

PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

NATIONAL
PREA
RESOURCE
CENTER



BJA
Bureau of Justice Assistance
U.S. Department of Justice

Name of Facility: Perry Multi-County Juvenile Facility	
Physical Address: 1625 Commerce Drive, New Lexington, OH 43764	
Date report submitted: 7/17/14	
Auditor information: Shirley L. Turner	
Address: 3199 Kings Bay Circle	
Email: shirleyturner3199@comcast.net	
Telephone number: 678-895-2829	
Date of facility visit: 6/18-19/14	
Facility Information	
Facility Mailing Address: same as above	
Telephone Number: (740) 342-9700	
The Facility is:	<input type="checkbox"/> Military <input checked="" type="checkbox"/> County <input type="checkbox"/> Federal
	<input type="checkbox"/> Private for profit <input type="checkbox"/> Municipal <input type="checkbox"/> State
	<input type="checkbox"/> Private not for profit
Facility Type:	<input type="checkbox"/> Detention <input checked="" type="checkbox"/> Correction <input type="checkbox"/> Other:
Name of PREA Compliance Manager: Steve Koenig; Karen Lucas Title: Dir.; Compliance Mgr.	
Email Address: steve.koenig@pmcjf.com ; karen.lucas@pmcjf.com Telephone Number: (740) 342-9700	
Agency Information	
Name of Agency: same as above	
Governing Authority or Parent Agency: Perry Multi-County Juvenile Facility Governing Board	
Physical Address: 1625 Commerce Drive, New Lexington, OH 43764	
Mailing Address: same as above	
Telephone Number: (740) 342-9700	
Agency Chief Executive Officer	
Name: Kandy Humphrey	Title: Board President
Email Address: khumphrey@lcounty.com	Telephone Number: (740) 403-7923
Agency Wide PREA Coordinator:	
Name: NA	Title:
Email Address:	Telephone Number:

AUDIT FINDINGS

NARRATIVE:

The Perry Multi-County Juvenile Facility (PMCJF) is a community treatment facility funded by the Ohio Department of Youth Services (ODYS) located in New Lexington, Ohio. It provides a treatment program, in a secure setting, for male juvenile offenders who have committed felony offenses and have a suspended commitment to ODYS. The facility serves eight core counties that include Coshocton; Delaware; Fairfield; Knox; Licking; Morgan; Muskingum; and Perry. The medium custody level program focuses on alcohol and drug intervention and involvement of the family in the treatment process. Program services are also provided for residents who do not have substance abuse issues. Residents are involved in treatment groups daily, focusing on various topics relevant to their treatment.

There are four phases within the program where treatment goals and services are identified for each phase. Residents complete an application to advance to the next phase when they feel they have achieved the goals of their current phase. The residents must obtain at least 85% of their treatment goals prior to advancing to the next phase. Decisions for advancement are made by the administrative treatment team. The age range of the residents is 12 to 18 years old and the average length of stay is approximately six to eight months. Thirty-three staff members and two contract staff have been employed at the facility during the past 12 months.

The residents spend approximately six hours per day in school. The education staff is provided by the New Lexington High School through the Muskingum/Perry County Education Servicing Commission. The facility collaborates with Hocking College for substance abuse treatment services. The director of the collaboration, a contractor, also provides individual, group and family treatment and supervises the Chemical Dependency Counselor Assistant interns. The other contractor who has contact with the residents is the physician; he is on-site at least once a month and as needed.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The PMCJF is located on five acres and consists of one main building, a garage and a storage bend. Cameras are located both inside and outside of the building and may be viewed at the central control area and in the Director's office. All camera activity is recorded. The designed facility capacity is 20.

The door from the lobby into the building is a secure door that is kept locked at all times. The intercom, located at the lobby door that leads to central control and other areas of the building, must be used in order to gain entrance into the primary areas of the building. The main building consists of administrative offices; kitchen; dining area; central control; three single cell housing units; one segregation cell; gymnasium; medical clinic that also contains a shower/bathroom; two classrooms; conference room; and storage rooms. There is a fenced outside recreation area. Bathrooms and showers are located in each unit and residents use them one at a time. A chime has been placed at the entry of the shower and it is activated each time a person enters the bathroom/shower area.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various parts of the facility at least six weeks prior to the on-site audit. Photographs were taken of the various sites where the notices had been posted and electronically sent to this Auditor, noting the locations.

The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive, which was received approximately four weeks prior to the on-site audit. After reviewing the information, notes were sent to the PREA Coordinators and a conference call was held. In response to the issues discussed in the conference call, additional documents were submitted as requested. Additionally, clarity of information was provided; revisions were made to various documents; and corrective actions were discussed that were implemented prior to the on-site audit.

The on-site audit was conducted June 18-19, 2014 and Flora Boyd, Certified PREA Auditor, served as the assistant to this Auditor. An entrance meeting was held, followed by a comprehensive tour of the facility. During the tour, staff members were observed to be interacting with residents and providing direct supervision. Cameras are strategically placed throughout the facility and all camera activity is recorded.

Randomly selected staff, specialized staff and residents were interviewed. The interviews of staff and residents revealed that both groups have been involved in PREA training. Staff members were interviewed from all shifts. The residents interviewed readily responded to the questions asked. Contact was made with the victim advocacy service by this Auditor, prior to the on-site visit, and the representative's responses were aligned with the information contained in the Memorandum of Understanding. It was also stated that no phone calls had been received from PMCJF requesting services.

The information for the audit process was provided in a well-documented manner on the flash drive and additional documentation was sent as needed. Documentation needed during the on-site audit was obtained immediately. A close-out meeting was held at the conclusion of the second day and a summary of the audit findings was provided. The corrective actions that have been implemented are discussed under the applicable standard.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment.

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

The Perry Multi-County Juvenile Facility's PREA policies are contained in the facility's policy and procedure manual in Chapter 6.0, Prison Rape Elimination Act (PREA). The policies in Chapter 6.0 provide guidelines for implementing the agency's approach to complying with the requirements of the PREA standards including, zero tolerance toward all forms of sexual abuse and sexual harassment.

The facility Director officially served as the PREA Coordinator for this audit cycle and was assisted by the Compliance Coordinator. A corrective action was implemented on March 1, 2014 to reorganize management positions to create the new position of Compliance Manager. While the creation of the new position provides for other duties it also allows for sufficient time for the management of PREA compliance. On July 1, 2014 all compliance issues, including PREA, became the responsibility of the Compliance Manager.

Standard 115.312 Contract with other entities for the confinement of residents.

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

This standard is not applicable. The facility does not contract with other entities for the confinement of residents.

Standard 115.313 Supervision and Monitoring

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

Does Not Meet Standard (requires corrective action)

Policy and Procedure Manual Chapter 3.0, Supervision section, requires a staffing plan that provides for adequate staffing levels with ratios of at least 1: 8 during resident waking hours and at least 1: 16 during the resident sleeping hours. There have not been any deviations from the staffing plan during this audit cycle. A review of documents showed that an Annual Staffing, Supervision and Monitoring Review had been conducted, by the Compliance Manager in collaboration with the Director. The Policy also requires intermediate or higher level staff to conduct unannounced rounds. A review of completed Vulnerability Assessment forms, staff interviews and a view of camera images confirmed that the rounds occur in accordance with the standard.

Standard 115.315 Limits to cross gender viewing and searches

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Policy Chapter 3.0, Supervision, prohibits cross-gender strip searches and cross-gender visual body cavity searches of residents. All body cavity searches are prohibited. Policy and procedures have been implemented that provide for one resident to shower at a time. A buzzer has been installed at the shower to indicate when someone has entered the shower.

According to the policy, cross-gender pat-down searches are only permitted in exigent circumstances. All security/direct care staff members have been trained on conducting cross-gender pat-down searches and searches of transgender and intersex residents. The policy also states that staff shall not search a transgender or intersex resident to determine the resident's genital status.

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

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Resident Screening and Housing Policy provides details for disabled residents to have an equal opportunity to receive the information on how to prevent, detect, and respond to sexual abuse and sexual harassment. Resident interpreters or readers are not allowed; age appropriate materials are provided; and staff assists residents with limited reading skills. Interpreters may be provided through the referring court.

The facility has a letter from the Regional Site Manager of the Muskingum Valley Educational Service Center's Regional Office for the Perry-Hocking County area verifying the provision of support services. The letter states that the Center has the means to provide an Interpreter, Hearing Impaired Specialist; Vision Impaired Specialist; Audiologist; ESL Specialist, equipment, technology, or other needs for a student with hearing impairment, vision impairment and English language learners.

Standard 115.317 Hiring and promotion decisions

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

The PMCJF adheres to the guidelines in the Personnel Policy in Chapter 1.0. The policy prohibits hiring, promoting or contracting with anyone who has been convicted of engaging in any activity prohibited within the standard. A review of the policy, interviews with staff and a review of documentation shows that background checks are performed in accordance with the standard. Eighteen staff members have been hired in the past 12 months who received a background records check.

Standard 115.318 Upgrades to facilities and technology

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

The camera system has been updated since August 2012. Cameras are strategically located inside and outside of the facility. All staff may monitor current activities for any camera from the central control desk. Recorded video may be accessed from the Director's office by the Director, Compliance Manager, and Supervisors. Videos may be retained in the server 30-40 days, depending on the amount of information stored. Requests for future improvements include additional cameras in the gymnasium and the outdoor recreation area.

Standard 115.321 Evidence protocol and forensic medical examinations

- Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The PMCJF conducts administrative investigations and a Memorandum of Understanding (MOU) exists stating that the Perry County Sheriff's Department will conduct criminal investigations. According to the MOU, the investigators from the Sheriff's office will use a uniform evidence of protocol and it states that they have received special training in sexual abuse investigations that involve juvenile victims.

Access to forensic medical examinations will be provided by Genesis Healthcare System and Nationwide Children's Hospital. There is a written Transfer Agreement between PMCJF and Genesis Healthcare System that says that Genesis will provide the services of a Sexual Assault Nurse Examiner to residents as needed. There has not been a need for forensic medical exams during this audit period.

The facility has a MOU with Family Health Services of East Central Ohio for victim advocacy services. The MOU states that, upon request, a victim advocate will accompany and support the victim through the medical examinations and the investigatory interview processes and provide emotional support, crisis intervention, information, and referrals. A Case Manager at the PMCJF has received a training certificate documenting completion of training for Victim Assistance. The facility provides for the trained Case Manager to provide support services, as needed and as requested by the victim, if there is an incident of sexual abuse.

Standard 115. 322 Policies to ensure referrals of allegations for investigations

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Response Policy provides for an administrative or criminal investigation to be completed for all allegations of sexual abuse and sexual harassment. Two allegations of sexual abuse were reported by residents during the past 12 months. A review of documentation and staff interviews showed that an administrative investigation was conducted for each allegation. The investigation included interviews and a review of the camera images. One allegation was determined to be unfounded and the other findings were that the allegations were unsubstantiated. There were no allegations referred to the Sheriff's Office for criminal investigation.

Standard 115.331 Employee training

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Training and Staff Development Policy provides for the PREA training. The staff training is comprehensive and covers all of the key areas referenced in the standard: zero tolerance policy; sexual abuse and sexual harassment prevention, detection, response, and reporting; resident's rights to be free of sexual abuse and sexual harassment; dynamics of sexual harassment and sexual assault; avoiding inappropriate relationships with residents; and detecting and responding to signs of threatened and actual sexual abuse. PREA training is provided annually and staff training rosters, certificates, and signed acknowledgement forms are maintained. Interviews with staff confirmed that the training is provided.

Standard 115. 332 Volunteer and contractor training

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Training and Staff Development Policy provides for PREA training for volunteers and contractors on their responsibilities according to the PREA standards. The facility's zero tolerance policy is reviewed with all contractors and volunteers and, where specialized training is not required, they view the video by the National Institute of Corrections, Keeping Our Kids Safe. Documentation is maintained and interviews confirm that the training occurs.

Standard 115.333 Resident education

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

According to the Resident Screening and Housing Policy, staff explains the zero tolerance policy to the residents during the intake process and reviews the resident education

information. Residents sign an acknowledgement statement indicating that they have received the training. In addition to the training being conducted during intake, a resident education session is held quarterly. All residents are required to attend, even if they have had a PREA education session previously. Staff and resident interviews, review of the resident education curriculum, and signed training acknowledgement forms by the residents, confirmed that the training occurs. The facility provides PREA information to residents through informative posters, resident handbook and other written information.

The Regional Site Manager of the Muskingum Valley Educational Service Center's Regional Office for the Perry-Hocking County area has informed the management staff that her agency has the means to provide support services for students with hearing impairment, vision impairment and English language learners.

Standard 115.334 Specialized Training: Investigations

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

Administrative investigations are conducted at the PMCJF. The Policy, Prohibitions and Employee Education, provides for employees who conduct administrative investigations to receive specialized training. Staff has completed the online course, PREA: Investigating Sexual Abuse in a Confinement Setting, through the National Institute of Corrections. Criminal investigations will be conducted by the Perry County Sheriff's Office, in accordance with the signed MOU.

Standard 115.335 Specialized training: Medical and mental health care

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

The policy, Training and Staff Development, provide for specialized training for medical and mental health staff. The records reviewed and staff interviews confirmed that they received the required training. Medical staff at the PMCJF does not conduct forensic examinations.

Standard 115.341 Screening for risk of victimization and abusiveness

- Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The policy, Resident Screening and Housing, requires that all residents are screened for risk of victimization and abusiveness within 24 hours of intake. The screening is conducted using an objective instrument that ascertains the information prescribed in the standard. The resident may be re-assessed periodically through the weekly administrative/treatment meetings.

Standard 115. 342 Use of screening information

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Resident Screening and Housing Policy, provides that the information used from the objective screening instrument be used to help determine housing and program assignments with the goal of keeping all residents safe. The policy prohibits placing lesbian, gay, bisexual, transgender or intersex residents in specific housing or other assignments solely based on how they self-identify or their status.

Standard 115. 351 Resident Reporting

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Reporting Policy provides for internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violations that led to sexual abuse. A resident may file a grievance; talk to any staff member; and third parties may report allegations to staff. The completed grievance may be placed in a locked box and the policy states that writing tools are available in the housing unit and the school. The facility has a MOU with the Family Health Services of East Central Ohio for the provision of advocacy services and a Case Manager on staff that has training in Victim Services.

During the review of the Pre-Audit Questionnaire, it was discovered that access to the hotline to report allegations of abuse required staff assistance and this was discussed on the follow-up conference call. A corrective action was implemented prior to the on-site audit and phones were placed in the housing units on a desk along with the hotline number, providing the residents direct access to the phone for reporting allegations of sexual abuse. The hotline number is highlighted with the same color as the button on the phone that, when pushed, directly connects to the support services.

Standard 115.352 Exhaustion of administrative remedies

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The PMCJF has policy that addresses the grievance process and information is provided to the resident in a brochure and on the back of the grievance form located near the grievance box in the housing unit. The grievance process includes the filing of an emergency grievance where there is an initial response to the resident within 24 hours and when there is an appeal, a final decision is made within five days. The resident has the option to give the emergency grievance to a staff member, place it in the Director's box located in the hall, or place it in the regular grievance box located in the housing area.

Corrective actions were put in place during the on-site audit regarding the grievance process. The grievance boxes were moved due to them being located in an area of the housing unit where residents had to ask staff's permission to enter. The re-location of the boxes provides the residents with direct access to place their grievances in the box without asking permission to enter the area where the boxes are located. The grievance form was also revised to indicate that if the grievance is an emergency, indicating a PREA issue, the instructions to the resident is that he only needs to check that box on the form indicating such. The form may then be placed in one of the locked boxes or given to a staff member without the resident completing the other requested information.

Standard 115.353 Resident access to outside confidential support services

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The facility has a MOU with the Family Health Services of East Central Ohio that outlines the advocacy services to be provided. The residents are given the contact information in a brochure they receive regarding PREA issues, resident handbook, and posters that are placed in areas of the facility occupied by residents. According to the advocacy personnel, there have been no calls from the PMCJF requesting services.

Residents are informed through the resident handbook and verbally by staff of the limitations of confidentiality of outside support services. The residents have confidential access to attorneys and their parents/legal guardians. These practices were confirmed by a review of documents and interviews with staff and residents.

Standard 115.354 Third-party reporting

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Reporting Policy, contains information about third party reporting. According to the Policy, facility staff will receive third party reports regarding sexual abuse and sexual harassment. Information regarding how to report allegations of sexual abuse is posted on the website in the document, Safety Letter. There is a link on the website to the Director for a user to send a message directly to him. Additionally, a pamphlet for parents/legal guardians also provides information on reporting allegations of sexual abuse.

Standard 115.361 Staff and agency reporting duties

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Reporting Policy provides for staff to immediately report any suspicion, knowledge, or information regarding sexual abuse or sexual harassment that occurred at the PMCJF or another facility. Additionally, staff must report any retaliation against a resident or another staff member due to them reporting an incident. The facility complies with the mandated reporting law.

Standard 115.362 Agency protection duties

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

The Policy, Protection from Imminent Harm and Retaliation, provides for protection measures such as housing changes and facility transfers of alleged victims or alleged abusers. During this audit period, the facility did not determine that any resident was subject to substantial risk of imminent sexual abuse. Interviews with staff confirmed their knowledge of their duties regarding risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

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

The Reporting policy states that upon receiving an allegation that a resident was sexually abused while confined in another facility, the Director will notify the head of that facility within 72 hours. The Director will ensure that the allegations are investigated according to the PREA standards. In the past 12 months, there have not been any allegations of sexual abuse occurring in another facility.

Standard 115.364 Staff first responder duties

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

Chapter 6 contains policies that detail the staff first responder duties in accordance with the PREA standard and according to the training curriculum. The policy provides information for security and non-security staff. The facility reports that in the past 12 months there were two allegations of sexual abuse. Both allegations were investigated administratively by facility staff, including a review of camera footage and interviews. The findings were that one was unfounded and the other unsubstantiated. There was no physical evidence involved.

Standard 115.365 Coordinated response

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

The Response Policy addresses this standard. There is a charted response for staff, Plan for Coordinated Response to Sexual Abuse or Assault. This Plan outlines the roles of facility staff and includes the role of medical support at the local hospital regarding forensic exams and also shows the role of the Perry County Sheriff's Office.

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

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

This standard is not applicable. The PMCJF does not maintain any collective bargaining agreements.

Standard 115.367 Agency protection against retaliation

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

The Protection from Imminent Harm and Retaliation Policy provides for the protection against retaliation for residents and staff who report allegations of sexual abuse, sexual harassment or cooperate with related investigations. The Director, Clinical Director and Compliance Manager are identified by the Policy as monitors of possible retaliation. The monitoring occurs for at least 30 days and longer if it is determined that it is needed. According to staff interviews, there has been no incident of retaliation within the past 12 months. Two forms, Sexual Abuse and Sexual Harassment Retaliation Status Check and Sexual Abuse and Sexual Harassment Retaliation Monitoring Checklist, have been developed to document the retaliation process and monitoring activities.

Standard 115.368 Post allegation protective custody

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Policy, Protection from Imminent Harm and Retaliation, allows for residents to be placed in isolation as a last resort and until alternative measures can be arranged. According to the Policy, a resident in isolation or segregated housing will get the services required as stated in the standard. The facility has a watch room that is used to isolate a resident for closer observation. The room is located in the central control area outside of the housing units for direct viewing by staff.

During the on-site audit tour it was observed that the observation window in the watch room door was long and wide for the times when a reasonable amount of privacy is expected. A corrective action was implemented and completed shortly after the on-site audit. A magnetic privacy screen was ordered and applied to the lower part of window, modifying the extent of the observation. The magnetic screen can be removed when needed. A picture was taken at different angles with the screen attached to the window and electronically sent to this Auditor.

Standard 115.371 Criminal and administrative agency investigations

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Response Policy addresses administrative and criminal investigations. Administrative investigations are conducted by the Director, Compliance Manager and two Supervisors. Criminal investigations will be conducted by the Perry County Sheriff's Department. A review of documentation show that investigations are not terminated solely because the source of the allegation recants the allegation. No allegations have been referred for criminal investigations. The four administrative investigators have received the training, PREA: Investigating Sexual Abuse in a Confinement Setting, through the National Institute of Corrections.

Standard 115.372 Evidentiary standards for administrative investigations

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Response Policy states that the facility imposes a standard of a preponderance of the evidence for determining whether allegations of sexual abuse or sexual harassment are substantiated. Reviewed documentation and staff interviews verified this practice.

Standard 115.373 Reporting to residents

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Response Policy requires that a resident who makes an allegation of sexual abuse be informed verbally or in writing whether or not the findings of the investigation are determined to be substantiated, unsubstantiated or unfounded. Two administrative investigations were completed by facility staff during this audit period; the findings were that one was unfounded and the other was unsubstantiated. A review of the documentation revealed that the policy is followed. During the past 12 months there has not been a substantiated or unsubstantiated allegation of sexual abuse committed by staff against a resident.

Standard 115.376 Disciplinary sanctions for staff

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Discipline Policy provides for staff disciplinary sanctions up to and including termination for violating the zero tolerance policy regarding sexual abuse or sexual harassment. The management staff reports that in the past 12 months, there has not been a staff member to violate the policies related to sexual abuse or sexual harassment.

Standard 115.377 Corrective action for contractors and volunteers

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Discipline policy addresses the corrective actions regarding any contractor or volunteer engaging in sexual abuse of residents. During the past 12 months, the management staff reports that no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse.

Standard 115.378 Disciplinary sanctions for residents

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Discipline Policy states that residents are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the resident engaged in resident-on-resident sexual abuse. It is reported that during the past 12 months, there have not been administrative findings of resident-on-resident sexual abuse or criminal findings of guilt of resident-on-resident sexual abuse.

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

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Resident Screening and Housing Policy requires a follow-up meeting with a medical or mental health practitioner, within 14 days, when the resident discloses any prior incidents of sexual victimization. Staff maintains records documenting the provision of any follow-up services.

Standard 115.382 Access to emergency medical and mental health services

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Response Policy includes that each victim will be provided the required medical examinations and services, free of charge, by qualified staff. The policy addresses the access to emergency medical and mental health services.

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

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

According to the Access to Care Policy, the facility offers medical and mental health evaluations and, where indicated, treatment to all residents who have been victimized by sexual abuse in a facility. The Policy provides that medical tests and mental health evaluations be provided in accordance with the standard.

Standard 115.386 Sexual abuse incident reviews

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Incident Review Policy provides for a team to review all incidents within 30 days of the conclusion of the investigation. A review of documentation showed that incident reviews were held after administrative investigations. A form is used, Sexual Abuse and Sexual Assault Incident Review Checklist. The form requires the notation of those in attendance, including Investigator(s) from the Sheriff's Office where applicable, and highlights the requirements of the standard for discussion and review.

Standard 115.387 Data collection

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

The Data Policy and practice provides for the collection of uniform data for allegations of sexual abuse using a standardized instrument and a set of definitions. A review of the report showed that the data is reviewed and collected from incident-based documents and in accordance with the standard.

Standard 115.388 Data review for corrective action

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

According to the Data Policy and staff interviews, the data will be reviewed to identify and address any opportunities for improvement related to staff training; resident education; and policies and procedures related to sexual abuse prevention. A report has been prepared and approved by the Director. A review of documentation revealed a corrective action plan has been developed for various areas in order to comply with the standards.

Standard 115.389 Data storage, publication and destruction

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

According to the Data policy, the information will be gathered and reported at least annually as required. A review of the report showed that there are no personal identifiers on the document. According to the Policy, the data collected will be maintained according to the standard.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

Shirley L. Turner
Auditor Signature

July 17, 2014
Date