PREA AUDIT: AUDITOR'S SUMMARY REPORT
COMMUNITY CONFINEMENT FACILITIES

FINAL REPORT			
Name of facility: ICCS - WEST			
Physical address: 11500 West Security Avenue, Lakewood, CO 80215			
Date report submitted: August 21, 2015			
Auditor Information			
Address: PO Box 732 Benicia, CA 94510-0732			
Email: eiw@comcast.net			
Telephone number: (707) 333-8303			
Date of facility visit: July 22nd thru July 24th, 2015			
Facility Information			
Facility mailing address: *(if different from above)*			
Telephone number: (303) 407-6200			
The facility is:	☐ Military	☐ County	Federal
	☐ Private for profit	☐ Municipal	State
	■ Private not for profit		
Facility Type:	☐ Community treatment center ☐ Halfway house Alcohol or drug rehabilitation center	■ Community based confinement facility ☐ Mental health facility	Other:
Name of Facility Head: Kristin Heath		**Title: Director**	(303)
Email address: kheath@int-iccs.org		**Telephone number:**	407-6225
Name of PREA Compliance Manager (if applicable): N/A		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of agency: Intervention Community Corrections Services (ICCS)			
Governing authority or parent agency: *(if applicable) N/A*			
Physical address: 1651 Kendall Street, Lakewood, CO 80214			
Mailing address: *(if different from above)*			
Telephone number: (303) 232-4002			
Agency Chief Executive Officer			
Name: Gregg Kildow	**Title:**	Executive Director	

Email address: gkildow@int-iccs.org	Telephone number:	(720) 544-5559
Agency-Wide PREA Coordinator		
Name: Joe Clark	**Title:**	PREA Coordinator
Email address: jclark@int-iccs.org	**Telephone number:**	(720) 544-5559

AUDIT FINDINGS

NARRATIVE:

SITE REVIEW:

An audit of the ICCS West Facility was conducted from July 22, 2015 to July 24, 2015 by a certified PREA Auditor. The following is a summary of the observations noted during the facility tour and a description of the audit process:

Staff accompanying Auditor during tour:

Joe Clark – PREA Coordinator
Kristin Ritter – Security Supervisor
Kristen Heath – Program Director
Brian Hulse – Quality Assurance
Nicole Levine – Security Supervisor
Gregg Kildow – Executive Director

Receiving and Discharge (Intake) – 1st Floor

- Strip Areas (Private?): UA Bathroom located inside security can be used as strip area if required and does not allow cross-gender viewing. Person search also conducted in the security area.
- Interview Areas (Confidential): Intake interviews conducted in Security. Case managers offices used for assessment interviews
- Information Posted: PREA SIGNAGE located outside security office & additional brochures available in the hallway.
- Cameras: Multiple camera viewing located in security. Camera views of facility video technology monitoring 52 facility cameras. Video storage 45-60 days.
- Phones?: Phone booth located along hallway for residents.
- Ask for Information Provided to Offenders: Agency provided resident handbook, brochure and PREA video with PAQ. PREA brochure is provided in pamphlet holders accessible to residents, in hallway outside security office.

Staff Offices – 2nd Floor:

- Camera Placement: Numerous Case Manager offices. Additional use resident counseling. BLIND SPOT - NO CAMERAS AT ALL. CAMERAS REQUIRED FOR RESIDENT AND STAFF SEXUAL SAFETY. NO PREA SIGNAGE ALONG HALLWAY OR IN CASE MANAGER OFFICES. BLIND SPOT IN STAFF CAFETERIA OFF MAIN HALLWAY. BLIND SPOT OFF HALLWAY WHERE COPY ROOM IS LOCATED – NEED CONCAVE MIRROR TO AUGMENT ADDITIONAL CAMERA PLACEMENT.
- Utility Room: Camera placement outside back door of staff offices in hallway provides security for stairwell and elevator. CAMERA PLACEMENT OUTSIDE BACK DOOR NEAR HALLWAY, STAIRWELL AND ELEVATOR DOES NOT COVER UTILITY ROOM. BLIND SPOT – NEED LARGE MIRROR TO AUGMENT CAMERA OR RE-POSITION CAMERA PLACEMENT.

Storage Areas: 1ST floor electrical room, storage rooms & is covered with cameras & located in back hallway. No blind spots & PREA signage is available.

Living Unit: 3rd FLOOR

- PREA Information Posted?:_NO PREA SIGNAGE IN CONFERENCE ROOMS WHICH ARE ALSO USED AS COUNSELING ROOMS FOR RESIDENTS. NO PREA SIGNAGE ALONG HALLWAY WHERE RESIDENT ROOMS AND PHONES ARE LOCATED._
- Opposite Sex Viewing?:__N/A_
- Announcement: All female staff in female facility
- Camera Placement?: Multiple digital cameras cover hallway – NO BLIND SPOTS
- General Discussion with Staff (Not Interviews): Information interview with the Education director. Facility is a no-contact facility between staff and residents/residents and residents. Therapeutic environment employed.
- General Discussion with Inmates (Not Interviews): Residents indicate they feel safe in West Facility. They were informally questioned regarding knowledge of PREA and what PREA provides. Residents indicate they feel Agency is doing quite well ensuring their sexual safety.
- Phones: Resident phones located on hallway.
- Grievance Process: Grievance forms & box locatedon 1st floor.
- Showers and Bathrooms: Showers & bathrooms located in each room. They proivdefor privacy and are PREA compliant.
- Recreation Areas/TV/Multi-Purpose: Recreation/multi-purpose room is located on 1st floor which provides direct supervision from Security office.
- Living Unit: Rooms provide for 2-6 residents and provide a small living room area in the middle of the room.
- PREA Information Posted?:_NO PREA SIGNAGE IN ROOMS OR IN HALLWAYS
- Camera Placement?: Multiple digital camera placement in hallways. No cameras in resident rooms or bathrooms.
- Announcement: N/A - All female staff in female facility

Living Unit: **4th FLOOR**

- PREA Information Posted?:_NO PREA SIGNAGE IN CONFERENCE ROOMS WHICH ARE ALSO USED AS COUNSELING ROOMS FOR RESIDENTS. NO PREA SIGNAGE ALONG HALLWAY WHERE RESIDENT ROOMS AND PHONES ARE LOCATED. PREA SIGNAGE LOCATED ALONG BACK STAIRWELL.
- Camera Placement? Multiple digital cameras cover hallway – no blind spots. Cameras in all stairwells.
- Announcement: N/A - All female staff in female facility
- General Discussion with Staff (Not Interviews) Informal interview with education director. Facility is a no-contact facility between staff & residents/residents & residents. Therapeutic environment employed.
- General Discussion with Inmates (Not Interviews): Residents indicate they feel safe in West facility. They were questioned regarding knowledge of PREA and what PREA provides. Residents indicate they believe Agency is doing quite well ensuring their sexual safety.
- Phones: Resident phones located on hallway.
- Grievance Process: Grievance forms & box located on 1st floor across from security office.

Showers and Bathrooms:

- Showers & bathrooms located in each room. They provide for privacy and are PREA compliant.
- Recreation Areas/TV/Multi-Purpose: Recreation/multi-purpose room located on 1st floor.
- Living Unit: Rooms hold from 4 to 8 residents and provide small living room area in the middle of the residence rooms.
- PREA Information Posted?: NO PREA SIGNAGE IN ROOMS OR IN HALLWAYS
- Opposite Sex Viewing?: N/A
- Camera Placement? Multople digital camera placement in hallways. No cameras in resident rooms or bathrooms.
- Announcement: N/A - ALL FEMALE STAFF FOR ALL FEMALE FACILITY

Roof: 5th FLOOR

- PREA Information Posted?:_N/A_
- Opposite Sex Viewing?_N/A_
- Camera Placement?: Cameras on all stairwells.
- Supervision: Roof access door locked. Administration management & maintenance has keys. BLIND SPOT - NO CAMERAS ON ROOF. SHOULD REQUIRE KEY DRAW FOR ROOF ACCESS FOR SEXUAL SAFETY.

Laundry

- Hidden areas?: NONE
- Camera Placement: Camera located in laundry room – 1st Floor.
- PREA Information Posted?:_NO PREA SIGNAGE IN ROOMS OR IN HALLWAYS
- Supervision: Security rover on all floors in addition to video technology.

Front Entrance (Reception Area)

- PREA Information Provided: Entry hallway 1st floor. Passpoint and waiting rooms. Direct supervision provided through large windows in security office. Area is reserved for out-client services. Waiting room/reception area UA bathrooms unlocked. Cameras provde for additional security. NO PREA SIGNAGE IN SECURITY AREA. Grievance forms and facility grievance box located in document box outside the security office. Residential and staff bathroom located along hallway to elevator. All hallways covered by multiple digital cameras.

Education (ACADEMIC)

- Classrooms: Literacy lab & library.
- Camera Placement: Cameras located in all counseling and library rooms.
- PREA Information Posted?: NO PREA SIGNAGE IN ROOMS OR IN HALLWAYS
- Supervision: Education staff supervises all residents in education.
- Storage Areas: Covered by video cameras.

Food Service

- Dining Rooms: One dining room for entire facility located on the 1st floor. Direct supervision provided through large windows in the securing office. PREA SIGNAGE IN DINING AREA

- Kitchen: Multiple cameras in kitchen provide security for Aramark staff. NO BLIND SPOTS.
- Coolers: 3 small reefers covered by cameras. Bareley room for 2 persons to fit.
- Freezers: 3 small reefers covered by cameras. Bareley room for 2 persons to fit.
- Dry Goods Storage: Kept in kitchen in small storage room covered by cameras
- Garbage Area: Outside covered by cameras & direct supervision by Aramark staff when garbage is taken out.
- Dishroom: Covered by digital kitchen cameras.
- Tool Room – Small locker on the back wall, locked with Aramark staff provided with only key. Tools are counted at end of shifts & locker is covered by camera.
- Camera Placement - 3 digital cameras throughout kitchen – NO BLIND SPOTS
- PREA Information Posted?:_NO PREA SIGNAGE
- Supervision: 1 Aramark staff per 3 to 4 resident workers per feeding.

MENTAL Health Services

- Reception Area:__Covered by 1 camera.
- PREA Information Posted?:_NO PREA SIGNAGE
- Exam Rooms: N/A
- Treatment Rooms: Mental health counseling rooms

Recreation Yard

- Bathrooms: Since yard is adjacent to resident housing access, no outside bathrooms.
- Camera Placement: Digital cameras cover all areas outside of the facility – 360% coverage.
- PREA Information Posted?:_NO PREA SIGNAGE IN ROOMS OR IN HALLWAYS

Review of Documentation:
The Auditor conducted a review of 11 random sampling of residents screening files, 11 random sampling of staff 11 personnel files and 4 random sampling of contractor files to determine compliance with the PREA Standards. Auditor conducted interviews with 14 Specialized Staff, 11 random sampling of staff and 12 random sampling of residents to determine Agency & Facility compliance with the PREA Standards.

DESCRIPTION OF FACILITY CHARACTERISTICS:

ICCS West is a all-female facility located at 1500 West Security Ave Lakewood, CO 80215. The facility is central to employment and service opportunities for our clients. Higher education is available to clients at Red Rocks Community College, located approximately three miles southwest of the facility.

Opened on December 5, 2011, the building is a state of the art 25,968 square foot 4-story structure with residential rooms on the third and fourth floors. Adequate ingress and egress is available for handicapped individuals. An elevator provides access to all levels of the building. Handicap accessible restrooms are available on all floors. In addition, each residential floor has rooms that provide handicap accessible showers.

The facility is in compliance with the Colorado Community Corrections Standards.

Programs Offered at this Facility

Transition - Transition residents are referred by the Department of Corrections (DOC) and are placed at ICCS prior to their sentence discharge, release to Parole, or release to the Inmate Intensive Supervision Program, under supervision of the Department of Corrections, Division of Adult Parole and Community Corrections.

Diversion - Diversion residents are placed in the program as a condition of their probation or as a direct sentence. Diversion clients who successfully complete the residential portion of the program move to non-residential supervision where they progress toward independent living utilizing community support and services.

Non-Residential - Diversion clients who successfully complete the terms and condition of the residential program progress to the ICCS non-residential program. On this level of supervision, clients have demonstrated an acceptable level of responsibility and ability to live independently in the community. Most non-residential clients continue in prescribed treatment on an aftercare basis and many continue to pay restitution and/or participate in other activities.

Residential Dual Diagnosis Treatment (RDDT) - This program provides treatment services designed to measurably reduce recidivism, incarceration and re-incarceration for the mentally ill and substance using offender population. The RDDT program is designed to effect a complete change in lifestyle, which includes control of compulsive behaviors, elimination of criminal behavior, and the acquisition of positive attitudes, values and behaviors which reflect honesty, responsibility, non-violence, and a balanced reliance on self and others. ICCS' goal is to retain or return those offenders to the community with the ability to succeed in society as productive individuals while preserving community safety.

John Eachon Re-Entry Program (JERP) - ICCS provides services to transition and diversion clients who have been diagnosed with serious and persistent mental illness and substance abuse problems. The provision of services to JERP clients is unique as it integrates services from ICCS and the Jefferson Center for Mental Health (JCMH). Upon approval referrals may be accepted with a singular mental health diagnosis. Most JERP clients are not fully employable. The multidisciplinary approach allows the JERP clients to receive appropriate treatment, evaluation, medication, and other support services, not otherwise attainable in the community setting.

START - The Short Term Alternative Residential Treatment program (up to 90 days) is a collaborative program for Jefferson County Probation and Recovery Court clients suffering from severe and persistent mental illness and substance abuse disorders. The program is specifically designed to help those struggling with housing, mental health, and treatment options.

Condition of Parole (COP) - ICCS provides services to parolees either as a condition of their parole ordered by the State Parole Board, or as a new parolee lacking an appropriate residence in the community.

Sex Offender (SXO) - Following Sex Offender Management Board (SOMB) standards, ICCS provides residential case management, accountability oversight and "Bridge Treatment" (provided by SOMB approved providers) to offenders who are or will become involved in Sex Offense Specific Treatment. ICCS staff is part of the containment team who meet regularly to insure compliance on the part of the offender. Per SOMB ICCS staff is a part of the Containment Team.

Sex Offender Lifetime Program - Along with RSA and parole, ICCS staff travels to prisons that facilitate the Sex Offender Treatment Monitoring Program and interview potential candidates face to face. ONLY those who are thoroughly vetted by the group are allowed to progress in the screening process. The program allows a step down program for offenders that need the support to become established with a residence, treatment and employment, which enhances community safety.

Community Return to Custody Facility (CRCF) - CRCF allows non-violent class four, five and six felony parole clients, who have been revoked from parole for technical violations, the opportunity to serve their revocation term of up to 180 days in a community based facility instead of being returned to the DOC. ICCS staff and the Community Parole Officer assigned to the facility require the clients to address specific issues that led to their regression from parole.

Work Release - ICCS provides housing and monitoring services to female offenders at ICCS-West who are serving a Work Release sentence, at no additional cost to the taxpayer.

SUMMARY OF AUDIT FINDINGS:

ON JULY 20, 2015 THROUGH JULY 22, 2015, A PREA AUDIT TOUR WAS CONDUCTED AT THE ICCS WEST COMMUNITY CORRECTIONS RESIDENTIAL FACILITY, LOCATED IN LAKEWOOD COLORADO. SUMMARY OF INTERIM AUDIT FINDINGS ARE AS FOLLOWS:

Number of standards exceeded: **1**

Number of standards met: **36**

Number of standards not met: **1**

Number of standards not applicable: **1**

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #160 INCORPORATES ZERO TOLERANCE TOWARDS SEX ABUSE & SEX HARASSMENT, OUTLINES IMPLEMENTATION OF AGENCY'S APPROACH TOWARDS PREVENTING, DETECTING AND RESPONDING TO SEX ABUSE/HARASSMENT. POLICY PROVIDES DEFINITIONS OF PROHIBITED BEHAVIORS & SANCTIONS FOR THOSE FOUND TO HAVE PARTICIPATED IN PROHIBITED BEHAVIORS TO INCLUDE DESCRIPTION OF AGENCY STRATEGIES TO REDUCE AND PREVENT SEXUAL ABUSE/HARASSMENT IN ACCORDANCE WITH STANDARD PROVISION 115.211(a).

b) PREA COORDINATOR IS PLACED 2ND LEVEL DOWN FROM THE EXECUTIVE DIRECTOR OF THE AGENCY, COMPLIANT WITH PROVISION 115.211(b). INTERVIEW WITH PREA COORDINATOR INDICATES HE HAS SUFFICIENT TIME AND AUTHORITY TO DEVELOP, IMPLEMENT AND OVERSEE AGENCY EFFORTS TO COMPLY WITH THE PREA STANDARDS FOR ALL OF THE AGENCY COMMUNITY CONFINEMENT FACILITIES. PREA COORDINATOR'S PRIMARY DUTY AND FUNCTION ISTO ENSURE AGENCY FACILITIES MEET PREA COMPLIANCE.

AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.211.

115.212	Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

■ Standard Not Applicable

Auditor comments, including corrective actions needed if does not meet standard

STANDARD 115.212 DOES NOT APPLY AS AGENCY HAS NOT ENTERED INTO A CONTRACT WITH ANY OTHER AGENCY OR ENTITY FOR THE CONFINEMENT OF RESIDENTS PER AGENCY CONTRACT ADMINISTRATOR. AUDITOR HAS DETERMINED THE STANDARD IS MET.

115.213	Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) REVIEW OF STAFFING PLAN PROVIDED BY AGENCY IS SPECIFIC TO ICCS KENDALL. PLAN IDENTIFIES LAYOUT OF THE FACILITY, VIDEO MONITORING PLACEMENT AND DEFICIENCIES WHICH COMPROMISE RESIDENT SAFETY WITH RECOMMENDATIONS. COMPOSITION OF THE RESIDENT POPULATION, PREVELANCE OF SUBSTANTIATED AND UNSUBSTANTIATED INCIDENTS OF SEX ABUSE AND OTHER RELEVANT FACTORS WERE INCLUDED IN THE STAFFING PLAN. INTERVIEW WITH DIRECTOR DESIGNEE AND PREA COORDINATOR VERIFIES STAFFING PLAN DEVELOPMENT CONSIDERS ALL 4 CRITERIA AS OUTLINED IN STANDARD PROVISION 115.213(a). ADMINISTRATION HAS MADE CHANGES FOR SEXUAL SAFETY OF RESIDENTS BASED UPON THE FACTORS IDENTIFIED IN THE STAFFING PLAN. DURING ON-SITE AUDIT REVIEW, AUDITOR OBSERVED A NUMBER OF BLIND SPOTS WITHIN THE FACILITY THAT REQUIRES EITHER VIDEO MONITORING OR INCREASED STAFF SUPERVISION. THE FOLLOWING BLIND SPOTS WERE IDENTIFIED:
   a. STAFF OFFICES 2ND FLOOR (CASE MANAGER OFFICES): HALLWAY, BREAK ROOM & COPY ALCOVES ARE BLIND SPOTS IN NEED OF SOME TYPE OF MONITORING FOR BOTH RESIDENT AND STAFF SEXUAL SAFETY.
   b. ROOF 5TH FLOOR ACCESS: ACCESS TO THIS AREA FOR MAINTENANCE. BLIND SPOT AREA THAT NEEDS ATTENTION.

b) INTERVIEW WITH PROGRAM DIRECTOR INDICATE NO DEVIATIONS FROM THE STAFFING PLAN SINCE AUGUST 2012. SECURITY SCHEDUE CALLS FOR EXTRA STAFF AT TIMES SO STAFF COVERAGE IS MAINTAINED. ICCS STAFFING IS OVER THE MINIMAL STAFFING REQUIREMENTS TO ENSURE COMPLIANCE WITH STANDARD PROVISION 115.213(B). . STAFFING PLAN INDICATED ONE DEVIATION FROM THE PLAN OCCURRED IN PAST 12 MONTHS & STAFF MEMBER WAS COUNSELED. DEVIATION WAS DOCUMENTED VIA COUNSELING MEMORANDUM SIGNED BY BOTH THE STAFF AND THE SUPERVISOR. DEVIATION WAS IDENTIFIED & DOCUMENTED IN STAFFING PLAN.

c) THIS IS AGENCY'S 1ST PREA AUDIT. NO PREVIOUS STAFFING PLAN OR ANNUAL REVIEWS CONDUCTED PRIOR TO THIS AUDIT. POLICY #400-B INCORPORATES CRITERIA AS IDENTIFIED IN PROVISION 115.113(c). STAFFING PLAN DATED MAY 2015, PROVIDED BY AGENCY EXHIBITS IMPLEMENTATION OF THE CONSIDERED CRITERIA. INTERVIEW WITH PREA COORDINATOR CORROBORATES PAQ. THIS IS AGENCY'S 1ST PREA AUDIT, THEREFORE, THERE HAVE BEEN NO PREVIOUS STAFFING PLAN REVIEWS. CURRENT STAFFING PLAN CONSIDERS CRITERIA IDENTIFIED IN STANDARD 115.213(c).

CORRECTIVE ACTION:
AGENCY TO CORRECT BLIND SPOTS IDENTIFIED IN STANDARD PROVISION 115.213(a) THROUGH ADDITIONAL VIDEO MONITORING OR OTHER MEANS TO PROVIDE SEXUAL SAFETY FOR RESIDENTS.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETED 3/16/16:
AGENCY INSTALLED NEW CAMERAS IN THE CASE MANAGER HALLWAY TO INCLUDE CONCAVE MIRRORS FOR THE BREAK ROOM AND COPY ROOM. AN ADDITIONAL CAMERA WAS ADDED TO COVER THE ENTRANCE TO THE CASE MANAGER HALLWAY THAT SHOWS THER AREA MORE FULLY TO COVER THE STAIRWELL, ELEVATOR AND UTILITY ROOM. AGENCY IMPLEMENTED A DRAW KEY SYSTEM FOR THE 5TH FLOOR ROOF, REMOVING ROOF KEYS FROM STAFF KEY RINGS..

AUDITOR HAS DETERMINED AGENCY HAS MET ALL PROVISIONS OF THIS STANDARD AND IS IN COMPLIANCE WITH STANDARD 115.213.

115.215	**Limits to cross-gender viewing and searches**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #450 COMPLIANT WITH STANDARD AS IT AUTHORIZES STRIP SEARCHES WITH AUTHORIZATION OF EXECUTIVE DIRECTOR OR PROGRAM DIRECTOR. THE PRESENCE OF TWO SAME-SEX STAFF MEMBERS ARE REQUIRED, ONE OF WHICH MUST BE A SUPERVISOR. UNDER EXIGENT CIRCUMSTANCES IF A CROSS-GENDER STRIP SEARCH IS CONDUCTED THE SEARCH MUST BE DOCUMENTED & FOWARDED TO THE PREA COORDINATOR OR DESIGNEE. BODY CAVITY SEARCHES ARE NOT ALLOWED. NO NON-MEDICAL STAFF INVOLVED IN CROSS-GENDER OR VISUAL SEARCHES IDENTIFIED. NO LOGS OF CROSS GENDER STRIP OR CROSS GENDER BODY CAVITY SEARCHES CONDUCTED IN PAST 12 MONTHS. NO DOCUMENTATION OF INSTANCES WHERE MEDICAL STAFF CONDUCTED SUCH SEARCHES AS NONE WERE CONDUCTED NOR REQUIRED, IN ACCORDANCE WITH STANDARD 115.215(a).
b) POLICY #450 STATES THAT ONLY STAFF OF SAME SEX IS ALLOWED TO CONDUCT PAT-DOWN SEARCHES. THIS IS AN ALL FEMALE FACILITY WITH AN ALL FEMALE STAFF. THIS IS AN INITIAL PREA AUDIT CONDUCTED IN JULY 2015. STANDARD PROVISION 115.215(b) DOES NOT APPLY TO THIS FACILITY. POLICY #450 MANDATES CROSS-GENDER STRIP SEARCHES ARE CONDUCTED ONLY UNDER EXIGENT CIRCUMSTANCES AND ARE DOCUMENTED. VISUAL BODY CAVITY SEARCHES ARE PROHIBITED. THIS IS A MALE FACILITY WITH BOTH MALE AND FEMALE STAFF. NO CROSS GENDER STRIP OR CROSS GENDER VISUAL BODY CAVITY SEARCHES CONDUCTED AT THIS FACILTY NOR HAS THERE BEEN ANY CROSS GENDER PAT DOWN SEARCHES. CROSS GENDER SEARCHES ARE CONDUCTED WITH ELECTRONIC WAND. NO PHYSICAL CONTACT BETWEEN MALE RESIDENTS AND FEMALE STAFF. NO DOCUMENTATION OF IDENTIFIED SEARCHES AS NONE OCCURRED. FACILITY IS IN COMPLIANCE WITH STANDARD 115.215(c).
c) POLICY #450 MANDATES CROSS-GENDER STRIP SEARCHES ARE CONDUCTED ONLY UNDER EXIGENT CIRCUMSTANCES AND ARE DOCUMENTED. VISUAL BODY CAVITY SEARCHES ARE PROHIBITED. CROSS –

GENDER PAT-DOWN SEARCHES OF FEMALE RESIDENTS IS NOT APPLICABLE DUE TO FACILITY STAFF ARE FEMALE IN AN ALL FEMALE FACILITY.

NO CROSS GENDER STRIP OR CROSS GENDER VISUAL BODY CAVITY SEARCHES CONDUCTED AT THIS FACILTY NOR HAS THERE BEEN ANY CROSS GENDER PAT DOWN SEARCHES. CROSS GENDER SEARCHES ARE CONDUCTED WITH ELECTRONIC WAND. CROSS –GENDER PAT-DOWN SEARCHES OF FEMALE RESIDENTS IS NOT APPLICABLE DUE TO FACILITY STAFF ARE FEMALE IN AN ALL FEMALE FACILITY.NO DOCUMENTATION OF IDENTIFIED SEARCHES AS NONE OCCURRED. FACILITY IS IN COMPLIANCE WITH STANDARD 115.215(c).

d) POLICY #160 AND HOUSE POLICY PAGE #9 SPECIFICALLY MANDATES RESIDENTS CHANGE CLOTHING ONLY IN BATHROOM AREAS TO PROVIDE PRIVACY. POLICY #410 INDICATE STAFF OF OPPOSITE GENDER ARE REQUIRED TO ANNOUNCE THEIR PRESENCE WITH ENTERING AN AREA WHERE RESIDENTS ARE LIKELY TO BE SHOWERING, PERFORMING BODILY FUNCTIONS OR CHANGING CLOTHING. THIS FACILITY IS FEMALE ONLY AND STAFF ARE ALL FEMALE STAFF. SHOULD A MALE ADMINISTRATOR OR VISITOR ARRIVE TO REVIEW THE ROOMS, AUDITOR OBSERVED FEMALE STAFF KNOCK & ANNOUNCE BEFORE ALLOWING MALES TO ENTER. USUALLY THE ROOM IS CLEARED OF RESIDENTS BEFORE A MALE CAN ENTER. POLICY MANDATES STAFF OF OPPOSITE GENDER CANNOT ENTER THE BATHROOM, ONLY KNOCK, ANNOUNCE AND STAND IN THE DOORWAY OF THE BATHROOM. THIS ALLOWS RESIDENTS PRIVACY IN THE TOILET AND CHANGING AREA STALLS. INTERVIEW WITH RANDOM STAFF VERIFIES CORROBORATES DEMONSTRATED POLICY MANDATE IN ACCORDANCE WITH STANDARD 115.215(d).

e) POLICY #450 MEETS STANDARD PROVISION IN PROHIBITING STAFF FROM SEARCHING OR PHYSICALLY EXAMINING A TRANSGENDER OR INTERSEX RESIDENT FOR THE SOLE PURPOSE OF DETERMINING THE RESIDENT’S GENITAL STATUS. POLICY MANDATES THAT IF STATUS IS UNKNOWN, IT MAY BE DETERMINED VIA REVIEW OF MEDICAL RECORDS OR PART OF A BROADER MEDICAL EXAMINATION CONDUCTED BY A PRIVATE MEDICAL PRACTITIONER. INTERVIEW WITH RANDOM SAMPLE OF STAFF VERIFIES EDUCATION AND PRACTICE REGARDING THE PROHIBITION OF STAFF PHYSICALLY EXAMINING A TRANSGENDER OR INTERSEX RESIDENT FOR THE SOLE PURPOSE OF DETERMINING THE RESIDENT’S GENITAL STATUS. INTERVIEW WITH TRANSGENDER RESIDENTS CORROBORATE STAFF’S CLAIM THIS DOES NOT OCCUR IN KENDALL FACILITY IN ACCORDANCE WITH POLICY AND STANDARD PROVISION 115.215(e)

f) SECURITY TRAINING CURRICULUM SECTION #4-A IDENTIFIES PAT DOWN SEARCHES OF A CLIENT, PERSON & PROPERTY SEARCHES. CURRICULUM PROVIDED IS A CHECKLIST OF TOPICS ONLY WITH INSTRUCTIONS FOR STAFF/CLIENTS TO INITIAL AND SIGN. FULL TRAINING PPT PROVIDED WHICH MEETS STANDARD 115.215(F). POLICY #450 A-9 INDICATES BEFORE A TRANSGENDER OR INTERSEX RESIDENT IS SUBJECT TO A PAT SEARCH, THEY SHOULD BE ASKED WHICH GENDER OF STAFF THEY WOULD FEEL MOST COMFORTABLE IN CONDUCTING THE SEARCH. POLICY #450 HAS NARRATIVE WHICH MANDATES ALL PAT-DOWN SEARCHES WILL BE CONDUCTED IN A PROFESSIONAL AND RESPECTFUL MANNER. DURING ON-SITE AUDIT TOUR, AUDITOR REVIEWED RANDOM SAMPLING OF 10 STAFF TRAINING RECORDS AND TRAINING ACKNOLEDEMENT FORMS. RANDOM SAMPLING OF RECORDS INDICATE SECURITY STAFF HAVE BEEN TRAINED IN CROSS GENDER PAT-DOWN SEARCHES. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATE ONLY 1/3 OF THOSE INTERVIEWED RECALLED THE CROSS GENDER PAT DOWN SEARCH AND SEARCH OF TRANSGENDER AND INTERSEX RESIDENTS IN A PROFESSIONAL AND RESPECTFUL MANNER. REVIEW OF TRAINING RECORDS INDICATE ALL 11 RANDOM STAFF INTERVIEWED HAD ATTENDED PREA TRAINING & SIGNED THEIR ACKNOWLEDGEMENT FORMS. RECOMMEND AGENCY CONDUCT A REFRESHER TRAINING FOR ALL SECURITY STAFF TO INCREASE THEIR KNOWLEDGE FACTOR REGARDING REQUIREMENT OF STANDARD PROVISION 115.215(f)

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.215.

115.216	Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICIES #160 & #450 ESTABLISHES PROCEDURES TO PROVIDE EFFECTIVE COMMUNICATION AS IT RELATES TO PREA FOR ALL DISABLED & LEP RESIDENTS TO INCLUDE WRITTEN DOCUMENTATION IN SPANISH, VOIANCE CONTRACT FOR INTERPRETERS. TRAINING CURRICULUM PROVIDED ENTAILS EXPLAINING THE SCOPE OF PREA 2003, WATCH STAFF & CLIENT ORIENTATION VIDEO, REVIEW REPORTING EXPECTATION & REQUIREMENT & READ POLICIES #160 & 165 AND SIGN PREA ACKNOWLEDGEMENT FORM. STAFF CURRICULUM FULL TRAINING PPT PROVIDED. RESIDENCE WATCH CDOC VIDEO, PROVIDED THE PREA BROCHURE IN BOTH ENGLISH & SPANISH & RULE BOOK WHICH IS AVAILABLE ONLY IN ENGLISH AT THIS TIME, BUT BEING TRANSLATED FOR SPANISH FOR FUTURE PUBLICATION. BILINGUAL STAFF ARE AVAILABLE TO PROVIDE EFFECTIVE COMMUNICATION FOR SPANISH SPEAKING RESIDENTS FOR PHYSICAL TRANSLATION OF PREA EDUCATIONAL MATERIALS. INTERVIEW WITH AGENCY HEAD DESIGNEE INDICATES AGENCY PROVIDES PREA LITERATURE IN ENGLISH & SPANISH AND ALSO PROVIDES FOR VOIANCE INTERPRETER SERVICES WITH WHICH THEY HAVE SECURED AN MOU TO PROVIDE EFFECTIVE COMMUNICATION FOR RESIDENTS. THERE ARE ALSO A NUMBER OF STAFF WHO SPEAK SPANISH AND CAN INTERPRET ALSO. THERE ARE NO RESIDENTS WHO ARE LIMITED ENGLISH PROFICIENT AT THE TIME OF THE ON-SITE TOUR. PREA BROCHURES IN BOTH ENGLISH AND SPANISH ARE PROVIDED DURING INTAKE ALONG WITH THE RULE BOOK. AUDITOR OBSERVED BROCHURES IN BOTH ENGLISH AND SPANISH PROVIDED IN THE HALLWAY OUTSIDE THE SECURITY OFFICE ACCESSIBLE TO RESIDENTS. AGENCY HAS TAKEN APPROPRIATE STEPS TO PROVIDE EFFECTIVE COMMUNICATION FOR RESIDENTS WITH DISABILITIES AND LIMITED ENGLISH PROFICIENT RESIDENTS PER STANDARD PROVISION 115.216(a).

b) POLICIES #160 & #450 ESTABLISHES PROCEDURES TO PROVIDE EFFECTIVE COMMUNICATION AS IT RELATES TO PREA FOR ALL DISABLED & LEP RESIDENTS TO INCLUDE WRITTEN DOCUMENTATION IN SPANISH, VOIANCE CONTRACT FOR INTERPRETERS. CURRICULUM PROVIDED IS A CHECKLIST OF TOPICS WITH INSTRUCTIONS FOR STAFF/CLIENTS TO INITIAL AND SIGN. REFRESHER TRAINING PPT FOR STAFF INCLUDES TRAINING ON EFFECTIVE COMMUNICATION FOR RESIDENTS WITH LIIMITED ENGLISH PROFICIENCY & HOW TO TAKE STEPS TO ENSURE RESIDENTS HAVE THE OPPORTUNITY TO BENEFIT FROM ALL ASPECTS OF AGENCY'S EFFORT TO RESPOND TO SEXUAL ABUSE/HARASSMENT, IN COMPLIANCE WITH STANDARD 115.216(b). NO LIMITED ENGLISH PROFICIENT RESIDENTS HOUSED IN FACILITY WHEN ON-SITE TOUR WAS CONDUCTED. AGENCY HAS MET STANDARD PROVISION 115.216(b).

c) POLICY #450 MANDATES THE USE OF CONTRACT INTERPRETERS OR STAFF INTERPRETERS. RESIDENT INTERPRETERS OR READERS MAY BE USED IN LIMITED CIRCUMSTANCES WHERE AN EXTENDED DELAY IN OBTAINING EFFECTIVE INTERPRETERS COULD COMPROMISE THE RESIDENT'S SAFETY. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATES THAT TRAINING HAS BEEN PROVIDED TO PROHIBIT USE OF RESIDENT INTERPRETERS EXCEPT IN EXIGENT CIRCUMSTANCES DURING INVESTIGATIONS OF A RESIDENT'S ALLEGATION OF SEXUAL ABUSE IN ACCORDANCE WITH STANDARD PROVISION 115.216(c).

AUDITOR HAS DETERMINED THAT AGENCY HAS COMPLIED WITH STANDARD 115.216.

115.217	Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) REVIEW OF 10 RANDOM SAMPLE OF PERSONNEL FILES INDICATED 100% OF STAFF HAVE CLEARED CCIC & 90% CLEARED NCIC BACKGROUND CHECK. ONE STAFF MEMBER'S BACKGROUND CHECK DID NOT HAVE THE CBI/FBI CLEARANCE DETERMINATION. PERSONNEL POLICY PROVIDES FOR PROMOTION CHECKS TO MEET STANDARD 115.217(a) CRITERIA. REVIEW OF 2 BTS CONTRACTORS ASSIGNED TO WEST FACILITY INDICATE BOTH HAVE CLEARED CBI/FBI BACKGROUND CHECKS. 3 CEO CONTRACTOR BACKGROUND DOCUMENTS ASSIGNED TO WEST FACILITY INDICATES ALL 3 CLEARED CCIC BUT NO CBI/FBI BACKGROUND CLEARANCE WAS CONDUCTED. 3 CEO CONTRACTOR RECORDS HAD NO DETERMINATION ON THE BACKGROUND CLEARANCE PROVISION FOR CBI/FBI CHECK. HUMAN RESOURCES ADMINISTRATOR INDICATES THIS WAS COMMON PRACTICE, HOWEVER, AGENCY WILL REQUIRE CBI/FBI CHECKS ON ALL CONTRACTORS GOING FORWARD. QUESTIONS REGARDING PAST CONDUCT IS ASKED DURING PROMOTION AND HIRING INTERVIEWS. AGENCY POLICY IS IN COMPLIANCE WITH STANDARD PROVISION 115.217(a). AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.217(a).

b) POLICY #220 CONTAINS NARRATIVE COMPLIANT WITH STANDARD PROVISION REGARDING THE CONSIDERATION OF ANY INCIDENTS OF SEXUAL HARASSMENT IN DETERMINING WHETHER TO HIRE OR PROMOTE AN APPLICANT. INTERVIEW WITH THE HUMAN RESOURCES ADMINISTRATOR VERIFIES DEMONSTRATION OF AGENCY POLICY REGARDING HIRING AND PROMOTION IN ACCORDANCE WITH STANDARD PROVISION 115.217(b).

c) POLICY #220 INCORPORATES THE NARRATIVE IDENTIFIED IN THIS STANDARD PROVISION AND IS COMPLIANT. 6 RECENTLY HIRED EMPLOYEE PERSONNEL FILES WERE REVIEWED BY AUDITOR WHO DETERMINED THE AGENCY HAD CONDUCTED BACKGROUND CHECKS IN ACCORDANCE WITH STANDARD PROVISION 115.217(c). BACKGROUND CHECKS WERE INITIALLY RUN THROUGH THE STATE CCIC CHECK, AND FINGERPRINT CARDS FORWARDED TO CBI/FBI FOR ADDITIONAL CLEARANCE CHECKS. AGENCY/FACILITY IS COMPLIANT WITH STANDARD PROVISION 115.217(c).

d) POLICY #220 MANDATES CRIMINAL BACKGROUND CHECK ON ALL APPLICANTS TO INCLUDE CONTRACTORS IN THE NARRATIVE. REVIEW OF 2 BTS & 3 CEO CONTRACTOR BACKGROUND DOCUMENTS ASSIGNED TO KENDAL INDICATES ALL 5 CLEARED CCIC BUT ONLY 2 CLEARED NCIC BACKGROUND. 3 CEO CONTRACTOR RECORDS HAD NO DETERMINATION ON THE BACKGROUND CLEARANCE PROVISION FROM CBI/FBI CHECK. IT HAS BEEN THE PRACTICE THAT CEO CONTRACTORS ARE PROVIDED A CCIC (STATE OF COLORADO) BACKGROUND CHECK BUT NOT THE CBI/FBI NATIONAL CLEARANCE. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.217(d).

e) POLICY #220 SPECIFICALLY MANDATES CRIMINAL BACKGROUND RECORDS CHECKS ON ALL EMPLOYEES AND CONTRACTORS. INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR INDICATES BACKGROUND RE-CHECKS ARE CONDUCTED EVERY 5 YEARS ON CURRENT EMPLOYEES. REVIEW OF SAMPLE NUMBER OF FILES CORROBORATES ADMINISTRATOR STATEMENT AND COMPLIANCE WITH BOTH POLICY AND STANDARD PROVISION 115.217(e).

f) POLICY #220 MANDATES THE CRIMINAL HISTORY BACKGROUND CHECK FORM ASKS ALL APPLICANTS DIRECTLY ABOIUT PREVIOUS SEXUAL ABUSE MISCONDUCT. NARRATIVE INCLUDES NARRATIVE FOR HIRING INTERVIEWS OR PROMOTIONS TO INCLUDE A CONTINUING AFFIRMATIVE DUTY TO DISCLOSE SUCH MISCONDUCT. Policy #230 MANDATES STAFF TO COMPLETE A WRITTEN SELF-EVALUATION DURING ANNUAL STAFF EVALUATION REGARDING CRITERIA IDENTIFIED IN STANDARD 115.217(f). INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR INDICATES APPLICANTS AND EMPLOYEES PENDING PROMOTION ARE ASKED DURING THE INTERVIEW PROCESS ABOUT PREVIOUS MISCONDUCT REGARDING SEX ABUSE OR SEXUAL HARASSMENT INCIDENTS IN ACCORDANCE WITH STANDARD PROVISION 115.217(f).

g) POLICY #220 MANDATES MATERIAL OMISSIONS REGARDING SUCH MISCONDUCT OR THE PROVISION OF MATERIALLY FALSE INFORMATION ARE GROUNDS FOR TERMINATION. AGENCY POLICY IS IN COMPLIANCE WITH STANDARD PROVISION 115.217(g).

h) POLICY #220 PROVIDES NARRATIVE COMPLIANT WITH STANDARD PROVISION 115.217(h) TO PROVIDE INFORMATION ON SUBSTANTIATED ALLEGATIONS OF SEX ABUSE/HARASSMENT INVOLVING A FORMER EMPLOYEE UPON RECEIVING REQUEST FROM INSTITUTIONAL EMPLOYER FOR WHOM SUCH EMPLOYEE HAS APPLIED TO WORK. INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR INDICATES AGENCY WILL PROVIDE INFORMATION ON SUBSTANTIATED ALLEGATIONS OF SEX ABUSE/HARASSMENT INVOLVING A FORMER EMPLOYEE UPON RECEIVING A REQUEST FROM AN INSTITUTIONAL EMPLOYER FOR WHOM SUCH EMPLOYEE HAS APPLIED TO WORK, ACCOMPANIED WITH A RELEASE OF INFORMATION SIGNED BY SAID EMPLOYEE. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.217(h).

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.217 AS PROVISIONs 115.217(a) & 115.217(d) ARE OUT OF COMPLIANCE.

CORRECTIVE ACTION:

1. FOR THOSE CONTRACTORS ASSIGNED TO THE WEST FACILITY WHO HAVE NOT CLEARED THE CBI/FBI BACKGROUND, AGENCY SHALL CONDUCT BACKGROUND CHECKS ON ALL CONTRACTORS THROUGH THE CBI/FBI SYSTEM TO ENSURE ALL CONTRACTORS WHO HAVE CONTACT WITH RESIDENTS POSSESS A CLEAR RECORD PRIOR TO CONDUCTING BUSINESS WITH AGENCY.
2. WRITTEN POLICY OR PROCEDURE TO BE PROVIDED AUDITOR TO INCLUDE DOCUMENTATION TO VERIFY AGENCY HAS DEMONSTRATED COMPLIANCE WITH STANDARD PROVISION 115.217(a) & 115.217(d).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETED 3/16/16:

POLICY #220 MANDATES CRIMINAL BACKGROUND CHECK ON ALL APPLICANTS TO INCLUDE CONTRACTORS. AGENCY PROVIDED AUDITOR WITH 2 CEO CONTRACTOR BACKGROUND CHECKS. ONE OF THE IDENTIFIED CEO CONTRACTORS WAS FOUND TO BE A VOLUNTEER, THEREFORE STANDARD 115.217 DOES NOT APPLY TO THE VOLUNTEER. BOTH CEO CONTRACTORS WERE CLEARED THROUGH CCIC, CBI/FBI CHECKS. AGENCY HAS COMPLIED WITH REQUIREMENTS OF STANDARD PROVISIONS 115.217(a) AND 115.217(d). AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.217.

115.218	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)

Auditor comments, including corrective actions needed if does not meet standard

a) AGENCY INDICATES NO ACQUISITION OF FACILITY, SUBSTANTIAL EXPANSION OR MODIFICATION TO EXISTING FACILITIES SINCE AUGUST 20, 2012. THIS IS AGENCY'S 1ST PREA AUDIT. STANDARD DOES NOT APPLY TO AGENCY. INTERVIEW OF AGENCY HEAD DESIGNEE AND DIRECTOR INDICATES THERE HAVE BEEN NO ACQUISITION OR SUBSTANTIAL EXPANSION OR MODIFICATION OF EXISTING FACILITIES SINCE AUGUST 2012. STANDARD PROVISION 115.218(a) DOES NOT APPLY TO THIS AGENCY/FACILITY.

b) INTERVIEW OF AGENCY HEAD DESIGNEE AND DIRECTOR INDICATES THERE HAVE BEEN NO ACQUISITION OR SUBSTANTIAL EXPANSION OR MODIFICATION OF EXISTING FACILITIES SINCE AUGUST 2012. STANDARD PROVISION 115.218(a) DOES NOT APPLY TO THIS AGENCY/FACILITY.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.218.

115.221	Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) AGENCY INVESTIGATORS ARE TRAINED VIA NIC INVESTIGATOR TRAINING FOR SEX ABUSE INVESTIGATION IN A CONFINEMENT SETTING. AGENCY CONDUCTS ONLY ADMINISTRATIVE INVESTIGATIONS. CRIMINAL INVESTIGATIONS ARE HANDLED VIA LAKEWOOD PD. POLICY 165 B PROVIDES EVIDENCE PROTOCOL TO BE FOLLOWED BY ALL STAFF, CONTRACTORS & VOLUNTEERS. BOTH WEST FACILITY COORDINATED RESPONSE PROTOCOL AND POLICY 165 B MEET STANDARD PROVISION 115.221(a). INTERVIEWS WITH RANDOM SAMPLE OF STAFF VERIFY THAT STAFF HAVE BEEN PROPERLY TRAINED TO RESPOND TO INCIDENTS OF SEXUAL ABUSE. AGENCY POLICY SECURES THE SCENE FOR LAW ENFORCEMENT TO GATHER EVIDENCE FOR INVESTIGATION. AGENCY INVESTIGATORS ASSIST LOCAL LAW ENFORCEMENT IN THE INVESTIGATION IN WHATEVER CAPACITY IS REQUIRED. AGENCY ONLY INVESTIGATES ADMINISTRATIVE CASES, CRIMINAL CASES ARE INVESTIGATED BY LOCAL LAW ENFORCEMENT.

b) PAQ INDICATES PROTOCOL NOT DEVELOPMENTALLY APPROPRIATE FOR YOUTH, HOWEVER, AGENCY INDICATES PROTOCOL IS GLEANED FROM THE NIC INVESTIGATOR TRAINING WHICH IS DEVELPMENTALLY APPROPRIATE FOR YOUTH. THIS IS AN ADULT ONLY FACILITY. POLICY 165 B PROVIDES EVIDENCE

PROTOCOL TO BE FOLLOWED BY ALL STAFF, CONTRACTORS & VOLUNTEERS. REVIEW OF EVIDENCE PROTOCOL FOR KENDALL FACILITY VERIFIES COMPLIANCE WITH STANDARD PROVISION 115.221(b). ICCS DOES NOT HOUSE ANYONE UNDER THE AGE OF 18 YEARS OF AGE, HOWEVER, THE PROTOCOL PROVIDES FOR CASES INVOLVING YOUTH AND VULNERABLE ADULTS TO BE REFERRED TO LOCAL LAW ENFORCEMENT FOR INVESTIGATION.

c) POLICY 165 MANDATES FORENSIC MEDICAL EXAMINATIONS BE OFFERED TO VICTIMS OF SEX ABUSE WITHOUT FINANCIAL COST PER STANDARD PROVISION 115.221(c). FORENSIC EXAMINATIONS ARE CONDUCTED AT AN OUTSIDE HOSPITAL – MOU PROVIDED WITH PAQ. INTERVIEW WITH SAFE/SANE NURSE AT ST ANTHONY'S HOSPITAL INDICATE THEIR FACILITY IS RESPONSIBLE FOR CONDUCTING ALL FORENSIC MEDICAL EXAMINATIONS FOR ICCS FACILITIES PER THEIR MOU WITH ICCS. ALL SANE/SAFE NURSES ARE ON CALL 24/7 TO PROVIDE SERVICES FOR RESIDENTS. NO SEXUAL ASSAULTS REQUIRING FORENSIC EXAMINATIONS HAVE OCCURRED OVER THE PAST 12 MONTHS AT WEST FACILITY.

d) POLICY 165 D-2 PROVIDES CONTACT WITH OUTSIDE RAPE CRISIS CENTER FOR VICTIM ADVOCACY. AGENCY PROVIDED AUDITOR WITH THE BLUE BENCH RAPE CRISIS CENTER MOU, WHICH PROVIDES ADVOCACY FOR VICTIMS OF SEXUAL ABUSE BOTH PRIOR TO AND DURING FORENSIC EXAMINATIONS AND CRIMINAL PROCEEDINGS IN ACCORDANCE WITH STANDARD PROVISION 115.221(d). INTERVIEW WITH PREA COORDINATOR VERIFIES AGENCY'S COMPLIANCE WITH STANDARD 115.221(d). THERE WERE NO RESIDENTS WHO REPORTED A SEXUAL ABUSE AT WEST FACILITY TO INTERVIEW.

e) BLUE BENCH RAPE CRISIS CENTER MOU PROVIDED & VERIFIED SCOPE OF SERVICES COMPLIANT WITH STANDARD PROVISIONS IN THAT ADVOCATES ACCOMPANY VICTIM THROUGH THE FORENSIC EXAMINATION PROCESS. INTERVIEW WITH PREA COORDINATOR INFORMED AUDITOR AGENCY DOES NOT POSSESS A QUALIFIED STAFF VICTIM ADVOCATE IN THE EVENT RESIDENT VICTIM OF SEXUAL ABUSE REQUESTS EMOTIONAL SUPPORT. THE BLUE BENCH MOU COMPLIES WITH STANDARD PROVISION 115.221(e) TO MEET THE NEEDS OF VICTIMS REQUESTING EMOTIONAL SUPPORT.

f) UNSIGNED LAKEWOOD PD MOU COMPLIANT WITH STANDARD PROVISION REGARDING THE AGENCY FOLLOWING INVESTIGATIVE PROTOCOLS PER STANDARD PROVISION 115.221(f). CHIEF OF POLICE REVIEWING MOU PER E-MAIL CORRESPONDENCE. AGENCY PROVIDED UNSIGNED LAKEWOOD PD MOU AND E-MAIL CORRESPONDENCES REGARDING MOU RATIFICATION. CHIEF OF POLICE HAS REFERRED MOU TO THE CITY ATTORNEY FOR FINAL REVIEW AND APPROVAL.

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.221.

115.222	Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY 165 MANDATES ALL REPORTED ACTS OF SEXUAL ABUSE OR SEXUAL MISCONDUCT WHETHER IT OCCURS IN COMMUNITY CORRECTIONS OR ANY OTHER LOCATION WHERE CLIENTS ARE HOUSED, WORK OR ARE PROVIDED SERVICES WILL BE INVESTIGATED IN ACCORDANCE WITH ESTABLISHED LOCAL LAW ENFORCEMENT AGENCY'S INVESTGATIVE STANDARDS & PROTOCOLS. PAQ ISSUED BY AGENCY REPORTS 2 ALLEGATIONS OF SEX ABUSE/HARASSMENT RECEIVED IN LAST 12 MONTHS. 1 ALLEGATION RESULTED IN ADMINISTRATIVE INVESTIGATION & 1 WAS REFERRED FOR CRIMINAL INVESTIGATION. ALL INVESTIGATIVE RESULTS WERE PROVIDED WITH PAQ. INTERVIEW WITH AGENCY DESIGNEE VERIFIES APPLICATION OF POLICY WHICH MANDATES ADMINISTRATIVE AND CRIMINAL INVESTIGATION OF ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT SHALL BE COMPLETED IN ACCORDANCE WITH STANDARD PROVISION 115.222(a). AUDITOR REVIEWED DOCUMENTATION OF THE 2 SEXUAL ABUSE ALLEGATIONS WHICH OCCURRED OVER THE PAST 12 MONTHS. 1 WAS ADMINISTRATIVE INVESTIGATIONS AND 1 WAS CRIMINAL INVESTIGATIONS. ALL INVESTIGATIONS HAVE BEEN COMPLETED.

b) POLICY 165 INCORPORATES NARRATIVE CONSISTENT WITH STANDARD PROVISION 115.222(B). INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES COMPLIANCE WITH STANDARD PROVISION 115.222(b) IN THAT ALL ALLEGATIONS OF SEX ABUSE/HARASMENT ARE REFERRED FOR INVESTIGATION TO PROPER AGENCY ASSIGNED TO CONDUCT SAID INVESTIGATIONS. AUDITOR VERIFIED POLICY LANGUAGE IS PUBLISHED ON AGENCY WEBSITE. AUDITOR VERIFIED THAT ALL REFERRALS TO LOCAL LAW ENFORCEMENT HAD BEEN DOCUMENTED VIA INCIDENT REPORT.

c) INVESTIGATIVE PROTOCOL IS PROVIDED ON POLICY #165 AND ON UNSIGNED LAKEWOOD PD MOU. WEBSITE PUBLICATION DESCRIBES INVESTIGATIVE RESPONSIBILITIES OF BOTH AGENCY AND LOCAL LAW ENFORCEMENT FOR CONDUCTING CRIMINAL INVESTIGATIONS FOR THE AGENCY IN ACCORDANCE WITH STANDARD PROVISION 115.222(c).

AUDITOR HAS DETERMINED THAT AGENCY/FACILITY IS IN COMPLIANCE WITH STANDARD 115.222.

115.231	Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #255 MANDATES 40 HOURS OF TRAINING OF ALL STAFF WITHIN 90 DAYS OF EMPLOYMENT. SECURITY TRAINING CURRICULUM PROVIDES CHECKLIST OF TRAINING TOPICS WHICH INCLUDE TRAINER COMPLETE OVERVIEW OF PREA, PROVIDE ORIENTATION VIDEO FOR CLIENTS AND STAFF VIDEO, READ POLICIES #160 & #165, SIGN PREA ACKNOWLEDGEMENT FORM. BOTH EMPLOYEE FULL LENGTH AND REFRESHER TRAINING PPT PROVIDED WHICH MEETS CRITERIA MANDATED BY STANDARD 115.231(a). INTERVIEW RESPONSES FROM RANDOM SAMPLE OF 10 STAFF INDICATE THEY HAVE RECEIVED TRAINING ON ALL 10 TRAINING ELEMENTS ESTABLISHED IN STANDARD 115.231(a). AUDITOR REVIEWED SAMPLE OF KENDALL STAFF TRAINING RECORDS AND DETERMINED ALL STAFF RECORDS REVIEWED CONTAINED SIGNED TRAINING ATTENDANCE AND PREA ACKNOWLEDGEMENT FOR EACH STAFF MEMBER.

b) POLICY #255 MANDATES EMPLOYEES REASSIGNED FROM FACILITIES HOUSING THE OPPOSITE GENDER ARE GIVEN ADDITIONAL TRAINING SPECIFIC TO THAT GENDER. FULL LENGTH & REFRESHER PPT FOR STAFF TRAINING COMPLIES WITH STANDARD 115.231(b). INTERVIEWS WITH RANDOM SAMPLE OF STAFF INDICATE THEY RECEIVE REFRESHER TRAINING COMPONENTS 2X PER MONTH, EVERY OTHER FRIDAY.

c) AGENCY CLAIMS 100% EMPLOYEE OR RETRAINING FOR STAFF IN PREA REQUIREMENTS. FULL LENGTH & REFRESHER PPT STAFF TRAINING PROVIDED WHICH MEETS MANDATE OF STANDARD 115.231(c). AUDITOR REVIEWED SAMPLE OF 10 STAFF TRAINING RECORDS & ALL RECORDS INDICATED STAFF HAVE BEEN TRAINED IN PREA & SIGNED LETTERS OF ACKNOWLEDGEMENT, INDICATING THEY UNDERSTAND THE TRAINING PROVIDED.

d) POLICY #265 #F MANDATES ALL STAFF RECEIVING TRAINING WILL SIGN A TRAINING FORM ACKNOWLEDGING THE TRAINING THEY HAVE RECEIVED. AUDITOR REVIEWED SAMPLE OF 10 STAFF TRAINING RECORDS & ALL RECORDS INDICATED STAFF HAVE BEEN TRAINED IN PREA & SIGNED LETTERS OF ACKNOWLEDGEMENT, INDICATING THEY UNDERSTAND THE TRAINING PROVIDED.

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.231.

115.232	Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #265-F MANDATES EACH INTERN, VOLUNTEERS AND CONTRACTORS WILL BE TRAINED ON ICCS ZERO TOLERANCE POLICY & HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT. TRAINING WILL BE BASED ON SERVICES THEY PROVIDE AND THE LEVEL OF CONTACT THEY HAVE WITH RESIDENTS. EACH WILL SIGN TRAINING FORM TO ACKNOWLEDGE THE TRAINING THEY HAVE RECEIVED. FULL LENGTH & REFRESHER PPT STAFF TRAINING PROVIDED. INTERVIEW WITH CONTRACTORS ASSIGNED TO WEST FACILITY INDICATE FOR THE MOST PART THEY HAVE BEEN TRAINED IN PREA RESPONSIBILITIES, HOWEVER INTERVIEW WITH ONE BTS STAFF CONTRACTOR INDICATED SHE HAS BEEN EMPLOYED SINCE 6/8/15, HAS UNSUPERVISED CONTACT WITH RESIDENTS BUT HAS NOT RECEIVED ANY PREA TRAINING. REVIEW OF SAMPLE NUMBER OF TRAINING RECORDS FOR 2 CEO CONTRACTORS FOR WEST FACILITY INDICATE BOTH HAVE RECEIVED PREA TRAINING.. REVIEW OF 2 CEO CONTRACTORS INDICATE BOTH HAVE RECEIVED THE REQUIRED PREA TRAINING. AGENCY/FACILITY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.232(a).

b) POLICY #265-F MANDATES EACH INTERN, VOLUNTEERS AND CONTRACTORS WILL BE TRAINED ON ICCS ZERO TOLERANCE POLICY & HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT. TRAINING WILL BE BASED ON SERVICES THEY PROVIDE AND THE LEVEL OF CONTACT THEY HAVE WITH RESIDENTS. EACH WILL SIGN TRAINING FORM TO ACKNOWLEDGE THE TRAINING THEY HAVE RECEIVED. FULL LENGTH & REFRESHER PPT STAFF TRAINING PROVIDED. INTERVIEW WITH CONTRACTORS AND REVIEW OF SAMPLE TRAINING RECORDS OF CONTRACTORS DETERMINE THE REQUIRED TRAINING RECEIVED MEETS STANDARD PROVISION 115.222(b). THEY RECEIVE THE SAME PREA TRAINING AS ICCS STAFF.

c) POLICY #265-F MANDATES EACH INTERN, VOLUNTEERS AND CONTRACTORS WILL BE TRAINED ON ICCS ZERO TOLERANCE POLICY & HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT. EACH WILL SIGN TRAINING FORM TO ACKNOWLEDGE THE TRAINING THEY HAVE RECEIVED. REVIEW OF TRAINING RECORDS FOR VOLUNTEERS & CONTRACTORS DEMONSTRATES APPLICATION OF AGENCY POLICY TO HAVE TRAINEES SIGN AND ACKNOWLEDGE RECIEPT OF PREA TRAINING IN ACCORDANCE WITH STANDARD 115.232(c).

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.232.

CORRECTIVE ACTION:

AGENCY TO PROVIDE COPIES OF PREA TRAINING ATTENDANCE AND SIGNED TRAINING ACKNOWLEDGEMENT FORMS FOR ALL CONTRACTORS AND VOLUNTEERS WHO HAVE COMPLETED PREA TRAINING FOR 4 MONTHS SINCE JUNE 22, 2015 TO VERIFY DEMONSTRATION OF COMPLIANCE WITH STANDARD PROVISION 115.232(a).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/16/16:
AGENCY HAS PROVIDED AUDITOR WITH PREA TRAINING ACKNOWLEDGEMENTS FOR BOTH CEO CONTRACTORS AND THE CEO VOLUNTEER IDENTIFIED IN THE INTERIM REPORT. 100% OF BTS AND CEO CONTRACTOR AND THE ONE VOLUNTEER HAVE BEEN TRAINED IN PREA. AGENCY HAS MET THE REQUIREMENTS OF STANDARD PROVISION 115.232(a). AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.232.

115.233	Resident education

■ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #160-A, #160-D-1, #405-C-16 MANDATE RESIDENT RECEIVE ZERO TOLERANCE POLICY, HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT & RELEVANT PREA POLICIES. RESIDENTS ARE PROVIDED PREA BROCHURE BOTH IN ENGLISH AND SPANISH. ONE RESIDENT REFUSED TO UNDERGO INTAKE. INTERVIEW WITH INTAKE STAFF REVEALS ALL RESIDENTS RECEIVE PREA BROCHURE, RESIDENT HANDBOOK AND REVIEWS PREA VIDEO BEFORE BEING HOUSED. BROCHURE PROVIDES CONTACT INFORMATION FOR REPORTING SEX ABUSE/HARASSMENT TO INTERNAL & EXTERNAL AGENCIES, MENTIONS ZERO TOLERANCE POLICIES & PROVIDES FOR LIMITS OF CONFIDENTIALITY AND MONITORING RESTRICTIONS WHEN RESIDENT WISHES TO CONTACT OUTSIDE AGENCIES TO REPORT A PREA INCIDENT. RESIDENT HANDBOOK HAS PREA SECTION AND COVERS ALL RELEVANT PREA INFORMATION. INTERVIEW OF RANDOM SAMPLE OF 10 RESIDENTS VERIFY STATEMENTS MADE BY INTAKE STAFF. ALL RESIDENTS VIVIDLY RECALL THE PREA VIDEO, HOWEVER, FEW READ THE PREA BROCHURE. ALL STATE THEY RECEIVED PREA TRAINING 1ST DAY OF INTAKE. REVIEW OF 6 RESIDENTS WHO HAVE ENTERED THE FACILITY IN LAST 12 MONTHS REVEALS ALL HAVE RECEIVED PREA EDUCATION. AGENCY PROVIDED PREA BROCHURE AND RESIDENT HANDBOOK TO AUDITOR. PREA BROCHURES WERE OBSERVED IN PAMPHLET HOLDERS OUTSIDE SECURITY OFFICE AVAILABLE TO RESIDENTS IN COMPLIANCE WITH STANDARD PROVISION 115.233(a).

b) POLICY #160-D MANDATES WHENEVER RESIDENTS TRANSFERRED TO A DIFFERENT FACILITY SHALL BE PROVIDED REFRESHER TRAINING. INTERVIEW WITH INTAKE STAFF AND RANDOM SAMPLE OF RESIDENTS INDICATE NO INTRA AGENCY TRANSFERS OF RESIDENTS HAVE BEEN CONDUCTED. INTAKE STAFF INDICATE IF A RESIDENT WERE TO BE TRANSFERRED TO OR FROM A DIFFERENT FACILITY, THEY WOULD RECEIVE REFRESHER TRAINING PER POLICY IN ACCORDANCE WITH STANDARD PROVISION 115.233(b).

c) POLICY #160 MANDATES ICCS PROVIDE RESIDENT EDUCATION IN FORMATS ACCESSIBLE TO ALL RESIDENTS INCLUDING RESIDENTS WHO MEET CRITERIA OF THIS STANDARD PROVISION. RESIDENT BROCHURES ARE PROVIDED IN BOTH ENGLISH & SPANISH, HOWEVER, THE RULES OF CONDUCT WHICH IDENTIFIES PREA ON PAGE 19 WAS PROVIDED WITH PAQ IN THE ENGLISH ONLY VERSION. SPANISH VERSION IS COMING, AGENCY USES PREA BROCHURE "FACTS TO KNOW" UNTIL SPANISH VERSION IS AVAILABLE. AGENCY PROVIDED MOU WITH VOIANCE WHICH PROVIDES FOR ALL INTERPRETIVE SERVICES. RESIDENT BROCHURE AND "FACTS YOU KNOW" ADDENDUM IS PUBLISHED IN BOTH ENGLISH & SPANISH. A NUMBER ON INTAKE STAFF MEMBERS CAN TRANSLATE INTO SPANISH & VOIANCE INTERPRETER SERVICES IS AVAILABLE PER CONTRACT SHOULD A DIFFERENT LANGUAGE BE NEEDED IN ACCORDANCE WITH STANDARD PROVISION 115.233(c).

d) POLICY #405-C-16 MANDATES AFTER RESIDENT VIEWS PREA VIDEO HE/SHE WILL SIGN THE TRAINING ACKNOWLEDGEMENT FORM FOLLOWED BY STAFF MEMBER WHO PROVIDED THE TRAINING. THE FORM WILL BE MAINTAINED IN RESIDENTS FILE. NO SPANISH VERSION OF VIDEO. AGENCY USES PREA BROCHURE "FACTS TO KNOW" AS AN ALTERNATIVE. AUDITOR REVIEWED RESIDENT SCREENING DOCUMENTS. 13 RANDOM RECORDS WERE REVIEWED AND ALL CONTAINED DOCUMENTED PREA TRAINING EDUCATION CONDUCTED ON DAY OF INTAKE IN ACCORDANCE WITH STANDARD PROVISION 115.233(d).

e) WRITTEN MATERIALS AVAILABLE VIA PREA BROCHURES IN BOTH ENGLISH & SPANISH. THE RULES OF CONDUCT, WHICH IDENTIFIES PREA ON PAGE 19 WAS PROVIDED WITH PAQ IN THE ENGLISH ONLY VERSION. SPANISH VERSION IS COMING, AGENCY USES PREA BROCHURE "FACTS TO KNOW", PUBLISHED IN BOTH ENGLISH AND SPANISH, UNTIL SPANISH VERSION OF RULES OF CONDUCT IS AVAILABLE. AGENY PROVIDED ZERO TOLERANCE POSTER WHICH INCLUDES CONTACT INFO FOR RAPE CRISIS CENTER & ESL ACCESS. DURING AUDIT TOUR, AUDITOR OBSERVED PREA BROCHURES IN PAMPHLET HOLDERS OUTSIDE SECURITY OFFICE AVAILABLE TO RESIDENTS. POSTERS WERE SCARCE THROUGHOUT THE FACILITY. DURING INTERVIEW WITH RANDOM RESIDENTS, THEY COULD NOT RECALL THE CONTACT INFORMATION OR WHAT SERVICES ARE PROVIDED FOR REPORTING INCIDENTS OF SEX ABUSE OR SEX HARASSMENT. FACILITY IS NOT IN COMPLIANCE WITH STANDARD 115.233(e)

AUDITOR HAS DETERMINED FACILITY IS NOT IN COMPLIANCE WITH STANDARD 115.233

CORRECTIVE ACTION:

FACILITY TO PROVIDE PREA POSTERS, WHICH PROVIDE CONTACT INFORMATION TO RESIDENTS IN EFFECTIVE COMMUNICATION FORMATS. POSTERS ARE TO BE LOCATED IN COMMON AREAS THROUGHOUT THE FACILITY SUCH AS ALL HALLWAYS, DAY ROOMS, INTERVIEW ROOMS, EDUCATION ROOMS, LIBRARY AND COUNSELING ROOMS. VERIFICATION OF COMPLIANCE PROVIDED TO AUDITOR WILL BE IN THE FORM OF DATED PHOTOS, EACH INDICATING THE AREA OF PLACEMENT THROUGHOUT THE FACILITY.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETED 12/4/15:
AGENCY INSTALLED 19 LARGE POSTERS (24X36) AT THE KENDALL FACILITY THROUGHOUT THE HALLWAYS WHICH PROVIDES CONTACT INFORMATION TO RESIDENTS. FLORESCENT COLORED POSTERS (11X7.5) PLACED IN EACH STAFF OFFICE. BLACK & WHITE STANDARD PAPER SIZE POSTERS HAVE BEEN PLACED INSIDE EACH RESIDENTIAL ROOM AND NEXT TO EACH PHONE. AGENCY VERIFIED PLACEMENT OF POSTERS VIA DATED PHOTOS OF PLACEMENT WHICH INCLUDED THE LOCATION OF EACH POSTER IN THE PHOTO. AGENCY HAS TAKEN STEPS TO PROVIDE PREA EDUCATION POSTERS NOT ONLY IN GENERAL AREAS OF THE FACILITY, BUT ALSO IN COUNSELOR OFFICES, STAFF OFFICES AND EACH RESIDENTIAL ROOM. POSTERS PROVIDE LIMITS OF CONFIDENIALITY TO INCLUDE INFORMATION TO INDICATE THAT CALLS TO THE CONFIDENTIAL SOURCES ARE NOT MONITORED.
AUDITOR HAS DETERMINED THAT AGENCY EXCEEDS THE REQUIREMENT OF STANDARD 115.233.

115.234	**Specialized training: Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #160 MANDATES THAT BEFORE CONDUCTING ANY ADMINISTRATIVE INVESTIGATION, ALL ICCS SUPERVISORS, PROGRAM DIRECTORS, AND THE PREA COORDINATOR WILL COMPLETE THE INVESTIGATOR

TRAINING AS OUTLINED IN 115.234 (a) THRU (c). WEST FACILITY HAS 4 INVESTIGATORS. VERIFICATION CERTIFICATES OF NIC INVESTIGATOR TRAINING COMPLETION PROVIDED. INTERVIEW WITH INVESTIGATION STAFF INDICATE ALL INVESTIGATORS HAVE RECEIVED TRAINING IN CONDUCTING INVESTIGATIONS IN A CONFINEMENT SETTING THROUG NIC INVESTIGATOR TRAINING. REVIEW OF ALL 5 TRAINING RECORDS FOR INVESTIGATORS REVEALED ALL 4 POSSESSED NIC INVESTIGATION TRAINING COMPLETION CERTIFICATES IN COMPLIANCE WITH STANDARD PROVISION 115.234(b).

b) POLICY #160 MANDATES THAT BEFORE CONDUCTING ANY ADMINISTRATIVE INVESTIGATION, ALL ICCS SUPERVISORS, PROGRAM DIRECTORS, AND THE PREA COORDINATOR WILL COMPLETE THE INVESTIGATOR TRAINING AS OUTLINED IN 115.234 (a) THRU (c). INTERVIEW WITH INVESTIGATIVE STAFF INDICATE THE NIC INVESTIGATION TRAINING INCLUDE MIRANDA & GARRITY WARNINGS, EVIDENCE COLLECTION, AND EVIDENCE & CRITERIA REQUIRED TO SUBSTANTIATE A CASE FOR ADMINISTRATIVE ACTION OR PROSECUTION REFERRAL IN ACCORDANCE WITH STANDARD PROVISION 115.234(b).

c) ALL 5 NIC INVESTIGATOR TRAINING COMPLETION SIGNED DOCUMENTS PROVIDED TO AUDITOR WITH PAQ. AUDITOR REVIEW OF SEX ABUSE INVESTIGATOR TRAINING RECORDS VERIFIES AGENCY MAINTAINS DOCUMENTATION OF THE REQUIRED SEX ABUSE INVESTIGATION IN A CONFINEMENT SETTING TRAINING DOCUMENTS.

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.234.

115.235	**Specialized training: Medical and mental health care**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165, IDENTIFIED TO SUPPORT COMPLIANCE OF THIS STANDARD PROVISION DOES NOT PROVIDE ANY SPECIALIZED TRAINING PROCEDURES SPECIFIC TO MENTAL HEALTH CARE. POLICY #165 MANDATES MENTAL HEALTH WORKERS MUST COMPLETE THE SAME PREA TRAINING AS EMPLOYEES. AGENCY HAS NOT PROVIDED # OF BTS STAFF THAT HAS BEEN TRAINED. MH STAFF IS CONTRACTED THROUGH BTS TO PERFORM SERVICES AT ICCS & NO MEDICAL STAFF ARE ASSIGNED TO ICCS AS ALL MEDICAL ACTIVITIES ARE CONDUCTED AT ST ANTHONY'S HOSPITAL. INTERVIEW WITH MENTAL HEALTH STAFF INDICATES THEY ARE TRAINED BY ICCS STAFF. AGENCY HAD NOT PROVIDED COPIES OF TRAINING RECORDS FOR BTS STAFF WITH PAQ. REVIEW OF 2 RANDOM TRAINING RECORDS REVEALED ONE BTS STAFF MEMBER WHO HAS BEEN EMPLOYED SINCE 6/8/15, HAS UNSUPERVISED CONTACT WITH RESIDENTS AND HAS NOT RECEIVED PREA TRAINING. ICCS DOES NOT EMPLOY OR CONTRACT MEDICAL STAFF TO WORK INSIDE IT'S FACILITIES. AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.235(a).

b) FORENSIC EXAMINATIONS ARE NOT CONDUCTED AT ANY ICCS FACILTIES. ALL SUCH EXAMINATIONS ARE PROVIDED THROUGH MOU CONTRACT WITH ST ANTHONY'S HOSPITAL. STANDARD PROVISION 115.235(b) IS NOT APPLICABLE TO THIS AGENCY/FACILITY.

c) AGENCY MAINTAINS PREA TRAINING DOCUMENTATION FOR MENTAL HEALTH STAFF (BTS). AUDITOR REVIEWED TRAINING RECORDS FOR SAMPLE BTS CONTRACTORS DURING AUDIT TOUR.

d) ALL STAFF, INCLUDING MENTAL HEALTH PRACTITIONERS, RECEIVE THE SAME PREA TRAINING PER POLICY#165 IN ACCORDANCE WITH STANDARD PROVISION 115.235 (d). NO MEDICAL STAFF EMPLOYED AT ICCS FACILITIES.

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.235.

CORRECTIVE ACTION:

AGENCY TO PROVIDE AUDITOR WITH PREA EDUCATION TRAINING RECORDS WHICH IDENTIFIES PREA EDUCATION ATTENDANCE AND EDUCATION ACKNOWLEDGEMENT FOR ALL BTS MENTAL HEALTH CONTRACT STAFF TO VERIFY ALL STAFF ASSIGNED TO THE WEST FACILITY HAVE BEEN TRAINED IN PREA PER BTS MOU CONTRACT AND POLICY #165 IN ORDER TO COMPLY WITH STANDARD PROVISION 115.235(a).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/16/16 :
AGENCY TRAINED ALL BTS STAFF IN PREA. AGENCY PROVIDED TRAINING ACKNOWLEDGEMENT FORMS WHICH INDICATE STAFF UNDERSTANDS THE PREA TRAINING THAT WAS PROVIDED, FOR ALL BTS STAFF. AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.235

115.241	**Screening for risk of victimization and abusiveness**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

■ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #160 & POLICY #600 MANDATES THAT WITHIN 72 HOURS OF ADMISSION, THE CASE MANAGER WILL CONDUCT A RISK ASSESSMENT TO ENSURE THOSE AT HIGH RISK OF BEING SEXUALLY ABUSED ARE NOT HOUSED WITH THOSE WHO ARE AT RISK OF BEING SEXUALLY ABUSIVE. INTERVIEW WITH CASE MANAGERS WHO CONDUCT RISK SCREENINGS, INDICATE THEY CONDUCT THE 72 HOUR RISK ASSESSMENT SCREENINGS AFTER INTAKE OF RESIDENTS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEY HAVE THE INITIAL SCREENING AND SEE THE CASE MANAGER AFTER THEIR INITIAL INTAKE IN COMPLIANCE WITH STANDARD PROVISION 115.241(a).
b) WITHIN 72 HOURS OF ADMISSION, THE CASE MANAGER WILL CONDUCT A RISK ASSESSMENT TO ENSURE THOSE AT HIGH RISK OF BEING SEXUALLY ABUSED ARE NOT HOUSED WITH THOSE WHO ARE AT RISK OF BEING SEXUALLY ABUSIVE. AGENCY DID NOT TRACK THE NUMBER OF RESIDENTS ENTERING FACILITY OVER PAST 12 MONTHS THAT WAS SCREENED FOR RISK OF SEXUAL VICTIMIZATION WITHIN 72 hOURS OF ENTRY INTO THE FACILITY. AGENCY HAS RECENTLY ADDED A 72 HOUR AND A 30 DAY EVENT TO MARK OFF IN CLIENT'S "SPECIAL CONCERNS" SECTION REGARDLESS IF A CLIENT HAS ANY CONCERNS OR NOT. INTERVIEW WITH CASE MANAGERS WHO CONDUCT RISK SCREENINGS, INDICATE THEY CONDUCT THE 72 HOUR RISK ASSESSMENT

SCREENINGS AFTER INTAKE OF RESIDENTS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEY HAVE THE INITIAL SCREENING AND SEE THE CASE MANAGER AFTER THEIR ARRIVAL AT FACILITY. REVIEW OF RANDOM SAMPLE OF 13 RESIDENT SCREENING RECORDS INDICATE THAT 5 RESIDENT SCREENINGS WERE BEYOND THE 72 HOUR LIMIT. INTERVIEW WITH PREA COORDINATOR INDICATES THE 72 HOUR SCREENING WAS NOT TRACKED VIA DATABASE OR REVIEW. AUDITOR REVIEWED SCREENING INSTRUMENT DURING ON SITE TOUR. SCREENINGS FOR DEPT. OF CORRECTIONS REFERRALS ARE CONDUCTED ON A DATABASE THAT DOES NOT ALLOW FOR CASE MANAGERS TO REVIEW DATA ONCE COMPLETED, THEREFORE THEY HAVE NO RECORD OF COMPLETED SCREENINGS ON THOSE RESIDENTS. FACILITY IS NOT COMPLIANT WITH STANDARD PROVISION 115.241(b).

c) SCREENING INSTRUMENTS USED FOR ALL RESIDENTS ARE COMPLIANT WITH STANDARD PROVISION 115.241(c).

d) SCREENING INSTRUMENT INCLUDES ALL 9 CRITERIA IDENTIFIED IN STANDARD 115.241(d). INTERVIEW WITH SCREENING STAFF INDICATE THEY ASK QUESTIONS FROM ALL RESIDENTS TO MEET CRITERIA OUTLINED IN STANDARD 115.241(d).

e) INSTRUMENT CONSIDERS CRITERIA AS IDENTIFIED IN STANDARD 115.241(e). INTERVIEW WITH SCREENING STAFF VERIFIES USE OF SCREENING INSTRUMENT AS OUTLINED IN STANDARD PROVISION 115.241(e).

f) POLICY #600 MANDATES REASSESSMENT WITHIN 30 DAYS OF INTAKE BASED UPON ADDITIONAL INFORMATION OR ANY RELEVANT INFORMATION RECEIVED AFTER THE INITIAL ASSESSMENT. NUMBER OF RESIDENTS REASSESSED WITHIN 30 DAYS OF INTAKE OR TRANSFER WAS NOT TRACKED & NO CALCULATIONS PROVIDED. AGENCY HAS RECENTLY ADDED A 72 HOUR AND A 30 DAY EVENT TO MARK OFF IN CLIENT'S "SPECIAL CONCERNS" SECTION REGARDLESS IF A CLIENT HAS ANY CONCERNS OR NOT. INTERVIEW WITH CASE MANAGERS WHO CONDUCT RISK SCREENINGS, INDICATE THEY CONDUCT THE 30 DAY RISK ASSESSMENT SCREENING REQUIREMENT BETWEEN 20 AND 30 DAYS AFTER INTAKE OF RESIDENTS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE 1/3 RECALL HAVING A 30 DAY RE-ASSESSMENT SCREENING. REVIEW OF RANDOM SAMPLE OF 13 RESIDENT SCREENING RECORDS INDICATE THAT 5 RESIDENT SCREENINGS MET THE 30 DAY RE-ASSESSMENT REQUIREMENT LIMIT, 5 RESIDENT RECORDS WERE BEYOND THE 30 DAY RE-ASSESSMENT REQUIREMENT LIMIT AND 3 RECORDS HAD NO DOCUMENTATION TO PROVE THE 30 DAY SCREENING RE-ASSESSMENT EVER OCCURRED. INTERVIEW WITH PREA COORDINATOR INDICATES THE 30 DAY RE-ASSESSMENT SCREENING WAS NOT TRACKED VIA DATABASE OR REVIEW. AUDITOR REVIEWED SCREENING INSTRUMENT DURING ON SITE TOUR. SCREENINGS FOR THE RESIDENTS WHO DEPT. OF CORRECTIONS REFERRALS ARE CONDUCTED ON A DATABASE THAT DOES NOT ALLOW FOR CASE MANAGERS TO REVIEW DATA ONCE COMPLETED, THEREFORE THEY HAVE NO RECORD OF COMPLETED SCREENINGS ON THOSE RESIDENTS. FACILITY IS NOT COMPLIANT WITH STANDARD PROVISION 115.241(f). FACILITY IS NOT COMPLIANT WITH STANDARD PROVISION 115.241(f).

g) POLICY #600 MANDATES REASSESSMENT WITHIN 30 DAYS OF INTAKE BASED UPON ADDITIONAL INFORMATION OR ANY RELEVANT INFORMATION RECEIVED AFTER THE INITIAL ASSESSMENT. INTERVIEW WITH CASE MANAGERS INDICATE ALL RESIDENTS ARE RE-SCREENED WITHIN 30 DAYS OF INTAKE REGARDLESS AS TO WHETHER ADDITIONAL OR RELEVANT INFORMATION WAS RECEIVED AFTER THE INITIAL ASSESSMENT. THERE WERE NO RECORDS OF RESIDENTS WHO HAD BEEN

VICTIMS OR PERPETRATORS OF SEXUAL ABUSE FOR CONFIRMATION OF REASSESSMENT. AGENCY IS COMPLIANT WITH STANDARD 115.241(g).

h) POLICY 600 PROVIDES NARRATIVE TO PROHIBIT DISCIPLINING A RESIDENT FOR REFUSING TO ANSWER OR NOT DISCLOSING COMPLETE INFORMATION IN RESPONSE TO THE INITIAL SCREENING OR REASSESSEMENT. INTERVIEW OF SCREENING STAFF VERIFIES DEMONSTRATION OF POLICY MANDATES AND COMPLIANCE WITH STANDARD PROVISION 115.241(h)

i) POLICY #600 HAS APPROPRIATE CONTROLS INCORPORATED INTO THE NARRATIVE TO MAINTAIN OR CONTROL DISSEMINATION TO SENSITIVE INFORMATION PROVIDED IN SCREENING RESPONSES. ALL INFORMATION IS ENTERED INTO THE E-TRAC SYSTEM BY THE CASE MANAGER WITHING 72 HOURS OF INTAKE. ACCESS TO SCREENING INFORMATION IS NEED TO KNOW FOR SAFETY PURPOSES. INTERVIEW WITH RISK SCREENING STAFF INDICATE SCREENING RECORDS ARE SECURED IN THE CASE MANAGER'S OFFICE. CASE MANAGERS, ADMINISTRATORS AND STAFF ON A NEED TO KNOW BASIS HAVE ACCESS TO THESE RECORDS. INTERVIEW WITH PREA COORDINATOR INDICATE DEPT. OF CORRECTION RESIDENT SCREENING RECORDS ARE MAINTAINED ELECTRONICALLY ON A DOC DATABASE & HAVE NO ACCESS TO THESE RECORDS AFTER UPDATING THE SCREENING INFORMATION. 72 HOUR AND 30 DAY ASSESSMENTS WERE NOT TRACKED PRIOR TO AUDIT. ALL UPDATES RELATED TO SCREENING WILL BE ENTERED ON THE E-TRACK DATABASE SYSTEM AND HARD COPY OF SCREENING INSTRUMENTS USED IN ASSESSMENTS WILL BE MAINTAINED ALSO IN THE RESIDENTS CASE FILE IN ORDER TO COMPLY WITH STANDARD PROVISION 115.241(i).

AUDITOR HAS DETERMINED THAT AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.241.

CORRECTIVE ACTION:

1. AGENCY TO AMEND POLICY #600 TO MANDATE INTAKE AND SCREENING STAFF CONDUCT E-TRAC ELECTRONIC UPDATES OF INTAKE DATES, 72 HOUR ASSESSMENTS AND 30 DAY ASSESSMENTS OF ALL RESIDENTS ENTERING THE FACILITY AND RESIDENTS WHO TRANSFER BETWEEN AGENCY FACILITIES. POLICY WILL MANDATE THAT THE UPDATES WILL BE CONDUCTED THE SAME DAY THE ASSESSMENTS OCCUR.

2. AGENCY WILL PROVIDE VERIFICATION OF COMPLIANCE THROUGH RANDOM SELECTION OF RESIDENTS BY AUDITOR TO VERIFY THAT AGENCY HAS DEMONSTRATED COMPLIANCE OF STANDARD PROVISIONS 115.241(b) and 115.241(f) THROUGH BOTH THE E-TRAC ELECTRONIC SYSTEM AND HARD COPY INTAKE, 72 HOUR ASSESSMENT AND 30 DAY REASSESSMENT RECORDS.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/18/16 :
AGENCY AMENDED POLICY #600 TO MANDATE REQUIREMENT FOR CASE MANAGER TO ENTER ALL INTAKE INFORMATION INTO THE E-TRAC SYSTEM WITHIN 3 WORKING DAYS OF CLIENT'S ARRIVAL. WITHIN 72 HOURS OF ADMISSION, CASE MANAGER IS MANDATED TO COMPLETE THE PREA RISK ASSESSMENT & REASSESS EACH RESIDENT WITHIN 30 DAYS OF INTAKE BASED ON ANY RELEVANT OR ADDITIONAL INFORMATION RECEIVED AFTER RISK ASSESSMENT. ALL ASSESSMENT RESULTS WILL BE ENTERED INTO THE SPECIAL CONCERNS SECTION OF THE E-TRAC SYSTEM.

ON 3/15/16, AGENCY PROVIDED AUDITOR WITH E-TRAC ASSESSMENT RESULTS FOR BOTH THE 72 HOUR SCREENING AND 30 DAY REASSESSMENTS WHICH OCCURRED BETWEEN AUGUST 2015 AND MARCH 2016. UPON REVIEW OF 255 72-HOUR INITIAL SCREENINGS, AUDITOR IDENTIFIED 23 NON-COMPLIANT 72-HOUR SCREENINGS. WITH A 9% ERROR RATE, AUDITOR DETERMINED AGENCY TO BE 91% COMPLIANT FOR THE 72-HOUR INITIAL SCREENINGS.
UPON REVIEW OF 150 30-DAY SCREENING RE-ASSESSMENTS, AUDITOR IDENTIFIED 20 NON-COMPLIANT 30 DAY REASSESSMENT SCREENINGS. WITH A 13% ERROR RATE, AUDITOR DETERMINED AGENCY TO BE 87% COMPLIANT FOR THE 30 DAY REASSESSMENT SCREENINGS. BOTH INITIAL 72-HOUR AND 30 DAY REASSESSMENT SCREENINGS WERE FOUND TO HAVE BEEN CONDUCTED AFTER THE 72-HOUR INTIAL SCREENING AND 30-DAY REASSESSMENT DEADLINES. AGENCY IS NON-COMPLIANT WITH STANDARD PROVISIONS 115.241(b) and 115.241(f).

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.241.

115.242	**Use of screening information**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) AGENCY USES SCREENING INFORMATION TO SEPARATE VICTIMS, POTENTIAL VICTIMS & PREDATORS DURING HOUSING & PROGRAMMING ASSIGNMENTS. AN OBJECTIVE SCREENING INSTRUMENT IS USED ALONG WITH THE CLASSIFICATION FOR HOUSING DOCUMENT, WHICH IDENTIFIES SPECIFIC HOUSING ASSIGNMENTS AND CHARACTERISTICS GLEANED FROM THE SCREENING TOOL. EACH RESIDENT IS EXAMINED INDIVIDUALLY TO PROVIDE SEXUAL SAFETY IN THE FACILITY. INTERVIEWS WITH PREA COORDINATOR & RISK SCREENING STAFF AND REVIEW OF CLASSIFICATION DOCUMENTS BY AUDITOR DURING ON-SITE TOUR, VERIFIES BOTH THE OBJECTIVE SCREENING TOOL AND CLASSIFICATION FOR HOUSING DOCUMENTATION IS USED FOR HOUSING AND PROGRAM ASSIGNMENTS FOR RESIDENTS TO PROVIDE SEXUAL SAFETY WHILE HOUSED AT THE FACILITY PER STANDARD PROVISION 115.242(a).
b) POLICY #600 MANDATES AGENCY MAKE INDIVIDUAL DETERMINATIONS ON CASE BY CASE BASIS TO ENSURE SAFETY OF EACH RESIDENT. INTERVIEWS WITH CASE MANAGERS RESPONSIBLE FOR RISK SCREENING INDICATE INDIVIDUAL DETERMINATION ARE MADE ON A CASE BY CASE BASIS TO ENSURE RESIDENT SAFETY. CASE MANAGERS COORDINATE WITH SECURITY INTAKE STAFF AND ADMINISTRATION IN ORDER TO MAINTAIN A SAFE ENVIRONMENT FOR RESIDENTS. IN ACCORDANCE WITH STANDARD PROVISION 115.242(b).

c) POLICY #600 MANDATES AGENCY MAKE INDIVIDUAL DETERMINATIONS ON CASE BY CASE BASIS TO ENSURE SAFETY OF EACH RESIDENT. INTERVIEWS WITH CASE MANAGERS RESPONSIBLE FOR RISK SCREENING INDICATE INDIVIDUAL DETERMINATION ARE MADE ON A CASE BY CASE BASIS TO ENSURE RESIDENT SAFETY. CASE MANAGERS COORDINATE WITH SECURITY INTAKE STAFF AND ADMINISTRATION IN ORDER TO MAINTAIN A SAFE ENVIRONMENT FOR RESIDENTS. NO TRANSGENDER RESIDENTS HOUSED IN THE FACILITY FOR AUDITOR TO INTERVIEW. FACILITY IS COMPLIANT WITH STANDARD PROVISION 115.242(c).

d) POLICY #160 PROVIDES FOR CONSIDERATION PROVIDED FOR TRANSGENDER OR INTERSEX RESIDENT'S OWN VIEWS WITH RESPECT TO HIS OR HER OWN SAFETY. INTERVIEWS WITH PREA COORDINATOR AND CASE MANAGERS RESPONSIBLE FOR RISK SCREENING INDICATE TRANSGENDER AND INTERSEX RESIDENTS ARE ASKED QUESTIONS REGARDING THEIR VIEWS WITH RESPECT TO THEIR OWN SAFETY & THEIR RESPONSE IS GIVEN CONSIDERATION WITH RESPECT TO HOUSING AND PROGRAMMING NEEDS, COMPLAINT WITH STANDARD PROVISION 115.242(d). NO TRANSGENDER RESIDENTS HOUSED AT WEST FACILITY FOR AUDITOR TO INTERVIEW.

e) POLICY #160 PROVIDES FOR TRANSGENDER AND INTERSEX RESIDENTS TO BE AFFORDED THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. INTERVIEWS WITH PREA COORDINATOR, CASE MANAGERS RESPONSIBLE FOR RISK SCREENING AND TRANSGENDER RESIDENTS VERIFY AGENCY PROVIDES TRANSGENDER & INTERSEX RESIDENT THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. DURING ON-SITE TOUR, AUDITOR VIEWED ALL BATHROOMS AND SHOWERS WHICH ARE CONNECTED TO EACH INDIVIDUAL ROOM. EACH BATHROOM PROVIDES SEPARATE SHOWER AND TOILETING STALLS WHICH ARE PREA COMPLIANT TO PROVIDE PRIVACY IN ACCORDANCE WITH STANDARD PROVISION 115.242(e).

f) POLICY #160 PROHIBITS AGENCY FROM PLACING RESIDENTS IN DEDICATED FACILTIES BASED UPON THEIR LGBTI STATUS. INTERVIEW WITH PREA COORDINATOR VERIFIES AGENCY POSSESSES NO DEDICATED FACILITIES FOR MEMBERS OF THE LGBTI COMMUNITY IN COMPLIANCE WITH STANDARD PROVISION 115.242(f).

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.242

115.251	Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 PROVIDES FOR MULTIPLE INTERNAL WAYS FOR RESIDENTS TO PRIVATELY REPORT TO AGENCY OFFICIALS ABOUT SEX ABUSE/HARASSMENT. POLICY PROVIDES NARRATIVE REGARDING REPORTING OF RETALIATION BY OTHER RESIDENTS OR STAFF FOR REPORTING SEX ABUSE/HARASSMENT AND INCLUDES REPORTING STAFF NEGLECT OR VIOLATION OF RESPONSIBILITIES THAT MAY HAVE CONTRIBUTED TO SUCH INCIDENTS. PREA BROCHURE IN BOTH ENGLISH AND SPANISH INCLUDES VERBIAGE RELATED TO RETALIATION IN COMPLIANCE WITH STANDARD PROVISION. ZERO TOLERANCE DOOR POSTER FOR WEST FACILITY INCLUDES CONFIDENTIAL REPORTING CONTACT NUMBERS AND INCLUDES RETALIATION AS A REPORTING CRITERIA. CONTACT NUMBER INFORMATION IS PROVIDED IN BOTH ENGLISH AND SPANISH TO PROVIDE FOR EFFECTIVE COMMUNICATION. RANDOM SAMPLE OF STAFF AND RANDOM SAMPLE OF RESIDENT INTERVIEWS DETERMINES THAT INTERNAL WAYS TO PRIVATELY REPORT SEX ABUSE/HARASSMENT IS THROUGH THE PROGRAM DIRECTOR IN COMPLIANCE WITH STANDARD PROVISION 115.251(a).

b) POLICY #165 DOES PROVIDES A METHOD FOR RESIDENTS TO REPORT ABUSE OR HARASSMENT TO A PUBLIC OR PRIVATE ENTITY WHICH IS NOT PART OF THE AGENCY BY DAILING 911 TO LOCAL LAW ENFORCEMENT. THIS INFORMATION IS ALSO AVAILABLE ON AGENCY WEBSITE. AGENCY IS IN PROCESS OF SECURITY AN MOU WITH LAKEWOOD PD AND HAS SECURED MOU FROM BTS FOR PRIVATE REPORTING. E-MAIL CORRESPONDENCE PROVIDED TO VERIFY ONGOING COMMUNICATION TO SECURE SAID MOU FROM LAKEWOOD PD. INTERVIEW WITH PREA COORDINATOR INDICATES THE DOC TIPS LINE AND BLUE BENCH RAPE CRISIS CENTER ARE BOTH AVAILABLE FOR RESIDENTS AND STAFF TO PRIVATELY REPORT INCIDENTS OF SEX ABUSE/HARASSMENT OUTSIDE THE AGENCY. PREA EDUCATION LITERATURE PROVIDED TO RESIDENTS INCLUDES CONTACT INFORMATION, LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING INFORMATION. AGENCY COMPLIES WITH STANDARD PROVISION 115.251(b).

c) POLICY #160 MANDATES IMMEDIATE REPORTING OF ANY INCIDENT OF SEX ABUSE/HARASSMENT. METHOD OF RECEIPT OF REPORTS IS INCLUDED IN POLICY. NARRATIVE IS INCLUDED IN THE RULES OF CONDUCT BOOK PAGE #20 PROVIDED TO ALL RESIDENTS AT INTAKE, WHICH INCLUDES METHOD STAFF MAY RECEIVE REPORTS. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATES THEIR EDUCATION AND KNOWLEDGE THAT THEY SHALL ACCEPT REPORTS MADE VERBALLY, IN WRITING, ANNONYMOUSLY AND FROM 3RD PARTIES AND SHALL DOCUMENT VERBAL REPORT IMMEDIATELY. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEIR KNOWLEDGE OF THEIR PREA RIGHTS THAT THEY CAN MAKE REPORTS OF SEX ABUSE & SEX HARASSMENT TO STAFF IN THE SAME WAY IN ACCORDANCE WITH STANDARD PROVISION 115.251(c).

d) POLICY #160 PROVIDES METHOD FOR STAFF TO PRIVATELY REPORT SEXUAL ABUSE/HARASSMENT OF RESIDENTS BY CONTACTING THE PROGRAM DIRECTOR OR PREA COORDINATOR IMMEDIATELY BY PHONE OR E-MAIL. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATE THEY MAY REPORT SEX ABUSE/HARASSMENT OF RESIDENTS BY CONTACTING THE PROGRAM DIRECTOR, PREA COORDINTATOR OR

THE DOC TIPS LINE FOR PRIVATELY REPORTING PURPOSES IN ACCORDANCE WITH STANDARD PROVISION 115.251(d).

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.251.

115.252	Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #340 INCLUDES NARRATIVE TO MANDATE PROCEDURES FOR SEX ABUSE COMPLIANTS & GRIEVANCES. INTERVIEW WITH PREA COORDINATOR DURING ON-SITE AUDIT VERIFIES DEMONSTRATION OF POLICY AND STANDARD PROVISION 115.252(a). ANY GRIEVANCE, WHICH RELATES TO A PREA RELATED INCIDENT DIRECTLY TO ANY STAFF MEMBER WHO IS TO IMMEDIATELY NOTIFY THE PROGRAM DIRECTOR OR ON-CALL SUPERVISOR. STAFF WILL TAKE IMMEDIATE ACTION TO PROTECT THE RESIDENT.

b) POLICY #340 MANDATES A TIME LIMIT WILL NOT BE IMPOSED WITH REGARDS TO THE FILING OF A GRIEVANCE REGARDING AN ALLEGATION OF SEXUAL ABUSE. GREIVANCES REGARDING SEX ABUSE ARE TO BE PROVIDED DIRECTLY TO ANY STAFF MEMBER WHO IS TO IMMEDIATELY NOTIFY THE PROGRAM DIRECTOR OR ON-CALL SUPERVISOR. STAFF WILL TAKE IMMEDIATE ACTION TO PROTECT THE RESIDENT. REVIEW OF RESIDENT HANDBOOK HAS NO RELEVANT INFORMATION REGARDING PROHIBITING TIME LIMITS ON GRIEVANCES ALLEGING SEX ABUSE/HARASSMENT. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.252(b).

c) POLICY #340 COMPLIES WITH STANDARD PROVISION 115.252(c) AS IT MANDATES THAT RESIDENT IS NOT REQUIRED TO SUBMIT A NORMAL GRIEVANCE TO STAFF MEMBER WHO IS SUBJECT OF THE GRIEVANCE OR HAVE IT REFERRED TO THAT STAFF MEMBER. THIS STATEMENT IS INCLUDED IN THE GRIEVANCE SECTION OF THE RULES OF CONDUCT HOUSE POLICY FOR FILING A GRIEVANCE REGARDING AN ALLEGATION OF SEXUAL ABUSE. REVIEW OF RESIDENT HANDBOOK RULES OF CONDUCT AND HOUSE POLICIES GREIVANCE SECTION, PAGE 12, COMPLIES WITH STANDARD PROVISION 115.252(c) & INCLUDES NARRATIVE TO MEET STANDARD.

d) POLICY #340 IS COMPLIANT WITH STANDARD PROVISION 115.252(d). POLICY 340 B 2 REQUIRES THAT THE ALLEGED VICTIM MUST AGREE TO HAVE A 3RD PARTY FILE THE GRIEVANCE ON THEIR BEHALF, VICTIM MUST ALSO AGREE TO PERSONALLY PURSUE ANY SUBSEQUENT STEPS IN THE ADMINISTRATIVE REMEDY PROCESS.NO GRIEVANCES FILED OVER PAST 12 MONTHS WHICH ALLEGES SEXUAL ABUSE.

e) POLICY #340 COMPLIANT WITH STANDARD PROVISION 115.252(d). NO GRIEVANCES FILED OVER PAST 12 MONTHS WHICH ALLEGES SEXUAL ABUSE.

f) POLICY #340 COMPLIES WITH STANDARD PROVISION 115.252(f). NO EMERGENCY GRIEVANCES FILED IN THE PAST 12 MONTHS.

g) POLICY #340 LIMITS ITS ABILITY TO DISCIPLINE RESIDENT FOR FILING A GRIEVANCE ALLEGING SEXUAL ABUSE TO OCCASIONS WHERE AGENCY DEMONSTRATES RESIDENT FILED THE GRIEVANCE IN BAD FAITH.

THERE HAVE BEEN NO RESIDENT GRIEVANCES IN THE PAST 12 MONTHS THAT RESULTED IN DISCIPLINARY ACTION AGAINST THE RESIDENT FOR FILING THE REPORT IN BAD FAITH. AGENCY IS IN COMPLIANCE WITH STANDARD PROVISION 115.252(g).

AUDITOR HAS DETERMINED AGENCY/FACILITY DOES NOT MEET STANDARD 115.252.

CORRECTIVE ACTION:

1. AGENCY TO AMEND RESIDENT HANDBOOK GRIEVANCE SECTION, PG#12-D TO INCLUDE NARRATIVE PROHIBITING TIME LIMITS ON GRIEVANCES ALLEGING SEXUAL ABUSE AND SEXUAL HARASSMENT TO COMPLY WITH STANDARD PROVISION 115.252(b).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 12/4/15 :

AGENCY AMENDED RESIDENT HANDBOOK GRIEVANCE SECTION WITH NARRATIVE, WHICH PROHIBITS TIME LIMITS ON GRIEVANCES ALLEGING SEXUAL ABUSE AND SEXUAL HARASSMENT. AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.252.

115.253	Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 PROVIDES RESIDENTS WITH ACCESS TO OUTSIDE VICTIM ADVOCATES (BLUE BENCH RAPE CRISIS CENTER) FOR EMOTIONAL SUPPORT. CONTACT INFORMATION IS PROVIDED IN RESIDENT BROCHURE IN ENGLISH & SPANISH PROVIDED AT INTAKE AND ON PREA DOOR POSTER PROVIDED ON ENTRY DOOR TO HOUSING UNITS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATED SOME WERE KNOWLEDGEABLE REGARDING ACCESS TO OUTSIDE VICTIM ADVOCATES FOR EMOTIONAL SUPPORT. HALF OF THOSE INTERVIEWED STATED A RAPE CRISIS CENTER OR POLICE DEPARTMENT. THE OTHER HALF MENTIONED THE PROGRAM DIRECTOR. AUDITOR RECOMMENDS INCREASED PREA SIGNAGE WHICH PROVIDES CONTACT INFORMATION FOR VICTIM ADVOCATES WHICH WOULD PROVIDE RESIDENTS WITH ONGOING EDUCATION AS TO THEIR RIGHTS TO ADVOCACY FOR EMOTIONAL SUPPORT OUTSIDE OF THE AGENCY. CURRENT EDUCATION PROVIDED RESIDENTS AT INTAKE MEETS STANDARD PROVISION 115.253(a).

b) POLICY #160 MANDATES MEDICAL AND MENTAL HEALTH PRACTITIONERS INFORM RESIDENTS OF DUTY TO REPORT & LIMITS OF CONFIDENTIALITY. POLICY #165 AND HOUSING DOOR POSTERS ARE NOT COMPLIANT WITH STANDARD PROVISION 115.253(b). THERE IS NO NARRATIVE DOCUMENTATION WHICH PROVIDES THE EXTENT TO WHICH OUTSIDE SUPPORT SERVICES COMMUNICATIONS WILL BE MONITORED. RULES OF CONDUCT & HOUSE POLICIES PROVIDES CONTACT INFORMATION FOR OUTSIDE VICTIM ADVOCATE SERVICES BUT NO MENTION OF AGENCY MONITORING CONTACT WITH THE ADVOCATE SERVICES. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEY ARE AWARE OF LIMITS TO CONFIDENTIALITY REGARDING ADVOCATE SERVICES BUT ARE UNSURE AS TO IF THESE CALLS ARE MONITORED IF CONTACTING THESE SERVICES VIA FACILITY PHONE. DUE TO AGENCY'S FAILURE TO INFORM RESIDENTS PRIOR TO PROVIDING THEM ACCESS TO OUTSIDE SUPPORT SERVICES OF THE MONITORING REQUIREMENT, AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.253(b).

c) AGENCY MEETS STANDARD PROVISION 115.253(c) AS A SIGNED MOU WITH BLUE BENCH RAPE CRISIS CENTER HAS BEEN REACHED AND SIGNED. BLUE BENCH PROVIDES ADVOCACY FOR EMOTIONAL SUPPORT FOR RESIDENTS AT ICCS FACILITIES. AGENCY MEETS STANDARD PROVISION 115.253(c) AS A SIGNED MOU WITH BLUE BENCH RAPE CRISIS CENTER HAS BEEN REACHED AND SIGNED. BLUE BENCH PROVIDES ADVOCACY FOR EMOTIONAL SUPPORT FOR RESIDENTS AT ICCS FACILITIES WHICH MEETS STANDARD PROVISION 115.253(c).

AUDITOR HAS DETERMINED AGENCY/FACILTY IS NOT COMPLIANT WITH STANDARD 115.253

CORRECTIVE ACTION:

1. AGENCY TO AMEND PREA EDUCATION BROCHURES, RESIDENT HANDBOOK, PREA DOOR POSTERS AND POSTERS PROVIDED IN COMMON AREAS THROUGHOUT RESIDENCE, TO PROVIDE LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING INFORMATION REGARDING COMMUNICATIONS WITH OUTSIDE VICTIM ADVOCATE SERVICE AGENCIES.
2. AGENCY TO PROVIDE AUDITOR WITH VERIFICATION DOCUMENTATION IN ORDER TO BE COMPLIANT WITH STANDARD PROVISION 115.253(b).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 12/4/15 :

AGENCY INSTALLED 19 LARGE POSTERS (24X36) AT THE KENDALL FACILITY THROUGHOUT THE HALLWAYS WHICH PROVIDES CONTACT INFORMATION TO RESIDENTS. FLORESCENT COLORED POSTERS (11X7.5) PLACED IN EACH STAFF OFFICE. BLACK & WHITE STANDARD PAPER SIZE POSTERS HAVE BEEN PLACED INSIDE EACH RESIDENTIAL ROOM, AND NEAR EACH PHONE. AGENCY VERIFIED PLACEMENT OF POSTERS VIA DATED PHOTOS OF PLACEMENT WHICH INCLUDED THE LOCATION OF EACH POSTER IN THE PHOTO. AUDITOR HAS DETERMINED THAT AGENCY EXCEEDS THE REQUIREMENT OF STANDARD 115.233. POSTERS PROVIDE LIMITS OF CONFIDENIALITY TO INCLUDE INFORMATION TO INDICATE THAT CALLS TO THE CONFIDENTIAL SOURCES ARE NOT MONITORED. POSTERS ALSO PROVIDE LIMITS OF CONFIDENTIALITY. RESIDENT RULEBOOK ALSO PROVIDES THE SAME INFORMATION. AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.253. AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.253.

115.254	Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

AGENCY NARRATIVE WITH RESPECT OF RECEIVING 3RD PART REPORTS IS PUBLISHED PUBLICLY ON THE AGENCY WEBSITE.

AUDITOR HAS DETERMINED AGENCY IS IN COMPLIANCE WITH STANDARD 115.254

115.261	Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #160 MANDATES ALL STAFF TO IMMEDIATELY REPORT ANY SEXUAL MISCONDUCT, KNOWLEDGE OR SUSPICION OF SEXUAL MISCONDUCT. INTERVIEW WITH RANDOM SAMPLE OF STAFF VERIFIES THEIR TRAINING AND KNOWLEDGE REGARDING STAFF AND AGENCY REPORTING DUTIES ARE COMPLIANT WITH STANDARD PROVISION 115.261(a).

b) POLICY #165 STATES ICCS WILL ONLY SHARE INFORMATION AS REQUIRED BY LAW IN ORDER TO PROTECT THE CONFIDENTIALITY OF ITS CLIENTS. INTERVIEW WITH RANDOM SAMPLE OF STAFF DETERMINES STAFF HAVE BEEN TRAINED TO PROVIDE INFORMATION REGARDING SEXUAL ABUSE TO ONLY SUPERVISORS AND OFFICIALS ON A NEED TO KNOW BASIS IN ACCORDANCE WITH STANDARD PROVISION 115.261(b).

c) POLICY #160 PROVIDES NARRATIVE THAT IDENTIFIES LIMITS OF CONFIDENTIALITYAND PROVIDES NARRATIVE STATING PRACTIONER WILL INFORM RESIDENTS AT THE INITIATION OF SERVICES WITH REGARDS TO THEIR DUTY TO REPORT. INTERVIEW WITH CONTRACTED MENTAL HEALTH STAFF VERIFIES THEY ALL ARE TRAINED AND ACKNOWLEDGE THEIR DUTY TO REPORT AND INFORM RESIDENTS OF THEIR DUTY TO REPORT AND THE LIMITATIONS OF CONFIDENTIALITY PRIOR TO PROVIDING SERVICES TO RESIDENTS PER POLICY AND STANDARD PROVISION 115.261(c). AGENCY DOES NOT EMPLOY MEDICAL PERSONNEL.

d) POLICY #261 MANDATES ALLEGED VICTIMS WHO ARE VULNERABLE ADULTS, ICCS WILL REPORT THE CASE TO THE DESIGNATED LOCAL SERVICES AGENCY FOR INVESTIGATION. ICCS DOES NOT HOUSE RESIDENTS UNDER THE AGE OF 18. INTERVIEW WITH DIRECTOR AND PREA COORDINATOR REVEALS ANY VICTIM CONSIDERED A VULNERABLE ADULT IS REFERRED IMMEDIATELY TO LOCAL LAW ENFORCEMENT AND

HEALTH & HUMAN SERVICES FOR THE ELDERLY SHOULD THEY BE VICTIM OF SEXUAL ABUSE. AGENCY DOES NOT HOUSE RESIDENTS UNDER THE AGE OF 18 YEARS, BUT VISITORS OF RESIDENCE MAY BE UNDER THE AGE OF 18 YEARS. SHOULD ANY VISITOR UNDER THE AGE OF 18 YEARS OF AGE REPORT AN ALLEGATION OF SEXUAL ABUSE, LOCAL LAW ENFORCEMENT IS CONTACTED IMMEDIATELY TO INVESTIGATE THE ALLEGATION. AGENCY PROTOCOLS ARE ENACTED TO PROTECT VICTIMS AND SECURE EVIDENCE RELATED TO SAID ALLEGATION(S) IN ACCORDANCE WITH STANDARD PROVISION 115.261(d).

e) POLICY #165 COMPLIES WITH STANDARD PROVISION 115.261(e) IN THAT ALL ALLEGATIONS, SUSPECTED, THREATENED OR REPORTED ACTS OF SEXUAL MISCONDUCT WILL BE REPORTED TO LOCAL LAW ENFORCEMENT. NARRATIVE TO INCLUDE 3RD PARTY AND ANNONYMOUS REPORTS IS PROVIDED IN THE POLICY. ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT HAS BEEN REPORTED AND INVESTIGATED BY AGENCY INVESTIGATORS AND/OR LOCAL LAW ENFORCEMENT IF SAID ALLEGATION IS CRIMINAL IN NATURE IN ACCORDANCE WITH STANDARD PROVISION 115.261(e). THERE HAVE BEEN NO ALLEGATIONS OF SEX ABUSE/HARASSMENT ALLEGATIONS WHICH OCCURRED OVER THE PAST 12 MONTHS. AGENCY IS COMPLIANT WITH POLICY AND STANDARD PROVISION 115.261(e).

AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.261.

115.262	**Agency protection duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

POLICY #340 MANDATES IMMEDIATE ACTION TO BE TAKEN BY STAFF REGARDING EMERGENCY SEX ABUSE COMPLAINTS OR GRIEVANCES, IN COMPLIANCE WITH STANDARD PROVISION 115.262(a). INTERVIEW WITH AGENCY HEAD DESIGNEE AND FACILITY DIRECTOR INDICATES STAFF HAVE BEEN TRAINED TO PROTECT RESIDENTS WHEN THEY LEARN THAT THE RESIDENT IS AT RISK OF IMMINENT SEXUAL ABUSE. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATES STAFF MEMBERS IMMEDIATELY TAKE ACTION TO PROTECT THE RESIDENT WHO MAY BE SUBJECT TO SUBSTANTIAL RISK OF SEXUAL ABUSE, SEPARATE RESIDENT FROM ABUSER, CONTACT IMMEDIATE SUPERVISOR, ON-CALL SUPERVISOR OR PROGRAM DIRECTOR & TAKE STEPS UP TO AND INCLUDING RE-HOUSING RESIDENT UPON APPROVAL OF ADMINISTRATION, IN COMPLIANCE WITH STANDARD PROVISION 115.262(a).

115.263	Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #160 MANDATES IMMEDIATE NOTIFICATION TO HEAD OF OTHER FACILITY WHERE ALLEGATION OF SEX ABUSE WHERE IT IS ALLEGED TO HAVE OCCURRED. AGENCY HAS NOT RECEIVED ALLEGATION THAT RESIDENT WAS ABUSED WHILE CONFINED AT OTHER FACILITY OVER PAST 12 MONTHS. AGENCY POLICY COMPLIANT WITH STANDARD PROVISION 115.263(a).

b) POLICY #160 MANDATES SUCH NOTIFICATION BE PROVIDED BY PROGRAM DIRECTOR TO HEAD OF FACILITY WHERE ALLEGED SEX ABUSE IS ALLEGED TO HAVE OCCURRED WITHIN 72 HOURS OF NOTIFICATION AND DOCUMENT THE CONTACT WITH HEAD OF THE FACILITY. AGENCY HAS NOT RECEIVED ALLEGATION THAT RESIDENT WAS ABUSED WHILE CONFINED AT OTHER FACILITY OVER PAST 12 MONTHS. AGENCY POLICY COMPLIANT WITH STANDARD PROVISION 115.263(b).

c) POLICY #160 MANDATES SUCH NOTIFICATION BE PROVIDED BY PROGRAM DIRECTOR TO HEAD OF FACILITY WHERE ALLEGED SEX ABUSE IS ALLEGED TO HAVE OCCURRED WITHIN 72 HOURS OF NOTIFICATION AND DOCUMENT THE CONTACT WITH HEAD OF THE FACILITY. NO SUCH ALLEGATIONS HAVE BEEN RECEIVED. AGENCY HAS NOT RECEIVED ALLEGATION THAT RESIDENT WAS ABUSED WHILE CONFINED AT OTHER FACILITY OVER PAST 12 MONTHS. AGENCY POLICY COMPLIANT WITH STANDARD PROVISION 115.263(c).

d) POLICY #165 MANDATES ALL RECEIVED ALLEGATIONS, SUSPICION OF , SEXUAL ASSAULT, SEXUAL VIOLENCE, THREATENED OR REPORTED ACTS OF SEXUAL MISCONDUCT OR SEXUAL CONTACT THAT OCCURS IN COMMUNITY CORRECTIONS OR ANY OTHER LOCATION WHERE CLIENTS ARE HOUSED, WORK, OR PROVIDED SERVICES WILL BE INVESTIGATED IN ACCORDANCE WITH ESTABLISHED LOCAL LAW ENFORCEMENT AGENCIES INVESTIGATIVE STANDARDS AND PROTOCOLS . OVER PAST 12 MONTHS, FACILITY RECEIVED ONE ALLEGATION OF SEXUAL ABUSE FROM ANOTHER AGENCY. INTERVIEW WITH AGENCY HEAD DESIGNEE AND FACILITY DIRECTOR INDICATES FACILITY FOLLOWS POLICY #165 & THE DIRECTOR NOTIFIES HEAD OF OTHER AGENCY/FACILITY OF ANY ALLEGATION RECEIVED BY WEST FACILITY. OVER THE PAST 12 MONTHS, FACILITY HAS NOT RECEIVED ANY ALLEGATIONS OF SEXUAL ABUSE FROM OTHER FACILITIES.

AUDITOR HAS DETERMINED AGENCY IS IN COMPLIANCE WITH EACH PROVISION OF STANDARD 115.263.

115.264	Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 HAS PROTOCOL ELEMENTS AS DICTATED IN STANDARD PROVISION 115.264(a). OVER PAST 12 MONTHS, THERE HAS NOT BEEN ANY ALLEGATION OF RESIDENT SEX ABUSE. INTERVIEWS WITH STAFF INDICATE THEY FOLLOW THE SPECIFIC PROTOCOL AS OUTLINED IN POLICY. MOST OF STAFF INTERVIEWED WERE FOUND TO HAVE A CARD WITH THE RESPONSE PROTOCOL ON A LANYARD AROUND THEIR NECK, PROVIDED TO THEM BY THE PREA COORDINATOR. FACILITY IS IN COMPLIANCE WITH STANDARD PROVISION 115.264(a).
b) POLICY #165 HAS PROTOCOL ELEMENTS AS DICTATED IN STANDARD PROVISION 115.264(a). OVER PAST 12 MONTHS, THERE HAS NOT BEEN ANY ALLEGATION OF RESIDENT SEX ABUSE.

AUDITOR HAS DETERMINED THAT AGENCY/FACILITY MEETS EACH PROVISION OF STANDARD 115.264.

115.265	Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) COORDINATED RESPONSE TO INCIDENTS OF SEXUAL ABUSE PROVIDES FOR ACTIONS TAKEN IN RESPONSE TO AN INCIDENT OF SEXUAL ABUSE AMONG STAFF 1ST RESPONDERS, MEDICAL AND MENTAL HEALTH PRACTITIONERS, INVESTIGATORS AND LEADERSHIP REVIEWED BY AUDITOR. INTERVIEW WITH PROGRAM DIRECTOR VERIFIES THE DEVELOPMENT OF A WRITTEN INSTITUTIONAL PLAN SPECIFIC TO KENDALL FACILITY THAT COORDINATES ACTIONS TAKEN IN RESPONSE TO AN INCIDENT OF SECUAL ABUSE AMONG STAFF 1ST RESPONDERS, MEDICAL AND MENTAL HEALTH PRACTITIONERS, INVESTIGATORS, AND FACILITY LEADERSHIP.

AUDITOR HAS DETERMINED FACILITY MEETS EACH PROVISION OF STANDARD 115.265

115.266	Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) INTERVIEW WITH AGENCY HEAD DESIGNEE DETERMINES AGENCY HAS NOT ENTERED INTO ANY COLLECTIVE BARGAINING AGREEMENTS SINCE AUGUST 20, 2012.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.266.

115.267	Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 MANDATES THE PROGRAM DIRECTOR AND PREA COORDINATOR AS DESIGNATED STAFF MEMBERS TO MONITOR RETALIATION IN ACCORDANCE WITH STANDARD PROVISION 115.267(a).
b) POLICY #165 INCLUDES NARRATIVE COMPLIANT WITH STANDARD PROVISION #115.267 WHICH OUTLINES THE MULTIPLE PROTECTION MEASURES TO PROTECT RESIDENTS FROM RETALIATION. INTERVIEW WITH AGENCY HEAD DESIGNEE & PROGRAM DIRECTOR INDICATES AGENCY EMPLOYS MULTIPLE MEASURES TO PROTECT BOTH RESIDENTS AND STAFF FROM RETALIATION AND FROM ABUSERS, USING MULTIPLE LAYERS OF PROTOCOLS WHICH INCLUDE MOVING VICTIMS TO OTHER ROOMS, HALLWAYS OR TRANSFERRING THEM TO OTHER FACILTIIES FOR THEIR SAFETY. STAFF CAN BE TRANSFERRED TO OTHER FACILTIES OR BUILDINGS FOR THEIR SAFETY & ALL ARE PROVIDED MONITORING. INTERVIEW WITH PREA COORDINATOR INDICATES HE IS RESPONSIBLE FOR MONITORING RETALIATION AND CITED THE SAME INFORMATION PROVIDED THE AUDITOR FROM THE PROGRAM DIRECTOR AND AGENCY HEAD DESIGNEE IN ACCORDANCE WITH STANDARD PROVISION 115.267(b).
c) POLICY #165 MANDATES MONITORING OF RESIDENT WHO REPORTED SEXUAL ABUSE OR SUFFERED SEXUAL ABUSE OR POSSIBLE RETALIATION ON A REGULAR BASIS FOR AT LEAST 90 DAYS, OR MORE SHOULD THERE BE EVIDENCE OF A CONTINUING NEED. INTERVIEW WITH PROGRAM DIRECTOR AND PREA COORDINATOR INDICATES RESIDENT VICTIMS WHO REPORT SEXUAL ABUSE/HARASSMENT & RETALIATION ARE MONITORED FOR SIGNS OF CONTINUED ABUSE FOR AT LEAST 90 DAYS UNLESS THERE IS A NEED FOR CONTINUED MONITORING FOR UNLIMITED TIMEFRAME UNTIL MONITORING IS NO LONGER REQUIRED IN ACCORDANCE WITH PROVISION 115.267(c). THERE HAS BEEN NO INCIDENT OF RETALIATION IN PAST 12 MONTHS.

d) POLICY #165 NARRATIVE MANDATES PERIODIC STATUS CHECKS DURING MONITORING PERIOD PER STANDARD PROVISION 115.267(d). PREA COORDINATOR INDICATES HE CONDUCTS PERIODIC FACE-TO-FACE PERIODIC CHECKS TO MONITOR RESIDENTS WHO HAVE REPORTED SEX ABUSE INCIDENTS OR VICTIMS OF RETALIATION IN ACCORDANCE WITH STANDARD PROVISION 115.267(d).
e) POLICY #165 MANDATES THAT ANY CLIENT OR STAFF THAT REPORTS OR IS A WITNESS TO ANY SEXUAL ABUSE OR SEXUAL HARASSMENT SHALL BE PROVIDED THE SAME PROTECTION AS ANY VICTIM. POLICY INCORPORATES NARRATIVE WHICH INCLUDES INDIVIDUAL WHO COOPERATES WITH AN INVESTIGATION EXPRESSING FEAR OF RETALIATION IS PROVIDED SAME PROTECTION AS ANY OTHER VICTIM. INTERVIEW WITH AGENCY HEAD DESIGNEE & PROGRAM DIRECTOR INDICATES AGENCY TAKES PROTECTIVE MEASURES AS OUTLINED IN POLICY #165 TO PROTECT ANY INDIVIDUAL WHO COOPERATES WITH AN INVESTIGATION OR IN FEAR OF RETALIATION IN ACCORANCE WITH STANDARD PROVISION 115.267(e).

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS EACH PROVISION OF STANDARD 115.267.

115.271	Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 PROVIDES INVESTIGATIVE DIRECTION WITH REGARDS TO BOTH ADMINISTRATIVE AND CRIMINAL AGENCY INVESTIGATIONS. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES AGENCY POLICY TO CONDUCT INVESTIGATIONS PROMPTLY, THOROOUGHLY AND OBJECTIVELY FOR ALL ALLEGATIONS OF SEX ABUSE TO INCLUDE 3RD PARTY & ANNONYMOUS REPORTS. THERE HAVE BEEN NO ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT OVER THE PAST 12 MONTHS. AGENCY'S IS IN COMPLIANCE WITH STANDARD PROVISION 115.271(a).
b) PAQ INDICATES THERE ARE 5 SPECIAL INVESTIGATORS ASSIGNED WHO HAVE COMPLETED TRAINING FOR SEX ABUSE IN A CONFINEMENT SETTING THROUGH NIC. 5 SIGNED CERTIFICATES OF COMPLETION PROVIDED WITH PAQ. INTERVIEW WITH INVESTIGATIVE STAFF CONFIRMS THEIR COMPLETION OF THE SPECIAL INVESTIGATOR TRAINING.
c) POLICY #165 MANDATES AGENCY CONDUCT ONLY ADMINISTRATIVE INVESTIGATIONS & ASSISTS LOCAL LAW ENFORCEMENT WITH CRIMINAL INVESTIGATIONS. IN CASE OF CRIMINAL INVESTIGATIONS, AGENCY INVESTIGATORS WILL SECURE CRIME SCENE & COLLECT EVIDENCE THAT CANNOT BE PROTECTED OR SECURED WITHOUT COMPROMISING SAFETY & SECURITY OF THE FACILITY, MAINTAINING IN FINDER'S POSSESSION UNTIL TURNED OVER TO INVESTIGATORS. INTERVIEW WITH INVESTIGATIVE STAFF DETERMINES THE EXTENT TO WHICH EVIDENCE IS SECURED. AGENCY ONLY INVESTIGATES ADMINISTRATIVE CASES, WHERE COLLECTION OF EVIDENCE MAY BE ONLY LIMITED TO VIDEO OF THE INCIDENT. WHEN IT IS DETERMINED THAT THE CASE MAY BE CRIMINAL IN NATURE, INVESTIGATORS SECURE THE CRIME SCENE, COLLECT EVIDENCE WHICH MAY BE DAMAGED OR TAMPERED WITH PRIOR TO

THE ARRIVAL OF LOCAL LAW ENFORCEMENT INVESTIGATORS & MAINTAIN CHAIN OF CUSTODY. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.271(c).

d) AGENCY CONDUCTS ONLY ADMINISTRATIVE INVESTIGATIONS & COMPELLED INTERVIEWS ARE ONLY CONDUCTED BY LOCAL LAW ENFORCEMENT. INTERVIEW WITH INVESTIGATIVE STAFF CONFIRMS THEY DO NOT CONDUCT COMPELLED INTERVIEWS WITHOUT THE EXPRESS APPROVAL OF LOCAL LAW ENFORCEMENT OR PROSECUTORS IN ACCORDANCE WITIH STANDARD PROVISION 115.271(d).

e) POLICY #165 PROHIBTS POLYGRAPH EXAMINATION AS CONDITION OF PROCEEDING WITH INVESTIGATION OF ALLEGATION OF SEXUAL ABUSE. CREDIBILITY OF ALLEGED VICTIM, SUSPECT OR WITNESS SHALL BE ASSESSEDON INDIVIDUAL BASIS & NOT DETERMINED BY PERSONS STATUS AS RESIDENT OR STAFF. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES AGENCY'S DEMONSTRATION OF POLICY TO PROHIBIT USE OF POLYGRAPH EXAMINATION TO DETERMINE THE CREDIBILITY OF AN ALLEGED VICTIM OF SEXUAL ABUSE. INVESTIGATORS TAKE ALL ALLEGATIONS OF SEX ABUSE SERIOUSLY AND INVESTIGATE EACH ONE COMPLETELY IN ACCORDANCE WITH 115.271(e).

f) POLICY #165 MANDATES INVESTIGATION SHALL BE DOCUMENTED. NARRATIVE ALSO STATES THAT INVESTIGATION SHALL INCLUDE EFFORT TO DETERMINE WHETHER STAFF ACTIONS OR FAILURES TO ACT CONTRIBUTED TO THE ALLEGED ABUSE IN COMPLIANCE WITH STANDARD 115.271(f). INTERVIEW WITH INVESTIGATIVE STAFF AND INTERVIEW OF ADMINISTRATIVE INVESTIGATIVE REPORTS VERIFIY AGENCY'S COMPLIANCE WITH STANDARD PROVISION 115271(f).

g) CRS 18-3-401 THROUGH 18-3-417 WILL GOVERN DETERMINATION OF SPECIFIC VIOLATIONS OF COLORADO LAW PERTAINING TO UNLAWFUL SEX ACTS. CRIMINAL INVESTIGATIONS WILL BE INVESTIGATED IN ACCORDANCE WITH ESTABLISHED LOCAL LAW ENFORCEMENT AGENCY'S INVESTIGATIVE STANDARDS AND PROTOCOLS DICTATED BY THE CRIMINAL INVESTIGATIONS DIVISION DUTY SUPERVISOR AND CASE INVESTIGATOR. INTERVIEW WITH INVESTIGATIVE STAFF INDICATES ALL CRIMINAL INVESTIGATIONS ARE DOCUMENTED IN WRITTEN FORMAT AND CONTAINS A THOROUGH DESCRIPTION OF THE INVESTIGATION TO INCLUDE FORENSIC FINDINGS, INTERVIEWS, DOCUMENTARY EVIDENCE ETS. IN ACCORDANCE WITH STANDARD PROVISION 115.271(g).

h) POLICY #165 COMPLIES WITH STANDARD PROVISION 115.271(h) LANGUAGE. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES THAT ANY CASE THAT APPEARS CRIMINAL IN NATURE IS REFERRED TO LOCAL LAW ENFORCEMENT FOR INVESTIGATION AS AGENCY INVESTIGATORS ONLY CONDUCT INVESTIGATIONS ON ADMINISTRATIVE CASES IN ACCORDANCE WITH STANDARD PROVISION 115.271(h).

i) POLICY #165 MANDATES INVESTIGATIVE REPORTS, ALL DATA, VIDEO SURVEILLANCE, ETC, WILL BE FORWARDED TO THE PREA COORDINATOR, OR DESIGNEE. THIS DATA WILL BE KEPT INDEFINATELY FOR RECORD-KEEPING. INVESTIGATIVE REPORTS ARE ARCHIVED IN RECORDS REPOSITORY ON SITE IN FACILITY IN ACCORDANCE WITH STANDARD PROVISION 115.271(I).

j) POLICY #165 MANDATES DEPARTURE OF ALLEGED ABUSER OR VICTIM FROM ICCS, WHETHER EMPLOYEE OR CLIENT, SHALL NOT PROVIDE BASIS FOR TERMINATING AN INVESTIGATION. POLICY IS COMPLIANT WTH STANDARD PROVISION 115.271(j). INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES DEMONSTRATION OF POLICY #165 IN THAT INVESTIGATION CONTINUES EVEN SHOULD THE ALLEGED ABUSER OR VICTIM FROM EMPLOYMENT OR CONTROL OF FACILITY OR AGENCY TERMINATES EMPLOYMENT OR CEASE TO RESIDE IN FACILITY IN ACCORDANCE WITH STANDARD PROVISION 115.271(j).

l) POLICY #165-C MANDATES WHEN OUTSIDE AGENCIES INVESTIGATE SEXUAL ABUSE, FACILITY WILL ASSIST WITH INVESTIGATION AND REQUEST INVESTIGATIVE AGENCY ADHERE TO ALL PREA STANDARDS WHILE INVESTIGATING ANY ALLEGATIONS. NO SPECIFIC NARRATIVE TO DIRECT AGENCY TO ENDEAVOR TO REMAIN INFORMED ABOUT THE PROGRESS OF THE INVESTIGATION.

STANDARD PROVISION 115.271(k) DOES NOT APPLY TO THIS AGENCY. AUDITOR HAS DETERMINED THAT AGENCY MEETS EACH PROVISION OF STANDARD 115.271.

115.272	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)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 MANDATES THAT AGENCY IMPOSES NO STANDARD HIGHER THAN PREPONDERANCE OF THE EVIDENCE IN COMPLIANCE WITH STANDARD PROVISION 115.272(a). INTERVIEW WITH INVESTIGATIVE STAFF & REVIEW OF INVESTIGATION CASES DETERMINE AGENCY IMPOSES NO STANDARD HIGHER THAT PREPONDERANCE OF THE EVIDENCE TO DETERMINE WHETHER ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT ARE SUBSTANTIATED IN ACCORDANCE WITH STANDARD PROVISION 115.272(a).

AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.272(a).

115.273	Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 IS COMPLIANT WITH STANDARD PROVISION 115.273(a). THE SEX ABUSE ALLEGATION PROVIDED WITH PAQ WAS IN REGARDS TO 3RD PARTY REPORTING SUSPECTED SEXUAL MISCONDUCT, WHICH WAS FOUND TO BE UNSUBSTANTIATED. THE 3RD PARTY REPORTER WAS NOT INFORMED OF THE OUTCOME OF THE INVESTIATION. THE PROVISION DOES NOT REQUIRE AGENCY TO INFORM 3RD PARTY REPORTERS OF THE OUTCOME OF THE INVESTIGATION. INTERVIEW WITH PROGRAM DIRECTOR INDICATES RESIDENTS ARE INFORMED WHETHER THE ALLEGATION HAS BEEN DETERMINED TO BE SUBSTANTIATED, UNSUBSTANTIATED OR UNFOUNDED. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES STATEMENT OF PROGRAM DIRECTOR & STATE THE INFORMATION IS PROVIDED FACE TO FACE TO RESIDENTS IN A VERBAL FORMAT. REVIEW OF UNSUBSTANTIATED INVESTIGATIVE CASE FILES WHICH INVOLVED A 3RD PARTY REPORTER INDICATE THE REPORTER WAS NOT INFORMED OF THE OUTCOME OF THE INVESTIGATION AS THE PROVISION DOES NOT REQUIRE IT. AGENCY/FACILITY IS IN ACCORDANCE WITH STANDARD PROVISION 115.273(a).

b) AGENCY REPORTS & LAW ENFORCEMENT REPORTS WERE PROVIDED TO AUDITOR INDICATING REQUESTED RELEVANT INFORMATION WAS PROVIDED FROM THE INVESTIGATIVE LAW ENFORCEMENT AGENCY. POLICY #165 F MANDATES AGENCY STAFF INFORM CLIENT-VICTIM OF THE OUTCOME OF ANY SEXUAL ABUSE INVESTIGATION WHETHER IT WAS INVESTIGATED BY AGENCY OR LOCAL LAW ENFORCEMENT. THE CASE PROVIDED BY AGENCY INVOLVED STAFF ALERTING LAW ENFORCEMENT OF ALLEGED STAFF ON RESIDENT SEXUAL MISCONDUCT, WHICH WAS FOUND TO BE UNSUBSTANTIATED. STAFF MEMBER WAS TERMINATED DUE TO EMPLOYMENT VIOLATION, NOT PREA VIOLATION. THERE IS NO DOCUMENTATION OR NARRATIVE IN THE CONCLUSION OF THE INVESTIGATION THAT NOTIFICATION WAS MADE TO THE REPORTING STAFF MEMBER AS STANDARD PROVISION DOES NOT REQUIRE STAFF REPORTERS BE NOTIFIED OF THE OUTCOME OF THE INVESTIGATION, ONLY RESIDENTS.

c) POLICY #165 COMPLIES WITH STANDARD PROVISION 115.273(c). PROVIDED INVESTIGATION INVOLVED STAFF ON RESIDENT MISCONDUCT, NOT SEX ABUSE, REPORTED BY A STAFF MEMBER. THE ALLEGATION INVOLVED A POSSIBLE RELATIONSHIP BETWEEN STAFF AND RESIDENT. THE INVESTIGATION FOUND THE ALLEGATION TO BE UNSUBSTANTIATED. REVIEW OF INVESTIGATIVE FILES VERIFY ALLEGATION WAS MADE BY STAFF THROUGH INFORMATION GLEANED FROM A PREVIOUS UNRELATED CASE. NO PREA REQUIREMENT TO NOTIFY STAFF OF THE OUTCOME OF THE INVESTIGATION.

d) POLICY #165 MEETS STANDARD PROVISION 115.273(d). THERE HAS BEEN NO ALLEGATION OF RESIDENT ON RESIDENT SEX ABUSE.

e) POLICY #165 MANDATES ALL NOTIFICATIONS TO CLIENT-VICTIMS OR ATTEMPTS TO NOTIFY SHALL BE DOCUMENTED IN CLIENT-VICTIM'S CHRONOLOGICAL NOTES. PER PAQ 115.273(e)-2, 1 NOTIFICATION TO RESIDENT WAS MADE, HOWEVER, THE NOTIFICATION WAS NOT DOCUMENTED. ALL FUTURE NOTIFICATIONS WILL BE LOGGED IN CLIENT NOTES PER PREA COORDINATOR. NOTIFICATION OR ATTEMPTED NOTIFICATION TO RESIDENT WAS NOT COMPLETED. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.273(e).

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.273

CORRECTIVE ACTION:

1. AGENCY TO EITHER NOTIFY OR ATTEMPT TO NOTIFY THE RESIDENT IDENTIFIED IN PAQ STANDARD PROVISION 115.273(e)-2.
2. SAID NOTIFICATION OR ATTEMPTED NOTIFICATION OF THE OUTCOME OF THE INVESTIGATION SHALL BE DOCUMENTED AND PROVIDED TO AUDITOR IN ORDER TO VERIFY COMPLIANCE WITH STANDARD PROVISION 115.273(e).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/1/16 :
AGENCY PROVIDED INVESTIGATION NOTIFICATION DOCUMENTATION WHICH WAS ACTED UPON ON TWO INVESTIGATIONS OF ALLEGED SEXUAL ABUSE. BOTH CASES WERE FOUND TO BE UNSUBSTANTIATED. ONE NOTIFICATION LETTER WAS SIGNED BY THE VICTIM. THE SECOND NOTIFICATION LETTER WAS PREPARED BUT RESIDENT WAS DISCHARGED FROM THE AGENCY PRIOR TO NOTIFICATION PRESENTATION. BOTH NOTIFICATIONS MEET STANDARD PROVISION 115.273(e). AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.273

115.276	**Disciplinary sanctions for staff**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #275 MANDATES STAFF IS SUBJECT TO DISCIPLINARY SANCTIONS UP TO & INCLUDING TERMINATION FOR VIOLATING SEX ABUSE/HARASSMENT POLICIES.
b) POLICY #275 MANDATES TERMINATION FOR STAFF WHO VIOLATE SEX ABUSE POLICY. OVER PAST 12 MONTHS THERE IS NOT DOCUMENTATION TO INDICATE STAFF VIOLATED AGENCY SEX ABUSE/HARASSMENT POLICY.
c) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.276(c). NO DISCIPLINE OF STAFF OVER PAST 12 MONTHS FOR VIOLATION OF SEX ABUSE/HARASSMENT POLICIES.
d) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.276(d). NO STAFF REPORTED TO LAW ENFORCEMENT FOR VIOLATION OF AGENCY SEX ABUSE/HARRASSEMENT POLICY OVER PAST 12 MONTHS.

AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.276.

115.277	Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.277 TO REPORT CONTRACTOR OR VOLUNTEER WHO ENGAGES IN SEX ABUSE REPORTED TO LAW ENFORCEMENT IF ACTION WAS CRIMINAL IN NATURE IN ACCORDANCE WITH STANDARD PROVISION 115.277(a). THERE HAVE BEEN NO CONTRACTORS OR VOLUNTEERS REPORTED TO LAW ENFORCEMENT FOR SEX ABUSE VIOLATIONS IN PAST 12 MONTHS.

b) POLICY #275 MEETS STANDARD PROVISION 115.277(b) AS IT TAKES APPROPRIATE ACTIONS TO PROHIBIT FURTHER CONTACT WITH RESIDENTS IN THE CASE OF ANY VIOLATION OF AGENCY SEX ABUSE/HARASSMENT POLICIES BY CONTRACTOR OR VOLUNTEER IN ACCORDANCE WITH STANDARD PROVISION 115.277(b)..

AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.277

115.278	Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #275 MANDATES DISCIPLINARY SANCTIONS AGAINST RESIDENTS WHO VIOLATE SEX ABUSE/HARASSMENT POLICIES IN THE CASE OF RESIDENT ON RESIDENT SEXUAL ABUSE EVEN IF ACT WAS CONSENSUAL, NOT COERCED OR FORCED, IN COMPLAINCE WITH STANDARD PROVISION 115.278. NO ADMINISTRATIVE OR CRIMINAL FINDINGS OF RESIDENT ON RESIDENT SEXUAL ABUSE OCCURRING IN THE PAST 12 MONTHS.. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.278(a).

b) POLICY #275 IS COMPLIANT WITH STANDARD PROVISION 115.278(b) AS IT MANDATES SANCTIONS SHALL BE COMMENSURATE WITH THE NATURE AND CIRCUMSTANCES OF THE ABUSE COMMITTED. INTERVIEW WITH PROGRAM DIRECTOR INDICATE ANY SANCTIONS LEVELED AT RESIDENTS IS COMMENSURATE WITH THE NATURE AND CIRCUMSTANCES OF THE ABUSE COMMITTED. THERE ARE LEVELS OF VIOLATIONS OUTLINED IN THE RESIDENTS RULE HANDBOOK AND SACTIONS FOR THOSE VIOLATIONS ARE PROVIDED FOR THE RESIDENTS IN ACCORDANCE WITH STANDARD PROVISION 115.278(b).

c) POLICY #275 MEETS STANDARD PROVISION 115.278(b) AS MANDATES CONSIDERATION IF RESIDENTS MENTAL DISABILITIES OR MENTAL ILLNESS CONTRINUTED TO HIS OR HER BEHAVIOR WHEN DETERMINING SANCTIONS TO BE IMPOSED. INTERVIEW WITH PROGRAM DIRECTOR INDICATES A RESIDENTS MENTAL

DISABILITIES OR MENTAL ILLNESS IS ALWAYS CONSIDERED WHEN DETERMINING THE TYPE OF SANCTION THAT SHOULD BE IMPOSED IN ACCORDANCE WITH STANDARD PROVISION 115.278(c).

d) POLICY #275 STATES IF THERE IS THERAPY & COUNSELING AVAILABLE TO ADDRESS AND CORRECT THE UNDERLYING REASONS FOR MOTIVATIONS FOR ABUSE ICCS WILL CONSIDER MANDATING OFFENDING RESIDENT TO PARTICIPATE. INTERVIEW WITH MENTAL HEALTH PRACTITIONER VERIFIES AGENCY PROVIDING RESIDENTS IDENTIFIED AS PREDATORS, THERAPY/COUNSELING FROM AN OUTSIDE AGENCY, TO ADDRESS UNDERLYING REASONS OR MOTIVIATIONS FOR ABUSE IN ACCORDANCE WITH STANDARD PROVISION 115.278(d).

e) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.278(e) AS IT CONTAINS SAME NARRATIVE AS INDICATED IN STANDARD PROVISION 115.278(e). THERE ARE NO DOCUMENTS WHICH REVEAL ANY DISCIPLINARY ACTIONS AGAINST RESIDENTS FOR SEXUAL CONDUCT WITH STAFF.

f) POLICY #275 PROVIDES FOR SEX ABUSE ALLEGATION MADE IN GOOD FAITH BASED UPON REASONABLE BELIEF ALLEGED CONDUCT OCCURRED, THIS SHALL NOT CONSITUTE FALSE REPORTING PER STANDARD PROVISION 115.278(f).

g) POLICY #275 CONSISTENT WITH STANDARD PROVISION 115.278(g) AND IS COMPLIANT. RESIDENT HANDBOOK PROHIBITS SEXUAL ACTIVITY BETWEEN RESIDENTS & IS COMPLIANT WITH STANDARD PROVISION 115.278(g).

AUDITOR DETERMINES AGENCY COMPLIES WITH EACH PROVISION OF STANDARD 115.278.

115.282	Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 MANDATES RESIDENT VICTIMS OF SEXUAL ABUSE RECEIVE IMMEDIATE MEDICAL TREATMENT AND ADVOCACY SERVICES. POLICY NARRATIVE MANDATES NATURE AND SCOPE OF SERVICES TO BE DETERMINED BY MEDICAL AND MENTAL HEALTH PRACTIONERS ACCORDING TO THEIR PROFESSIONAL JUDGEMENT AS REQUIRED BY STANDARD PROVISION 115.282(a).
b) INTERVIEW WITH MENTAL HEALTH STAFF DETERMINES AGENCY FOLLOWS POLICY AND STANDARD PROVISION 115.282 AS RESIDENTS ARE PROVIDED TIMELY AND UNIMPEDED ACCESS TO EMERGENCY MEDICAL AND CRISIS INTERVENTION SERVICES.
c) POLICY #165-B 1ST RESPONDERS PROTOCOL MEETS STANDARD PROVISION 115.282(b)
d) INTERVIEW WITH SECURITY STAFF & 1ST RESPONDERS INDICATE PROTOCOL IN RESPONSE TO SEXUAL ABUSE CASE INDICATE ADMINISTRATION IS IMMEDIATELY NOTIFIED & THEY CONTACT THE APPROPRIATE MEDICAL & MENTAL HEALTH PRACTITIONERS WHILE THEY PROTECT THE VICTIM, PRESERVE THE CRIME SCENE & ENSURE NO PHYSICAL EVIDENCE IS DESTROYED BY VICTIM OR ABUSER.
e) POLICY #165-D MANDATES RESIDENT VICTIMS RECEIVE TIMELY INFORMATION ABOUT AND TIMELY ACCES TO EMERGENCY CONTRACEPTION & STDs AND PROPHYLAXIS PER PROFESSIONALLY ACCESPTED STANDARDS OF CARE. INTERVIEW WITH MENTAL HEALTH STAFF & SAFE/SANE NURSE VERIFY AGENCY'S COMMITMENT TO ENSURE VICTIMS OF SEXUAL ABUSE ARE PROVIDED TIMELY INFORMATION AND ACCESS TO EMERGENCY CONTRACEPTION & STD PROPHYLAXIS IN ACCORDANCE WITH STANDARD 115.282(c).
f) POLICY #165 MANDATES TREATMENT SERVICES PROVIDED TO EVERY VICTIM WITHOUT FINANCIAL COST IN ACCORDANCE WITH STANDARD PROVISION 115.282(d).

AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.282.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 MANDATES MEDICAL/MENTAL HEALTH TREATMENT TO ALL RESIDENT VICITMS OF SEX ABUSE. INTERVIEW WITH INTAKE STAFF & CASE MANAGERS INDICATE ALL RESIDENTS TO ALLEGE PRIOR SEX ABUSE

VICTIMIZATION IS OFFERED MENTAL HEALTH TREATMENT. MEDICAL TREATMENT IS ALWAYS PROVIDED TO ALL RESIDENTS AT ANY TIME DURING THEIR RESIDENCY PER STANDARD PROVISION 115.283(a).

b) POLICY #165-D MANDATES EMERGENCY & ONGOING MEDICAL AND MENTAL HEALTH TREATMENT TO VICTIMS OF SEXUAL ABUSE IN COMPLIANCE WITH STANDARD PROVISION 115.283(b). RESIDENTS TO CLAIM VICTIMIZATION PRIOR TO ENTERING THIS FACILITY REFUSED TO BE INTERVIEWED. POLICY PROVIDES TREATMENT TO ANY AND ALL VICTIMS OF SEXUAL ABUSE TO INCLUDE FOLLOW-UP SERVICES WHILE THEY ARE RESIDENTS AT WEST FACILITY & IS PROVIDED REFERRALS TO OUTSIDE TREATMENT FACILITIES UPON RELEASE PER STANDARD PROVISION 115.283(b).
c) MEDICAL HEALTH SERVICES TO VICTIMS IS CONDUCTED AT ST ANTHONY'S HOSPITAL. MENTAL HEALTH SERVICES ARE CONTRACTED THROUGH BTS, WHO IS MANDATED TO PROVIDE MENTAL HEALTH SERVICES PER PREA PROVISIONS. INTERVIEW WITH MENTAL HEALTH PRACTITIONERS VERIFY RESIDENTS ARE PROVIDED MENTAL HEALTH SERVICES CONSISTENT WITH THE COMMUNITY LEVEL OF CARE PER STANDARD PROVISION 115.283(c). ST. ANTHONY'S HOSPITAL PROVIDES MEDICAL SERVICES PER MOU.
d) POLICY #165 MANDATES LEVEL OF CARE REQUIRED BY STANDARD PROVISION 115.283(d). INTERVIEW WITH SAFE/SANE NURSE AT ST. ANTHONY'S HOSPITAL INDICATE ALL PREA PROTOCOLS ARE MET PER MOU WITH ICCS TO INCLUDE PREGNANCY TESTS FOR SEXUALLY ABUSED FEMALE RESIDENTS.
e) POLICY #165 PROVIDES FOR COMPLIANCE WITH STANDARD PROVISION 115.283(e) WITH NARRATIVE STATING "ONGOING MEDICAL AND MENTAL HEALTH CARE". INTERVIEW WITH MENTAL HEALTH PRACTITIONER INDICATES AGENCY COMPLIES WITH STANDARD PROVISION 115.283 TO PROVIDE TIMELY ACCESS TO ALL MEDICAL TREATMENTS REQUIRED IN PREA STANDARDS.
f) POLICY #165 MANDATES RESIDENTS WHO ARE VICTIMS OF SEX ABUSE BE PROVIDED INFORMATION & TREATMENT FOR STD's & PROHYLAXIS IN ACCORDANCE WITH STANDARD PROVISION 115.283(f). NO MEDICAL RECORDS OR SECONDARY DOCUMENTATION TO DEMONSTRATE VICTIMS WERE OFFERED SDT TESTS AS CASES OF RESIDENTS TO REPORTED SEXUAL ABUSE DID NOT INVOLVE SEXUAL PENETRATION OR SKIN CONTACT.
g) POLICY #165 MANDATES TREATMENT SERVICES PROVIDED TO RESIDENT VICTIM OF SEXUAL ABUSE WITHOUT FINANCIAL COST PER STANDARD PROVISION 115.283(g).
h) POLICY #165 INCLUDES NARRATIVE COMPLIANT WITH STANDARD PROVISION 115.283(h) MANDATING AGENCY CONDUCT MENTAL HEALTH EVALUATION OF ALL KNOWN RESIDENT ON RESIDENT ABUSERS WITHIN 60 DAYS F LEARNING SUCH ABUSE HISTORY AND OFFER TREATMENT WHEN DEEMED APPROPRIATE BY MENTAL HEALTH PROFESSIONALS. INTERVIEW WITH MENTAL HEALTH PRACTIIONER VERIFIES AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.283 IN PROVIDING MENTAL HEALTH EVALUATION OF ALL KNOWN RESIDENT ON RESIDENT ABUSERS WITHIN 60 DAYS OF LEARNING OF SUCH ABUSE HISTORY AND OFFER TREATMENT DEEMED APPROPRIATE BY MENTAL HEALTH PRACTITIONERS THROUGH A COUNTY AGENCY SPECIALIZING IN SUCH TREATMENT..

AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.283

115.286	Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 MANDATES SEXUAL ABUSE INCIDENT REVIEW & PROVIDES EVALUATION CRITERIA FOR EACH CASE, COMPLIANT WITH STANDARD PROVISION 115.286(a). 2 INVESTIGATIVE REPORTS WERE PROVIDED WITH PAQ, HOWEVER, NO INCIDENT REVIEW ACCOMPANIED THE REPORTS. POLICY HAS BEEN UPDATED TO MANDATE COMPLIANCE WITH THIS STANDARD PROVISION IN THE FUTURE. THIS IS AGENCY'S 1ST PREA AUDIT & INCIDENT REVIEWS WILL BE CONDUCTED FOR FUTURE INVESTIGATIONS. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.286(a).

b) 2 INVESTIGATIVE REPORTS WERE PROVIDED WITH PAQ, HOWEVER, NO INCIDENT REVIEW ACCOMPANIED THE REPORTS. POLICY HAS BEEN UPDATED TO MANDATE STANDARD PROVISION COMPLIANCE GOING FORWARD. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.286(b).

c) POLICY #165 MANDATES NON-INVESTIGATING SUPERVISOR, PROGRAM DIRECTOR, WITH INPUT FROM INVESTIGATING SUPERVISOR AND APPLICABLE STAFF WILL MAKE UP THE INCIDENT REVIEW TEAM. POLICY IS COMPLIANT WITH STANDARD PROVISION 115.288(c).

d) POLICY #165 INCLUDES CRITERIA SPECIFIC TO STANDARD PROVISION 115.286(d). FINDINGS OF SEX ABUSE INCIDENT REVIEW IS FORWARDED TO QUALITY ASSURANCE DIRECTOR TO ENSURE ALL RECOMMENDED IMPROVEMENTS AND CHANGES ARE IMPLEMENTED. FACILITY HEAD AND PREA COORDINATOR IS INCLUDED IN THE DISTRIBUTION OF THE RECOMMENDATIONS IN ACCORDANCE WITH STANDARD 115.286(d). ANY FAILURE TO IMPLEMENT RECOMMENDATIONS WILL BE DOCUMENTED. INTERVIEW WITH PROGRAM DIRECTOR, PREA COORDINATOR AND AN ADDITIONAL MEMBER OF THE INCIDENT REVIEW TEAM VERIFY CONSIDERATIONS OF INCIDENT REVIEW TEAM AS IDENTIFIED IN THE CRITERIA OUTLINED IN STANDARD PROVISION 115.286(d).

e) POLICY #165 INCLUDES CRITERIA SPECIFIC TO STANDARD PROVISION 115.286(d). FINDINGS OF SEX ABUSE INCIDENT REVIEW IS FORWARDED TO QUALITY ASSURANCE DIRECTOR TO ENSURE ALL RECOMMENDED IMPROVEMENTS AND CHANGES ARE IMPLEMENTED. ANY FAILURE TO IMPLEMENT RECOMMENDATIONS WILL BE DOCUMENTED. THIS IS THE FACILITY'S 1ST PREA AUDIT. NEWLY FORMED INCIDENT REVIEW TEAM HAS NOT YET REVIEWED ANY INVESTIGATIVE FINDINGS TO MAKE RECOMMENDATIONS, HOWEVER, REVIEW OF CASES FOR THE STAFFING PLAN HAS BEEN CONDUCTED, RECOMMENDATIONS FORWARDED AND IMPLEMENTED BY AGENCY TO INCREASE MONITORING FOR SEXUAL SAFETY OF RESIDENTS.

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.286.

CORRECTIVE ACTION:

1. AGENCY TO DEMONSTRATE COMPLIANCE WITH STANDARD PROVISION 115.286(a) BY CONDUCTING INCIDENT REVIEW ON CASE(S) GOING FORWARD. PROVIDE VERIFICATION OF COMPLIANCE TO AUDITOR.

2. AGENCY TO DEMONSTRATE COMPLIANCE WITH STANDARD PROVISION 115.286(b) BY CONDUCTING INCIDENT REVIEW ON CASES GOING FORWARD WITHIN 30 DAYS OF THE COMPLETION OF THE INVESTIGATION. PROVIDE VERIFICATION OF COMPLIANCE TO THE AUDITOR.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/16/16:
THE INITIAL 2 INVESTIGATION IDENTIFIED PRIOR TO ON-SITE AUDIT OCCURRED IN 2014, OUTSIDE THE 12 MONTHS PRIOR TO THE ON-SITE AUDIT. CASE REVIEWS WERE NOT BEING CONDUCTED AT THAT TIME. SINCE THOSE INCIDENTS OCCURRED, 2 ADDITIONAL INVESTIGATIONS WERE CONDUCTED, COMPLETED, AND FOUND AS UNSUBSTANTIATED. AGENCY CONDUCTED INCIDENT REVIEWS ON BOTH INVESTIGATIONS AND PROVIDED AUDITOR WITH CASE REVIEW DOCUMENTATION WHICH VERIFIES DEMONSTRATION, PRACTICE AND COMPLIANCE WITH STANDARD PROVISION 115.286(a). THE REVIEW PROVIDES CONSIDERATION OF THE FOLLOWING:

1. POLICY & PROCEDURE BEING FOLLOWED BY STAFF
2. CHANGES OR IMPROVEMENTS OF POLICY OR PROCEDURE
3. MOTIVATIONS FOR THE INCIDENT TO OCCUR
4. EXAMINATION OF THE AREA WHERE THE INCIDENT OCCURRED
5. STAFFING LEVELS, VIDEO TECHNOLOGY IN THE AREA WHERE THE INCIDENT OCCURRED
6. ANY OTHER RECOMMENDATIONS FOR IMPROVEMENT.

AUDITOR HAS DETERMINED AGENCY MEETS EACH PROVISION OF STANDARD 115.286

115.287	**Data collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #160 & #165 PROVIDES SET OF DEFINITIONS & STANDARDIZED INSTRUMENT USED IN DATA COLLECTION FOR EACH PREA RELATED INVESTIGATION. AGENCY PROVIDED PREA INVESTIGATION REPORT DATA COLLECTION INSTRUMENT, WHICH PROVIDES DEFINITIONS. REQUESTED DATA MEETS REQUIREMENTS TO ANSWER ALL QUESTIONS FROM MOST RECENT SURVEY OF SEXUAL VIOLENCE CONDUCTED BY THE DOJ. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.287(a)/(c).
b) POLICIES #160 & 165 MANDATE AGGEGATED INCIDENT-BASED DATA BE COLLECTED ANNUALLY. SAMPLE OF AGGREGATED DATA AVAILABLE ON AGENCY WEBSITE PER STANDARD PROVISION 115.287(b).
c) POLICY #160 & #165 PROVIDES SET OF DEFINITIONS & STANDARDIZED INSTRUMENT USED IN DATA COLLECTION FOR EACH PREA RELATED INVESTIGATION. AGENCY PROVIDED PREA INVESTIGATION REPORT DATA COLLECTION INSTRUMENT, WHICH PROVIDES DEFINITIONS. REQUESTED DATA MEETS

REQUIREMENTS TO ANSWER ALL QUESTIONS FROM MOST RECENT SURVEY OF SEXUAL VIOLENCE CONDUCTED BY THE DOJ. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.287(a)/(c).

d) POLICY #165 MANDATES AGENCY MAINTAIN & COLLECT DATA FROM ADMINISTRATIVE REVIEWS, DOCUMENTATION OF ALL NON-IMPLEMENTED RECOMMENDATIONS, INVESTIGATION REPORTS, VIDEO SURVEILLANCE ETC, KEEPING DATA INDEFINATELY FOR RECORD KEEPING. INTERVIEW WITH PROGRAM DIRECTOR AND FACILITY VIDEO EXPERT DETERMINE VIDEO SURVEILLANCE IS MAINTAINED FOR 45 - 60 DAYS BEFORE BEING OVERWRITTEN, UNLESS ALLEGATION OF SEXUAL ABUSE HAS BEEN MADE. EVIDENCE IS THEN COPIED OFF THE DVR SERVER & MAINTAINED INDEFINATELY PER POLICY AND IN ACCORDANCE WITH STANDARD PROVISION 115.287(d).
e) STANDARD IS NOT APPLICABLE TO THIS FACILITY AS AGENCY DOES NOT CONTRACT FROM OTHER FACILITIES FOR THE CONFINEMENT OF ITS RESIDENCE.
f) DOJ HAS NOT REQUESTED AGGREGATED DATA FROM PREVIOUS CALENDAR YEAR.

AUDITOR HAS DETERMINED THAT AGENCY MEETS EACH PROVISION OF STANDARD 115.287

115.288	Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) THIS IS AGENCY'S 1ST PREA AUDIT & HAS NO ANNUAL REPORTS FROM PREVIOUS YEARS. ADDITIONALLY, THIS IS THE FIRST YEAR AGENCY IS COLLECTING DATA TO PROVIDE ANNUAL REPORT FOR YEAR 2015. INTERVIEW WITH AGENCY HEAD DESIGNEE & PREA COORDINATOR INDICATE THEY HAVE REVIEWED, COLLECTED AGGREGATED DATA FROM ALL AGENCY FACILITIES FOR YEAR 2014 AND USE CRITERIA IDENTIFIED IN STANDARD PROVISION 115.288(a). AUDITOR VERIFIED AGGREGATED DATA ON AGENCY WEBSITE. NO ANNUAL REPORT AVAILABLE UNTIL 2015. CORRECTIVE ACTION PLANS USING AGGREGATED DATA USED IN CREATING & IMPLEMENTING RECOMMENDATIONS FROM THE FACILITY STAFFING PLAN. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.288(a).

b) 1ST PREA REPORT, NO DATA COLLECTION OR ANNUAL REPORT COMPARISON FROM PREVIOUS YEARS AVAILABLE. AGGREGATED DATA AVAILABLE FOR YEAR 2014. THIS IS AGENCY'S 1ST PREA AUDIT & WILL PROVIDE ANNUAL REPORT COMPARISON WITH YEAR 2015.

c) ANNUAL REPORT AVAILABLE ON AGENCY WEBSITE, HOWEVER, IT IS AN EXCEL SPREADSHEET WHICH PROVIDES ONLY DATA FOR 2014 FROM ALL FACILITIES. INTERVIEW WITH AGENCY HEAD DESIGNEE INDICATES THE AGENCY HEAD REVIEWS AND APPROVES ALL AGGREGATED DATA REPORTS PRIOR TO PROVIDING PUBLIC ACCESS ON THE AGENCY WEBSITE. THIS IS AGENCY'S 1ST PREA AUDIT & WILL HAVE THE OPPORTUNITY TO PROVIDE DATA COMPARISON BETWEEN 2014 AND 2015 THIS YEAR.

d) POLICY #165 MANDATES PERSONAL IDENTIFIERS REMOVED & REDACTING SPECIFIC MATERIAL WHICH MAY PRESENT A CLEAR AND SPECIFIC THREAT TO THE SAFETY & SECURITY OF THE FACILITY PRIOR TO MAKING PUBLICATION PUBLIC. NATURE OF THE MATERIAL REDACTED MUST BE INDICATED PER STANDARD PROVISION 115.288(d). INTERVIEW WITH PREA COORDINATOR VERIFIES ALL SPECIFIC MATERIAL WHICH MAY PRESENT A CLEAR & SPECIFIC THREAT TO THE SAFETY AND SECURITY OF A FACILITY WILL BE REDACTED. NATURE OF THE REDACTION WILL BE INDICATED.

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.288.

CORRECTIVE ACTION:

1. AGENCY TO PROVIDE ANNUAL REPORT TO INCLUDE ALL AGGREGATED DATA FROM AGENCY FACILITIES, IDENTIFYING PROBLEM AREAS, DEMONSTRATION OF TAKING CORRECTIVE ACTION ON AN ONGOING BASIS AND INCLUDE FINDINGS FROM DATA REVIEW TO INCLUDE CORRECTIVE ACTIONS FROM EACH FACILITY AND THE AGENCY AS A WHOLE.
2. ANNUAL REPORT SHALL BE PUBLISHED ON AGENCY WEBSITE OR OTHER MEANS TO MAKE THE DOCUMENT READILY AVAILABLE TO THE PUBLIC.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETED 3/18/16:
AGENCY PROVIDED 2014/2015 ANNUAL REPORT AND PLACED SAID REPORT UPON AGENCY WEBSITE FOR PUBLIC ACCESS. THE ANNUAL REPORT INCLUDES AGGREGATED DATA SUMMARY FROM ALL 5 ICCS FACILITIES FOR SUBSTANTIATED, UNSUBSTANTIATED AND UNFOUNDED SEXUAL MISCONDUCT FROM BOTH RESIDENTS AND STAFF. ANNUAL REPORT PROVIDED COMPARISONS BETWEEN THE 2014 AND 2015 AGGREGATED DATA FROM ALL AGENCY FACILITIES. DATA PROVIDED INCLUDED IDENTIFICATION OF PROBLEM AREAS, CORRECTIVE ACTIONS RECOMMENDED AND CORRECTIVE ACTIONS TAKEN TO IMPROVED RESIDENT AND STAFF SEXUAL SAFETY WITHIN EACH FACILITY. AUDITOR HAS DETERMINED THAT AGENCY MEETS EACH PROVISION OF STANDARD 115.288.

115.289	**Data storage, publication and destruction**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

a) POLICY #165 MANDATES ALL COLLECTED DATA IS MAINTAINED BY PREA COORDINATOR, COMPLIANT WITH STANDARD 115.289(a). INTERVIEW WITH PREA COORDINATOR VERIFIES COLLECTED DATA IS SECURITY MAINTAINED BY HIM IN LOCKED OFFICE AND/OR SECURE RECORD STORAGE AREA PER STANDARD PROVISION 115.289(a).
b) POLICY #165 MANDATES COLLECTION OF DATA FROM AGENCY FACILITIES & MAKE IT AVAILABLE THROUGH THE AGENCY WEBSITE. POLICY DOES NOT MAKE A DISTINCTION OF “AGGREGATED DATA” PER STANDARD PROVISION 115.289(b).
c) POLICY #165 MANDATES ALL PERSONAL IDENTIFIERS SHALL BE REMOVED BEFORE MAKING DATA PUBLICLY AVAILABLE. POLICY #165 MANDATES ALL PERSONAL IDENTIFIERS SHALL BE REMOVED BEFORE MAKING DATA PUBLICLY AVAILABLE. REVIEW OF DATA ON AGENCY WEBSITE VERIFIES AGENCY COMPLIANCE WITH STANDARD PROVISION 115.289(c).
d) POLICY #165 MANDATES AGENCY RETAIN SEX ABUSE DATA FOR A MINIMUM OF 10 YEARS.

AUDITOR HAD DETERMINED AGENCY DOES NOT MEET STANDARD 115.289.

CORRECTIVE ACTION:

1. AGENCY TO AMEND POLICY #165 H-3 TO INCLUDE A NARRATIVE WHICH DEFINES THE USE OF “AGGREGATED DATA” IN ACCORDANCE WITH STANDARD PROVISION 115.289(b).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 12/4/15:

AGENCY AMENDED POLICY #165 H-3 TO INCLUDE NARRATIVE WHICH INVOLVES THE USE OF "AGGREGATED DATA" IN ACCORDANCE WITH STANDARD PROVISION 115.289(b). AUDITOR HAS DETERMINED THAT AGENCY MEETS EACH PROVISION OF STANDARD 115.289.

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.

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Auditor Signature