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

☐ **Interim** ☒ **Final**

Date of Report October 29, 2018

Auditor Information

Name: Kayleen Murray	**Email:** kmurray.prea@yahoo.com
Company Name: Click or tap here to enter text.	
Mailing Address: P.O. Box 2400	**City, State, Zip:** Wintersville, Ohio 43953
Telephone: 740-317-6630	**Date of Facility Visit:** October 22-23, 2018

Agency Information

Name of Agency: Oriana House, Inc.		**Governing Authority or Parent Agency** *(If Applicable)*: Oriana House, Inc., Board of Directors	
Physical Address: 885 E. Buchtel Avenue		**City, State, Zip:** Akron, Ohio 44305	
Mailing Address: P.O. Box 1501 Buchtel Avenue		**City, State, Zip:** Akron, Ohio 44309	
Telephone: 330-535-8116		**Is Agency accredited by any organization?** ☐ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency mission: Oriana House provides quality and humane chemical dependency treatment and community corrections services to clients while contributing to safer communities. It is the policy of Oriana House, Inc., to treat all clients regardless of race, ethnicity, color, national origin, disability, veteran, or military status, age, sex, or religion.

Agency Website with PREA Information: www.orianahouse.org

Agency Chief Executive Officer

Name: James Lawrence	**Title:** President & CEO
Email: jameslawrence@orianahouse.org	**Telephone:** 330-535-8116

Agency-Wide PREA Coordinator

Name: Mary Jones	**Title:** Vice President of Administration & Legal Counsel/PREA Coordinator

Email: maryjones@orianahouse.org	**Telephone:** 330-535-8116
PREA Coordinator Reports to: Bernie Rochford, Executive Vice President of Administrative Services & Business Relations	**Number of Compliance Managers who report to the PREA Coordinator** 13

Facility Information

Name of Facility:	CROSSWAEH Community Based Correctional Facility			
Physical Address:	13055 S. St. Rt. 100, Tiffin, Ohio 44883			
Mailing Address (if different than above):	N/A			
Telephone Number:	419-447-1444			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Community treatment center	☐ Halfway house	☐ Restitution center	
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center		
	☒ Other community correctional facility			

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Facility Website with PREA Information: www.orianahouse.org

Have there been any internal or external audits of and/or accreditations by any other organization? ☒ Yes ☐ No

Director

Name: Jason Varney	**Title:** Vice President of North Central Ohio
Email: JasonVarney@orianahouse.org	**Telephone:** 419-618-8214

Facility PREA Compliance Manager

Name: Dawn Root	**Title:** Program Administrator/Facility PREA Compliance Manager
Email: DawnRoot@orianahouse.org	**Telephone:** 419-447-1444

Facility Health Service Administrator

Name: N/A	**Title:** N/A
Email: N/A	**Telephone:** N/A

Designated Facility Capacity: 50 Male Beds and 36 Female Beds	**Current Population of Facility:** Male = 43; Female = 25		
Number of residents admitted to facility during the past 12 months			Male = 154; Female = 82
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			0
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			Male = 148; Female = 79
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			Male = 153; Female = 82
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults Male = 22-67; Female = 21-49	☐ Juveniles N/A	☐ Youthful residents N/A
Average length of stay or time under supervision:			Male = 166; Female = 172
Facility Security Level:			Minimum
Resident Custody Levels:			minimum
Number of staff currently employed by the facility who may have contact with residents:			31
Number of staff hired by the facility during the past 12 months who may have contact with residents:			23
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			10

Physical Plant

Number of Buildings: 2	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	Male = 2; Female = 2

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

DVRs in server rooms with 30 day retention period.

Medical

Type of Medical Facility:	N/A
Forensic sexual assault medical exams are conducted at:	Mercy Hospital at Tiffin

Other

Number of volunteers and individual contractors, who may have contact with residents, currently	Male = 2 Volunteers

authorized to enter the facility:	and 25 Contractors; Female = 8 Volunteers and 27 Contractors
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	1.5

Audit Findings

Audit Narrative

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

The PREA onsite visit for CROSSWAEH Community Based Corrections Facility (CBCF), 3055 South State Route 100, Tiffin, Ohio, was conducted on October 22-25, 2018. The facility is a part of Oriana House, Inc. operated community confinement programs. The goal of the audit is to ensure operational compliance with the Prison Rape Elimination Act standards for community confinement facilities. CROSSWAEH is receiving this audit I conjunction with another Oriana House, Inc. operated facility (Lake Erie Community Corrections Center) located in Sandusky, Ohio. The facilities operated under the same policies and procedures, and have the same administrative staff oversite. The auditor was able to interview administrative staff (Human Resource Director, Administrative Investigators, PREA Coordinator, PREA Compliance Specialist, Agency Head, and Crisis Counselor) for both facilities during the onsite visit for both facilities. All other interviews are specific to the facility.

The facility elected to use Power DMS to upload documentation relevant to showing compliance with each standard. The auditor received notification that the information was available approximately four weeks prior to the onsite visit. The information included the pre-audit questionnaire, policy and procedures, MOUs, facility staffing plan, table of organization, job descriptions, and post orders. The auditor received photos showing proof of audit notices posted in client and staff areas six weeks prior to the onsite visit. The auditor was met with agency and facility staff prior to the onsite visit and discuss the audit schedule, changes since the last PREA audit, and additional information/documentation needed by the auditor. The auditor has conducted the audits for this agency in the past, including CROSSWAEH's initial audit in 2015. The auditor reviewed the prior final audit report and previous documentation for comparison to the current audit.

The audit notice posting photographs sent to the auditor, showed the dates of the onsite visit; the name, address and email address of the auditor; and the availability to have

private correspondence with the auditor. The auditor did not receive any correspondence from clients or staff prior to the onsite visit. The auditor had one client request for an interview during the onsite visit.

In addition to the documentation sent prior to the onsite visit, the auditor reviewed ten client files, eight staff files, staff and client training curriculum, staff and client training rosters, risk for victimization/abusiveness screenings, acknowledgment forms, posters, brochures, floor plan with cameral views, volunteer/contractor information, and other relevant material during the onsite visit. After the onsite visit, the auditor made contact with relevant community agencies.

The onsite visit was conducted over two days where the auditor received a complete tour of both the male and female buildings and perimeter areas. The tour included observations of the housing units, dorm rooms, bathrooms, dayroom, laundry rooms, dining hall/multipurpose room, staff offices, group rooms, closets/storage rooms, intake area, clinic, and outdoor recreation yards. During the walkthrough, the auditor was able to have informal conversations with both staff and clients. The auditor notes, cameras, security mirrors, blind spots, and staff/client interaction. The auditor was given the ability to move about the facility as needed and provided a private office to conduct formal interviews with clients and staff.

The auditor selected sixteen clients to interview based on the population of sixty-two (twenty three females and thirty-nine males) during the onsite visit. The clients were based on the requirements of the PREA Resources Center's Auditor's Handbook. The clients were selected based on their housing unit, targeted interview status, risk assessment screening, intake dates, and commitment status. The auditor conducted the following client interviews:

- Random = 11
- Targeted = 5

The breakdown of the number of targeted interviews is as follows:
Clients that identify as lesbian, gay, or bisexual = 4
Clients that identify as transgender or intersex = 1
Clients that have a physical or cognitive impairment = 1
Clients that have reported sexual abuse while at the facility = 1
Clients that have reported prior sexual victimization during risk screening (in the community) = 3
*Where there are multiple clients in targeted categories, only one is being counted toward the targeted interview. The other clients in those categories were counted as random interviews.

The facility did not house clients who are blind, deaf, or hard of hearing; who reported prior sexual victimization during the risk screening (while incarcerated); or who are limited English proficient. The auditor conducted the interviews in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Clients. The auditor ensured no client felt pressured to agree to be interviewed, and asked clients to discuss their experience with PREA education, allegation reporting requirements, retaliation, communication with staff, knock and announcements, grievance procedures, searches (including pat, strip, body cavity, cross-gender, and transgender/intersex searches), housing unit concerns, limits to confidentiality, outside supportive services, safety, disciplinary sanctions, and other PREA related concerns.

The facility has thirty-two staff members. The auditor was able to talk with agency leadership during the onsite visit, which includes:

- Jason Varney, Vice President of Correctional Programs, North Central Region
- Mary Jones, PREA Coordinator
- Lori Schoenfelder, PREA Compliance Specialist

The auditor conducted the following specialized interviews with agency/facility staff:

- Human Resource Director, Jodi Glitzenstein
- Administrative Investigators, Denny Sizemore and Jim McFarland
- Crisis Counselor, Deanna England
- Facility Director, Dawn Root
- Risk of Victimization/Abusiveness screener
- Retaliation monitor
- SART team members
- First Responders (security and non-security)
- PREA education facilitators
- Volunteer

The six random staff interviews include Resident Supervisors (RS) and Programing staff. The auditor interviewed security staff from all three shifts. Due to the limited number of staff, the auditor was unable to interview the required twelve random staff members. Several staff members were responsible for more than one specialized area. All staff interviews, random and specialized, were conducted using the PREA Compliance Audit Instrument Interview Guide and the PREA Auditor Handbook's Effective Strategies for Interviewing Staff and Client Guide. The auditor was able to ask questions on the agency's zero tolerance policy, training, reporting protocols, first responder duties, coordinated response plan, grievance procedures, investigation protocols, confidentiality,

retaliation monitoring, risk screening, protection from abuse, LGBTI policies and procedures, data collection, annual reports, staffing plans, electronic surveillance, reporting to other confinement facilities, disciplinary procedures, searches, knock and announcements, cross-gender supervision policies.

The facility had one volunteer during the onsite visit. The auditor was able to interview the volunteer and discuss the training, understanding of the agency's zero tolerance policy, and reporting procedures. The volunteer received level one training before she was allowed to work with the clients. She states that understands her training and the requirements to report all allegations of sexual abuse and sexual harassment.

The auditor reached out to community resources via phone to confirm the MOU's and scope of services. These community partners include the SANE director, Megan Holman and the Director of Cocoon, Jodie Broadwell. The auditor was able to talk with both directors and confirmed the services each agency would provide to CROSSWAEH free of charge.

On the final day of the audit, the auditor sat down with agency leadership to review preliminary audit findings.

Facility Characteristics

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

CROSSWAEH is a community based correction facility in Tiffin, Ohio that serves both male and female offenders. There is a separate male and female facility that are located across the parking lot from each other. Staff and visitors enter through the main entrance by ringing a buzzer that will alert staff at the control office. Once inside the main lobby, visitors and staff must sign into the facility and sign acknowledgement of Oriana House's zero tolerance policy. There is a separate entrance for offenders. The offender entrance leads clients to the intake area. In this area, the client will receive a pat search or if necessary, an enhanced pat search (see standard 115.215 for a detailed description of a pat and enhanced pat search). All searches are captured on camera.

Male Facility: The male facility is a single level brick building. The visitor/staff entrance lobby has a male and female visitor bathroom and access to administrative offices and a sally port entrance to the housing unit. After entering through the sally port, one would be in the male day room. The dayroom has exercise and recreation equipment, television, payphones, bulletin board with PREA related information (hotline numbers, ways to report, phone number and addresses for state and local rape crisis agencies, rules and regulations, and client rights), and dorm rooms, dining hall/multipurpose room, laundry room, rec yard entrance, and entrance to the second housing unit around the perimeter. Clients have access to staff at the main post from the dayroom.

All rooms around the perimeter of the dayroom have windows in the door for clear line of site views into the rooms. Rooms with corners or difficult viewing angles, have security mirrors inside to allow for views from the doorway.

The facility has a treatment wing that clients must have a staff unlock the door or escort for access to this area. The treatment wing has staff offices and group rooms. These offices and group rooms have windows in the doors and some also have security mirrors.

The auditor entered all dorm rooms. There are six dorm rooms in the main housing unit area. The dorm rooms are set up with bunk beds and wardrobes around the perimeter of the room. The set up makes for good line of site views into the room from the doorway. The auditor noted the dorm room assigned to clients who may need increased monitoring from Resident Security staff. Staff are aware of any client that may need more monitoring for any reason by the number of required "whereabout" checks list on the daily count sheet.

There are two bathrooms for clients in the main housing unit. There is no door at the entrance of either bathroom and each is set up to provide clients an appropriate level of privacy (see standard 115.215 for detailed bathroom descriptions). Staff members are required to increase the number of circulation checks in the bathrooms due to it being designated a blind spot area.

The second housing unit is designated for low-level offenders and can be accessed through the dayroom. This housing unit is significantly smaller, but contains its own dayroom area, laundry room, bathroom, and outdoor recreation yard. Clients that are assigned to this area can also access the amenities in the main housing unit, however; the clients assigned the main housing unit cannot enter into the one designated for low-level offenders.

The outdoor recreation yard for the main housing unit is surrounded by a 16 foot curved fence. The area has outdoor rec equipment and smoking area. The clients have designated times for access to the rec yard and smoke breaks.

The dining hall/multipurpose room has a wall of glass that separates the room from the dayroom. Clients have access to the dayroom at all times except when vendors are filling the vending machine. Off of the dining hall is a serving room. This room is used by Aramark staff for the setup of all meals. Clients serve the meals under staff supervision. There is a clean tray area in the serving room where clients clean trays after meals.

The facility has seventeen cameras and four of those cameras also have the ability to record audio. The cameras can record and playback up to thirty days. Some of the perimeter cameras also cover the female building. Security staff have access to these cameras at the main post. Administrative staff can access the cameras from their desktop computers. The main post also has access to door cameras. The facility is equipped with video camera coverage over all strike doors that require staff to provide access. This is new technology since the first audit in 2015 and has greatly reduced blind spot areas.

Female Facility: The female facility is a single level brick building. The visitor/staff entrance lobby has a male and female visitor bathroom and access to administrative offices. After entering through the sally port, one would be in the dayroom. The dayroom has exercise and recreation equipment, television, payphones, bulletin board with PREA related information (hotline numbers, ways to report, phone number and addresses for state and local rape crisis agencies, rules and regulations, and client rights), and dorm rooms, dining hall, conference room, laundry room, group rooms, rec yard entrance, and entrance to the second housing unit around the perimeter. Clients have access to staff at the main post from the dayroom.

All rooms around the perimeter of the dayroom have windows in the door for clear line of site views into the rooms. Rooms with corners or difficult viewing angles, have security mirrors inside to allow for views from the doorway.

The auditor entered all dorm rooms. There are five dorm rooms in the main housing unit area. The dorm rooms are set up with bunk beds and wardrobes around the perimeter of the room. The set up makes for good line of site views into the room from the doorway. The auditor noted the dorm room assigned to clients who may need increased monitoring from Resident Security staff. Staff are aware of any client that may need more monitoring for any reason by the number of required “whereabout” checks list on the daily count sheet.

There are two bathrooms for clients in the main housing unit. There is no door at the entrance of either bathroom and each is set up to provide clients an appropriate level of privacy (see standard 115.215 for detailed bathroom descriptions). Staff members are required to increase the number of circulation checks in the bathrooms due to it being designated a blind spot area.

The second housing unit is designated for high risk offenders and can be accessed through the dayroom. This housing unit is significantly smaller, but contains its own dayroom area, laundry room, bathroom, and outdoor recreation yard. Clients that are assigned to this area can also access the amenities in the main housing unit, however; the clients assigned the main housing unit cannot enter into the one designated for high risk offenders.

The outdoor recreation yard for the main housing unit is surrounded by a 16 foot curved fence. The area has outdoor rec equipment and smoking area. The clients have designated times for access to the rec yard and smoke breaks. The scheduled times are not at the same time the male clients would have access to their rec yard.

The dining hall/multipurpose room has a wall of glass that separates the room from the dayroom. Clients have access to the dining hall at all times except when vendors are filling the vending machine. Off of the dining hall is a serving room. This room is used for the setup of all meals. Staff and clients pick up the meals from the male facility and return the trays to the male facility at the end of the day. Clients serve the meals under staff supervision.

The facility has twenty cameras and six of those cameras also have the ability to record audio. The cameras can record and playback up to thirty days. Some of the perimeter cameras also cover the male building. Security staff have access to these cameras at the main post. Administrative staff can access the cameras from their desktop computers. The main post also has access to door cameras. The facility is equipped with video camera coverage over all strike doors that require staff to provide access. This is new technology since the first audit in 2015 and has greatly reduced blind spot areas.

Staff can be assigned to work in either building and receive cross training in gender specific sexual abuse and sexual harassment issues.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

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

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

115.231

Number of Standards Met: Click or tap here to enter text.

115.111,115.212, 115.213, 115.215, 115.216, 115.217, 115.217, 115.218, 115.221,115.222, 115.232, 115.233, 115.234, 115.235, 115.241, 115.242, 115.251, 115.252, 115.253,115.254, 115.261,115.262, 115.263, 115.264, 115.265, 115.266, 115.267, 115.271, 115.272, 115.273,115.276, 115.277, 115.278, 115.282, 115.283, 115.286, 115.287, 115.288, 115.289, 115.401, 115.403

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

N/A

Summary of Corrective Action (if any)

The facility has complied with all parts of the PREA standards for community confinement facilities. There was no need for corrective action.

PREVENTION PLANNING

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

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual

abuse and sexual harassment? ☒ Yes ☐ No

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

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☐ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House has an agency wide zero tolerance policy. Policy 1080 mandates zero tolerance on all forms of sexual abuse and sexual harassment as defined by the Prison Rape Elimination Act of 2003 Community Confinement Standards. The policy requires each facility under the Oriana House umbrella to implement a systematic means of monitoring, identifying, reporting, and investigating employee and client sexual misconduct in an effort to provide a safe environment. The policy includes definitions of prohibited behavior, sanctions for those found to have participated in sexual abuse or sexual harassment, and appropriate strategies to prevent, detect, and respond to allegations. These strategies include having adequate staffing levels, an electronic monitoring system, and educating both clients and staff on the agency's zero tolerance policy and all ways to report an allegation.

According to the agency's table of organization, the agency wide PREA Coordinator is the agency's Vice President of Administration and Legal Counsel, and reports directly to the agency's executive Vice President of Administrative Services and Business Relations. During an interview with the PREA Coordinator, she indicated that the bulk of her responsibilities are to ensure that each facility under the Oriana House umbrella complies with the standards. She indicated that she has enough time and authority to develop, implement, and oversee the agency's efforts to comply. The PREA Coordinator supervises the agency's PREA Compliance Specialist, as well as each facility's PREA Compliance Manager. During the onsite visit, the auditor also spoke to the Vice President of Correctional Programs, North Central Ohio Region. He spoke of using the guidance of the PREA Coordinator for the development of policies, procedures, and practices to ensure each facility is not only complying with the standards, but maximizing the facility's ability to prevent, detect, and respond to sexual abuse and sexual harassment. He agrees that the PREA Coordinator has great latitude toward implementing policy and procedures where PREA is concerned.

The agency has a PREA Compliance Specialist that acts as a liaison between the PREA Coordinator and the facility's PREA Manager. The PREA Compliance Specialist helps with implementing PREA strategies at each facility. She also develops the training curriculum for required monthly PREA training at each facility. During an interview with the PREA Compliance Specialist, she discussed working at each facility for a period of time to gain firsthand knowledge of how policies and procedures where being practiced at the facility. She was able to see where facilities struggled and offer guidance and assistance. During the onsite visit, the auditor was able to witness the interaction between the PREA Compliance Specialist and staff and clients. It is obvious that both staff and clients look to her for guidance and support. She is a Department of Justice Certified PREA Auditor and reports directly to the PREA Coordinator.

The facility's PREA Manager is the facility's Program Manager. The Program Manager reports directly to the PREA Coordinator for anything related to complying with the PREA standards. The auditor was able to review the Program Manager's job description which includes conducting quality assurance monitoring for PREA standards, ensuring facility walkthroughs in order to address any safety issues, overseeing the day-to-day PREA facility issues, and ensures staff meet PREA training requirements. The Program Manager discussed her process with the auditor for ensuring the facility is meeting all required standards. The Program Manager is new to this position, but has worked for the agency for several years. She is familiar with the agency's policies and procedures and uses the PREA Compliance Manager to learn her responsibilities in regards to

maintaining compliance. She reports that she has enough time to ensure compliance with the standards.

Oriana House has an appropriate PREA Zero Tolerance policy and staff who have sufficient time and authority to ensure compliance to the standards.

Review:
Policy 1080
Program Manager job description
Agency table of organization
Interview with PREA Coordinator
Interview with Vice President of Correctional Programs, North Central Region
Interview with PREA Compliance Specialist
Interview with PREA Manager

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

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

115.212 (a)

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

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

N/A: The PREA Coordinator reported to the auditor that the agency is a private not for profit agency and does not contract with other facilities/agencies to house offenders.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

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

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

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

115.213 (b)

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

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

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

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires each Oriana House facility to develop a staffing plan that addresses the physical layout of the facility, adequate staffing levels, composition of client population, prevalence of substantiated and unsubstantiated allegations of sexual abuse, other relevant factors, and deviations to the staffing plan. The policy requires the plan to be reviewed on an annual basis and assess the effectiveness of the plan, prevailing staffing patterns, the deployment monitoring systems and other monitoring technologies, and resources to ensure adequate staffing levels.

The facility provided the auditor with their most recent staffing plan. The staffing plan reviewed the availability of video surveillance (Twenty cameras strategically placed throughout the interior and exterior of the female building and sixteen cameras strategically placed throughout the interior and exterior of the male building), security mirrors, and identified blind spot areas. The staffing levels noted on the plan includes availability of security staff 24 hours a day, seven days a week, three hundred sixty-five days per year. The plan also identified the minimum number of staff for each shift:
6:00 am – 2:00 pm: five security staff
2:00 pm – 10:00 pm: five security staff
10:00 pm – 6:00 am: four security staff
The plan identifies several vacant security staff positions. The auditor spoke with the Program Manager and the Vice President of Correctional Programs, North Central Ohio Region concerning the vacancies and the possibility of deviating from the staffing plan. Both spoke about offering overtime and pulling staff from other facilities to fill open spots in the schedule. Administrative staff from both the facility and the agency have also filled open spots when needed. The deviation report was sent to the auditor as part of the staffing plan. The report does not list any deviations. When conducting random and targeted staff and client interviews, both addressed having administrative staff working various shifts. Program staff addressed having to temporarily halt groups due to program staff assisting with security duties. All were understanding of the circumstances and did not mind helping. The facility is currently staffed enough that program staff have resumed providing groups. The VP of Correctional Programs discussed the facility's ongoing recruitment efforts in order to fill all vacancies.

The floor plans provided to the auditor include locations that have video surveillance, audio surveillance, and security monitors. During the onsite visit, the auditor toured both the male and female building. The auditor noted camera placement, security mirror placement, and blind spot areas. The male and female buildings are also equipped with door cameras that house an intercom system. The video surveillance cameras have the capability to record and playback up to thirty days, while the door cameras only show live views. The auditor viewed the video monitors as well as the door camera monitors

to inspect the views from each camera, confirm coverage and blind spot areas, and ensure the intercom system works. The facility has not identified on its staffing plan the need for increased video monitoring systems.

The facility had one allegation of client to client sexual abuse during the past twelve months. The allegation was determined to be unsubstantiated. The auditor discussed the allegations reported at this facility with the agency investigators. All other allegations fall under the definition of sexual harassment or staff integrity/boundary issues. The auditor spoke with the Program Manager concerning any planned changes based on any allegation that was reported. She stated that there is an emphasis on integrity/boundary issues during training especially with new staff members.

The Program Manager, along with other facility leadership discussed how the facility uses its staff, video surveillance, and risk assessments to ensure adequate staffing. The facility has the resources necessary to hire an appropriate amount of staff, and has the ability to offer overtime or pull from other facilities to ensure minimum staffing requirements.

Review:
Policy 1080
Staffing Plan
Floor plan
Video monitors
Deviation report
Interview with Program Manager
Interview with VP of Correctional Program, North Central Region
Interview with agency investigators
Building tour

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents) ☐ Yes ☒ No ☐ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☒ Yes ☐ No ☐ NA

115.215 (c)

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

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

115.215 (d)

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 8089 outlines Oriana House's agency search procedures. The policy does not allow for strip or body cavity searches. The policy also does not allow cross-gender pat searches. The policy states that pat (a search overtop the first level of street clothing) or enhanced pat (a search overtop underclothing) searches will be completed by a member of the same gender in a professional and respectful manner. Female staff members are allowed to conduct an observation search. During an observation search, the staff member will have the male client remove everything from his pockets, go down to the first layer of street clothing, and have the client run his own hands down person. The female staff member will also use a hand-held metal detector to inspect the person. Male staff members are not allowed to search female clients, per policy.

During the onsite visit, the auditor was able to view the room that is used for pat searches and the room used for enhanced pat searches. Both searches will be conducted in rooms that have video surveillance. The PREA Coordinator and PREA Compliance Specialist both explained the process for conducting an enhanced pat search. Two staff members of the same gender as the client will perform the search. The monitor that can view into that specific room will be blacked out from the monitoring station. The camera will record the session in case an allegation would arise from the search. The window the gives clear line of site views into the room will be covered by a medical screen. In the room where a female client would have an enhanced pat search, the auditor noted that the room is also used for urinalysis testing. The auditor reviewed the video monitor to ensure that clients using the toilet for those purposes would not be viewed on camera. The view is only of the area where an enhanced pat search would take place.

The auditor watched a male staff to male client pat search while at the onsite visit. The search was conducted in accordance with agency policy 8089.

Oriana House policy 1080 specifies the pat search procedures for transgender and intersex clients. The policy does not allow for transgender/intersex clients to be searched for the sole purpose of determining a client's genital status. Searches are to be conducted in a professional and respectful manner and in the least intrusive manner possible. The agency will meet with a transgender/intersex client before placement and determine the gender of the staff that will conduct searches. Each determination will be done on a case-by case basis. A duel search (one male staff and one female staff) of a transgender/intersex client is strictly prohibited. All searches of a transgender client are required to be documented in the agency's client database system.

CROSSWAEH Community Based Correction Facility would house a transgender/intersex client. The auditor interviewed all clients that identified as transgender or intersex during the onsite visit. During the interviews it was determined that no transgender or intersex client has been searched in an effort to determine his/her genital status, all searches have been conducted in a professional and respectful manner, and the client was allowed to voice his/her preference on the gender of staff that completed the searches.

The auditor spoke with the PREA Coordinator, PREA Compliance Specialist, and VP of Correctional Programs on the process of addressing the needs of a transgender client before placement. The VP stated that all staff were given refresher training on how to complete a pat and enhanced pat search of a transgender individual. The staff were also questioned on their comfortability on performing pat searches, enhanced pat searches, and urinalysis testing on transgender clients. No staff member voiced concerns or comfortability with the process. The PREA Coordinator states that the client was interviewed on his/her gender preference before placement and the team took his/her views into consideration before placement was determined.

The auditor was able to interview random and targeted staff during the onsite visit. Because staff members in the male building could also work in the female building, all security staff interviewed where asked about their training concerning transgender/intersex clients. All staff reported to the auditor that they were comfortable with the training provided, and felt they could conduct searches in a respectful and professional manner based on their training. Staff was also questioned by the auditor on their cross-gender search training. All male staff interviewed stated that at no time are they allowed to conduct a female search of any kind. The facility ensures that female

staff work each shift; therefor female clients are never refused programing outside the facility. Female staff were able to discuss the observation pat search. The process described to the auditor lines up with agency policy. The lead resident supervisor discussed with the auditor her practice of reviewing pat searches either in person or reviewing video footage in order to ensure pat searches are completed according to policy and make correction if necessary.

Policy 1080 requires all staff to announce their presence when entering an area where clients shower, perform bodily functions, and change clothing. All non-medical staff are prohibited from viewing a client's breast, buttocks, or genitalia except in exigent circumstances or when such viewing is incidental to routine security checks. The facility requires all clients to change in the bathroom in order to ensure the most private space for changing clothing.

The male building has three client restrooms including one that is contained in a separate housing unit. The bathroom in the housing unit for clients that have been assessed as low risk offenders contains three sinks with mirrors above directly across from open entrance, one urinal that is incased in a stall with no door, and one toilet stall that has a half door. The shower/changing area is blocked from view by a shower curtain. Inside the shower/changing area are two single use showers each covered by a shower curtain. The other two bathrooms are located in the main housing unit. One bathroom contains three sinks with mirrors above directly across from open entrance. The two toilet stalls are across from the sings and have half doors for privacy. The one urinal is not covered by a stall but cannot be seen from the open entrance. The three individual use showers are covered by shower curtains. The second bathroom in the main housing unit contains four sinks with mirrors above, two toilet stalls with half doors, and one urinal. During the facility's initial PREA audit in 2015 it was noted that the urinal could be seen from outside the bathroom entrance. The facility has corrected this by installing a half partition around the urinal. The four individual shower stalls with curtains are located on the others side of the divided bathroom. All shower curtains, including the one at the entrance to the shower/changing area in all three bathrooms allow for staff to view the lower half of clients without viewing the breast, buttocks, or genital areas. The male facility also has a single use bathroom with a door at the entrance in the client intake area. If requested, transgender/intersex clients would have use of this private bathroom.

The female building also has two housing units. The bathroom in the self-contained housing unit reserved for clients with a high risk score does not have a door at the entrance, but does have an opaque shower curtain at the entrance in order to offer more privacy. The bathroom contains two sinks with mirrors above, two toilet stalls with half

doors across from the sink area, and two individual shower stalls with shower curtains. The two bathrooms in the main housing unit both contain two sinks with mirrors, two toilet stalls with half doors, and two individual shower stalls with curtains. There is a private single use bathroom in the client intake area. If requested, transgender/intersex clients would have use of this private bathroom.

The auditor was able to interview sixteen clients during the onsite visit. The clients were asked about privacy for changing, showering, and performing bodily functions. All clients stated that all staff regardless of sex announce themselves before entering the bathroom or dorm rooms, they knew the facility's dress policy concerning changing only in bathrooms, and did not encounter an incident of cross-gender viewing. The transgender clients reported to the auditor that they did not request special accommodations for showering or using the restroom. No client reported any issues with sharing a bathroom or shower area with the transgender client due to the privacy provided in each of the bathrooms.

The auditor was able to witness the facility's practice of cross-gender announcements while on the onsite visit. The Program Manager reports that there are no documented incidents of cross-gender viewing.

The facility's policy, procedures, practice, training, and physical layout ensure that all clients are provided an appropriate, professional, and respectful pat or enhanced pat search, as well as providing them areas where they can privately shower, perform bodily functions, and change clothing.

Review:
Policy 1080
Policy 8089
Facility tour
2015 PREA audit report
Interview of target clients
Interview of random clients
Interview of staff
Interview of PREA Coordinator
Interview of Program Manger
Interview of PREA Compliance Specialist
Interview of VP of Correctional Programs, North Central Region

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 8004 states that Oriana House facilities must ensure that all clients understand the program rules, regulations, and guidelines. This includes ensuring that clients who have disabilities and are limited English proficient have equal opportunity to participate and

benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

The agency provided the auditor with the PREA Plan to Assist Residents with Disabilities. The plan states that at intake a client will be asked to indicate how he/she communicates most effectively, if he/she has a language barrier, literacy issue, and/or sensory impairment. If such barrier exist, assistance shall be provided to the client by a staff member or other qualified person. The assistance shall be provided at no cost to the client. Assistance can take the form of closed caption videos, closed caption videos in Spanish, auxiliary items for clients who may be deaf/hard of hearing or blind/seeing impaired, and interpreter services. Staff are required to read the agency's Guide for Client Sexual Abuse and Sexual Harassment Prevention to each client at intake. Should community resources be necessary, the facility has partnered with Heidelberg College or International Institute for language interpreter services and Deaf Resource Center for hearing impairment services.

Policy 1080 does not allow for the use of client interpreters unless circumstances are such as where an extended delay in interpretation could compromise a client's safety, the performance of first-responder duties, or the investigation of the client's allegation of sexual abuse or sexual harassment.

During the onsite visit, the auditor was able to view the intake process. The auditor witnessed staff reading all material to the client regardless of reading ability. Clients were also asked their preferred method of communication, requirement of auxiliary services, and if any other barrier existed that would prevent the client from understanding program rules, regulations, and guidelines. All material provided is at a 9th grade reading level and all clients must read a passage to ensure that they are capable of reading all provided materials and instructions.

The auditor interviewed any client that was identified as having a reading, cognitive and/or sensory impairment as well as any client identified as being limited English proficient. No client in this targeted category were in need of any additional services in order to benefit from the agency's effort to prevent, detect, or respond to sexual abuse or sexual harassment. All clients interviewed were capable to describing the facility's zero tolerance policy, reporting options, and services that are provided free of charge to any client that request such services.

During the onsite visit the auditor interviewed both security and program staff on the facility's policy to accommodate clients that may have reading, cognitive, sensory, or

English proficiency limitation. Both security and program staff indicated that should a client be in need of services, it would be documented in the facility's client database system along with the type of assistance needed. Staff indicated that an appropriate staff member may be tasked with providing assistance to the client during their stay or the facility would provide auxiliary items or interpreter services should it be necessary. Staff stated that community resources would be arranged by the Program Manager.

Oriana House provides in-house or community assistance for clients in accordance with this standard in order to ensure all clients benefit from the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Review:
Policy 1080
Policy 8004
PREA Plan to Assist Residents with Disabilities
Viewed new client intake
Interviewed target clients
Interviewed staff

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 prohibits hiring or promoting anyone who may have contact with the residents and prohibits the services of any contractor who may have contact with residents who: has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted or engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied treats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described in the above section.

Policy 3006 requires the agency to conduct background check for all prospective employees, including temporary employees, independent contractors, volunteers, and student interns or required the contractor, vendor, volunteer to provide a background check. Record checks are completed every five years. The auditor interviewed the Director of Human Resources during the onsite visit. The director states that every five

years the Human Resource Department will run background checks on the entire facility regardless when a person was hired in order to guarantee all staff received the required updated check. The updated background check will be stamped with a red PREA label to signify that the employee has received an updated background check as required by the standard. All employees, independent contractors, volunteers, and interns are required by policy 1080 to immediately report to their supervisor any arrests, citations, and complaints to professional licensing boards. Employees document this continued affirmation during annual personnel evaluations. All successful applicants are notified of the PREA background check requirement and that any omission regarding sexual misconduct is grounds for termination. Employees are required to document their adherence to this policy.

The Director of Human Resources reports that the Human Resource Department will review the personnel file, specifically any disciplinary action, of any employee who is up for a promotion. The agency has developed a form that indicates in red that the Human Resource Department must check discipline records for anything related to PREA. This form is then placed in the employee's file. This information is reported to the hiring/promotion committee before a decision is made.

The Director also reports the Human Resource Department conducts referral checks for all new hires and specifically documents whether or not a potential employee has been found to have substantially sexually abused an offender or resigned during a pending investigation of an allegation of sexual abuse.

The agency documents any request from outside confinement facilities requesting PREA reference checks on potential employees.

The auditor conducted a review of eight randomly chosen employee's files and confirmed the background checks (initial and five-year update), documentation of the continual affirmation to disclose any sexual misconduct, referral checks, disciplinary records, and the promotion process. All files reviewed had the appropriate documentation to show compliance with this standard. The agency also provided documentation of background checks for contract employees.

The auditor conducted a lengthy interview with the Director of Human Resources who took the auditor step by step through the hiring and promotion process. The Director states that during the hiring process, applicants are questioned about criminal or administrative sexual misconduct allegations on the application, during the telephone interview, and during the in person interview. Once hired, all new employees are

provided the agency's zero tolerance policy 1080 and continued affirmation policy 3009 to disclose misconduct. Employees document their acknowledgment of this annually. The Director reports that to be eligible for a promotion, all interested employees must submit a letter of interest to the Human Resource Department. The department will review the employees file including disciplinary actions. Employees with disciplinary action that includes sexual misconduct are not eligible for promotion.

The agency makes every effort to ensure the facility does not hire nor promote anyone that has engaged in sexual misconduct.

Review:
Policy 1080
Policy 3006
Policy 3009
Employee files
Continued affirmation
Prior institutional referral
Applicant interview questions
Background checks
Promotion documentation
Disciplinary records
Interview with Director of Human Resources

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed

or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The Vice President of Correctional Programs, North Central Region reports that the facility has not acquired any new facility nor is it planning any substantial expansion or modification to the current facility.

The Program Manager reports that she, along with facility management during the annual staffing plan review will assess the needs to its video monitoring system. This includes taking into consideration how such technology may enhance its ability to protect from sexual abuse. The facility has increased its camera coverage by four (two in each facility) and has added audio in a total of ten cameras (four in the male facility and six in the female facility). In addition to traditional cameras, the facility had added cameras to the door strike system. This has decreased the number of blind spot areas in the facility and allows for clients to speak with staff at main post.

The Program Manager will continue to monitor and address technology monitoring issues as needed.

Review:
Floor plan with additional camera placement
Video monitoring station
Door strike camera monitors
Interview with VP of Correctional Programs, North Central Region
Interview with Program Manager

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

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

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The PREA Coordinator states that any allegation of sexual abuse or sexual harassment will be administratively investigated by a trained internal PREA investigator, and when necessary criminally investigated by the agency with legal authority to conduct such investigation. The agency has shown the auditor documentation where they have entered into a Memorandum of Understanding (MOU) with the Seneca County Sheriff's Department to investigate any allegation of criminal sexual abuse and/or sexual harassment at CROSSWAEH. The MOU with the Seneca County Sheriff's Department request the criminally investigative agency to:

- Use a uniform evidence protocol that, if necessary, has been adapted from or based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examination, Adults/Adolescents," or similarly comprehensive and authoritative protocol developed after 2011
- Investigators shall have specialized training in conducting investigations in confinement settings
- Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data
- Investigators shall interview victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving suspected perpetrators
- Polygraph examination or other truth-telling device shall not be required as a condition for proceeding with the investigation of such an allegation
- Investigation shall be documented in a written report that contains a through description of physical testimonial and documentary evidence with attached copies of all evidence where feasible.
- Substantiate allegations of conduct that appears to be criminal shall be referred to prosecution
- The departure of the alleged victim or abuser from Oriana House facilities shall not provide a basis for terminating an investigation

The MOU has been signed by the Seneca County Sheriff's Department and Oriana House.

A review of the allegations at CROSSWAEH for the past twelve month indicates that one allegation of client to client sexual abuse was referred to the Seneca County Sheriff's Department for a criminal investigation. A detective from the department arrived at the facility and interviewed the alleged victim and alleged abuser. The detective documented the statements in a report and advised the facility that due to the evidence provided, the agency could not move forward with an investigation. The detective advised that should the situation change, he would move forward.

Clients that are in need of a forensic medical examination will be taken to Mercy Medical in Tiffin, Ohio. The auditor spoke with the SANE Supervisor who stated that hospital would provide Sexual Assault Nurse Examiners to any client from the Oriana House when necessary free of charge. The hospital employs five SANE nurses including the supervisor. The Supervisor reports that SANEs are on duty for most shifts; however, should one not be available, the hospital would make the on-call nurse available. The hospital works in conjunction with local advocate agencies and would offer the services of a victim advocate should the client request one. The supervisor states that the hospital has never provided SANE services to any client at CROSSWAEH.

The facility provided the auditor with documentation of a MOU with Cocoon for rape crisis, victim advocacy, and emotional support services. Services in the MOU include a toll-free hotline number, emergency room advocates, emotional support, crisis intervention, community resource referrals, and assistance during law enforcement interviews and/or court proceedings. The auditor spoke with the Director of Cocoon who has confirmed the services offered to the clients at CROSSWAEH and these services are free of charge to the clients. The Director also states that no one from the facility has requested any of these services.

The PREA Coordinator states that every effort is made to provide a victim advocate from Cocoon; however, should one not be available, the facility's Crisis Counselor has been trained by Ohio Department of Rehabilitation and Correction to serve as an emotional support person. During the Crisis Counselor's interview, she confirmed her training and availability as an emotional support person at the client request.

The facility offers emotional supportive services for all clients that report sexual harassment or sexual abuse. During the past twelve months, no client has requested these services.

The auditor was provided verification of the administrative investigators training as well as training for the emotional support person.

Review:
Policy 1080
Cocoon MOU
Seneca County Sheriff's Department MOU
Interview with SANE supervisor
Interview with Cocoon Director
Training certificates
Investigation reports

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

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

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

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

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 requires the Sexual Abuse Response Team to refer all allegations of sexual abuse to law enforcement promptly. An administrative investigation will be conducted at the conclusion of a criminal investigation.

The auditor reviewed the agency's website (www.orianaouse.org//accreditations/prea/prea.php) to ensure that the investigative policy for PREA allegations was posted. The website advises that all allegations of sexual abuse will be referred to the local legal authority for a criminal investigation. The website also gives notice that all allegations (criminal or not) will have an administrative investigation conducted by a trained investigator. Sexual abuse allegations will receive an administrative investigation at the conclusion of a criminal investigation. The criminal investigatory agency will make referral to the local prosecutor for any allegation deemed appropriate according to their agency policy.

The facility has had six allegations reported during the past twelve months. During the onsite visit, the auditor reviewed all six investigation reports with the Administrative Investigators.

Investigation #1: A third-party client verbal report to staff of staff to client sexual harassment. The administrative investigators state that they interviewed both the alleged abuser, and the reporter. The alleged victim was already released from the facility. The investigators also reviewed the staff member's phone to see if there was any contact. The investigators advise that no contact was made until three days after the client was released from the facility. The investigators report that no statements or other evidence could confirm a relationship while the client was in the facility or the nature of the relationship once the client left the facility. The staff member was terminated based on a violation of the agency's boundary/integrity policy. The PREA Coordinator determined that the allegation was unsubstantiated. No referral to the Seneca County Sheriff's Department was necessary.

Investigation #2: A third party (outside of the agency) verbal report of staff to client sexual harassment. The administrative investigators state they interviewed the alleged abuser (the alleged victim was already released from the facility). The investigators also reviewed the staff members phone to see if there was any contact with client prior to the client being released from the facility. The alleged abuser denied the relationship but did admit to boundary/integrity violations. The investigators could not prove any sexual misconduct on the staff part. The staff member was terminated based on a violation of the agency's boundary/integrity policy. The PREA Coordinator determined the allegation was unsubstantiated. No referral to the Seneca County Sheriff's Department was necessary.

Investigation #3: This was a client verbal report to staff of client to client sexual harassment. The administrative investigations interviewed both the alleged abuser and alleged victim. The incident did not take place at the facility, but on an approved work pass. The abuser admitted making an inappropriate sexual comment and apologized. The victim accepted the apology and did not want further action. Due to this being an initial incident (client did not make repeated comments to victim nor has any other client made an allegation against abuser) the facility disciplined the client based on the misconduct policy. The report will remain with administrative investigators in case of another allegation which any substantiated allegation will then be disciplined under the PREA misconduct policies.

Investigation #4: This was a client verbal report to staff of staff to client sexual harassment. The administrative investigator advised that the client reporter recanted the story during the interview. The investigators interviewed the alleged abuser and reviewed phone records. There was no other witnesses or other evidence to substantiate the allegation. The allegation was determined to be unfounded. During the interview

process, the investigators state that two clients made allegations against a different staff member. The client was already terminated from the facility. The investigators interviewed the alleged abuser and other staff, reviewed staff phone records, and contacted the former client's probation officer to see if they could verify any inappropriate contact. While the investigation did not reveal any sexual misconduct, the alleged abuser along with other staff were terminated based on violations of agency policy. The PREA Coordinator determined the allegation to be unsubstantiated. No referral to the Seneca County Sheriff's Department was necessary.

Investigation #5: This was a third party anonymous report to the outside hotline of client sexual misconduct. The administrative investigators interviewed the alleged abuser along with the alleged abuser's roommate. There was no identified victim. The allegation focused on the alleged abuser masturbating in the dorm room. The alleged abuser denied the allegation and the roommates denied being sexually harassed. The allegation was removed from the PREA administrative investigation process because it did not meet the definition of sexual abuse or sexual harassment. The clients were given verbal reminders of the agency's policy on sexual misconduct and their right to report should they feel sexually harassed. The auditor interviewed the alleged abuser during the onsite visit. The abuser denied the allegation.

Investigation #6: This was a client verbal report to staff of client to client sexual abuse. The staff referred the allegation to the Seneca County Sheriff's Department due to the nature of the allegation. The deputy advised the facility that he would not be able to proceed with a criminal investigation because the alleged victim did not want to pursue criminal charges. The victim was advised that changes to this status could be changed at any time. The allegation was then investigated by administrative investigators. The investigators interviewed the alleged victim, abuser, staff, and possible client witnesses. The investigators also reviewed video footage. The investigation found no witness or video corroboration of the incident. The PREA Coordinator determined the allegation to be unsubstantiated. The auditor interviewed the alleged victim. The victim at this time does not want to pursue criminal charges and understood the possibility of going forward at a later date.

Review:
Policy 1080
Agency website
Interview with Administrative investigators
Interview with alleged abuser
Interview with alleged victim

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

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

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires all staff to be trained on the agency's zero tolerance policies and procedures relative to client sexual abuse and sexual harassment. This training is required to be given to all employees every two years and provide refresher information on the current sexual harassment and abuse policies and procedures during the year full training is not offered.

The agency has trained staff on the agency zero tolerance policy, employee responsibilities, residents rights to be free from sexual abuse and sexual harassment and be free from retaliation from reporting sexual abuse and sexual harassment, common reactions for males and females, dynamics of sexual abuse and sexual harassment in a confinement setting, detecting and responding to incidents of sexual abuse and sexual harassment, avoiding inappropriate relationships, effective communication with LGBTI clients, and compliance with mandatory reporting laws. These training topics are taught to new employees during the onboarding process. All staff are required to attend this training before the employee can work directly with clients.

The facility provided the auditor with the power point used for training new staff. The training sufficiently covers section a.1-10 of standard 115.231. After completing training, the staff member documents their training by signing a sign-in sheet. The auditor discussed PREA training with both targeted and random staff. All staff interviewed was able to discuss their training and acknowledged receiving training on the required topics.

The agency does not train on section a. 1-10 every other year. The agency conducts mandatory PREA training on a monthly basis. Every month, each facility conducts a training on a PREA subject directed by the agency.

January: Common reactions of sexual abuse and sexual harassment victims (male and female)
February: How to detect and respond to signs of threatened and actual sexual abuse
March: How to avoid inappropriate relationships with residents
April: How to communicate effectively and professionally with LGBTI residents; Oriana House policy 8089
May: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities
June: Pat down training; policies, procedures, and practice for conducting proper pat searches (all pat search types are reviewed)
July: PREA screening policies and procedures
August: Agency zero tolerance policy; Oriana House policy 1080
September: Prevention, detection, reporting, and response to sexual abuse and sexual harassment (part 1)
October: Prevention, detection, reporting, and response to sexual abuse and sexual harassment (part 2)
November: Right of residents and employees to be free from sexual abuse and sexual harassment and from retaliation for reporting sexual abuse and sexual harassment

December: Dynamics of sexual abuse and sexual harassment in a confinement setting.

During staff interviews, most commented on the monthly training being the most helpful in addressing their concerns with dealing with PREA related issues. The staff discussed using role plays and games to remember agency policies, procedures, and practices. The program director is responsible for conducting monthly PREA training. Should a staff member miss training, the program manager will provide training material and address questions at a later date.

The Human Resource Director discussed the agency's training practices. She states that the agency cross trains all staff concerning PREA gender specific topics because staff can work with male and/or female clients. The agency also offers staff gender specific training on PREA related topics. Each facility will provide training on building specific issues related to PREA. These topics can include: transgender clients, PREA assessment interview, coordinated response plan, and first responder duties.

The Human Resource Director states that monthly training sign-in sheets are provided to the Training Department where quarterly reports are conducted to ensure that staff are completing the required topics.

Review:
Policy 1080
PREA training power point
Training records
Interview with Human Resource Director
Interview with Program Manager
Interview with staff

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Oriana House policy 1080 requires all contractors and volunteers who have contact with clients receive training on the agency's policies and procedures relating to sexual abuse and sexual harassment. The level and type of training provided will be based on the services provided and amount of contact with the clients. Minimally, all contractors and volunteers will be informed of the agency's policies and how to report allegations.

The PREA Coordinator discussed the agency's system for determining the type of training required of a contractor or volunteer. The agency has a level system where individuals identified as a level one would receive a three-hour training on the agency's policy on how to prevent, detect, respond, and report sexual abuse and sexual harassment. A level two individual will receive a thirty-minute training that consist of a fifteen-minute video and fifteen minutes of instruction of a trained facilitator. A level three individual would be asked to read and sign a PREA acknowledgement form. The form explains the agency's zero tolerance policy and the signer agrees to agreement to abide by these rules. Anyone assigned a level four status will have to be escorted throughout

the facility by staff. The auditor was assigned a level three status, and read and signed the PREA acknowledgment form during the onsite visit.

Documentation of received training is forwarded to the Compliance/Accreditation Manager. Once documented, the individual who has a level one or two status will receive a special name badge which identifies to security staff that this person has received PREA training and does not need to sign the PREA acknowledgment form. Should a level one or two contractor or volunteer forget their badge, they would be required to read and sign the PREA acknowledgement form.

The auditor reviewed the training material for contractor training and signed acknowledgments.

During the onsite visit, the auditor conducted an interview with the Aspire Coordinator. Aspire partnered with Oriana House to provide GED instruction to the clients at CROSSWAEH. The coordinator reports that all teachers including herself have participated in the level one PREA contractor/volunteer training. She states that she feels equipped to prevent, detect, and report any allegation or suspicion of sexual abuse or sexual harassment. The coordinator states that she schedules training appointments for any new teacher to complete before they can begin to work with clients.

Review:
Policy 1080
Contractor/volunteer training material
Level three PREA acknowledgement form
Interview with PREA Coordinator
Interview with Aspire Coordinator

Standard 115.233: Resident education

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

115.233 (a)

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

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

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

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

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

115.233 (b)

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

115.233 (c)

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

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

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

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

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

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 states that during the intake process, all clients shall receive information explaining the agency's zero tolerance policy regarding all forms of sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. The policy also states that clients that are transferred into the facility will receive refresher training which includes the location of PREA posters and information on how to report allegations or suspicions of sexual abuse or sexual harassment.

The auditor received a copy of the intake packet that all clients including transfer clients receive. The packet includes information on the program rules which includes possible sanctions for violating the facility's zero tolerance policy. The form is signed and dated by the client. The intake packet also includes a Guide for Sexual Abuse and Sexual Harassment Prevention. This form includes information on how to report, phone numbers and address for facility, local, and stated reporting agencies, limitations of confidentiality, and how to keep oneself safe. This form is signed and dated by the client. The client is also provided a form explaining the facility's search policy and the types of searched that the facility conducts. The client also signs and dates this form.

The auditor reviewed ten client files while at the onsite visit. The auditor ensured that all ten files showed documentation that the clients received this information at intake.

The auditor witnessed an intake interview of a new client. The Resident Supervisor staff read the entire intake packet to the client and asked questions of the client to ensure the client understood the information. At the conclusion of the interview, the client is given a copy of the client handbook which contains all the information reviewed with the client. Should the client be limited English or reading proficient, deaf, visually impaired, or otherwise disabled the staff member would ensure the client received proper assistance (see standard 115.216).

During the onsite visit, the auditor noted various posters in English and Spanish throughout the facility. The posters provided information to clients, visitors, and staff on how to report allegations and phone numbers and address to reporting agencies. The auditor used the payphone in the dayroom to call the outside reporting agency. The phone number listed connected the auditor with a PREA hotline recorded message that requested certain information in order to investigation the allegation. The recording reminded the caller that they could report anonymously and that all allegations would be investigated.

The auditor interviewed sixteen clients (targeted and random) during the onsite visit. The clients interviewed stated that at intake the staff member read all the intake packet material, they received a tour where reporting information was pointed out to them, and they have a client handbook that contains the information reviewed at intake.

Review:
Policy 1080
Client intake packet
Client handbook
PREA posters
PREA reporting phone numbers
Client files
Interview with clients

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Agency policy 1080 requires all administrative investigators to receive specialized training. The agency has two investigators as well as the PREA Compliance Specialist who received in-person training from the Moss Group. The training provided includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garity warnings, evidence collection in a confinement setting, and required evidence to

substantiate a case for administrative action or criminal referral. The agency retains completion of training certificates as proof of training.

The auditor was able to review the curriculum and training material provided by the Moss Group. The training was appropriate to the requirements of this standard.

The agency policy prohibits administrative investigators from conducting a criminal investigation. All criminal investigations will be conducted by the local legal authority.

Review:
Policy 1080
Training curriculum and material
Training certificates

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

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

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

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 requires specialized training for medical and mental health practitioners. These employees or contractors are also required by this policy to receive the same training mandated for employees or the same training mandated for contractors/volunteers.

CROSSWAEH has contract medical staff that has completed the required training for level one contractors/volunteers and also the specialized training for medical practitioners. According to the Agency PREA Coordinator, contract medical staff administer triage treatment to the clients and would not perform any type of forensic examination. All forensic exams would take place at Tiffin Mercy Hospital.

The facility does not employ nor contract with medical health practitioners. The PREA Coordinator states that all clients needing mental health care will be referred to a

community practitioner. The agency does employ crisis counselors. These counselors provide crisis intervention and make referral to community resources. The counselors receive the mandated employee training as well as the PREA mental health professionals training.

The auditor was provided with the training certificates of completion for contract medical staff.

Review:
Policy 1080
Training Certificate
Interview with PREA Coordinator

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.241 (b)

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

115.241 (c)

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

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☐ Yes ☐ No

115.241 (g)

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

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

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

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 states that all clients will be assessed for risk of victimization or abusiveness within 72-hours of arrival at the facility. This includes new intake or transfer clients. The Resident Supervisor will administer the screening instrument and considers the following:

a. Whether the client has a mental, physical, or developmental disability
b. The age of the client
c. The physical build of the client
d. Whether the client has a prior conviction for sex offenses against an adult or child
e. Whether the client is or is perceived to be gay, lesbian, bisexual, transgender, gender non-conforming, or intersex
f. Whether client has previously experienced sexual victimization
g. The clients own perception of vulnerability
h. Prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse

The policy does not allow for clients to be disciplined for refusing to answer or not disclosing complete information to questions a, d, f, or g. The staff member is required to mark those responses as "refused to answer."

The auditor was able to interview Resident Supervisors from each shift and both the male and female building. The RS's interviewed stated that they received training on how to conduct an interview in order to complete the screening instrument. The training has appropriately prepared the staff to complete the form. The staff state that after asking the screening questions, the form requires the screening to address their perceptions of the client's behavior while completing the form, LGBTI status, and any other concern that may have them override the score that is solely based on the client's answers.

The auditor was given a copy of the risk assessment instrument and allowed to sit in on a new intake risk screening. The auditor was able to verify that the screener asked all the required criteria and at the conclusion, reviewed the paperwork that includes the screeners perceptions. After the screening is complete, the screener will score the instrument based on the client's answers. The client can receive a classification of susceptible, highly susceptible, abuse, highly abusive, or no risk.

The auditor interviewed the Program Coordinator who states that she completes a quality assurance check on initial screenings. She is able to add information to the screening based on additional information that the Resident Supervisor would not have access. The Program Coordinator states that once screenings are complete, the classification is entered into the client database system while the paper form is placed in a client's file and

if a client has an assessment classification of highly susceptible or highly abusive, they will be automatically reassessed before 30-days. All other assessment classifications are only reassessed due to new information, referral, request, or incident of sexual abuse. This reassessment can happen at any time during the client's stay. The auditor was able to see multiple assessment for a client that reported a sexual abuse allegation.

The auditor interviewed sixteen clients during the onsite visit, including clients that have received both an initial and reassessment. All clients interviewed stated that they received an initial assessment the day they reported to the facility. Those clients that received a reassessment stated that it was completed by their case manager. All clients understood the purpose of safety for the assessment and stated they gave honest answers to the questions. Some clients even noted that their room placement was based on their assessment. The auditor also reviewed ten client files during the onsite visit. Each file contained the client's completed risk assessment, signature of quality assurance check, and date of reassessment if necessary. If the client needed a reassessment, the form was also contained in the file. During the past twelve months, the facility completed eighty-two female and one hundred fifty-three male initial risk assessments and twelve female and one male reassessments. All assessment information is kept in the client's file which only limited staff have access.

Review:
Policy 1080
Client risk assessment instrument (initial/rescreen)
Client files
Assessment report
Interview with Resident Supervisor staff
Interview with clients
Interview with Program Manager

Standard 115.242: Use of screening information

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

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 states that the screening information will be made available to appropriate staff to ensure that all housing, programming, and community assignments are given in a way to minimize the risk of the client being sexually victimized. The facility has specifically assigned dorms and beds for clients that have been identified as being highly susceptible or highly abusive. These rooms are the most visible to staff at the main post. Programming staff will make every effort when scheduling groups not to place clients with opposing PREA statuses in the same group. The policy states when that is not possible, that the staff will monitor appearance and behavior and report any significant changes.

While interviewing case management staff, the auditor was able to discuss how highly PREA statuses are addressed while in the facility. Clients who wish to deal with any underlining issues can have it addressed on their individual program plan or be referred to outside agencies.

The policy states that clients with a highly susceptible or highly abusive PREA status will have increased whereabout checks. Clients with no status or a status of susceptible or abusive receive three whereabout checks per shift while clients with highly PREA statuses will receive six whereabout checks per shift.

During the onsite visit, the auditor was shown the whereabout check sheet and verification of increased checks for those with PREA statuses. The auditor was also able to view the designated PREA rooms/beds from the main post. Room set up along with security mirrors strategically placed assist staff into having clear views into most areas of these rooms.

The agency has developed a team that includes the PREA Coordinator, PREA manager, admissions personnel, crisis counselor, and the offender that will address issues that come with the placement of a transgender client. The PREA Coordinator states that the team will meet prior to meeting with the client to discuss which facility under the Oriana House umbrella is the best facility for placement. The client will be included in conversations concerning the clients own view to their own safety, opportunities to shower separately, and program assignments. The Crisis Counselor states that she will complete periodic checks with the transgender client to address any concerns that may arise during the transgender clients stay.

During the onsite visit the auditor interview all clients that identified as being transgender or intersex. The clients were able to discuss the process before and after placement. They were happy with the placement and felt like administration as well as facility staff did everything to ensure their safety while at the facility. The clients did not feel like they were in housing units reserved for LGBTI offenders nor did the feel like they were targeted in any other type of way. They stated that they were able to give their views as to their own perception of safety and were offered the choice of showering privately in the facility intake bathroom.

Review:
Policy 1080
Interview with Case manager
Interview with transgender/intersex clients

Interview with PREA Coordinator
Interview with Crisis Counselor

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

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

115.251 (b)

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

115.251 (c)

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 requires Oriana House to provide clients with the opportunity to report sexual abuse and sexual harassment, retaliation by other clients or employees for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse. The policy allows for clients to report anonymously and lists the following as ways a client can report:

- Verbally telling any Oriana House employee
- Completing a Client Sexual Abuse/Harassment Reporting form (located in the client handbook
- Oriana House website at www.orianahouse.org/contactus
- Calling the Oriana House Client Sexual Abuse Hotline 330-258-1271 free of charge
- Emailing SexualAbuseReporting@orianahouse.org
- Calling an outside third party hotline at 614-728-3399 free of charge

The clients can use the payphone in the dayroom to privately report an allegation using the available hotline numbers. Clients can also speak directly to any staff member, including during private case manager meetings to report an allegation.

During the onsite visit, the auditor was able to see various postings in English and Spanish informing clients on the ways to report sexual abuse, sexual harassment, or retaliation. The postings included the phone numbers, website address, and email address. The auditor called the phone numbers posted as ways to report an allegation using the client payphones. Both the Oriana House hotline and the outside third party hotline could be reached toll-free and consisted of a recording message asking the caller to leave a message with the details of the allegation and that if the caller wished, could

remain anonymous. The auditor also sent an email to the email address posted. The auditor received a return message from the agency administrative investigator within two hours from the auditor's initial email. The auditor reviewed the agency website and the links for complete a report for an allegation of sexual abuse or sexual harassment. The links lead to a Client Sexual Abuse/Harassment Reporting Form and instructions to complete the form and return to the email listed on the form (SexualAbuseReporting@orianahouse.org)

The auditor viewed a new client intake during the onsite visit. During the intake, the client was informed of the PREA reporting information and was given a copy of the various ways to report sexual abuse and sexual harassment. The clients were also notified of the various postings around the facility that contained reporting information.

During the past twelve months, the facility has received a total of six allegations. Two of the allegations were client verbal reports to staff. All other allegation reports were third party reports. The two verbal reports from clients to staff were documented on the Client Sexual Abuse/Harassment Reporting Form and forwarded to the PREA Coordinator and administrative investigators. The auditor was able to review all allegations with the administrative investigators. The auditor was also able to confirm during client interviews one verbal report and subsequent administrative investigation and criminal referral with a client who was still at the facility.

During the onsite visit, the auditor interviewed a total of sixteen clients. The clients were asked questions in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Clients. This includes questions on ways a client can report, private and anonymous reporting, and how clients received this information. Out of the sixteen clients interviewed, all sixteen agreed that they received PREA reporting information at intake, that the reporting phone numbers and email address were listed in the client handbook, they knew the location of PREA posters which contained the information, and that they could report an allegation privately to any staff member, contractor, or volunteer verbally or writing. Three of the sixteen clients interviewed did not fully understand that they could make an allegation anonymously but stated that they were not fully paying attention during PREA education because they did not think the topic applied to them.

During staff interviews, the auditor was able to discuss reporting methods with both targeted and random staff. All staff interviewed were able to describe the reporting process should a client give them a verbal or written allegation of sexual abuse or sexual harassment. The staff was asked about privately reporting allegations or suspicions of

sexual abuse or sexual harassment. All staff interviewed stated that the Facility Director is available for private reporting of allegations or suspicions of sexual abuse or sexual harassment. Staff interviewed also stated that they could privately report by calling or emailing the PREA Coordinator or administrative investigators directly.

One staff member interviewed who had an allegation verbally reported to him discussed how once an allegation is reported, he accesses a PREA binder at the main post where a Client Sexual Abuse or Sexual Harassment Reporting Form could be found and that he completed the form and then send it to the PREA auditor and administrative investigators. The staff informed the auditor that he also notified the Facility Director at the time an allegation is made.

Review:
Policy 1080
Client Sexual Abuse and Sexual Harassment Reporting Form
Agency website
Reporting hotline numbers
Investigation reports
Interview with Administrative investigators
Interview with staff
Interview with clients

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)] , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A: The PREA Coordinator advised the auditor that the agency does not have administrative procedures to address client grievance regarding sexual abuse. The agency has an explicit policy and procedure (policy 1080: Client Sexual Abuse and Sexual Harassment Prevention) that addresses all aspects of the agency's compliance with the PREA standards. The Coordinator states that should a client file a grievance alleging sexual abuse or sexual harassment, the allegation will be investigated under agency policy 1080.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 requires each facility to provide clients with access to outside victim advocates for emotional support services related to sexual abuse by giving clients mailing addresses and telephone numbers of local, state, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between clients and these organizations, in as confidential manner as possible.

The facility has placed posters in English and Spanish around the building in conspicuous places that provide the telephone number and address to the local victim advocate and emotional supportive services agency. A review of the client handbook shows a listing of the addresses and telephone numbers to state and national victim advocate agencies.

CROSSWAEH has an MOU with Cocoon Rape Crisis Center in Bowling Green, Ohio. The MOU states that facility has the agency's permission to provide clients at CROSSWAEH Cocoon's toll-free hotline number and address, and that agency agrees to provide the clients emotional supportive and rape crisis services. The auditor was given a copy of the MOU to review.

After the onsite visit, the auditor contacted the director of Cocoon, Julie Broadwell. Ms. Broadwell was able to confirm that the agency would provide rape crisis and emotional supportive services to any client at CROASSWAEH who has experienced sexual abuse. The director confirmed the hotline number and the address provided to the clients would in fact contact a client with an agency advocate. Ms. Broadwell states that she has not received a phone call or mail from a client requesting services.

Both the national and local advocacy rape crisis agencies state that should a client contact the national (RAINN) toll-free hotline, they would be directly connected with the local agency. RAINN states that they accept all calls anonymously and do not keep track of calls into the center.

Policy 1080 requires the facility inform clients prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The auditor witnessed clients receiving this information at the onsite visit during intake. The clients are informed that they have the right to privacy while making a report of sexual abuse to outside agencies; however, due to state and federal mandatory reporting laws, the agency may be required to report allegation. The clients can also find this information inside the client handbook.

Review:
Policy 1080
PREA Postings
Cocoon MOU
Client Handbook
Interview with Cocoon Director
Intake interview

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Agency policy 1080 requires the posting of information on how a third-party can report sexual abuse or sexual harassment on behalf of a resident on the agency website. The auditor reviewed the agency website (www.orianahouse.org//accreditations/prea/prea.php) and was able to see the posted information on how to report an allegation. The auditor tested the reporting method posted and received a reply from an administrative investigator within two hours of the auditor's initial email.

The facility has posted in conspicuous places, including areas where visitors would frequent, notices on how a person can make a third-party report of sexual abuse or sexual harassment on behalf of a client. The notices include toll-free hotline numbers and the email address that is listed on the agency website.

The agency received one outside third-party report and one anonymous hotline report, and three client third-party reports during the past twelve months.

Review:
Policy 1080
Agency website
Investigation reports
PREA notices

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

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

115.261 (b)

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

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

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

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

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

Auditor Overall Compliance Determination

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Instructions for Overall Compliance Determination Narrative

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Oriana House policy1080 requires all employees, including medical and mental health staff, to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment including third-party and anonymous reports to the Client Sexual Abuse Response Team via email. This includes allegations of retaliation for reporting incidents of sexual abuse or sexual harassment or cooperating in an investigation concerning an allegation of sexual abuse or sexual harassment and any knowledge, suspicion, or information regarding staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse, sexual harassment, or retaliation.

Policy 1027 states that all client information related to PREA will be maintained in a confidential manner in compliance with Federal PREA requirements. Release of information concerning PREA allegations will be done as necessary and in accordance with Federal PREA requirements.

Policy 1005 requires states staff, without reservation, must report to the appropriate supervisor any corrupt or unethical behavior, including sexual misconduct or sexual abuse as defined by the Prison Rape Elimination Act that could affect a client or the integrity of the Agency.

The PREA Compliance Specialist reviewed the process with the auditor. According to the Specialist, the staff are to:

- Immediately email the Client Sexual Abuse Response Team
- Report any sexual abuse allegation between staff and a federal client to the Federal Bureau of Prison's Residential Reentry Manager
- Documenting the allegation, including verbal reports to management staff
- Limit the number of people who have knowledge of the allegation to designated officials who are responsible for making treatment, investigation, and other security decisions
- Perform any first responder duties as needed

During staff interviews, staff stated that they understood the reporting process, who they are required to report allegations of sexual abuse, sexual harassment, or retaliation to, and

that all allegations must be investigated by a trained investigator. All staff interviewed could tell the auditor the location of the "PREA Book" that contains the proper forms, instructions, and reporting phone numbers. Two staff members interviewed stated that they have reported suspicions of sexual misconduct in the past and all staff stated that they would feel comfortable reporting an allegation to their supervisor. When asked about private reporting, staff stated that they have access to the PREA Coordinator, Administrative Investigators, or PREA Compliance Specialist and could make a private report with any of those people.

In reviewing the investigations conducted by the facility, the auditor noted that verbal allegations made by clients, third-party reports, and anonymous allegations were all administratively and criminally (if necessary) investigated.

The facility Crisis Counselor was also interviewed during the onsite visit. She states that at the beginning of services she informs clients to the limits of confidentiality. This information is also given to the clients at intake and is listed in the client handbook. The auditor verified this by sitting in on a new client intake, reviewing the client handbook, and inspecting ten client files for a signed acknowledgement of receiving this information.

The auditor reviewed eight employee files during the onsite visit. It was noted by the auditor that each staff file contained a signed acknowledgment of receiving the following information:

- Client confidentiality
- Code of ethics
- Employee discipline
- Clients rights and grievance procedure
- Ethics and accountability
- PREA annual acknowledgement

The facility does not accept clients that are under the age of 18 and does not have a duty to report to child protective services. The State of Ohio does not require institutions or facilities licensed by the state in which a person resides as a result of voluntary, civil, or criminal commitment to report to adult protective services (Chapter 5101:2-20 and 5101:2-20-01).

Review:
Policy 1080
Policy 1005

Policy 1027
Employee files
Client files
Intake interview
Interview with PREA Compliance Specialist
Interview with Crisis Counselor
Interview with staff

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Agency policy 1080 requires the agency to take immediate action to protect a client when the facility learns of a substantial risk of imminent sexual abuse. The PREA Coordinator states that the agency can take action to protect any client by moving the alleged victim or abuser to a different dorm, housing unit, or facility. The agency can also move an alleged staff abuser to another facility or place on administrative leave during an investigation.

In reviewing the administrative investigations from the past twelve months, the facility has placed every staff member on administrative leave during the investigation. The

facility has also moved an alleged client abuser whose administrative investigation determination was unsubstantiated, in a separate housing unit to ensure the safety of the alleged victim.

The PREA Coordinator reports that the type of protection used will depend upon the situation and that protecting victims is an agency priority.

Review:
Policy 1080
Investigation reports
Interview with PREA Coordinator

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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Agency policy 1080 states that upon receiving an allegation that a client was sexually abused while confined at another confinement facility, the Program Manager/Administrator shall notify in writing the head of that facility or appropriate central office of the agency where the abuse occurred. The policy mandates that the notification shall be provided as soon as possible, but no later than 72-hours after receiving the allegation.

Policy 1080 also mandates an administrative investigation into any allegation that is made to the facility including investigations reported to the facility by another confinement facility. Should the investigation reveal criminal activity, the allegation will be referred to the local legal authority.

During the onsite visit, the auditor interviewed both agency investigators. The investigators reviewed all allegations from the past twelve months with the auditor. There were no investigations that were conducted based on an allegation reported from another confinement facility.

During an interview with the PREA Coordinator, she reports that the process outlined in the policy is the current facility practice. She states that she would receive a copy of any writing report sent to another confinement facility due to an allegation reported, and she would also be notified should another confinement facility report an allegation that occurred in CROSSWAEH. The Coordinator stated that no allegations have been reported to other confinement facilities, nor have any confinement facilities made a report to the facility during this audit cycle.

Policy 1080
Interview with Administrative Investigators
Interview with PREA Coordinator

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

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

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

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

115.264 (b)

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

Auditor Overall Compliance Determination

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Oriana House policy 1080 outlines first responder duties for any allegation of sexual abuse. The policy instructs first responders to:

- Separate the alleged victim and abuser
- If there is a crime scene, preserve and protect it by clearing all clients and unnecessary staff from the area until law enforcement can assume responsibility of the crime scene
- If the abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim not take any action that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.
- If the abuse occurred within a time period that still allows for the collection of physical evidence, do not allow the alleged abuser to take any action that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating
- Staff shall not collect evidence or disturb the crime scene as must as possible

In addition, the required first responder steps mandated by this standard, the policy also requires first responders to:

- Staff shall immediately notify, by telephone, Management staff following the internal chain of command and shall notify by telephone the Clinical Director.
- Management staff will contact appropriate law enforcement and notify the Client Sexual Abuse Response Team appropriate to the designated region via email.
- If the Clinical Director is on the premise, they will assess the client to determine services and support needed. If a sexual abuse incident occurs outside of normal business hours, and the Clinical Director is not available, the Clinical Administrator will assess the client via telephone to determine services and support needed.
- Clients who request to talk with a counselor immediately will be referred to emergency mental health services (Cocoon Rape Crisis Services). Clients who request to see a mental health counselor but state their need is not immediate will be seen by the facility crisis counselor the following business day and referred for appropriate services.

During the onsite visit, the auditor was able to review the "PREA Book" that is located at all main post. The book contains:

- First responder duties
- Staff reporting instructions
- Instructions for assisting clients who are limited English proficient
- Agency PREA Policy 1080
- Ensuring transgender/intersex client safety

All staff are trained on first responder duties (security and non-security staff) including role-playing potential situations. The training is giving during onboarding training, and again during the monthly training. The auditor was given a copy of the

Interviews of security and program staff indicate that staff know the appropriate steps to take to preserve and protect evidence and support the victim. All staff seemed comfortable with the first responder duties and confident that they would respond appropriately based upon their training.

The facility has had one allegation of sexual abuse during the past twelve months. The security staff on duty separated the alleged abuser from the victim and reported the allegation to management for further instruction. The facility management contacted the Seneca County Sheriff's Department due to the nature of the allegation. There was no need for the preservation and protection of evidence or the need for medical attention.

Review:
Policy 1080
PREA Book
Interviews with staff
Investigation report

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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Policy 1080 list the coordinated response plan as the following:

- Staff shall immediately notify, by telephone, Management staff following the internal chain of command and shall notify by telephone the Clinical Director.
- Management staff will contact appropriate law enforcement and notify the Client Sexual Abuse Response Team appropriate to the designated region via email.
- If the Clinical Director is on the premise, they will assess the client to determine services and support needed. If a sexual abuse incident occurs outside of normal business hours, and the Clinical Director is not available, the Clinical Administrator will assess the client via telephone to determine services and support needed.
- Clients who request to talk with a counselor immediately will be referred to emergency mental health services (Cocoon Rape Crisis Services). Clients who request to see a mental health counselor but state their need is not immediate will be seen by the facility crisis counselor the following business day and referred for appropriate services.

The coordinated response plan is contained in the "PREA Book" that is at each main post. During onboarding and monthly back to basic training, staff learn the coordinated response pan and the located of the posted plan.

The Coordinated Response to an Incident of Client Sexual Abuse Plan:

- Enact first-responder duties
- Management staff shall contact law enforcement

- First responders will notify in-house mental health staff if available and call 9-1-1 to arrange for immediate access to emergency medical and/or mental health services
- Offer to contact Cocoon, rape crisis services, at 419-352-1545 for victim advocate services
- Document incident as a violation report
- Follow all directives of law enforcement

The auditor was given a copy of the coordinated response plan and viewed the posted plan during the onsite visit.

Review:
Policy 1080
PREA Book
Coordinated Response to an Incident of Client Sexual Abuse

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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N/A: The Human Resource Director reported during her interview with the auditor that the agency does not have a union and does not enter into contracts with its employees. The agency is an "At Will" employer.

Review:
Interview with Human Resource Director

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct

and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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Policy 1080 requires the facility to protect all clients and employees who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other clients or employees. The facility does this by employing multiple ways to protect such as dorm changes, housing unit changes, transfer to another facility, or if applicable placed on electronic monitoring. The facility can also transfer staff members to a different facility or place on administrative leave.

The Program Manager reports to the auditor that she is responsible for the 90-day retaliation monitoring of staff and/or clients. She or the Crisis Counselor will make contact with the client once a week for a period of 90-days after the incident was reported or until the client is release from the program. The report will include periodic status checks, and a review of the client's disciplinary records, housing, program changes, or negative performance reviews and reassignments of staff. The report will be sent to the appropriate facility and administrative team members.

Clients that are on 90-day retaliation monitoring will also be placed on the facility "whereabout" checklist at an increased rate. During the onsite visit, the auditor was able to review the protection protocol for a client that has reported sexual abuse. The allegation was administratively investigated and found to be unsubstantiated. The alleged abuser has been placed in a separate housing unit (separate dayroom, bathroom, rec yard, and dining area); should the abuser and victim have a programming event together, staff will ensure that there is no contact during that time; and the victim has been placed on the increased "whereabout" list.

The auditor interviewed both the alleged abuser and alleged victim. The alleged victim reports no experience of any retaliation since reporting the allegation. The victim is comfortable with the separation arrangements made by staff. The alleged abuser was

upset with the move to another housing unit, but understands that the staff is just ensuring everyone's safety.

Agency policy 1080 states that the agency's obligation to monitor shall terminate if the allegation is determined to be unfounded. The Program Manager reports that if necessary, the facility will continue to monitor past the 90-day obligation.

Review:
Policy 1080
Whereabout checklist
Interview with Program Manager
Interview with alleged victim
Interview with alleged abuser

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (c)

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

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

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

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 requires an administrative investigation on any allegation on sexual harassment and sexual abuse. This includes allegations received through third-parties or anonymous reports. If the allegation is of sexual abuse/assault or appears to be criminal in nature, the Sexual Abuse Response Team will promptly refer the allegation to the Seneca County Sheriff's Department. In instances of sexual abuse or sexual harassment that are not criminal in nature, the facility shall gather and preserve direct and circumstantial evidence, including any physical and electronic data; interview alleged victims, suspected perpetrators, and witnesses; and review prior complains, and reports of sexual abuse/sexual harassment involving the suspected perpetrator.

The policy requires the facility to document the investigation in a written report that is retain by the administrative investigators for as long as the alleged abuser is an Oriana House client, or is employed by Oriana House, plus five years. The Oriana House Investigative Form includes the following information:

- Name of all victims, witnesses, and abusers
- Names of staff working during incident
- Date, time, and location of incident
- Type of incident
- How the incident was reported
- Description of incident
- Medical and/or counseling treatment (SANE services/Rape crisis)
- Statements from all available sources
- Separation from abuser
- Increased supervision
- Transfer to another facility
- LGBTI status
- Gang affiliation
- PREA Screening Status
- Law enforcement referral
- Parent agency notification
- Interpreter services
- Video evidence available
- Physical barriers
- Investigation determination
- Disciplinary action

The auditor reviewed the training curriculum and certificates for completion for both administrative investigators. The PREA Coordinator and PREA Compliance Specialist have also received administrative investigator training. The training was conducted by the Moss Group and included techniques for interviewing sexual abuse victims, proper use of Miranda and Garity warnings, sexual abuse evidence collection in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

During the onsite visit, the auditor interviewed the administrative investigators, PREA Coordinator, and the PREA Compliance Specialist. The process of investigation, referral, and outcome determination was described to the auditor. The PREA Coordinator states that the agency prohibits administrative investigators from requiring a

polygraph examination or other truth telling devise during an investigation. She states that all investigators are also prohibited from conducting any type of criminal investigation. All criminal investigations are conducted by the local legal authority and the administrative investigators will remain in contact with the criminal investigators in order to remain informed about the progress of the investigation. The PREA Coordinator and policy state that the departure of the allege abuser or victim from employment or control of the facility or Agency shall not provide a basis for terminating an investigation.

The administrative investigators reported the following methods of investigating an allegation:

- Trauma informed victim interviews
- Witness interviews
- Staff interviews
- Alleged abuser interviews
- Reviewing video evidence
- Reviewing past incident reports if available
- Credibility assessments based on documented behavior
- Consultation with other investigators/PREA Coordinator if necessary

The administrative investigators reviewed all six allegations reported at the facility during the past twelve months (see standard 115.222). Only one allegation was referred to the Seneca County Sheriff's Department for a criminal investigation based on the allegation information. The investigators state that they are not to question a suspected abuser during a criminal investigation. The administrative investigation would only begin at the conclusion of the criminal investigation or with the permission of the legal authority. The investigators report that they are responsible for maintaining and securing investigation reports for as long as the abuser is incarcerated or in the case of staff abusers until the employee in no longer employed, plus five years for both cases.

Review:
Policy 1080
Investigation reports
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Interview with Administrative Investigators

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 states that the agency imposes a standard of preponderance of evidence or 51% to substantiate an allegation of sexual abuse or sexual harassment. The PREA Coordinator who determines allegation findings confirmed that she uses the standard of preponderance of evidence to determine investigation outcomes.

Review:
Policy and procedure 1080
Interview with PREA Coordinator

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 1080 states that following an investigation into a client's allegation of sexual abuse, the facility will inform the client whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. If the agency did not conduct the investigation, the facility will request the information from the investigatory agency in order to inform the client. The facility will also notify the client whenever:

- The employee is no longer working at the client's assigned facility
- The employee is no longer employed by the agency
- The agency learns the employee has been convicted on a charge related to sexual abuse within the agency
- The agency learns the alleged client abuser has been indicted on a charge related to sexual abuse within the facility
- The agency learns that the alleged client abuser has been convicted on a charge related to sexual abuse in the facility

All such notifications or attempted notification are documented in the agency's client database system. The obligation to make such report under this standard shall terminate if the client is release from the agency prior to an investigation determination.

The facility had one allegation of client to client sexual abuse during the past twelve months. The allegation was administratively investigated and referred to the Seneca County Sheriff's Officer for a criminal investigation. The Sheriff's office did not file charges due to the victim not wanting to pursue charges. The administrative investigation determined that the allegation was unsubstantiated.

The auditor received a copy of the notification form that was signed by the client acknowledging that they received notification of the investigation determination. The investigation was completed two days prior to the client receiving notification. The auditor interviewed the alleged victim during the onsite visit. The alleged victim confirmed the receipt of the allegation outcome notification.

Review:
Policy 1080
PREA Sexual Abuse Victimization Notification report
Interview with alleged victim
Interview with administrative investigators

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 states that employees shall be subject to disciplinary action up to and including termination for violating the Client Sexual Abuse and Sexual Harassment Prevention policy. Policy 3037 specifically outlines employee discipline. This policy states disciplinary action may take the following steps:

- Formal verbal warning
- Written warning
- Disciplinary probation
- Disciplinary suspension
- Disciplinary discharge
- Suspension pending investigation

The agency outlines its progressive disciplinary plan in its employee handbook. A review of the handbook states that any staff member found to have engaged in sexual abuse will be terminated. Termination or resignation by a staff member who otherwise would have been terminated for violations of the Client Sexual Abuse and Sexual Harassment Prevention, will be reported to law enforcement agencies and any relevant licensing bodies.

The auditor interviewed the Human Resource Director during the onsite visit. The Human Resource Director reports that it is agency practice to place a staff member on administrative leave during the course of an investigation. She states the agency enforces their strict zero tolerance policies by terminating employees found to be in violation of

the policy, and terminating employees whose allegation was determined to be unsubstantiated but a major violation of the boundaries/integrity policy has been committed.

The auditor reviewed the investigations that took place during the past twelve months at the facility. The auditor noted that in every case where a staff member's allegation was unsubstantiated but a violation of the boundary/integrity policy was committed, the employee was terminated from the agency. No employee had a substantiated allegation.

Review:
Policy 1080
Policy 3037
Employee Handbook
Investigation reports
Interview with Human Resource Director

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 1080 states that any contractor or volunteer who engages in sexual abuse has be prohibited from contact with clients and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The agency will take appropriate remedial measure, and shall consider whether to prohibit further contact with clients, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

During the onsite visit, the auditor reviewed all allegations reported within the past twelve months. There have been no allegations against a contractor or volunteer.

The Human Resource Director stated during her interview that CROSSWAEH has not had any incident concerning the interactions between a contractor/volunteer and a client.

Review:
Policy 1080
Investigation reports
Interview with Human Resource Director

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

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Oriana House policy 1080 requires all clients to face disciplinary action up to and including termination from the program following a substantiated allegation of client to client sexual abuse and sexual harassment or a criminal finding of guilt for client to client sexual abuse. The policy requires the agency to consider whether a client's mental disabilities or mental illness contributed to his/her behavior, the client's disciplinary history and sanctions imposed for comparable offenses by other clients with similar histories, when determining what type of sanction, if any, should be imposed.

The PREA Coordinator stated during an interview with the auditor that should a client be found to have a substantiated allegation of sexual harassment, dependent upon the circumstances; client disabilities, mental health, and disciplinary record; and other sanctions imposed for similar circumstances, the abuser will be disciplined according to the progressive discipline policy laid out in the client handbook.

In reviewing the investigations conducted at the facility during the past twelve months, the facility disciplined one client that was initially reported as a PREA sexual harassment allegation, but was disciplined based on client misconduct due to the allegation being a first offences, offender negative discipline record, and the abuser correcting the behavior without staff intervention. The discipline was in line with agency policy.

The PREA Coordinator states that all substantiated allegations of sexual abuse will result in a client being terminated from the program. During the past twelve months, the facility has not had a substantiated allegation of sexual abuse against a client.

Agency policy does not allow for the disciplining of a client for a good faith report of sexual abuse when there is a reasonable belief that the alleged conduct occurred even if an investigation does not establish evidence sufficient to substantiate the allegation.

The policy also does not allow for offenders to have consensual sexual contact; however, such conduct will not be defined as client sexual abuse. The policy also does not allow for the discipline of offenders for client sexual contact with staff unless the staff member did not consent to such contact. The facility has not disciplined a client for filing a false allegation, nor a client who had consensual sexual contact with a staff member.

Review:

Policy 1080
Client Handbook
Investigation reports
Interview with PREA Coordinator

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 1080 mandates the offering of timely, unimpeded access to emergency medical treatment and crisis intervention services free of charge to an alleged victim of sexual assault. The treatment offered also includes timely information about and timely access to sexually transmitted infection prophylaxis and emergency contraception.

During the onsite visit, the auditor spoke with the agency crisis intervention counselor. The counselor states that her responsibility to any client that has experienced sexual victimization is for immediate crisis intervention or to complete weekly status checks. The agency would refer sexual abuse victims to community rape crisis counseling or other appropriate community resources. The counselor also states that she provides trauma response training to Oriana House staff. This training better prepares staff to assist abuse victims.

The PREA Compliance Specialist states that staff are also trained on the agency's PREA Medical Response Plan. The auditor reviewed the plan. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. The scope of services, length of services, and type of services will be at the discretion of the medical provider and is at no cost to the client.

The Specialist reviews the PREA Medical Response Plan annually to ensure that all service provider information is current and that the range of services are still available. Clients are informed of the rights to these services free of charge during PREA education at intake.

The facility has received one allegation of client to client sexual abuse during the past twelve months at this facility. The alleged victim was offered rape crisis, medical, and mental health counseling. The alleged victim refused services and is currently receiving mental health services for other issues. During an interview with the alleged victim, it was reported to the auditor by the alleged victim that any issues stemming from the

incident could be discussed with the current counselor. The alleged victim reported to the auditor the refusal of offered services.

Review:
Policy 1080
Medical Response Plan
Interview with alleged victim
Interview with Crisis Counselor
Interview with PREA Compliance Specialist

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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CROSSWAEH offers community medical and mental health counseling services for clients who have been sexually abused in jail, lockup, or juvenile facility. Policy 1080 states that all treatment including testing for sexually transmitted disease and treatment within sixty-days to all known resident on resident abusers be offered free of charge.

During a mandatory monthly PREA training. Staff are notified of the agency's PREA Medical Response Plan. The auditor reviewed the Medical Response Plan. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. The PREA Compliance Specialist states that all ongoing medical or mental health care will be at the discretion of the medical provider and is at no cost to the client. The specialist reviews the plan annually to ensure that all service provider information is current and that he range of services are still available.

The PREA Compliance Specialist states that the agency has not been notified of any known resident to resident abuser. This information would be collected at intake in documentation provided to the facility from the client's parent agency or a client could self-report during risk assessments. Should the facility become aware that a client has previously abused another client, the Specialist reports the client's case manager would meet with the client and make a determination if additional treatment or referrals for community treatment is necessary.

The policy also states that should a pregnancy result from sexually abusive penetration while incarcerated, timely and comprehensive information about and timely access to all lawful pregnancy related medical services will be offered.

The facility has not received a report of a client being sexual abused while in a jail, lockup, or juvenile facility prior to intake at this facility during this audit cycle. The facility has received one allegation of client to client sexual abuse during the past twelve months at this facility. The alleged victim was offered rape crisis, medical, and mental health counseling. The alleged victim refused services and is currently receiving mental health services for other issues. During an interview with the alleged victim, it was reported to the auditor by the alleged victim that any issues stemming from the incident could be discussed with the current counselor. The alleged victim reported to the auditor the refusal of offered services.

The PREA Compliance Specialist has confirmed the process and practice of the agency's Medical Response Plan.

Review:
Policy 1080
Medical Response Plan
Interview with PREA Compliance Specialist
Interview with alleged victim

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

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

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Oriana House policy 1080 states that the PREA Coordinator will activate a Client Sexual Abuse Review of all substantiated or unsubstantiated allegations of sexual abuse within thirty days of the conclusion of the investigation. The review team shall include an upper management designee, compliance/accreditation manager, admissions manager, and input from a designated resident supervisor and/or caseworker, administrative investigator, and mental and/or medical practitioner.

According to agency policy and as well as the PREA Coordinator, the team shall consider the following when reviewing the allegation and investigation:

- Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse
- Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility
- Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse
- Assess the adequacy to staffing levels
- Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff

The team is then tasked with preparing a report of its findings and any recommendations for improvement and submit the final report to the Vice President of Administration and Legal Counsel (PREA Coordinator) who will be responsible to distribute the final report to the Executive Team. The Executive Team will review and determine (with the input of the PREA Coordinator) which recommendations will be implemented or will document the reasons for not doing so. The regional Vice President of Corrections will

be responsible for distribution the report to facility management and overseeing the implementation of the approved recommendations.

The auditor interviewed the Vice President of Correctional Program North Central Region to discuss his role on the incident review team and his responsibility in ensuring any and all recommendations that stem from the review are implemented at the facility. The VP states that he would report on the facility dynamics that might have contributed to the report, conduct a review of the physical plan to see if there are physical barriers that may have led to the incident, and collect reports from facility staff that may assist in discerning whether the facility could have prevented the incident. As far as implementation of recommendations, he would ensure facility staff had the resources to comply with the recommendations and report to the PREA Coordinator after implementation.

The PREA Coordinator states that she is not a part of the incident review team; however, she does participate in the Executive Team's review of the report and makes recommendations based on the PREA standards.

There was one allegation of sexual abuse during the past twelve months at the facility. The allegation is currently in the process of being reviewed by the Client Sexual Abuse Review Team therefore no allegations were reviewed by the auditor. The facility provided the auditor with the Client Sexual Abuse Review form. The form list a summary of the allegation and findings, the considerations of the committee as listed above, collateral information, and committee recommendations. The second section of the form is completed by the Executive Team. This section lists the approved recommendations, reasons for not approving recommendations, and the implementation plan.

Review:
Policy 1080
Client Sexual Abuse/Harassment Review form
Interview with PREA Coordinator
Interview with VP of Corrections North Central Region

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires the tracking of accurate, uniform data for every allegation of sexual abuse in all Oriana House facilities and that information will be aggregated at least annually. The PREA Coordinator reports that the information is collected, reviewed, and retained from all PREA related reports.

The auditor reviewed the form used to collect the data and confirmed that the information collected is appropriate enough to complete the Survey of Sexual Victimization for all Oriana House facilities.

The Coordinator reports that the Department of Justice has not made a request for this information.

Review:
Policy 1080
Sexual Victimization report form
Interview with PREA Coordinator

Standard 115.288: Data review for corrective action

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

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 states that the agency will use the information collected in standard 115.287 to assess and improve the effectiveness of the agency's client sexual abuse prevention, detection, and response policies, practices, and training which includes:

- Identifying problem areas
- Taking corrective action on an ongoing basis
- Preparing an annual report of its findings and corrective actions for each facility as well as the agency as a whole

The auditor reviewed the report and ensured that the report compares the current year's data with those of previous years and includes updates made from previous year's reports. The report states that the agency has developed a training schedule on the required PREA topics that is completed on a monthly basis; executive staff review and update if necessary agency policy and procedures; staffing plan assessment of the need for additional security mirrors and cameras was conducted at each facility; installation of

shower curtains with clear tops and bottoms at each facility; and a mandate for increased staff circulations in the bathrooms during designated shower times.

The information in the report does not contain any identifying information that would need to be redacted in order to protect the safety of the clients, staff, or facility.

The information in the report has been reviewed and approved by the agency's President and CEO. The report is posted on the agency's website at:
http://www.orianahouse.org//docs/prea/2017%20Annual%20Report.pdf

Review:
Policy 1080
PREA annual report (2017)
Oriana House website

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

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

115.289 (b)

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

115.289 (c)

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

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires the agency collect data requested in standard 115.287 and that this information will be aggregated, and made available to the public through the agency's website. The information posted to the agency's website is required to have all personal identifying information removed. The PREA Coordinator is mandated by policy to securely retain the information collected and to retain the data collected for at least ten years.

The auditor accessed the agency's website, www.orianahouse.org/accreditations/prea/prea.php, To ensure that the agency has posted its annual report. The annual reports are completed based on a calendar year and the agency has posted the 2017, 2016, 2015, and 2014 annual reports. The information in the report is collected by each facility's PREA Manager and is then submitted to the agency's PREA Compliance Specialist. The agency PREA Compliance Specialist aggregates the information and prepares the information for the annual report. The report is then submitted to the PREA Coordinator for approval.

The PREA Coordinator reports that all information is only accessible to approved staff members and that she retains control of all information. The information is kept for ten-years.

The information collected in standard 115.287 is made available to the public through the agency website.

The auditor did not view any information in the report that could jeopardize the safety and security of the facility, nor was there any personal identifying information contained in the report.

Review:
Policy 1080
Oriana House website
PREA annual reports 2014-2017
Interview with PREA Coordinator

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once.? (N/A before August 20, 2016.) ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited? ☒ Yes ☐ No

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency post all final PREA reports of each of its facilities on the agency website. The auditor reviewed the agency website to ensure that during the first year of the audit cycle the agency ensured that one-third (1/3) of its facilities had been audited. The agency has a total of ten facilities that require PREA audits. During year one of the audit cycle, the agency had four facilities audited, and during year two, including this audit, the agency had four facilities audited. The last two facilities will be audited during year three of the audit cycle and have been scheduled for an onsite visit in April 2019.

The auditor was given full access to the facility during the onsite visit. The Program Manager, PREA Compliance Manager, and PREA Coordinator escorted the auditor around the facility and opened every door for the auditor. The facility provided the auditor a private room in order to conduct staff and resident interviews. The auditor received documentation on the agency and facility prior to the onsite visit through Power DMS web based audit system. The auditor was also provided requested documentation during the onsite visit.

The auditor also reviewed electronic documentation during the onsite visit. This includes camera views, ORION client database system, and intercommunication system. The auditor reviewed ten client files and eight staff files for additional documentation and confirmation of reported information.

Appropriate audit notices were posted in conspicuous areas throughout the facility. These places included areas client, staff, and visitors would frequent. The notices included the auditors mailing and email addresses. The PREA Compliance Specialist sent the auditor photographic proof of the notices being posted approximately six weeks prior to the onsite visit. During the onsite visit, one client requested to speak to the auditor. The auditor interviewed the client whose concern was not PREA related. The auditor relayed the client's concern to the Program Manager. The auditor did not receive any correspondence with a staff or client prior to or after the onsite visit.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has published on its agency website the final PREA reports for all Oriana House operated facilities. The final PREA report for CROSSWAEH from the previous

audit is currently posted. The auditor reviewed the agency website and verified that the facilities that were audited during year one and year two of this audit cycle, had their final reports posted, and the facilities that will be audited during year three of this audit cycle had their previous reports posted. The PREA Coordinator states that she understands the requirement of having all final reports posted, and that the Ohio Department of Rehabilitation and Correction Bureau of Community Sanctions also post final PREA reports on their agency website for any facility that houses offenders for the state of Ohio. The auditor also reviewed ODRC agency website and found final PREA reports for Oriana House facilities posted.

AUDITOR CERTIFICATION

I certify that:

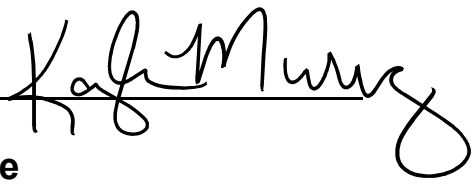
☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Kayleen Murray  November 25, 2018

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.