Prison Rape Elimination Act (PREA) Audit Report
Community Confinement Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: 9/17/2022 ☐ **N/A**

Date of Final Audit Report: March 22, 2023

Auditor Information

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Mailing Address: 3105 S. Martin Luther King Blvd #236	**City, State, Zip:** Lansing, MI 48910
Telephone: 517 303 4081	**Date of Facility Visit:** August 5, 2022

Agency Information

Name of Agency: Operation Get Down, Inc.			
Governing Authority or Parent Agency *(If Applicable)*: Health Management Systems Administration			
Physical Address: 10100 Harper, Ave		**City, State, Zip:** Detroit, MI 48213	
Mailing Address:		**City, State, Zip:**	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: Click or tap here to enter text.			

Agency Chief Executive Officer

Name: Rodney L. Barnes, MSW	
Email: rbarnes@operationgetdown.org	**Telephone:** (313) 921-9422

Agency-Wide PREA Coordinator

Name: Clarence Powell	
Email: cpowell@operationgetdown.org	**Telephone:** (313) 921-9422
PREA Coordinator Reports to: Rodney L. Barnes	**Number of Compliance Managers who report to the PREA Coordinator:** 0

Facility Information

Name of Facility: Operation Get Down, Inc.			
Physical Address: 10100 Harper, Ave		**City, State, Zip:** Detroit, MI	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: Click or tap here to enter text.

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

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

☐ ACA

☐ NCCHC

☐ CALEA

☒ Other (please name or describe: Commission on Accreditation of Rehabilitation Facilities

☐ N/A

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

Facility Director

Name: Rodney L. Barnes			
Email: rbarnes@operationgetdown.org		**Telephone:** (313) 921-9422	

Facility PREA Compliance Manager

Name: NA	
Email:	**Telephone:**

Facility Health Service Administrator ☒ N/A

Name:	
Email:	**Telephone:**

Facility Characteristics

Designated Facility Capacity:	190
Current Population of Facility:	142
Average daily population for the past 12 months:	140

Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	18-80
Average length of stay or time under supervision	3 months
Facility security levels/resident custody levels	Community setting

Number of residents admitted to facility during the past 12 months	Information never received, requested three times
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	Information never received, requested three times
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	Information never received, requested three times
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No

Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☒ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☐ N/A

Number of staff currently employed by the facility who may have contact with residents:	30
Number of staff hired by the facility during the past 12 months who may have contact with residents:	2
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	5
Number of single resident cells, rooms, or other enclosures:	140
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☐ Yes ☒ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	1
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☐ Facility investigators ☒ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Audit Findings

Audit Narrative

On, August 8, 2022, an audit was conducted at Operation Get Down, inc. to determine compliance with the Prison Rape Elimination Act standards finalized August 2012. This is this facility's/organization first audit for certification of compliance with the PREA standards. There were no barriers to completing the audit. The auditor was selected to complete the audit by responding to and informational request from the agency, forwarding a proposed contract, and being awarded the contract.

Audit Methodology:
The PREA Resource Audit Instrument used for Community Confinement is furnished by the National PREA Resource Center. This tool includes the following: A) Pre-Audit Questionnaire, sent by Eastern Correctional Facility; B) the Auditor Compliance Tool; C) Instructions for the PREA Audit Tour; D) the Interview Protocols; E) the Auditor's Summary Report; F) the Process Map; and G) the Checklist of Documentation. In addition, the Auditor Handbook 2021 was used to guide the audit process.

Pre-audit:
The facility reported that posters announcing the audit with the auditor's name and address were placed throughout the facility on announcing the audit on June 28, 2022, identifying the auditor's address in English and Spanish. Photographs were also sent to the auditor for further verification. They were observed by the auditor throughout the facility during the tour. The posters indicated that any correspondence sent to the auditor would be confidential and not disclosed unless required by law. The exceptions in the law were noted. One confidential correspondence letter was received in response to the posters announcing the audit. The Pre-Audit Questionnaire and documentation was reviewed prior to the on-site audit.

The auditor reviewed the mandatory reporting laws, laws regarding where and how juveniles are housed and laws regarding vulnerable adults for the State of Michigan prior to the audit.

On-site audit:
A brief formal meeting was held with the Executive Team and the auditor the morning of the audit. The following items were reviewed: purpose of audit, goals and expectations, and the tentative schedule. Tentative schedules were developed regarding the tour, interviews and review of additional documentation. It had been arranged for interviews to be conducted in a private setting. A list of specialized, random and targeted interviews was developed.

A complete tour of the facility was conducted on August 8, 2022. All areas of the facility were visited that have resident access. Supervision practices, blind spots, bathroom facilities, living areas were observed and cross-gender announcements were made prior to the opposite gender auditor entering the living units. Posters announcing the audit were observed throughout the facility.

Facility Characteristics

The facility is located in Detroit, Michigan. It is a homeless shelter for which the Michigan Department of Corrections contracts for the placement of parolees who have served prison time for committing a criminal sexual offense who have not secured appropriate community housing and are deemed to need extra community supervision.

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded:

Standards Met

Number of Standards Met: 10

§115.212 - Contracting with other entities for the confinement of residents §115.216 – Residents with Disabilities and Residents who are Limited English Proficient §115.218 – Upgrades to Facilities and Technology §115.232 – Volunteer and Contractor Training §115.234 – Specialized Training: Investigations §115.235 – Specialized training: Medical and mental health care §115.266 – Preservation of ability to protect residents from contact with abusers §115.277 – Corrective action for contractors and volunteers §115.401 – Frequency & Scope of Audits§115.403 – Audit contents and findings

Standards Not Met

Number of Standards Not Met: 30
List of Standards Not Met:

§115.211 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator,
§115.213 – Supervision and Monitoring
§115.215 – Limits to Cross-Gender Viewing and Searches
§115.217 – Hiring and Promotion Decisions
§115.221 – Evidence Protocol and Forensic Medical Examinations
§115.222 – Policies to Ensure Referrals of Allegations for Investigations
§115.231 – Employee Training
§115.233 – Resident Education
§115.241 – Screening for Risk of Victimization and Abusiveness
§115.242 – Use of Screening Information
§115.251 – Resident Reporting
§115.252 – Exhaustion of Administrative Remedies
§115.253 – Resident Access to Outside Confidential Support Services
§115.254 – Third-Party Reporting
§115.261 – Staff and Agency Reporting Duties
§115.262 – Agency Protection Duties
§115.263 – Reporting to Other Confinement Facilities
§115.264 – Staff First Responder Duties
§115.265 – Coordinated Response
§115.267 – Agency protection against retaliation
§115.271 – Criminal and Administrative Agency Investigations
§115.272 – Evidentiary Standard for Administrative Investigations
§115.273 – Reporting to Resident
§115.276 – Disciplinary sanctions for staff
§115.278 – Disciplinary sanctions for residents
§115.282 – Access to emergency medical and mental health services
§115.283 – Ongoing medical and mental health care for sexual abuse victims and abusers
§115.286 – Sexual abuse incident reviews

§115.287 – Data Collection
§115.288 – Data Review □ for Corrective Action
§115.289 – Data Storage, □ Publication, and Destruction □

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

115.211 (a)

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

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

115.211 (b)

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

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

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and retained the following evidence related to this standard:
- OGD Policy
- Interview with the PREA Coordinator/Program Director
- organization chart

OGD PREA Documents states the following, *This policy and its procedures apply to OGD MDOC Prison Rape Elimination Act of 2003 from admission to discharge.*

The Program Director has been designated as the PREA Coordinator. He will also be responsible for conducting/reviewing investigations, monitoring training, involvement with the annual staffing plan review, grievances, and compiling the Annual Report. He indicated that these duties fit well with his current role. This is the first PREA audit, the operation has been implementing the standards for less than one year. He reports directly to the Chief Executive Officer. This was additionally confirmed by the review of the organization chart.

Corrective Action needed:
Policy needs to be updated to be more concise about the obligation to meet the requirements of the PREA standards and articulate how this facility will prevent, detect and respond to sexual abuse and sexual harassment and include definitions as established by the law.

Update: No policy was received.

Standard 115.212: Contracting with other entities for the confinement of residents

115.212 (a)

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

115.212 (b)

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

115.212 (c)

- 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.) ☐ Yes ☐ No ☒ 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.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

This facility/agency does not contract with another entity or the confinement of its clients. Therefore, the standard is not applicable- compliant.

Standard 115.213: Supervision and monitoring

115.213 (a)

- 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 ☒ No

- 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 ☒ No

- 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 ☒ No

- 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 ☒ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☐ Yes ☒ No

115.213 (b)

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

115.213 (c)

- 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 ☒ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☐ Yes ☒ No

- 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 ☒ No

- 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 ☒ No

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview with the Chief Executive Officer
- Interview with PREA Coordinator
- Informal conversations with staff
- Observations during the tour
- PAQ

The PAQ indicates that the staffing plan is predicated on the average daily population of the facility, one hundred forty (140) residents. It indicates that they do not deviate from the staffing plan, overtime is utilized.

The interview with the Chief Executive Officer and PREA Coordinator confirmed that staffing is reviewed, however, a more formalized document should be developed to ensure an analysis of the staffing needs are assessed, at least annually in accordance with the PREA Standards. Currently, the organization chart reflects eight building monitors are on staff, three case managers, two medication clerks, one driver, two front desk staff, and four cooks are employed. The Executive Administrative Assistant addresses training needs, and other administrative functions.
Building monitors were observed during the tour; the have office space located on each floor.

Corrective Action Required:
A staffing summary analysis needs to be completed
Language should be added to policy.

Update: No policy was received, no staffing plan was provided.

Standard 115.215: Limits to cross-gender viewing and searches

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)
  ☐ Yes ☐ No ☒ NA

- 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 the facility does not have female residents.) ☐ Yes ☐ No ☒ NA

115.215 (c)

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

- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). ☐ Yes ☐ No ☒ NA

115.215 (d)

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

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☐ Yes ☒ No

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy – OGD
- Video – PREA Cross Gender and Transgender Pat Searches

- Documentation of quiz after viewing video
- Interviews random staff
- Interviews with residents
- View of security monitors
- Observations of living areas and shower/bathroom facilities
- PAQ
- FAQ (Frequently Asked Questions, PREA Resource Center) December 2016

The PAQ indicates that no cross-gender strip searches occurred during the 12-month audit review period that involved exigent circumstance. The auditor found no reason to dispute this during the audit process.

Policy – OGD states, *All persons entering the facilities of Operation Get Down whether personnel, person's served and visitors are subject to search and should be searched if there is reason to suspect the possession of contraband.*

It provides directions of how to conduct strip searches and Frisk Searches. It confirms that a report must be sent to the CEO on any strip searches conducted.

The auditor reviewed the monitors for the facility and found that it does not allow staff to view the nonmedical staff of the opposite gender to view buttocks, or genitalia.

Staff complete "PREA Cross Gender and Transgender Pat Search" training and complete a quiz to test their knowledge of the training.

The auditor viewed the living areas. They are single occupancy with doors. There is one common bathroom with showers, sinks, toilets and urinals. There are appropriate curtains and barriers to ensure that if opposite gender staff pass by, they do not view buttocks or genitals. Resident interviews confirmed to the auditor that female staff do not enter their rooms without knocking, announcing and they have never seen a female on their floor.

Corrective Action Required:
Need training records of the searches for all staff required to take it.
Policy should be changed to reflect the provisions of the standard.

Update: No updated policy was received. Training resources were provided but no evidence that staff completed the training was received.

Standard 115.216: Residents with disabilities and residents who are limited English proficient

115.216 (a)

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

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect,

and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy – OGD
- Documentation demonstrating access to professional interpreters
- Observations during the tour
- Interview with the Chief Executive Officer
- Random staff interviews
- Interviews with Case managers
- PAQ

The PAQ indicates there have been no instances where another resident was used to interpret for a LEP offender. The auditor found no reason to dispute this during the audit process.

Policy – OGD states,
Communication with Non-English Speaking or Limited-English Proficient People

Policy - Operation Get Down provides no cost, accurate, and timely language assistance and effective communication to limited-English-proficient (LEP) people, including current and prospective clients, family members, and other interested people to ensure equal access to services.

Procedures - The following procedures ensure that information is communicated to LEP people in a language that they understand.

Assessment - Operation Get Down identifies the non-English languages that are most commonly encountered by estimating the number of LEP people that are eligible for services and are likely to be directly affected by its programs. It will complete this assessment by reviewing census data, client utilization data from client files, and data from school systems and community agencies and organizations; identifying the language needs of each LEP client and recording this information in the client's file; identifying the points of contact in the program or activity where language assistance is likely to be needed; identifying the resources that will be needed to provide effective language assistance; identifying the location and availability of these resources; and identifying the arrangements that must be made to access these resources in a timely fashion.

Accessing an Interpreter - Whenever an interpreter is needed, the clinical supervisor is responsible for contacting one of the in-house interpreters if one is available. If a staff interpreter is not available or there

is none for a particular language, arrangements have been made with Language Line to provide such interpreters. If the clinical supervisor is not on site, the staff person on duty is to immediately contact either the clinical supervisor or chief executive officer, who are authorized to contact the Language Line at 1-800-752-0093 to obtain the interpreter. (If consent forms, waivers of rights and information about services, benefits, requirements, letters regarding benefits, legal notices, etc. are available in languages other than English, the materials will be requested from the Recipient Rights Advisor at the Detroit Health Department, Bureau of Substance Abuse Services).

Family members or friends of the LEP person are not to be used as interpreters unless specifically requested by the individual after an offer of an interpreter has been made by the clinical supervisor or staff person on duty.

Such an offer and the response of the individual to that offer are to be documented in the client's case record. Whenever an LEP person refuses the offer of an interpreter supplied by the clinical supervisor or staff person on duty and prefers to use a family member or friend, the documentation is to include the name, relationship to the client, and confirmation that the individual is not a minor.

Documentation is also to include a brief statement of what the interpreter helped to communicate. This documentation is to be completed in an LEP client's file for each individual offer, or in a log that includes every contact with LEP people who are not yet clients.

If an LEP elects to use a family member or friend, but the clinical supervisor or staff person on duty suspects that the use of this family member or friend could compromise the effectiveness of services or violate the LEP person's confidentiality, the clinical supervisor or staff person on duty may suggest that a trained interpreter sit in on the encounter to ensure accurate interpretation. Staff members are not, under any circumstances, ask a person to bring their own interpreter or use another client to interpret.

Translating Written Materials - Written materials are translated for each LEP group of 10% or 3000 (whichever is less) of the eligible population. Vital documents are translated for each LEP group of 5% or 1000 (whichever is less) of the eligible population (e.g., application forms, enrollment forms, letters or notices about eligibility or any change in benefits, medical or discharge information). For each language group with fewer than 100 people, the entity provides written notice of the right to receive oral interpretation of written materials in the primary language of the group.

The clinical supervisor is be responsible for the determination of the necessity for written materials for each office based on its study of each office's eligible LEP population.

The clinical supervisor is also responsible for the dissemination and translation of these written materials.

Notice Regarding the Availability of Interpreter Services and Materials Translated into Other Languages.

The clinical supervisor ensures that notice is posted regarding the availability of interpreter services and available materials translated in other languages for LEP people in all entrances. The notice clearly states that the service is at no cost to the current and prospective clients, family members, and interested people. The notice also informs people that forms that are less common will be orally communicated to the current and prospective clients, family members, and interested people in their native language. This notice describes how to request an interpreter in each language most commonly encountered other than English.

Responsibility for Training and Compliance for the LEP Policy - The clinical supervisor is to train all new employees during their orientation and all current employees who have client contact regarding the LEP policy and procedures. In addition, the clinical supervisor maintains a training registry on which the names and dates of employees trained is recorded.

Monitoring Conformance - The clinical supervisor monitors conformance with this policy by annually assessing the current LEP makeup of each service area, the current communication needs of LEP applicants and clients, whether existing assistance is meeting the needs of such people, whether staff members are knowledgeable about the LEP policy and procedures and how to implement them, and whether sources of and arrangements for assistance are still current and viable.

Reasonable Accommodations for Visual/Mobility Impairments

Policy - Operation Get Down makes every effort to accommodate consumers and staff-persons with visual or mobility impairments given the structural limitations of its physical plant.

Procedures - The following procedures ensure that every effort is made to accommodate consumers and staff-persons with visual or mobility impairments:

Essential materials are transferred to audio tape if required. Office or peer assistants are assigned if necessary.

The interview with the Chief Executive Officer (agency head) confirmed to the auditor that the agency does have procedures to ensure that residents with limited English proficiency are provided 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. The auditor confirmed that the Program Director assumes the role of ensuring this policy is met.

The interview with the Case managers demonstrated to the auditor that individual attention is given when the client first enters the resident and throughout their stay.

Resident interviews confirmed to the auditor that their needs are met. Specifically, during the onsite audit this included those with cognitive challenges and one resident who was hard of hearing and one resident who had limited English speaking skills. Interviews confirmed to the auditor that these residents have the resources needed to ensure effective communication. This facility has five floors; residents have to have the ability to access the floors by stairs in order to be accepted for housing here.

Summary of evidence supporting a finding of compliance:
The facility has a policy to address effective communication for limited English residents and disabilities. There are language interpretation services, both audio and video to assist when needed. Case managers demonstrated they are very attentive to the individual needs of each client, ensuring that they understand their rights under this law. The PAQ confirmed that no resident has been used to interpret for another resident who was making a report about sexual abuse or sexual harassment. The auditor finds the agency/facility has provided sufficient evidence to support a finding of compliance.

Standard 115.217: Hiring and promotion decisions

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

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

115.217 (c)

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

- Before hiring new employees who may have contact with residents, does the agency, 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 ☒ No

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Application
- Interview Form
- Interview with Human Resources Operation Manager
- Documents observed from personnel files
- Documentation of background checks status employees
- Policy - OGD
- PAQ

The PAQ indicates there have been 2 staff hired in the last twelve months for the agency, zero contractual staff. The interview with PREA Coordinator and Program Manager confirmed that there are no contractual staff who work at this facility.

The Employee Application requires employees to sign the following: “I agree to comply with the policies, rules and regulations of Operation Get Down as appropriate. I certify that all statements made on this form are true and accurate to the best of my knowledge. I understand that suppling false

information may be sufficient cause for termination. Furthermore, I understand that my employment with Operation Get Down is contingent upon:

Policy – OGD states, *The references and backgrounds of personnel are checked as required or indicated prior to the person assuming any responsibilities and conducted at stated intervals throughout employment.* Additionally, in order to comply with contract requirements, OGD completes iChat background checks on all employees annually.

Corrective Action needed:
Add standard language to policy
Develop questions that address provision (a), also impose upon employees a continuing affirmative duty to disclose any such misconduct. (g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.
I can provide a form that addresses this.

Update: A policy was not received. A form was developed to address provisions a,b,f, and h. All staff currently working completed the form and it was sent to the auditor.

Standard 115.218: Upgrades to facilities and technologies

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview with the Chief Executive Officer
- Interview with the PREA Coordinator
- Observations during the tour
- View of security monitors
- PAQ

The PAQ indicates there have been no substantial expansion or modification of existing facilities; there has been upgrades to the video monitoring system.

The interview with PREA Coordinator and the Chief Executive Officer indicates that there have been no substantial modifications to the facility; there has been upgrades to the video monitoring. This facility currently has cameras that monitor specific corridor areas of the facility, outside areas and entrance. The auditor was assured by these interviews that any changes to the physical building or upgrades to video cameras are to ensure safety of residents and staff and subsequently protection from sexual abuse. The auditor observed the camera monitors and supports this conclusion, therefore finding there is sufficient evidence to support a finding of compliance.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☒ No ☐ NA

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

115.221 (e)

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

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

115.221 (f)

- 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 ☐ No ☒ NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview with the CEO
- Interview with the PREA Coordinator
- State of Michigan law
- PREA Incident Checklist

The PAQ indicates there have been no SANE/SAFE exam, no forensic medical examinations or examinations conducted by a qualified medical practitioner in response to a sexual abuse allegation. The auditor found no reason to dispute this during the audit process.

The auditor researched the law in the State of Michigan. The State of Michigan has implemented a Sexual Assault Kit Tracking and Reporting System (SAEK) in accordance with MCL 752.962. That Act charged the Commission with developing plans and guidelines for (1) a uniform statewide system to track the submission and status of sexual assault evidence kits (kits), with secure electronic access for victims, (2) a uniform system to audit untested kits that were collected on or before March 1, 2015, and were released by the victims to law enforcement, and (3) auditing the ongoing submission of kits under the Sexual Assault Kit Evidence Submission Act, MCL 752.931-752.935. According to the michigan.gov webpage, A Sexual Assault Evidence Kit Submission Act established time frames for submission and retrieval of SAEKS. The legislature established a Sexual Assault Evidence Kit Tracking and Reporting Commission. Evidence collected at the hospital would be collected in accordance with this law.

Interviews with the CEO, PREA Coordinator, and Program Manager confirmed to the auditor that any allegation of sexual abuse that allowed for the collection of evidence would be reported to the local police and the resident would be transported to the local hospital for a SANE exam, a victim advocate would be provided, if requested, and this would be for no charge to the resident even if they did not name the accuser or cooperate with the investigation.

Corrective Action needed:
Add standard language to policy
Obtain MOU with a rape crisis center that would be available if sent to the hospital for a SANE exam
Complete a letter to the local PD requesting they follow requirements of PREA
Verification of which hospital(s) would conduct a SANE exam in the area

No updated policy was received, no evidence of an MOU or letter to the local PD was provided.

Standard 115.222: Policies to ensure referrals of allegations for investigations

115.222 (a)

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

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

115.222 (b)

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

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

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

115.222 (c)

- 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 ☒ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy – OGD
- Interview with the Vice President for Programs
- Interview with the PREA Coordinator
- Interview with the Residential Manager
- Letter to local police department
- PAQ

The PAQ indicates there have been no allegations of sexual abuse and/or sexual harassment during the previous twelve months, no referrals for criminal investigation. The auditor found no reason to dispute this during the audit process and review of the investigations.

Corrective Action needed:
Add standard language to policy
Obtain MOU with a rape crisis center that would be available if sent to the hospital for a SANE exam
Complete a letter to the local PD requesting they follow requirements of PREA
Verification of which hospital(s) would conduct a SANE exam in the area

Update: No updated policy was received, no letter to the PD or attempt to obtain an MOU was provided.

TRAINING AND EDUCATION

Standard 115.231: Employee training

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☐ Yes ☒ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☐ Yes ☒ No

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy - OGD
- Training curriculum
- Training records
- Interviews with random staff
- FAQ October 2014
- PAQ

The PAQ indicates that there are currently sixteen staff at this facility.

Policy – OGD states the following:
MDOC STAFF EDUCATION AND TRAINING
POLICY
It is the policy of Operation Get Down, Inc. (hereinafter referred to as "OGD") to train all staff for the purpose of adhering to all PREA standards to prevent, detect, and respond to inappropriate sexual conduct
PROCEDURES

Staff will complete a questionnaire after viewing the "Guidance in Cross- Gender and Transgender Pat Searches" which includes questions to prevent trauma during Transgender Pat and Search activities.

Staff will be trained on and effectively, ethically, and professionally, communicate with all participants, including those who may be lesbian, gay, bisexual, transgender or intersex participants.

Staff will be trained on how to avoid inappropriate relationships with participants.

During employee orientation, the staff member is given, "MDOC VENDOR HANDOBOOK FOR VENDOR EMPLOYEES NOT ENTERING A SEUCRE FACILITY (Rev.5-16-2016). A quiz is given to staff during Quarterly Staff Meetings to keep employees abreast of and refreshed regarding MDOC's *current contract expectations.*

These policies and procedures will be provided to each member of the Operation Get Down, Inc. program staff. Each OGD staff member will review this material and will sign an orientation check list to indicate he/she understands and agrees to abide by OGD's client rights policies and procedures. It is the responsibility of the program supervisors to ensure that each staff member fully comprehends the intent of these policies and procedures. A copy of the signed orientation check list will be maintained in each staff member's personnel file; a second copy will be maintained by the Operation Get Down, Inc. staff member.

Each staff member has a copy of the State of Michigan DEPARTMENT OF CORRECTIONS "EMPLOYEE HANDBOOK" and signs the
"Acknowledgement and Receipt" and is familiar with DEPARTMENT WORK RULES as it relates to rules 50-52.
Rule #50 overly Familiar of Unauthorized Conduct
Rule #51 Sexual Conduct with Offender
Rule #52 Sexual Harassment of Offender
(Page 36)
(Page 39)
(Page 40)

Staff will be trained on Rules # 50; 51; and 52 during pre- and in-service training sessions.

Four copies of signed acknowledgements of this Handbook were requested and received during the audit.

It was reported to the auditor that staff receive training as required by the Michigan Department of Corrections. The auditor reviewed the training curriculum. The agency uses the National Institute of Corrections PREA training. Review of the curriculum supports that it addresses all topics required by the provision of the standard. It addresses male and female differences.

Corrective Action needed:
Add standard language to policy
Still need to conduct interviews with staff to confirm the received training in the requirements noted.
Need to see training records of completion

Update: Staff training records were provided that demonstrated acknowledgement of completion of the training. Their credibility is questionable. Policy was not updated.

Standard 115.232: Volunteer and contractor training

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

The PAQ indicates that the agency/facility does not use volunteers or contractual staff for their clients. All services are provided outside the facility. The auditor found this credible during the audit process. Therefore, this standard is not applicable – compliant.

Standard 115.233: Resident education

115.233 (a)

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

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

- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☐ Yes ☒ No

- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☐ Yes ☒ No

- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☐ Yes ☒ No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy – OGD
- Random resident interviews
- OGD Declaration of Zero Tolerance
- OGD Sexual Harassment Policy
- Intake Staff interviews (Case Manager)
- Observations

- Documentation of resident education (review of five files)
- PREA posters

The PAQ indicates that 27 residents were admitted to the program and were given resident education at intake in the previous twelve months, zero transferred from another facility.

Policy – OGD indicates the following:
Information regarding the facility's zero tolerance policy for sexual abuse and sexual harassment and reporting methods must be provided to offenders when they arrive at the facility.
All MDOC clients entering OGD will be given the forms below:
Receive a copy of "Know your rights" and the recipient rights advisor contact information
"Zero tolerance for Sexual Abuse and Sexual Harassment" by staff or offender form (Intake)
How to report a sexual violation or harassment complaint

The auditor reviewed the OGD Declaration of Zero Tolerance. It addresses the following:
- Zero tolerance of all forms of sexual abuse and sexual harassment
- Definitions of sexual misconduct
- Staff's obligation to immediately report any allegations, suspicions, knowledge and all information
- Signature acknowledging orientation and written information

Additionally, the OGD reviews the following Sexual Harassment Policy with each client. To insure the safety of all participants admitted to a OGD facility we are asking you to report inappropriate sexual indiscretions and or advances by a participant or staff listed below:

- SEXUAL HARRASSMENT
- LEWDSEXUALLANGUAGE
- SEXUAL NOTES AND LETTERS
- SUGGESTIVE SEXUAL BODY LANGUAGE
- REQUEST FOR SEXUAL FAVORS
- INDECENT GENITAL EXPOSURE
- INAPPROPRIATE TOUCHING

PLEASE BE ADVISED ALL "SEXUAL" ALLEGATIONS AND SEXUAL ASSAULT WILL BE INVESTIGATED TO THE FULLEST EXTENT OF THE MICHIGAN PENAL CODE 750.520g. Clients sign and date this form acknowledging it was addressed.

As noted in response to 115.216, resources are available to assist with communication if identified.

To further support compliance, the auditor requested to review the files of the five randomly selected resident files (all files were available to the auditor to review) to assess that they signed for resident education including the information sheet specific to PREA. All demonstrated compliance with signatures acknowledging the information. All the resident interviews supported that they were educated on their rights to be free from sexual abuse and sexual harassment and they were aware they should not have to experience retaliation for doing so. All residents confirmed to the auditor that they have a cell phone and call make a report to the police or parole officer anytime. Additionally, they indicated they could find the phone number to a rape crisis hotline if they wanted to access this service.

Information educating the residents on their right to be free of sexual abuse and sexual harassment and the zero-tolerance policy was not visible in the facility anywhere.

Corrective Action needed:
Add standard language to policy
Update the Declaration of Zero tolerance to include their right to be free from sexual abuse, sexual harassment and retaliation, grievance form not used to report allegations, phone number, address to outside emotional support services (i.e. rape crisis hotline).

Posters were added, photographs provided. An updated Declaration was created, but no evidence was received that it was used. It added additional information relevant to the law for the residents. No updated policy was received.

Standard 115.234: Specialized training: Investigations

115.234 (a)

- 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 administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☐ Yes ☐ No ☒ NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☐ Yes ☐ No ☒ NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
  ☐ Yes ☐ No ☒ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview with the PREA Coordinator
- PAQ

The PAQ indicates that this facility does not have trained investigators; allegations of criminal abuse are referred to the local police.

Summary of evidence supporting a finding of compliance:
The auditor concluded that the agency does not conduct investigations into sexual abuse; they would all be referred to the local police.

Standard 115.235: Specialized training: Medical and mental health care

115.235 (a)

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) ☐ Yes ☐ No ☐ 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 if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

The facility does not have medical or mental health staff on site as a part of the staffing for this operation. These needs are addressed with community providers. Therefore, the standard is not applicable – compliant.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

115.241 (a)

- 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 ☐ No

- 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 ☐ No ☐ NA

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?
  ☒ Yes ☐ No

115.241 (c)

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

115.241 (d)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.241 (e)

- 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 ☐ No ☒ NA
-

- 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 ☐ No ☒ NA

- 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 ☐ No ☒ NA
-

115.241 (f)

- 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 ☒ No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☐ Yes ☒ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☐ Yes ☒ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☐ Yes ☒ No

- 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 ☒ No

115.241 (h)

- 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 ☒ No

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy - OGD
- PREA Risk Assessment Questionnaire
- Randomly requested risk forms – five total
- Interviews staff who perform risk screens (Case Manager)
- Interview random residents
- Interview PREA Coordinator
- FAQ
- PAQ

The PAQ indicates that _____residents entered the facility in the previous twelve-month review period that were screened within 72 hours for risk of victimization and/or sexual abusiveness towards other residents, and _____ remained for at least 30 days and were reassessed for their risk of victimization or of being sexually abusive. Information never received, requested several times.

Policy – OGD addresses that all residents complete a risk victimization and abuse questionnaire which is evaluated for room assignment.

Screening for Risk Assessment of Victimization

1. Have you been diagnosed with a mental health, physical health, educational or developmental disorder?
2. Describe (circle) your physical build: _Small _Medium _Large _Heavy _Extra Large
3. How old are you? _____
4. When was the last time you were incarcerated? Date_____Length of stay? _____
5. Were you charged with a [ ] violent or [] non-violent crime? Please check box.
6. Do you have prior convictions for sex offenses against an adult or a child? Yes [] NO []
7. Do you consider yourself or do others consider you to be gay, lesbian, bisexual, transgender, intersex, or gender non conforming? Please circle all or one that apply. (Screener Assessment)
8. Have you previously experienced sexual victimization in any of the following ways:
    a. When you have been with a staff member or offender, have you been afraid or uneasy about the possibility of a sexual or physical assault? Yes [ ] NO [ ]
    b. Have you ever experienced unwanted sexual advances or victimization? Yes [] NO []
    c. Have you ever agreed to a sexual encounter with another offender or staff to avoid negative consequences or repercussions? Yes [ ] NO [ ]
    d. Have you ever had a sexual encounter because you felt pressured or were physically threatened by an offender or staff? Yes [] NO []

e. Have you ever been touched by a staff or offender in a sexual way that made you uncomfortable? Yes [] NO []

f. Has a staff or another offender ever said or done sexually degrading things to you? Yes [] NO []

9. Please describe your perception of vulnerability as it relates to sexual trauma. _____

_____Ho

w would you rate your risk of vulnerability? [ ] Low [] MEDIUM [] HIGH

10. If you have been sexually harassed or abused:

a. How often did it occur? Seldom [ ] Occasionally [ ] Frequently [ ]

b. What have the emotional or psychological effects you've experienced as a result of the sexual abuse? [] Hospitalization [ ] Therapy [] Suicide Attempt [] Transfer to another facility [] Cutting [] Thoughts of suicide, harming yourself, or wishing you were dead?

c. Have you ever told anyone or received help as a result of sexual harassment or

abuse? Yes [] NO [] Counselor_____Date._____

Positive responses in 3 or more risk factor areas (questions 1-9) warrant protective planning measures.

The assessment addresses all the requirements of the provision. The agency does not screen for prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive, as this facility only receives residents who have a predatory history. However, the auditor is requiring that a narrative assessment be conducted to designate residents who may be predatory to ensure separation from those deemed vulnerable.

The interview with the Case managers demonstrated the process and assured the auditor that this is completed, privately and verbally. They additionally assured the auditor that they meet with residents frequently and address any needs in person for updated information or changes that may change the outcome of the risk assessment. They indicated they would also complete a new risk assessment if they received any new information.

Summary of evidence supporting a finding of compliance:
In making a conclusion of compliance, the auditor analyzed the policy, analyzed the risk assessment profile and instructions, reviewed the resident interview responses, responses from the interview with staff who conduct the risk assessment, review of randomly requested risk assessment screenings, and the interview with the PREA Coordinator. The auditor observed that the information is a hard copy is maintained in the resident file which is securely stored in the Case Manager office.

Corrective Action Required:
Formalize the process for a review of the risk assessment within 30 days in person with the resident. Add it to policy. Assess predatory behavior. Make the highlighted adjustment to the risk assessment.

Update: No evidence of use of an updated risk assessment was provide. Policy was not provided.

Standard 115.242: Use of screening information

115.242 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

- 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 ☐ No ☒ NA

- 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 ☐ No ☒ NA

- 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 ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Risk assessment tool
- Observations facility tour – housing/living conditions
- Interviews PREA Coordinator
- Interview with the Program Manager
- Interview with staff who conduct Risk screens
- Interview with Resident Coordinators
- Observations

Interviews with the CEO, PREA Coordinator, and Case managers provided the auditor with anecdotal information on how they have placed residents they believed may be more vulnerable in rooms closer to the Resident staff. As indicated, residents have their own rooms. Shower stalls are separate;

however, the auditor was assured that if an individual shower time was warranted, it would be arranged. All residents have frequent contact with the case manager. The Case managers confirmed that they would consider the transgender/intersex views seriously regarding safety that may include a transfer to a female facility. To date, they indicated this has not occurred. There is no dedicated wing for such placement at this facility.

Corrective Action: Add language to policy

Update: No policy was provided supporting that the provisions will be followed.

REPORTING

Standard 115.251: Resident reporting

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☐ Yes ☒ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☐ Yes ☒ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☐ Yes ☒ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☐ Yes ☒ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☐ Yes ☒ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☐ Yes ☒ No

115.251 (c)

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interviews with residents
- Interview random staff
- Outside organization who will accept allegations from residents, allow them to remain anonymous and transmit the allegation back to the agency immediately – check with the parole officer
- FAQ

Corrective Action Needed:
Update policy to include standard language. I still need to interview random staff. Written confirmation from an outside organization who will accept reports.

Random staff were interviewed. Policy was not updated.

Standard 115.252: Exhaustion of administrative remedies

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.252(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.) ☐ Yes ☐ No ☒ NA

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

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

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

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

115.252 (f)

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

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion

thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
☐ Yes ☐ No ☒ NA

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

The agency has opted to be exempt form this standard.

Corrective Action: Clients need to be informed that sexual abuse allegations on grievances forms are closed out and immediately forwarded to the investigator/local police for investigations. – Need to add to the intake information.

Update: The auditor assisted with creating an updated education form for residents which included this language. The auditor received no evidence that this form is being used.

Standard 115.253: Resident access to outside confidential support services

115.253 (a)

- 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 ☒ No

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Corrective Action Needed:
Update policy to include standard language.
Local a community victim advocate organization, attempt to obtain a MOU (documentation will be needed of the attempt or the completed MOU, I can provide an example you can model).
Put this information on the client brochure they receive at intake regarding zero tolerance.

Update: the auditor work with the facility to update the zero tolerance form to include phone numbers for the national hotline. The auditor received no evidence that this form was used. A policy update was not received.

Standard 115.254: Third-party reporting

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Corrective action required: Update policy to include standard language. Update website for a PREA page where annual reports, PREA audit reports and information for the public on how to report any information to include a specific person – PREA Coordinator

Update: No policy update was received. The auditor worked with the facility regarding updating the webpage, no evidence that this was completed was received.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

115.261 (a)

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

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

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

115.261 (b)

- 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 ☒ No

115.261 (c)

- 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 ☒ No

- 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 ☒ No

115.261 (d)

- 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 ☒ No

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy - OGD
- Interviews Random staff
- Interview with the investigator/PREA Coordinator

Policy – OGD states, POLICY
It is the policy of Operation Get Down, Inc. (hereinafter referred to as "OGD") that all staff will be able to identify individual behaviors that are to be considered sexual assault and understand their responsibilities for responding and reporting.
This policy and its procedures apply to OGD MDOC program.
PROCEDURES
A staff member who is aware of a sexual assault will interview the participants to obtain the name of the assailant.

The assailant is taken to a designated room and monitored by the security staff.

If an allegation has been made, staff must immediately contact the Treatment Program Director and Recipient Rights Advisor.

The Mental Health caseworker will assess the psychological needs and conduct harm reduction measures with the participant. The participant will be offered counseling by the therapist on record an\ or a licensed social worker

If the client has been physically violated, staff will take precautions, so the participant does not remove bedding, shower, eat or use mouthwash of any kind. All evidence of the assault must remain intact.

The participant is briefed on OGD's Zero Tolerance Policy during the intake interview. If the participant makes an allegation, the participant will be advised by the Recipient Rights Officer of the protections OGD offers against retaliation for reporting physical violations under its Zero Tolerance Policy.

If the client is afraid to remain at the treatment facility (CGC, G3 TX), the participant will be removed from the facility and placed in another PRS/PAS11 contracted residential facility with the aid of the probation officer on record.

Corrective Action Needed:
Update policy to include standard language.

Update: No updated policy was received.

Standard 115.262: Agency protection duties

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview CEO and the Residential Manager
- Interviews with random staff

The PAQ indicates there have been no instances in which a resident was subjected to substantial risk of imminent sexual abuse. The auditor found no reason to dispute this during the audit process.

The interview with the CEO and PREA Coordinator provided the auditor with assurances that anytime there was a belief that a resident was at imminent risk of sexual abuse, protective action would be taken immediately.

Corrective action required: Add language to policy.

Update: No updated policy was received.

Standard 115.263: Reporting to other confinement facilities

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview CEO
- Interviews PREA Coordinator
- Notification template

The PAQ indicates there were no allegations received that resident was abused while confined at another facility, no allegations received from another facility. The auditor found this statistic credible.

Corrective Action: Update current policy language to ensure it addresses the requirements of the standard. Complete the notification template provided.

Update: No updated policy was received. No verification of adoption of the notification form was received.

Standard 115.264: Staff first responder duties

115.264 (a)

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

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

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

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Observations
- Interviews with Random staff
- Interviews with the President/CEO
- PAQ

The PAQ indicates there was no allegation that a resident was sexually abused, zero allegations allowing for the collection of evidence.

OGD states, POLICY
It is the policy of Operation Get Down, Inc. (hereinafter referred to as "OGD") that all staff will be able to identify individual behaviors that are to be considered sexual assault and understand their responsibilities for responding and reporting.
This policy and its procedures apply to OGD MDOC program.
PROCEDURES

A staff member who is aware of a sexual assault will interview the participants to obtain the name of the assailant.

The assailant is taken to a designated room and monitored by the security staff.

If an allegation has been made, staff must immediately contact the Treatment Program Director and Recipient Rights Advisor.

The Mental Health caseworker will assess the psychological needs and conduct harm reduction measures with the participant. The participant will be offered counseling by the therapist on record an\ or a licensed social worker

If the client has been physically violated, staff will take precautions, so the participant does not remove bedding, shower, eat or use mouthwash of any kind. All evidence of the assault must remain intact.

If the client is afraid to remain at the treatment facility (CGC, G3 TX), the participant will be removed from the facility and placed in another PRS/PAS11 contracted residential facility with the aid of the probation officer on record.

Corrective Action Required:
Update current policy language to ensure it addresses the requirements of the standard.
Update: No updated policy was received.

Standard 115.265: Coordinated response

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:
- Policy - OGD
- Random staff interviews

OGD states, POLICY
It is the policy of Operation Get Down, Inc. (hereinafter referred to as "OGD") that all staff will be able to identify individual behaviors that are to be considered sexual assault and understand their responsibilities for responding and reporting.
This policy and its procedures apply to OGD MDOC program.
PROCEDURES

A staff member who is aware of a sexual assault will interview the participants to obtain the name of the assailant.

The assailant is taken to a designated room and monitored by the security staff.

If an allegation has been made, staff must immediately contact the Treatment Program Director and Recipient Rights Advisor.

The Mental Health caseworker will assess the psychological needs and conduct harm reduction measures with the participant. The participant will be offered counseling by the therapist on record an\ or a licensed social worker

If the client has been physically violated, staff will take precautions, so the participant does not remove bedding, shower, eat or use mouthwash of any kind. All evidence of the assault must remain intact.

If the client is afraid to remain at the treatment facility (CGC, G3 TX), the participant will be removed from the facility and placed in another PRS/PAS11 contracted residential facility with the aid of the probation officer on record.

Corrective Action Required:
Update current policy language to ensure it addresses the requirements of the standard. Develop an incident checklist.

Update: No updated policy was received. An updated Coordinated Response Plan was developed with the facility. The auditor received no evidence that it has been adopted for use.

Standard 115.266: Preservation of ability to protect residents from contact with abusers

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

This agency/facility does not use unionized staff; therefore the standard is not applicable – compliant.

Standard 115.267: Agency protection against retaliation

115.267 (a)

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

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

115.267 (b)

- 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 ☒ No

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy - OGD
- Observations:
- Interview with the CEO
- Interview with the Designated staff member charged with monitoring for retaliation – Director of Quality
- Interview with the Case Manager
- PAQ

The PAQ indicates there have been no instances of retaliation. The auditor found no reason to dispute this during the audit process. There have been no reported allegations of sexual abuse and sexual harassment.

PROTECTING THE RECIPIENT FROM RETALIATION AND HARM

POLICY – OGD,

It is the policy of Operation Get Down, Inc. (hereinafter referred to as "OGD") to protect the participant.

PURPOSE

A staff member who is aware of a sexual assault will interview the participants to obtain the name of the assailant.

The assailant is taken to the Multipurpose Room on the first floor and monitored by the security staff.

If an allegation has been made, staff must immediately contact the Program Director and/or Recipient Rights Advisor.

A Mental Health qualified caseworker will assess the psychological needs and conduct harm reduction measures with the participant. The participant will be offered counseling by the therapist on record an\or a licensed social worker

If the client has been physically violated, staff will take precautions, so the participant does not remove bedding, shower, eat or use mouthwash of any kind. All evidence of the assault must remain intact.

The participant is briefed on OGD's Zero Tolerance Policy during the intake interview. If the participant makes an allegation, the participant will be advised by the Recipient Rights Officer of the protections OGD offers against retaliation for reporting physical violations under its Zero Tolerance Policy.

If the client is afraid to remain at OGD, the participant will be removed from the facility and placed in another PRS/PA511 contracted residential facility or its equivalent with the aid of the Supervising Agent on record.

Corrective Action Required:
Update current policy language to ensure it addresses the requirements of the standard. A Retaliation Form was provided for use by the facility.

Update: No updated policy was received. No evidence that the form would be used for this requirement was provided.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) ☐ Yes ☒ No ☐ NA

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

criminal OR administrative sexual abuse investigations. See 115.221(a).)
☐ Yes ☐ No ☒ NA

115.271 (b)

- 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 ☒ No

115.271 (c)

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

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

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

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

- 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 ☒ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☐ Yes ☒ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) ☐ Yes ☒ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview with the CEO
- Interviews Investigative staff (administrative, sexual harassment allegations)
- PAQ

The PAQ indicates there have been no substantiated allegations referred for criminal prosecution since the implementation of the PREA standards.

Corrective Action Required:
Update current policy language to ensure it addresses the requirements of the standard. Develop an incident checklist.

Update: No updated policy was received. No evidence of use of a consistent format for investigations was received. A recommendation for this had been provided.

Standard 115.272: Evidentiary standard for administrative investigations

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☐ Yes ☒ No

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy - OGD
- Interviews with the investigator(s)/PREA Coordinator

Corrective Action Required:
Update current policy language to ensure it addresses the requirements of the standard.

Update: No updated policy was received.

Standard 115.273: Reporting to residents

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☐ Yes ☒ No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☐ Yes ☒ No ☐ NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☐ Yes ☒ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☐ Yes ☒ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☐ Yes ☒ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☐ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interview with the CEO

- PAQ

The PAQ indicates the following: There have been zero investigations of alleged sexual abuse completed by an outside agency

Corrective Action:
Update policy to include the requirements of the standard, develop a notification form which I can provide template.

Update: No updated policy was received. A notification form was provided for use and adoption. No evidence of adopting this form was received.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☐ Yes ☒ No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☐ Yes ☒ No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☐ Yes ☒ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☐ Yes ☒ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☐ Yes ☒ No

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Policy - OGD
- Interviews with the PREA Coordinator
- PAQ

The PAQ indicates there have been zero staff who have been disciplined for violation of agency sexual abuse or sexual harassment policies, one staff who had been reported to law enforcement and licensing bodies following resignation for violating agency sexual abuse or sexual harassment policies.

Corrective Action:
Add standard language to policy and/or other HR documentation.

Update: No updated policy was received.

Standard 115.277: Corrective action for contractors and volunteers

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☐ Yes ☐ No ☒ NA
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☐ Yes ☐ No ☒ NA
-
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☐ Yes ☐ No ☒ NA

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☐ Yes ☐ No ☒ NA
-

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interviews PREA Coordinator
- Interview with CEO
- PAQ

The PAQ indicates there have been no contractors or volunteers who have been reported to law enforcement and/or relevant licensing bodies. The auditor found no reason to dispute this during the audit process.

OGD does not use volunteers or contractual staff for the delivery of services. All services provided to clients are through community providers. Therefore, this standard is not applicable – compliant.

Standard 115.278: Interventions and disciplinary sanctions for residents

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☐ Yes ☒ No

115.278 (b)

- 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 ☒ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☐ Yes ☒ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☐ Yes ☒ No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☐ Yes ☒ No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☐ Yes ☒ No

115.278 (g)

- If the agency prohibits all sexual activity between 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 ☒ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interviews PREA Coordinator
- Interview with the CEO

The PAQ indicates there have been no administrative or criminal findings of guilt for resident-on-resident sexual abuse during the audit reporting period. The auditor found no reason to dispute this during the audit process.

Corrective Action:
Update policy to include the requirements of the standard, provide additional information on how sanctions are issued.

Update: No updated policy was received.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☐ Yes ☒ No

115.282 (b)

- 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 ☒ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☐ Yes ☒ No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☐ Yes ☒ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☐ Yes ☒ No

Auditor Overall Compliance Determination

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

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

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

The auditor gathered, analyzed and/or retained the following evidence related to this standard:

- Interviews with staff

Corrective Action:
Standard language needs to be added to policy, noting how the services will be provided.

Update: No updated policy was received.

Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☐ Yes ☒ No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☐ Yes ☒ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☐ Yes ☒ No

115.283 (d)

- 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.*) ☐ Yes ☐ No ☒ NA

115.283 (e)

- 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.*) ☐ Yes ☐ No ☒ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☐ Yes ☒ No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☐ Yes ☒ No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Resident abusers would not receive a mental health evaluation as they would be terminated from the program for any sexually abusive behavior.

Corrective Action required: Standard language needs to be added to policy, noting that all continuation of care will be addressed through community providers.

Update: No updated policy was received.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☐ Yes ☒ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☐ Yes ☒ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☐ Yes ☒ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☐ Yes ☒ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☐ Yes ☒ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☐ Yes ☒ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☐ Yes ☒ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☐ Yes ☒ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☐ Yes ☒ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☐ Yes ☒ No

Auditor Overall Compliance Determination

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

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

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

No sexual abuse allegations have occurred during the audit review period.

Corrective Action: Standard language needs to be added to policy and a template form developed for the sexual incident reviews to ensure the data is collected in accordance with the requirements of the standard.

Update: No updated policy was received. A form for sexual abuse incident reviews was developed for use; the auditor received no evidence that the facility adopted it for use.

Standard 115.287: Data collection

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☐ Yes ☒ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☐ Yes ☒ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☐ Yes ☒ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☐ Yes ☒ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☐ Yes ☒ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Corrective Action: Standard language needs to be added to policy and a template form developed for the annual report to ensure the data is collected in accordance with the requirements of the standard.

Update: No updated policy was received. A template was developed for use; the auditor received no evidence that the facility adopted it for use.

Standard 115.288: Data review for corrective action

115.288 (a)

- 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 ☒ No
- 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 ☒ No
- 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 ☒ No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☐ Yes ☒ No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☐ Yes ☒ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☐ Yes ☒ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Corrective Action: Standard language needs to be added to policy and a template form developed for the annual report to ensure the data is collected in accordance with the requirements of the standard.

Update: No updated policy was received. A template was developed for use; the auditor received no evidence that the facility adopted it for use.

Standard 115.289: Data storage, publication, and destruction

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☐ Yes ☒ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☐ Yes ☒ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☐ Yes ☒ No

115.289 (d)

- 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 ☒ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☒ **Does Not Meet Standard** (*Requires Corrective Action*)

This standard has the following requirements: (a) The agency shall ensure that data collected pursuant to § 115.287 are securely retained. (b) The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means. (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. (d) 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.

Corrective Action: Standard language needs to be added to policy and a template form developed for the annual report to ensure the data is collected in accordance with the requirements of the standard.

Update: No updated policy was received. A template was developed for use; the auditor received no evidence that the facility adopted it for use.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☐ Yes ☒ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

This was the first PREA certification audit for this facility.

Standard 115.403: Audit contents and findings

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY 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 that there has never been a Final Audit Report issued.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

AUDITOR CERTIFICATION

I certify that:

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

☒ No conflict of interest exists with respect to my ability to conduct an audit of the

agency under review, and

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

Amy J. Fairbanks
Auditor Signature **Date March 22, 2023**