are available through the recovery center.
- ODRC PREA Hotline: 614-728-3399; A recorded message was received from the ODRC Division of Parole and Community Service. The message stated to leave a call-back

number and there would be a call back within 24 hours.

Based on the evidence provided, the facility meets this provision.

115.282(c)
The facility PAQ indicates 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 800-51 is provided as supportive documentation. Policy section IV. 1. C. 4. states, *"Upon receiving an allegation that a client was sexually abused while confined at another institution, the agency PREA Coordinator shall notify the Managing Officer/designee of the institution or appropriate office of the agency where the alleged incident occured."* Policy section IV. 2. C. 6 states, *"All clients who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility shall be offered medical and mental health evaluations, and treatment as appropriate."*

The auditor reviewed policy 402-15 as supportive documentation. Section II. D. of the policy affirms the language of this provision Based on evidence provided, the facility meets this provision.

115.282(d)
The facility PAQ indicates treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Policy 800-51 is provided as supportive documentation. Policy section IV. 2. C. 7. states, *"Treatment services shall be provided to the alleged victim without financial cost, and regardless of whether the victim names the alleged abuser or cooperates with any investigation arising out of the incident."* The auditor interviewed nine (9) security first responder staff. All nine stated they would follow the chain of command if a client victim medical, or mental health treatment. Six of nine stated the facility director or PREA coordinator would take care of the victim's medical needs. Three staff stated they would contact the Victim Support Person on shift. The PREA coordinator articulated during her interview that she or the facility director would navigate the process to ensure a client was not financially responsible for a medical bill, should they report such was received. The facility response in the PAQ stated there have been no allegations where medical or mental health services were needed.
Based on the evidence provided, the facility meets this provision.

Based on evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

Recommendation:

1. Revise policy 402-15, section II. D. to explicitly state, in accordance with 115.282(d), the treatment services shall be provided to the victim "without financial cost", rather than "regardless of their ability to pay".

115.283	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response 2. CTC Policy 402-15: Mental Health 3. Client files 4. Agency Table of organization Findings: 115.283(a) The facility PAQ indicates it 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. The auditor reviewed the Employee Roster to confirm the facility does not have medical staff or mental health practitioners on staff, or contracted to provide such services. Policy 800-51 Section IV. 2. C. 6. states *"All clients who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility shall be offered medical and mental health evaluations, and treatment as appropriate."* The auditor reviewed policy 402-15 as supportive documentation. Policy section II. B. states, in part, *"Clients that are victims of sexual abuse, whether in CTC or prior to entering CTC, shall be afforded both medical and mental health services in a timely manner...".* The auditor observed a signed MOU with Family Health Service of East Central Ohio. The entity will assist clients who report or disclose prior sexual abuse, with medical and/or mental health needs related to being sexually victimized. The entity will coordinate medical forensic examinations with Fairfield Medical Center, and provide emotional support, if desired. The Intake staff (PREA investigator) stated in her interview that she would arrange transportation to the Emergency Room, if a client disclosed prior sexual abuse while incarcerated, and the incident was recent. The PREA coordinator stated during informal conversation that if EMT were not needed, one of the transportation staff would be asked to take the client to the Emergency Room to get checked out, if the client reported he had been sexually abused prior to arriving to CTC. During the onsite audit, the auditor reviewed 17 client files. The PREA screening form was reviewed. The screening form asks about prior sexual victimization, including during incarceration. The screening form also asks if the client has ever been identified as sexually abusive. Based on the evidence provided, the facility meets this provision. 115.283(b) The facility PAQ indicates 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 PAQ indicates a client's case manager is responsible for assisting with scheduling medical

and/or mental health services, if desired. Policy 402-15 is provided as supportive documentation. Policy section II. D. states, in part, *"...Evaluation and treatment shall include, but not limited to, 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."* Policy 800-51 is provided as supportive documentation. Policy section IV. 2. B. 1-2. identifies a MOU with a community resource, which is accessible to client victims after the victim is no longer at the CTC program. The section identifies Fairfield Medical Center, which is the local hospital, as where clients are referred if in need of medical services resulting from sexual abuse. The facility PAQ indicates there have been no reported allegations of sexual abuse, which required medical or mental health services. Based on the evidence provided, the facility meets this provision.

115.283(c)
The facility PAQ indicates it shall provide such victims with medical and mental health services consistent with the community level of care. Policy 800-51 is provided as supportive documentation. Policy section IV. 2. B. 1-2. identifies a MOU with a community resource, which is accessible to client victims after the victim is no longer at the facility. The section identifies Fairfield Medical Center, which is the local hospital, as where clients are referred if in need of medical services resulting from sexual abuse. The PREA coordinator stated during her interview that clients, depending on the situation, may also be transported to a local Urgent Care clinic. The facility director stated during his interview that he or the PREA coordinator would contact, or authorize staff to contact Lancaster Police Department to assist if medical services were needed. The facility indicated in the PAQ there have no reported allegations in the last 12 months, which required a client to received medical of mental health services. Based on the evidence provided, the facility meets this provision.

115. 283(d)
There are no female clients at the CTC facility. Therefore, this provision is not applicable.

115.283(e)
There are no female clients at the CTC facility. Therefore, this provision is not applicable.

115.283(f)
The facility indicates in the PAQ that resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Policy 402-15 was reviewed as supportive documentation. Policy section II. D. states, *"Sexual abuse victims shall be offered timely information about and timely access to emergency contraception sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate."* The PREA screening tool asks clients to disclose previous sexual victimization, which may have occurred during incarceration. The agency Intake staff confirmed during her interview that sexual victimization while incarcerated is part of the client PREA screening. During the onsite audit, the auditor observed a client Intake. The auditor observed the client respond to questions pertaining to sexual abuse, or abusiveness, during incarceration. Based on evidence provided, the facility meets this provision.

115.283(g)
The facility PAQ indicates that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Policy 800-51 is provided as supportive documentation. Policy section IV. 2. C. 7. states clients have no financial obligation for medical

	or mental health treatment or services, related to an alleged sexual abuse. The PAQ indicates there have been no reported allegations in the last 12 months, which involved a client needing medical treatment. During the onsite audit, no client files were reviewed, which contain evidence that a client received medical services for an alleged sexual abuse, and whether such services were provided at no financial cost to the alleged victim. Based on the evidence provided, the facility meets this provision. 115.283(h) The facility PAQ indicates the facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Policy 402-15 is provided as supportive documentation. Section II. F. states, *"The facilty shall attempt to have a mental health evaluation completed within 60 days of all known resident-on-resident abusers and offer treatment when deemed appropriated."* The facility PAQ states there have been no reported allegations of client sexual abuse, which required mental health or medical services. During the onsite audit no client files were reviewed of client allegations of sexual abuse, which required a mental health evaluation. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.286	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response 2. CTC PREA Investigation 2020 template 3. PREA Form 1.1 4. PREA Investigation file (2019) Interviews: 1. Facility head 2. PREA coordinator Findings: 115.286(a) The facility PAQ indicates 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 auditor reviewed Policy 800-51 as supportive documentation. Policy section IV. 3. J. states, *"Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse, and shall be documented in written reports that include a description of the physical and testimonial evidence, the reason behind credibility assessments, and investigative facts and findings."* The PREA coordinator provided during the pre-audit phase, PREA Form 1.1, which identifies specialized staff and clients. Section 4. k. identifies the facility Sexual Abuse Incident Review Team. The document identifis three staff are identified as the team: • Facility Director - Travis Mathes • PREA Coordinator - Mindy Morrison • PREA Intake/Investigator - Carol Combs The facility uploaded the PREA investigation report template as supporitve evidence. Page six (6) of the document begins a section titled 'Sexual Abuse Incident Review'. The template form is dated 2020. The facility provided no sexual misconduct investigations in 2020, for which the document was utilized. The facility PAQ indicates there was one allegation of sexual abuse in the past 12 months, which was in 2019. There is no evidence that the investigation template document was used in a sexual misconduct investigation. The completed Sexual Abuse Incident Review form in the 2019 case, is not signed, or dated. The PREA coordinator stated during her interview that all she did not particpate in the PREA investigation from 2019. Based on the evidence provided, the facility does not meet this provision.

115.286(b)
The facility PAQ indicates sexual abuse incident reviews are usually conducted within 30 days of the conclusion of an administrative or criminal investigation. The auditor reviewed Policy 800-51 as supportive documentation. Policy section IV. 3. B. a. states, *"A final decision on all allegations of sexual abuse shall be issued by the PREA Coordinator within 30 days of the initial filing unless extenuating circumstances require more time to make a final decision."* The policy does not outline procedural steps, which describe the process for conducting a Sexual Abuse Incident Review. The auditor observed a previous form used to document the 2019 PREA allegation investigation. However the form contained no signature, or date of completion. A PREA Investigation form dated 2020 was provided in the PAQ. Page 6 identifies the section as Sexual Abuse Incident Review. The page contains an underlined statement in the Header, "To be completed in 30 days". However, there is no evidence that the 30-day period begins when the investigation is concluded. Policy 800-51 states a final decision is made within 30 days of the initial filing. The facility director stated he, the PREA coordinator, and PREA investigator review investigations to determine what can be done better in the future. Based on the evidence provided, the facility does not meet this provision.

115.286(c)
The facility PAQ indicates the Sexual Abuse Incident Review Team consists of upper-level management officials, and includes input from investigators, line supervisors, medical and mental health professionals. PREA Form 1.1 lists in section 4. k. whom the team consists of. The facility provided the agency Table of Organization as supportive documentation. The facility director reports to the Agency Head (Exec. Director). The PREA coordinator reports to the facility director, and the PREA investigator/Intake staff reports to the PREA coordinator. Collectively, the tem represents 'upper-evel management, and investigator. The auditor was provided an allegation report for review, as there as been one reported allegation of sexual abuse in the
past 12 months. The investigation file includes a Sexual Abuse Incident Review form is included in the investigative file. The document reflects the identified staff who make up the team. Based on the evidence provided, the facility meets this provision.

115.286(d)
The facility PAQ indicates the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator. A documented Sexual Abuse Incident Report form, included in the PREA investigation report template dated 2020 was provided as supportive documentation. The form covers the five aspects required in section (d)1-5 of this standard, each of which requires a
'yes/no', or narrative response. The form contains a response to each of the five components of this provision. The PREA coordinator stated during her interview that she is the designated team member to complete the Sexual Abuse Incident Report, as part of the review team. During onsite interviews with 17 random clients, none stated they reported an allegation of sexual abuse. Review of 17 client files did not result in identifying any allegation(s) of sexual abuse. Based on the evidence provided, the facility meets this provision.

115.286(e)
The facility PAQ indicates the facility implements the recommendations for improvement or documents its reasons for not doing so. The PREA coordinator stated during her interview that

she normally prepares the incident review report; the document was updated in 2020 though not yet utilized. The facility head stated he, along with the PREA coordinator work as a team, along with other managers and relevent staff. He indicated there is a structured incident review process in place, which is supported by a documented report dated 2020, provided in the PAQ. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:

1. Update policy 800-51 to specify that sexual abuse incident reviews are conducted within 30 days of the conclusion of any substantiated or unsubstantiated sexual abuse investigation, not 30 days from the initial filing.
2. Require that sexual abuse incident review documents are signed, and dated, as evidence of timely completion of the process.
3. Define the 30-day timeframe on page 6 of the Investigation template document (i.e., "To be completed 30 days of the conclusion of any substantiated or unsubstantiated sexual abuse investigation").

FACILITY RESPONSE:

The facility has developed a post-incident review process, which occurs within 30 days of the conclusion of any substantiated or unsubstantiated sexual abuse investigation. Policy 800-51, Section 3. (Investigations), O. was provided as supportive documentation. Staff were trained on the updated information. The Investigation form was updated with a corrected timeline related to the 30-day period.

Training documentation was provided indicating policy 800-51 was reviewed on 3/6/2020, 3/9/2020; 9/11/2020, and 9/14/2020.

Based on the evidence provided, the facility meets this standard.

Review:

Policy 800-51

Staff training documentation

115.287	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51: PREA Report Response 2. PREA Investigation file (2019) 3. CTC Investigative Report 2020 template Interviews: None Findings: 115.287(a) The facility PAQ indicates the agency collects accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions. The facility's PREA Investigative Report template document was provided in the PAQ as evidence of a standardized instrument. The facility PAQ indicates there has been one allegation of client sexual abuse in the last 12 months. The auditor reviewed one completed PREA Investigative Report from 2019. Based on the evidence provided, the facility meets this provision. 115.287(b) The facility PAQ indicates the aggregated incident-based sexual abuse data is reviewed at least annually. Policy 800-51 section IV. 6. B. c. states the agency PREA coordinator and other staff as designated by the Director shall review the aggregated data for the purpose of "Preparing an annual report of the agency's findings and corrective actions". The auditor observed the agency's 2017-2019 aggregated report posted on its website: https://www.communitytransitioncenter.com/. Based on the evidence provided, the facility meets this provision. 115.287(c) The facility PAQ indicates the aggregated incident-based data includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. A review of policy 800-51 section IV. 6. Data Collection and Monitoring, corroborates the PAQ response that such data is maintained. Based on the evidence provided, the facility meets this provision. 115.287(d) The facility PAQ indicates the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Policy 800-51 was reviewed as supportive documentation. Policy section IV. 6. E. outlines steps for reporting allegations, preparing aggregated reports; the content of the report, including the redacting of Personal Identifying Information (PII), and that such reports are securely retained.

	The policy states that the agency PREA coordinator collects allegation reports, reviews aggregated data, and prepares an annual report for review and approval by the facility director. The auditor verified that the final report is posted on the CTC website. All allegation records of sexual abuse are securely maintained. During the onsite audit, the auditor observed client files in locked cabinets in the PREA Intake/Investigator's office. The auditor observed employee files, including the PREA investigation file from 2019, located in locked cabinets in the PREA coordinator's office. The facility director's/HR office is adjacent to the PREA coordinator's office, separated by an inside door. The facility director stated during an informal conversation that the door is rarely locked, unless the director is not present. Based on the evidence provided, the facility meets this provision. 115.287(e)(f) These provisions are not applicable, as the agency does not contract for the confinement of its clients, and the Department of Justice has not requested agency data. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.288	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC Policy 800-51 PREA Report Response 2. Agency website: https://www.communitytransitioncenter.com/ 3. PREA Allegation Summary Report 2017-2019 Interviews: 1. Agency head 2. PREA coordinator Findings: 115.288(a) The facility PAQ indicates that the agency reviews data collected ad aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: (a) identifying problem areas: (b) taking corrective action on an ongoing bases; and (c) preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The PAQ includes an annual report from 2017-2019, as supportive documentation. Policy 800-51 is provided as supportive documentation. Policy section IV. 6. b. states, *"The Agency PREA Coordinator and other staff as designated by the Director shall review the aggregated data for the purposes of:* *(a) Identifying problem areas;* *(b) Taking corrective action on an ongoing basis; and* *(c) Preparing an annual report of the agency's findings and corrective actions".* The agency head stated in her interview that the facility director provides the annual report pursuant to 115.287. The PREA coordinator confirmed during her interview that data is collected for review, and there has been one reported allegation of client sexual abuse in the last 12 months. Based on the evidence provided, the facility meets this provision. 115.288(b) The facility PAQ indicates the annual report includes a comparison of the current year's data and corrective actions with those from prior years. It further states that the annual report provides an assessment of the agency's progress in addressing sexual abuse. Policy 800-51 was provided as supportive documentation. Policy section IV. 6. C. states, in part, *"The agency's annual report includes 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 misconduct....".

The agency head stated during her interview that the agency prepares an annual report, which the facility director oversees. The auditor verified the facility's annual report posted on the agency website: *https://www.communitytransitioncenter.com/*. The agency PREA coordinator stated during her interview that she and the director prepare the facility's annual report. Based on the evidence provided, the facility meets this provision.

115.288(c)
The facility PAQ indicates the agency's report shall be approved by the agency head and made readily available to the public through its Web site or, if it does not have one, through other means. Policy 800-51 was reviewed as supportive documentation. Policy section IV. 6. C. states the annual report, once approved by the Director, shall be posted on the CTC internet site. The auditor reviewed the agency's website at: *https://www.communitytransitioncenter.com/*; the annual report was observed posted on the site. The agency's website states the facility's PREA audit report from 2019 is available upon request. Based on the evidence, the facility meets this provision.

115.288(d)
The facility PAQ indicates when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. Policy 800-51 was reviewed as supportive documentation. Policy sections IV. 6. C., D. state:

C. "...Any information redacted from the report due to a clear and specific threat to the safety and security of the facility must indicate the reason for redaction".

D. "All personal identifiers must be removed from publicly available data".

The agency head stated during her interview that the facility director prepared the annual report. She has the ultimate approval of what goes on the website, but he and the PREA coordinator are designees to prepare, and oversee the process. The agency PREA coordinator confirmed that she and the facility director prepare the annual report with information redacted, if there is any Personal Identifying Information (PII). The facility provided to the auditor an investigation file related to reports of alleged sexual abuse. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.289	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. CTC policy 800-51: PREA Report Response 2. CTC website: https://www.communitytransitioncenter.com/ Interviews: 1. PREA coordinator Findings: 115.289(a), (b), (c) The facility PAQ indicates that the agency ensures incident-based and aggregate data are securely retained. The PREA coordinator corroborated that she collects and maintains sexual abuse data for creating the annual report; keeping confidential data secure in "under lock and key" in her office. She articulated that she creates the annual report, and ensures personal identifying information (PII) is not included. The agency has no private facilities under its control. The PAQ indicates that aggregated sexual abuse data is made readily available on its website. The auditor verified that the annual report is currently available on the agency website. The link to the agency website is: *https://www.communitytransitioncenter.com.* Based on the evidence provided, the facility meets this provision(s). 115.289(d) The facility PAQ indicates the agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. Policy 800-51 was reviewed as supportive documentation. Policy section IV. 6. F states, *"All case records associated with sexual misconduct shall be retained for a minimum of 10 years after the date of initial collection."* The auditor reviewed the facility's annual report. The report only provides aggregated data; no 'PII' is included to redact. Therefore, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Emails regarding Notice of PREA audit Interviews: 1. PREA investigator Onsite facility review: 1. Client dorm bulletin board 2. Case management office bulletin board 3. Control room Findings: 115.401(a) The facility PAQ indicates that during the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency ensures that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once. The auditor reviewed the agency website at: https://www.communitytransitioncenter.com/. The agency website contains a live link named 'PREA Audit Report'. The link opens to the Notice of PREA Audit posting for the 2020 audit. There is no evidence of a PREA audit report in the link. The website lists "2019 PREA Audit Report upon request", and is not a live link. There is no evidence of a PREA Interim, or Final Audit Report posted on the website. The PREA coordinator stated the facility was audited in 2015, 2019; the 2020 audit completes the facility's first audit cycle. A copy of the 2019 PREA Interim Audit Report would be provided, if requested. Based on the evidence provided, the facility meets this provision. 115.401(b) The facility PAQ indicates that during each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited. This PREA compliance audit is the third audit of PREA cycle 1 for the facility. The agency has one location, which was audited in 2015, and 2019. The 2019 PREA compliance audit was conducted at the same facility as the 2015 PREA audit. Based on the evidence provided, the facility meets this provision. 115.401(h) The facility PAQ indicates the auditor shall have access to, and shall observe, all areas of the audited facilities. The facillity director guided the auditor onsite through the all areas of the facility. The PREA coordinator uploaded in the OAS agency policies, procedures, reports, documents, and forms, where such was requested. Those not uploaded, were provided to the auditor onsite. Based on the evidence provided, the facility meets this provision. 115.401(i)

The facility PAQ indicates the auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information). The auditor was permitted to request and receive copies of any relevant documents (including electronically stored information). During the onsite facility review, the facility director provided access to, and explained the functionality of the facility's security video surveillance system, including the system's capacity to retain footage for approximately 30 days, and to record isolated video footage onto an external flash drive. Client and employee files are maintained in hard copy form, and were available for the auditor's review. Based on the evidence provided, the facility meets this provision.

115.401(m)
The facility PAQ indicates the auditor shall be permitted to conduct private interviews with residents. During the onsite audit, the auditor was provided space and time to conduct private interviews with clients on a one-one basis. The auditor interviewed a representative sample of 17 clients chosen at random, as well as targeted populations (i.e., LGBTI, reported prior sexual abuse), as identified in the PREA Compliance Audit Instrument Interview protocols, retrieved from the National PREA Resource Center website. The number of clients interviewed were based on the population grid outlined in the 2017 PREA Auditor Handbook. Based on the evidence provided, the facility meets this provision.

115.401(n)
The facility PAQ indicates that residents shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. Upon entering into an agreement with CTC to conduct a PREA compliance audit, the auditor sent to the facility PREA coordinator, who was the designated point of contact, instructions for the pre-audit phase, to begin six weeks prior to the onsite audit.

The auditor provided PREA audit notices in English, and Spanish, to be posted in conspicuous locations throughout the facility. The notices contained Auditor contact information for staff, or clients who may wish to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. The auditor advised that such notice be posted on brightly colored paper. A photo of the notices was requested to be sent to the auditor via email. The facility submitted, via email attachments, photos of posted notices, with the corresponding locations. The email was received on the requested date. The notices, however, were printed on standard white paper, which the auditor communicated with the PREA coordinator. During the onsite facility site review, the auditor verified via observation that the notices were re-posted, as instructed, on brightly colored, green paper. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:

No corrective action is recommended.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Agency website, listed as https://www.communitytransitioncenter.com/index.html Findings: 115.403(f) The facility PAQ indicates that 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 auditor reviewed the CTC website, and verified that the facility 2019 PREA audit reportf is not a live link; the site states the audit report will be provided, upon request. Based on the evidence provided, the facility meets this provision.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	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 community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	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.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	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.)	na

115.212 (c)	Contracting with other entities for the confinement of residents	
	If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	yes

115.213 (c)	Supervision and monitoring	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)	yes
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents)	yes
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	no
	Does the facility document all cross-gender pat-down searches of female residents?	no

115.215 (d)	Limits to cross-gender viewing and searches	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical 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
	Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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
	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?	yes
115.215 (e)	**Limits to cross-gender viewing and searches**	
	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
	If the 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
115.215 (f)	**Limits to cross-gender viewing and searches**	
	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
	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
115.216 (a)	**Residents with disabilities and residents who are limited English proficient**	
	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
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all	yes

	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?	
	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
	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
	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
	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
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	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
	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
	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
	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: Who are blind or have low vision?	yes

115.216 (b)	Residents with disabilities and residents who are limited English proficient	
	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
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	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 §115.264, or the investigation of the resident's allegations?	yes

115.217 (a)	Hiring and promotion decisions	
	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
	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
	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 two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the 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
	Does the agency prohibit the enlistment of the 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
	Does the agency prohibit the enlistment of the 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 two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes

115.217 (c)	Hiring and promotion decisions	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency, 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?	yes
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	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
115.217 (f)	**Hiring and promotion decisions**	
	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
	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
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes

115.217 (h)	Hiring and promotion decisions	
	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
115.218 (a)	**Upgrades to facilities and technology**	
	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.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	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 any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	yes
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	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

115.221 (b)	Evidence protocol and forensic medical examinations	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	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? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	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
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	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
	Has the agency documented its efforts to secure services from rape crisis centers?	yes

115.221 (e)	Evidence protocol and forensic medical examinations	
	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
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency 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
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	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? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	yes
115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.222 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy 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
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes

115.222 (c)	Policies to ensure referrals of allegations for investigations	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes
115.231 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	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
	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
	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
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	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?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	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
	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

115.231 (b)	Employee training	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	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
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	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
	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
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	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
115.232 (b)	**Volunteer and contractor training**	
	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
115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes

115.233 (a)	Resident education	
	During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes
115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	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

115.234 (a)	Specialized training: Investigations	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	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 criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	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 criminal or administrative sexual abuse investigations. See 115.221(a).)	yes

115.235 (a)	Specialized training: Medical and mental health care	
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	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 victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (b)	**Specialized training: Medical and mental health care**	
	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 does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na

115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes

115.241 (d)	Screening for risk of victimization and abusiveness	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?	yes

115.241 (e)	Screening for risk of victimization and abusiveness	
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?	yes
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?	yes
115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident's risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?	yes
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?	yes
115.241 (i)	**Screening for risk of victimization and abusiveness**	
	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

115.242 (a)	Use of screening information	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes
115.242 (c)	**Use of screening information**	
	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
	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

115.242 (d)	Use of screening information	
	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
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.242 (f)	**Use of screening information**	
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes

115.251 (a)	Resident reporting	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	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
	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
115.251 (b)	**Resident reporting**	
	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
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	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

115.252 (b)	Exhaustion of administrative remedies	
	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.)	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.)	na
115.252 (c)	**Exhaustion of administrative remedies**	
	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.)	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.)	na
115.252 (d)	**Exhaustion of administrative remedies**	
	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.)	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 is 70 days per 115.252(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.)	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.)	na

115.252 (e)	Exhaustion of administrative remedies	
	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.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party 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.)	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.)	na

115.252 (f)	Exhaustion of administrative remedies	
	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.)	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.)	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.)	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.)	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.)	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.)	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.)	na
115.252 (g)	**Exhaustion of administrative remedies**	
	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.)	na
115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes

115.253 (b)	Resident access to outside confidential support services	
	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
115.253 (c)	**Resident access to outside confidential support services**	
	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
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.261 (a)	**Staff and agency reporting duties**	
	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
	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
	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
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain 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

115.261 (c)	Staff and agency reporting duties	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes
115.261 (e)	**Staff and agency reporting duties**	
	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
115.262 (a)	**Agency protection duties**	
	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
115.263 (a)	**Reporting to other confinement facilities**	
	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
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.264 (a)	Staff first responder duties	
	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
	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
	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
	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
115.264 (b)	**Staff first responder duties**	
	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
115.265 (a)	**Coordinated response**	
	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
115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	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

115.267 (a)	Agency protection against retaliation	
	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
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency 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 who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes

115.267 (c)	Agency protection against retaliation	
	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
	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
	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
	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
	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:4. Monitor resident housing changes?	yes
	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
	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
	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 reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes

115.267 (e)	Agency protection against retaliation	
	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
115.271 (a)	**Criminal and administrative agency investigations**	
	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 115.221(a).)	yes
	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 115.221(a).)	yes
115.271 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?	yes
115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.271 (d)	**Criminal and administrative agency investigations**	
	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

115.271 (e)	Criminal and administrative agency investigations	
	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
	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
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	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
115.271 (g)	**Criminal and administrative agency investigations**	
	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
115.271 (h)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	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 and form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes

115.272 (a)	Evidentiary standard for administrative investigations	
	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
115.273 (a)	**Reporting to residents**	
	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
115.273 (b)	**Reporting to residents**	
	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
115.273 (c)	**Reporting to residents**	
	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
	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
	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
	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

115.273 (d)	Reporting to residents	
	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
	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
115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	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
115.276 (d)	**Disciplinary sanctions for staff**	
	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
	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: Relevant licensing bodies?	yes

115.277 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	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
115.278 (a)	**Disciplinary sanctions for residents**	
	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, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?	yes
115.278 (b)	**Disciplinary sanctions for residents**	
	Are 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
115.278 (c)	**Disciplinary sanctions for residents**	
	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
115.278 (d)	**Disciplinary sanctions for residents**	
	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 require the offending resident to participate in such interventions as a condition of access to programming and other benefits?	yes
115.278 (e)	**Disciplinary sanctions for residents**	
	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

115.278 (f)	**Disciplinary sanctions for residents**	
	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
115.278 (g)	**Disciplinary sanctions for residents**	
	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
115.282 (a)	**Access to emergency medical and mental health services**	
	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
115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	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
115.282 (d)	**Access to emergency medical and mental health services**	
	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
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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

115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(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. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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

115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.286 (a)	**Sexual abuse incident reviews**	
	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
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes

115.286 (d)	Sexual abuse incident reviews	
	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
	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
	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
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	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
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287 (c)	**Data collection**	
	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

115.287 (d)	Data collection	
	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
115.287 (e)	**Data collection**	
	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.)	na
115.287 (f)	**Data collection**	
	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.)	na
115.288 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.287 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
	Does the agency review data collected and aggregated pursuant to § 115.287 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
	Does the agency review data collected and aggregated pursuant to § 115.287 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
115.288 (b)	**Data review for corrective action**	
	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
115.288 (c)	**Data review for corrective action**	
	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

115.288 (d)	**Data review for corrective action**	
	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
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes
115.289 (b)	**Data storage, publication, and destruction**	
	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
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	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

115.401 (b)	Frequency and scope of audits	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	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.)	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
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. 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, there has never been a Final Audit Report issued.)	yes