PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 08/02/2016

Auditor Information			
Auditor name: Kayleen Murray			
Address: P.O. Box 2400 Wintersville, Ohio 43953			
Email: kmurray.prea@yahoo.com			
Telephone number: 740-317-6630			
Date of facility visit: June 29-30, 2016			
Facility Information			
Facility name: Residential Institution Probation Program			
Facility physical address: 40 East Glennwood Avenue			
Facility mailing address: *(if different from above)* P.O. Box 1501 Akron, Ohio 44310			
Facility telephone number: 330-996-2222			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Heather Roper			
Number of staff assigned to the facility in the last 12 months: 37			
Designed facility capacity: 148			
Current population of facility: 136			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 18 and up			
Name of PREA Compliance Manager: Heather Roper		**Title:** Program Administrator	
Email address: heathermroper@oriana.org		**Telephone number:** 330-996-2222 x2511	
Agency Information			
Name of agency: Oriana House, Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 885 Buchtel Avenue, Akron, Ohio, 44305			
Mailing address: *(if different from above)* P.O. Box 1501 Akron, Ohio 44309			
Telephone number: 330-535-8116			
Agency Chief Executive Officer			
Name: James Lawrence		**Title:** President and CEO	
Email address: jameslawrence@orianahouse.org		**Telephone number:** 330-535-8116	
Agency-Wide PREA Coordinator			
Name: Mary Jones		**Title:** Vice President of Administration and Legal Counsel	
Email address: maryjones@orianahouse.org		**Telephone number:** 330-535-8116	

AUDITFINDINGS

NARRATIVE

The PREA audit for the Residential Institution Probation Program (RIPP) Halfway House was conducted on June 29-30, 2016 in Akron, Ohio. Oriana House was founded in 1981 and has been nationally recognized for community corrections and chemical dependency treatment. The facility uses the Power DMS web based compliance system to supply the auditor with documentation relevant to showing compliance with each of the standards. The pre-audit questionnaire and a list of community partners and their phone numbers was also included in the documentation. The auditor is notified by email that the facility has uploaded all documentation and is then supplied a unique assess key from Power DMS. The auditor received this information four weeks prior to the audit.

During the audit the auditor toured the facility and conducted formal staff and client interviews. During the tour it was noted that multiple PREA audit notices were posted in both resident and staff areas in conspicuous places. The notices included the name and address of the PREA auditor and the date posted was six weeks prior to audit. All resident areas including the bathroom and lounge and near phones, the facility has posters which informs residents on the ways in which they can report an allegation; the phone numbers and addresses of agencies they can report including anonymously; and that they can report to any staff member at any time in writing or verbally. Staff post areas have a PREA binder which includes first responder duties and the facility's coordinated response plan.

Nine random clients from the two housing units (10% of the population that was currently in the building) were interviewed, one from each of the nine dorms. The facility is a halfway house and most of the population was out of the facility either working or job seeking. There were no residents who identified as LGBTI, so a random sample of clients was chosen from the various dorm rooms. Residents were asked about their experience with PREA education, allegation reporting, communication with staff, safety, restrooms, knock and announcements, grievance procedures, pat downs, PREA brochures and postings, and the zero tolerance policy.

Also interviewed were specialized staff. This staff includes the Executive Vice President of Administrative Services and Business Relations, PREA Coordinator, Agency Administrator, PREA Manager, Investigators (2), Human Resource Manager, Emotional Support Personnel, the local hospitals SANE Coordinator, and the Rape Crisis Center of Media and Summit Counties Director. The facility does not provide on-site medical or mental health services. Random staff were questioned about PREA training, how to report, to whom to report, filing reports, investigations, conducting interviews, follow-up and monitoring retaliation, first responder duties, and the facility's coordinated response plan.

After a brief opening with agency staff, the auditor toured the facility. The tour consisted of examining all dorm areas, group rooms, day rooms, bathrooms, operations post, utility areas, and maintenance areas. A review of employee files, training records, PREA acknowledgments, PREA forms, and data logs were also completed. The auditor gave a closeout and shared some of the immediate findings.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Residential Institution Probation Program (RIPP) is a halfway house located in Akron, Ohio that serves adult male felony offenders. The facility is a converted four story brick building including a basement that can house up to 148 offenders. The facility is connected to the Glenwood Jail which is operated by the county sheriff's department. The facilities are completely separate and cannot be accessed internally. To access the facility one must report to the lobby area where all residents, staff, and/or visitors must be signed in. Residents will receive a pat down that is visible by video surveillance or residents may receive an enhanced pad down (residents receiving an enhanced pat down will be moved to a room where they will strip down to their underclothes) which is also visible by video surveillance. Visitors will read and sign an acknowledgment of Oriana House's zero tolerance policy. The facility's goals are to alleviate jail and prison overcrowding; improving the community integration process for residents; addressing chemical dependency, employment, education, and other issues prior to release; and reducing recidivism by addressing certain behaviors, attitudes, and thought processes. RIPP accomplishes these goals by using programming that has demonstrated the ability to reduce crime. Programs offered at the facility include: case management; chemical dependency assessment, education, and treatment; education classes and GED preparation and testing; employment assistance, cognitive skills classes; anger management; community service; and life skills development.

The outside recreation area is enclosed with a 10 ft fence and is under video surveillance. The residents are supervised by staff for outside recreation activities at least once a day. The facility also has an outside smoke pit that is enclosed by a 8ft wooden fence and wire gate fencing over top. RIPP's electronic surveillance program includes 32 cameras placed throughout the facility (interior and exterior) that have the capability to record and playback up to 30 days. Camera footage reviewed by Resident Supervisor staff four times per shift and documentation of the review is done on the facility's database. Supervisors are required to review live footage at least one time per week. The Program Administrator, Lead Resident Supervisor, and Program Coordinator have access to the facility camera system on their office desk top computer. Resident supervisor staff also are required to conduct "where abouts" 3x per shift and 6x per shift for residents who have been classified as highly abusive or highly susceptible until a review can be done by a supervisor team to remove the resident from the increased "where abouts". During a "where about" staff must document physically seeing each resident. Along with "where abouts", Resident Supervisor staff circulate throughout the whole facility once every 30 minutes. Area's that do not have cameras (dorms, restrooms, kitchen, stairwells) have increased circulation. The stairwell and most dorm rooms have surveillance mirrors. All rooms within the facility have windows in the doors to offer good line of site views and the use of mirrors to capture areas that are not immediately seen by looking through the window. The facility recently experienced a flood in the basement. This area has been off limits to the residents until the facility has had a chance to repair all damage. Residents can still use the laundry that is located in the basement, but the lounge area and bathroom have been shut down. Residents are currently using the cafeteria as a lounge/multipurpose room and all residents must now use the third floor for showers. There are toilet stalls located on the first and third floor for resident use.

There are several dorm areas in the facility. Dorm #1 can house up to 18 residents, dorm #2 can house up to 18 residents, dorm #3 can house up to 16 residents, dorm #4 can house up to 16 residents, dorm #5 can house up to 16 residents, dorm #6 can house up to 22 residents, dorm #7 can house up to 20 residents, dorm #8 can house up to 10 beds, and dorm #9 can house up to 10 residents. The facility has developed a plan to determine which dorms and specific beds would be used to house residents who have been identified as highly vulnerable or highly abusive.

SUMMARY OF AUDIT FINDINGS

Residential Institution Probation Program has had 2 PREA allegations during the reporting period. One allegation was staff to client sexual harassment that was administratively investigated and found substantiated. The second allegation was resident-on resident sexual harassment that was administratively investigated and found unsubstantiated. There was no indication during the investigations any criminal activity took place.

The staff of RIPP indicated that they received formal PREA training during orientation training or as part of their annual training along with refresher training during a monthly staff meeting. Staff was able to specifically talk about their responsibilities as first responders, how they were to respond to any allegation reported to them or if they suspected incidents of sexual abuse/sexual harassment, how to communicate effectively with offenders who may be LGBTI, and impressed upon the auditor that their main duty was to keep everyone safe.

The offenders at RIPP expressed that they have no doubt that the staff would keep them safe and would respond appropriately should an incident of sexual harassment/sexual abuse take place. The offenders were able to clearly recite the education they received concerning their rights under the PREA standards, and knew the location of PREA related postings. All offenders affirmed being screened at intake for risk of vulnerability or abusiveness and again by their case manager at a later date.

All MOU's documented the partnership between the facility and the contracting agency concerning services to be provided should there be a need. The auditor was able to contact victim advocate and the SANE nurse coordinator and confirmed the free services the agencies would provide to a victim of sexual abuse/assault.

Overall, the auditor was left with the impression that the leadership and staff of RIPP have made implementing the PREA standards a priority and that they have received the necessary training and authority to detect, protect, and respond to any incident of sexual abuse/sexual harassment. Oriana House as an agency has had every facility audited during this three-year audit cycle. Each facility has made changes and improvements based on auditor recommendations. Agency leadership has developed policies and practices that shows a commitment to the safety of residents, and provides the necessary support to implement all aspects of the PREA standards.

Number of standards exceeded: 5

Number of standards met: 34

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has an agency wide written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy includes how the facility will implement its approach to preventing, detecting, and responding to sexual abuse and sexual harassment; definitions of prohibited behavior; sanctions for those found to have participated in sexual abuse or sexual harassment; and appropriate strategies to reduce and prevent sexual abuse and sexual harassment of residents.

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 staff interviews, the PREA coordinator indicated that she has enough time and authority to develop, implement, and oversee the facility's efforts to comply with the PREA standards.

The facility's PREA Manager is the agency's Program Administrator. The PREA Manager reports directly to the Program Manager and works directly with the PREA Coordinator on issues pertaining to complying with the PREA standards. She indicates that she has ample time to comply with the PREA standards.

Review:
Policy and Procedure
Interview with PREA Coordinator
Interview with Program Administrator
Interview with Program Manager

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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N/A: The PREA Coordinator advises that the facility is not a public agency and does not contact with other facilities.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility has a staffing plan that provides for adequate levels of staffing, and where appropriate video monitoring to protect residents against sexual misconduct. The staffing plan takes into consideration the physical layout of the facility, types of residents housed at the facility, and the number of substantiated and unsubstantiated incidents. The facility management has considered all blind spot areas and developed an appropriate response to maintain the safety and security of the facility.

The staffing plan was developed with the agency PREA coordinator and the facility PREA manager along with other facility leadership. The team conducts an annual walk through of the facility and documents ways the facility can improve its methods of preventing and detecting any incidents of sexual abuse/sexual harassment. Staffing levels are continuously monitored and the facility has the ability to pull from other facilities if necessary to ensure appropriate coverage.

There have been four deviations to the staffing plan during this audit cycle. The facility has documented the dates of the deviations, listed what the deviation was, and a justification for the deviation. The facility has since corrected the issue causing the deviation and has had no futher issues.

The auditor has reviewed the agency's written policy concerning what information is to be contained in the staffing plan and the number of staff members required to operate each shift. A review of floor plans, camera placement, and identified blind spot areas was conducted by the auditor prior to the audit and during the walk through. During interviews with facility staff, the auditor was informed how staff placement, required "where about" checks and circulations, and video monitoring are used to ensure maximum safety and security. There is a policy requirement to have the staffing plan reviewed annually and updated if necessary.

The facility has recently experienced a flood in the basement. RIPP administrators have made appropriate adjustments to staffing levels, circulations, video monitoring reviews to ensure safety and security while the basement is being repaired. The facility has a manned post on both the first and third floors. Residents need to use the restroom on these floors would have to pass a manned post (even at night). The lounge area has been moved to the cafeteria/multipurpose room. The room is under staff supervision and on camera. The laundry room is in the basement and is still accessible to residents. The laundry room is under video surveillance.

Review:
Policy and Procedure
Facility tour
Staffing plan
Deviation Report
Floor plans with camera placement
Interview with PREA Coordinator
Interview with Compliance Manager
Interview with Program Administrator
Interview with Lead Resident Supervisor

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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The facility does not conduct cross-gender strip or cross-gender body cavity searches of residents. Residents receiving an "enhanced pat-down" (stripped down to underclothing) will have two members of the same sex perform this type only. All pat downs and enhanced pat downs are recorded on the facility's video monitoring system. The facility does not allow for a total strip search or a body cavity search. Cross-gender pat-down searches are also not allowed.

The facility allows residents to shower, perform bodily functions, and dress in areas not viewable to staff. The facility has two restrooms for residents to be able to shower and use the toilets. The basement bathroom consist of four shower stalls with three shower heads in each. The shower curtains have see-through tops and bottoms. There are six toilet stalls around the corner from the showers that have stall dividers but no doors. Resident laundry is located on the same side of the restroom as the toilets. The laundry section has a camera that points directly at the machines but not in the toilet area. The third floor bathroom has multiuse shower stalls with shower curtains that have see-through tops and bottoms. The toilets have staff dividers but no doors. Currently the residents on the second floor have to use the showers on the third floor. There is an operations post on the third floor near the showers. All residents would have to pass the post to use the restroom. This allows for appropriate supervision during the increase use of this restroom. The facility has urine restroom on the first floor that is now open to residents until the basement bathroom is fixed. This is a single use restroom and has a door that is capable of locking. The restrooms allow for privacy while in use however has increased circulations due to it not being easily viewable to staff. During residents interviews, all indicated that staff announce their presence before entering the restroom or dorm areas, and the auditor witnessed this while walking through the facility. The agency has a dress policy that requires residents to be fully dressed in common areas.

The facility has not housed a transgender or intersex resident. The agency has implemented a policy addressing the proper housing, search, and showering of any transgender or intersex resident. A transgender or intersex resident would be housed in a small bed number dorm room with a bed that is easily viewable from the door window. The policy does not allow staff to physically examine a transgender or intersex resident for the sole purpose of determining genital status.

Facility staff have received proper training for patting down a transgender or intersex resident. This training is completed during a new staff's orientation. A Shift Supervisor is required to periodically review pat downs, live or reviewing surveillance video, and provide training/guidance to staff if necessary. Reviews of this training is conducted annually.

Review:
Policy and procedure
Staffing plan
Facility tour
Training records
Interview with PREA Coordinator
Interview with Program Administrator
Interview with Lead Resident Supervisor
Interview with random Resident Supervisor staff
Interview with residents

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has been able to partner with other agencies to provide disabled resident equal opportunity to participate in all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility identifies residents who may be limited

English proficient and works with interpreters so that residents can benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Per policy, the facility will only rely on resident interpreters if a delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-responder duties, or the investigation of the resident's allegations.

As a part of the agency's PREA training program, all staff are trained on how to ensure that PREA is communicated with clients having a cognitive or physical disability and who to call to help clients who may have a language barrier. The facility will use a qualified employee to aid any resident in understanding agency rules, PREA, and other regulations. If a qualified staff member is unavailable, outside assistance by a qualified person will be used at no cost to the resident. At this time, the facility does not have a resident who is in need of these services.

The facility has an agreement with The International Institute for language interpreter services and the Greenleaf Family Center for hearing impaired services.

Interviews with staff and a review of agency policy confirmed the process of how the facility would assist any resident with a disability or is limited English proficient.

Review:
Policy and Procedure
Oriana House, Inc. plan for assisting residents with disabilities
Training Curriculum
Interpreter service providers
Interview with Program Administrator
Interview with Intake Coordinators (Operational and Programing)

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency has a policy that 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.

The agency conducts a 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 will be completed every five years. Each year the Human Resource Department will run a report to determine which employees, contractors, and volunteers need to have their background check updated. All employees, independent contractors, volunteers, and interns are required by policy to immediately report to their supervisor any arrests, citations, and complaints to professional licensing boards.

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 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 for 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 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 auditor conducted a review of nine randomly chosen employees files and confirmed the background checks (initial and five year update), documentation of the continual affirmation to disclose any sexual misconduct, referral checks, and the promotion process. The auditor conducted a lengthy interview with the Human Resource Manager who took the auditor step by step through the hiring and promotion process.

Review:
Policy and procedure
Employee files
On boarding documentation
Interview with Human Resource Manager

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility has not acquired a new facility or made any substantial expansion or modification to the existing facility.

An interview with the Agency's Executive Vice President of Administrative Services and Business indicated that the facility has no immediate plans to add or upgrade video monitoring technology, electronic surveillance system, or other monitoring technology. The facility will address needs to these areas as the budget allows.

Review:
Policy and procedure
Interview with Executive Vice President of Administrative Services and Business Relations

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility has two trained investigators to conduct administrative sexual abuse investigations. The Akron Police Department is responsible

for conducting criminal investigations. The department has acknowledged that they are the responsible party to investigate any criminal activity at the facility but does not feel there needs to be a formal MOU.

The facility has an agreement with SUMMA Health System to provide a Sexual Assault Nurse Examiner for any resident who is a victim of sexual abuse. The auditor spoke with the SANE nurse coordinator who confirmed that any resident taken to one of the local hospitals in the Akron area (SUMMIT- Summa or SUMMIT- Akron General) would be treated by a certified SANE nurse. The services provided by the hospital would be at no cost to the resident.

The facility has a MOU with the Rape Crisis Center of Medina and Summit Counties to provide a victim advocate to any victim of sexual abuse, and a trained staff member who can provide victim support services. A phone interview with Cindy Bloom, Director of the Rape Crisis Center confirmed the services available free of charge to sexual abuse victim.

The facility also has a crisis counselor that can provide emotional supportive services or make a recommendation for outside services if necessary. These services will be provided to the resident at no cost. The services were confirmed with the agency.

Review:
Policy and Procedure
MOU with SUMMA Health System
MOU with Rape Crisis Center of Medina and Summit Counties
Interview with Administrative Investigators
Interview with PREA Coordinator
Phonen interview with Rape Crisis Center of Media and Summit Counties Director
Phone interview with SUMMA Health System SANE Nurse Coordinator
Previous interview with Crisis Counselor

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency has a policy that requires an administrative investigation of all allegations of sexual abuse and sexual harassment, and that any allegation that is criminal in nature is referred to the Akron Police Department. The facility has had one allegation of staff-to-resident sexual harassment and one allegation of resident-to resident sexual harassment. The auditor reviewed the investigation documentation along with interviewing the agency's two administrative investigators.

The staff to resident allegation involved a Resident Supervisor sending text messages to a resident. The allegation was reported by a staff member who was conducting a resident phone check. The allegation was investigated by a trained investigator. The text messages where sexual in nature, but there was not enough evidence to prove criminal activity had taken place. The resident-to resident allegation was a verbal report to staff. The allegation was administratively investigated but administrators could not find any corroborating evidence that the harassment took place. The administrative investigation in either case did not uncover any criminal behavior therefore no criminal investigation referral was made.

The Oriana House website post the investigative policy of the agency and the responsibilities of both the agency and the investigating entity. The auditor reviewed the agency's website and confirmed that the appropriate policy was posted.

Review:
Policy and procedure
Oriana House website
Investigative Reports

Interview with Administrative Investigators

Standard 115.231 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency has trained all staff on the PREA required topics. The agency holds monthly trainings which included role plays, games, and quizzes to ensure all staff knew the proper way to prevent, detect, report, and respond to any allegations of sexual abuse or sexual harassment that is specific to each facility. Staff practice being a first responder and deploying the facility coordinated response.

During staff interviews, all staff were able to discuss the various PREA related training they received either at orientation or during on of the monthly training sessions. Staff was well versed on the PREA policies and protocols.

The agency cross-trains its staff because staff can be transferred to work in any facility. All staff received gender specific training. The agency has recently held staff gender specific training on PREA related topics. This allowed staff to speak on issues that they may not bring up during coed trainings. Staff interviewed commented on the benefit of this training in conjunction with the coed trainings. The agency used video conferencing as a training tool so that all employees in any facility would receive the same zero tolerance message. The facility uses a video produced by the Ohio Department of Rehabilitation and Correction to train on trans-gender and intersex pat downs and searches.

PREA training is provided to all staff at the beginning of employment and all staff will receive PREA training every six months during one of the facility's monthly meetings. Additional training topics include: transgender clients, client reporting, PREA assessment interview, coordinated response plan, effective use of communication with LGBTI residents, response to allegations, avoiding inappropriate relationships, and PREA definitions.

Facility managers are provided with a list of required PREA training topics and will include one topic a month throughout the year.

All staff sign an acknowledgment of the training they received.

Review:
Policy and procedure
Training curriculum
ODRC transgender/intersex pad-down search video
Training records
Interview with PREA Coordinator
Interview with Human Resource Manager
Interview with Program Manager
Interview with Program Administrator
Interview with random staff

Standard 115.232 Volunteer and contractor training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency has developed a 30 minute training for contractors, vendors, volunteers, and service providers. The training includes the agency's policy on how to prevent, detect, respond, and report sexual abuse and sexual harassment. Each provider will watch a 15 minute video and receive instruction from a trained facilitator. Documentation of received training is forwarded to the Compliance Accreditation Manager.

Oriana House contracts with food service provider Aramark. These contract employees receive the same type of training that Oriana House employees receive.

Every visitor who enters an Oriana House facility must read and sign an acknowledgment of understanding on the agency's zero tolerance policy each time they enter the facility. The auditor sign this notification upon entrance to the facility each day of the onsite visit.

The auditor reviewed the training material and documentation of completed training from various contractors/volunteers.

Review:
Policy and procedure
Contract/vendor training
Visitor zero tolerance notification
Interview with PREA Coordinator

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All residents receive information at the time of intake about the facility's zero tolerance policy, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. This information is read and reviewed with all residents to ensure each resident understands their rights under the PREA guidelines. If a resident does not understand English or has other disabilities that prevent normal communication, the facility contracts services with other agencies so that each resident can benefit from the facilities efforts to prevent, detect, report, and respond to sexual abuse and sexual harassment (See standard 115.216). Residents sign acknowledgment of receiving this information.

All residents watch a PREA education video during orientation and receive handouts that include ways to report and reporting phone numbers. This information is also on posters located throughout the facility. During this orientation group, the facility manager ensures that residents understand the services available to them at no cost and the limits to confidentiality.

During resident interviews, all offenders reported receiving the PREA education and information at intake and during orientation group. Residents also indicated that their case managers reviewed ways to keep themselves safe, how to report including anonymously, and the toll free numbers posted near the phones. Posting with PREA related information was located in conspicuous areas throughout the facility.

Review:
Policy and procedure

Resident training curriculum
PREA postings
Facility tour
Interview with residents
Interview with Intake Coordinator
Interview with Program Administrator

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a standardized process for administratively investigating any allegations. All criminal investigations are referred out to the Akron City Policy who have the legal authority for criminal investigations. The agency has two former police officers with experience in dealing with sexual abuse/assault investigations as their administratively trained investigators. The training included techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, evidence collection in a confinement setting, and required evidence to substantiate a case for administrative action or criminal referral. The training was provided by the Moss Group.

Review:
Policy and procedure
Administrative Investigator training curriculum
Administrative investigator training certificate
Interview with Administrative Investigators

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not provide in house medical services. All residents will receive outside medical treatment if necessary. The facility has a qualified clinician who knows how to respond effectively and professionally to victims of sexual abuse and sexual harassment. The clinician also received training on how to prevent, detect, report, and respond to sexual abuse and sexual harassment. Interviews of the clinician indicate he knows how and whom to report allegations of sexual abuse and sexual harassment.

The facility also has the option of referring victims to outside counseling services at Portage Path.

Review:

Policy and procedure
Previous Interview with Crisis Counselor
Interview with PREA Coordinator

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All residents are screened for risk of vulnerability or abusiveness at intake. The screening tool used included all required criteria in order to accurately assess the resident's risk. The PREA screening form is placed in a residents file to which limited staff have access. A resident's case manager will complete a re-screen anytime any additional, relevant information is received, a referral, request, or incident of sexual abuse occurs. The policy does not allow for a resident to be disciplined for refusing to answer or for not disclosing complete information in response to questions on the residents mental health, sexuality, or previous victimization.

All staff are training on how to complete the screening tool appropriately. The intake coordinator will complete the initial assessment with the resident during intake. An interview with the Intake Coordinator confirmed his training on completing the form appropriately and the steps to take should a resident be classified as highly abusive, abuse, highly susceptible, or susceptible.

An interview with the Program Administrator alerted the auditor to a lack of a quality assurance system on the PREA screening.

Review:
Policy and procedure
Initial PREA assessment screen
PREA assessment rescreen
Interview with Program Administrator
Interview with residents
Interview with Intake Coordinator
Interview with case managers

RECOMMENDATION:
The auditor recommended that the facility develop a quality assurance plan for ensuring the accuracy of the screens.

FACILITY RESPONSE:
The facility currently has a quality assurance program that ensures proper procedures are being followed. The quality assurance review is conducted once a quarter. The Program Administrator will include a review of a random sample of intake and re-screens in the review.

The auditor agreed with the quality assurance plan for reviewing initial PREA screenings and re-screenings.

Standard 115.242 Use of screening information

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All residents receive a classification based upon their PREA screening information. Classifications include: none, vulnerable, highly vulnerable, abusive, or highly abusive. A resident's classification will be documented in the facilities data base but no staff member will be able to see the screening form or answers. Any resident who is classified as highly vulnerable or highly abusive will be housed in a designated dorm with a bed that is easily viewable by staff. These residents will also be placed on the "where about" check list 6 times per shift verses 3 times for those who do not have the highly vulnerable or highly abusive classification. The increased checks will continue until management team meets and deems it appropriate to have the increased checks reduced to 3 times per shift. THE facility has a resident count board where each resident has an identification badge. The badge will indicate to staff members if the resident has been placed into one of the PREA designated beds, has increased surveillance, and risk classification.

All residents with a classification have it addressed on their individual program plan. These residents work with their case worker to work on the issues underlining their classification and residents can also be referred to outside counseling if necessary.

The facility has never housed a transgender or intersex resident, but has a plan to house such residents safely which include opportunities to shower separately and make housing and program assignments with a transgender or intersex resident's own views taken into consideration. The agency has recently developed a team that includes the PREA coordinator, PREA manager, Admission's personnel, Mental Health personnel, and the offender that will address placement issues for any transgender resident housed with agency.

The auditor and facility management discussed the facility's plan to house residents that are highly vulnerable, highly abusive, or transgender/intersex. The facility was able to describe specific bed placement, group separation, ability to shower separately, and the new protocol on safely housing transgender/intersex residents as ways to ensure the safety of each resident.

Review:
Policy and procedure
Facility tour
Initial PREA assessment screening
PREA re-screen assessment
Individual case plan
Staffing plan
Interview with Case Managers
Interview with Intake Coordinator

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Residents at RIPP have multiple ways of reporting sexual abuse. Posters throughout the facility indicate how residents can report as well as how to report to an outside agency. Interviews with the residents indicate that they are aware of all means of reporting and that they could report anonymously. They received the information at intake, during orientation training, and in case manager meetings.

RIPP has public pay phones with the reporting numbers unblocked to allow free calls to the reporting entities. Residents are allowed to have cell phones in the facility which they can use to make a report.

All residents received information at intake and in their handbooks regarding PREA reporting. Staff received information on how to privately report during staff training.

The facility has received a resident report of resident-on-resident sexual harassment. The resident called the facility and spoke with a Resident Supervisor who took the verbal report over the phone.

Review:
Policy and procedure
PREA postings
PREA brochure
Facility tour
Investigation report
Interview with Program Administrator
Interview with residents

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A: The PREA Coordinator states that the agency does not use its grievance system to investigate PREA allegations. Any resident who uses a grievance form to report an allegation will have the form removed from the grievance process and it will be handled like any other reporting method.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

he facility has a MOU with Rape Crisis Center of Medina and Summit Counties to provide emotional support services to any resident who is a victim of sexual abuse. The facility provides the phone number and address of this service to residents as wells as train them during orientation of the limitations to confidentiality and mandatory reporting.

Residents who were interviewed verified that they received this information and that the information is available on posters located throughout the facility.

The auditor took note of the information on posters located throughout the facility and ensure that the posting contained all the accurate

information. A review of the MOU was also completed.

The auditor spoke with the SANE Coordinator at SUMMIT-Summa who reviewed the services available to any resident who may need emotional support after an incident of sexual assault/abuse. The services included support while in the hospital, during any investigation/questioning, court appearances, and any on-going counseling needs. The coordinator confirmed that the services are free of charge.
The facility can also utilize the services at the Rape Crisis Center of Medina and Summit Counties. The center offers the same supportive services available from SUMMIT hospital. The agency also has trained staff that can offer victim support services at the request of the victim.

The facility has not had an allegation of sexual abuse or sexual assault and not had to use these services.

Review:
Policy and procedure
MOU with Rape Crisis Center of Medina and Summit Counties
MOU with SUMMIT-Summa
Phone interview with SANE Coordinator
Phone interview with Rape Crisis Center of Medina and Summit Counties Director
Emotional Support Training Certificate
Interview with PREA Coordinator

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has posted on its website ways that anyone can report sexual abuse or sexual harassment on behalf of a resident. Residents are also educated that they can report to family members who can then make a third party report. This information is also on posters located in the visitation room.

The facility has not had a third party report.

Review:
Policy and procedure
Oriana House website
PREA postings
Facility tour
Interview with Administrative Investigators

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Oriana House policy requires all employees to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment including third party and anonymous reports. Apart from the employee's supervisor, no one shall reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. All allegations of sexual abuse or sexual harassment are reported to the facility's investigators.

The auditor interviewed all required specialized staff and several random staff members. All staff members indicated that they were given and understand the agency's policy on reporting PREA incidents and were trained on the appropriate way to document a report and to whom they should report an allegation. Staff indicated they understood that they are required to report their own suspicions, or information regarding sexual abuse, sexual harassment, or retaliation.

RIPP's staff-to resident sexual harassment allegation was initiated by a staff member who suspected an inappropriate relationship when he conducted a phone check of a resident's cell phone. Once the staff member confirmed that the phone number listed was in fast another staff member's phone number, he immediately reported the incident to his supervisor.

All staff members with a duty to report based on local law and medical and mental health practitioners are required to inform residents of their status and the limitation of confidentiality at the initiation of services. Interviews with staff members who have a duty to report indicated that they understood their duty to inform residents before providing services.

The facility does not admit residents under the age of 18. The State of Ohio does not require institutions or facilities licensed by the state or facilities 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 and procedure
Ohio revised code
Investigation report
Interview with RIPP staff
Interview with Administrative Investigators
Interview with Program Administrator
Interview with Program Manager

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Oriana House has several facilities in the Akron, Ohio area as well as other halfway house facilities throughout Ohio. This allows the facility to move either the alleged victim or the alleged abuser to another dorm within the facility, to another facility in the Akron area, to another facility in Ohio, or to release the resident on electronic monitoring. During the interview process, it was very clear that the safety

and security of all residents is their primary concern.

An interview with the PREA Coordinator and Agency Investigators describe the process on how they determine if an alleged victim or abuse should be moved to another facility in order to protect the victim from imminent abuse. The practice is to place a staff member on administrative leave or place in another facility (if possible) if they are accused of sexual harassment or sexual assault during the investigation. The staff member is to have no contact with the facility or other staff member until a determination has been made. If another resident is the alleged abuser, the abuser and victim will be separated either by housing unit or facility until a determination has been made.

RIPP has conducted one resident-to-resident sexual harassment allegation. During the investigation, the alleged victim reported to staff that he is afraid of his alleged abuser and did not want to be around him. The facility addressed the alleged victim's concerns by placing him in another facility in the Akron area. During the one staff-to-resident sexual harassment investigation, the staff member who was being investigated was placed on administrative leave pending the outcome of the investigation.

Review:
Policy and procedure
Investigation reports
Interview with Administrative Investigators
Interview with PREA Coordinator
Interview with Program Administrator
Interview with Program Manager

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Upon receiving an allegation that a client was sexually abused while confined at another corrections facility, the Program Manager/Administrator shall notify in writing the head of the facility or appropriate central office of the agency where the alleged abuse occurred and notify the facility's Vice President of Administration and Legal Counsel. The policy requires that notification within 72 hours.

Interviews with the Agency's PREA Coordinator and the facility's PREA Manager confirmed this practice.

The facility has not received any report from another agency nor have they had to make a report to another agency.

Review:
Policy and procedure
Interview with Program Administrator
Interview with Program Manager

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Oriana House has a policy outlining first responder duties for any allegation of sexual abuse. The policy contains instructions for how to separate the abuser and victim, protect and preserve evidence until it can be collected by appropriate authorities, do not allow the abuse to destroy evidence, request that the victim does not destroy any evidence, and enacting the PREA coordinated response plan. All staff are trained on first responder duties (security and non-security staff) including role playing potential situations.

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.

Each security post has a posting of the first responder duties.

The facility has never received an allegation of sexual abuse.

Review:
Policy and procedure
Coordinated response plan/first responder duties posting
Training records
Interviews with RIPP staff

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Oriana House has an appropriate written coordinated response plan to respond to any incident of sexual abuse. The plan includes the steps to take for first responders, medical and mental health practitioners, investigators, and facility leadership. All staff is trained on the plan and this was confirmed through interviews with security and program staff.

While on the tour, the auditor noted that the written coordinated plan is posted at each security post in the facility. The posting is within a flip chart which is highly visible and clearly marked.

During staff interviews, staff knew and could articulate the coordinated response plan. All staff knew the entire plan and did not differentiate between security and non-security tasks. Staff was able to disclose the location of the plan and discussed how they practice using the plan in various scenarios during training.

Review:
Policy and procedure
Coordinated response plan/first responder duties posting
Interview with RIPP staff

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A: The PREA Coordinator indicates that the facility is not under any collective bargaining agreements – a non-union agency.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has 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. The facility has assigned the Program Manager or supervisory designee well as the PREA Coordinator as the staff responsible for monitoring against retaliation for at least 90 days. In the case of resident victims, a status check is completed by the facility's emotional support person or if necessary the agency's crisis counselor.

The facility has the ability to move victim, offender, or employees to various other facilities under the Oriana House umbrella in order to protect against retaliation. During the investigations during this audit cycle, a resident was moved to another facility to ensure his safety and a staff member was placed on administrative leave.

Interviews with the agency's PREA Coordinator, the Program Manager, and the Program Administrator confirmed the monitoring process. The auditor reviewed the form that is to be completed for status checks and the team would review the status reviews to determine if an extension in monitoring is necessary.

The facility has not had a case where retaliation monitoring was necessary.

Staff verified during interviews that their PREA training includes how to detect and protect others from retaliation, and that they have a right to be free from retaliation when reporting or cooperating in an investigation. Residents also verified that they have received information on their right to be free from retaliation.

Review:
Policy and procedure
Training records
Investigation reports
Interview with Program Manager
Interview with Program Administrator
Interview with PREA Coordinator
Interview with Human Resource Manager
Interview with RIPP staff

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All allegations of sexual abuse or sexual harassment including third party and anonymous reports are administratively investigated by 2 trained investigators and any report that appears criminal in nature are referred to the Akron City Police who has the legal authority to conduct a criminal investigation.

Both the agency investigators were interviewed and walked through their process of investigating any PREA related complaint and how this information is used determine whether an allegation is substantiated, unsubstantiated, or unfounded. The investigators collect all relevant information (interviews with staff, victim, witness, and the abuser; review any surveillance information, and make note of any facility issue that could have aided in the allegation) and pass this information along with a recommendation to the PREA Coordinator. The PREA Coordinator determines the outcome of the investigation. Both investigators are former police officers and 1 has extensive knowledge in monitoring technology.

The investigators written report includes whether staff actions or failures to act contribute to the abuse and a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Both investigators have a relationship with Akron Police Department and work well with the department and remain informed about the progress of any referred allegation.

The investigators maintain all records from all allegations for as long as the abuser is incarcerated or employed by the agency, plus five years.

Investigation #1: Staff-to-Resident sexual harassment allegation. The Administrative Investigators reviewed electronic evidence and determined that there was enough evidence to substantiate the allegation. The evidence did not lead investigators to believe a crime was committed.

Investigation #2: Resident-to-Resident sexual harassment allegation. The Administrative Investigators interviewed the alleged victim and abuser, but did not have any corroborating evidence to either prove the allegation or determine it to be unfounded.

The auditor discussed with the administrative investigators their assessment for how a case would be determined to be substantiated, unsubstantiated, or unfounded, and their process for referring to Akron City Police Department for a criminal investigation.

The auditor was able to review the investigation notes as well as interview both investigators. No allegations required referral to the local legal authorities.

Review:
Policy and Procedure
Investigation reports
Interview with Administrative Investigators

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

By agency policy and confirmed by investigators and PREA Coordinator interviews, the agency imposes a standard of preponderance of evidence or 51% to substantiate an allegation of sexual abuse or sexual harassment.

The auditor reviewed the two allegations with the two administrative investigators to ensure that the evidentiary standard of preponderance of evidence was used in each case. The staff-to resident allegation had electronic evidence (text message and phone logs from the resident's cell phone) to substantiate the allegation. The resident-to-resident allegation had no witness, video surveillance, or any other corroborating evidence. There was also no evidence to prove that the alleged victim was lying. The appropriate determination of unsubstantiated was made.

The PREA Coordinator makes the final determination of investigation outcome.

Review:
Policy and Procedure
Investigation reports
Interview with Administrative Investigators
Interview with PREA Coordinator

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Program Manager or Program Administrator is responsible for informing a resident who alleges sexual abuse the outcome of the investigation. The facility request information from the legal authority if the investigation is criminal in nature to inform the alleged victim of the outcome of an investigation.

The notice includes whether the abuser, if a staff member, is no longer posted in the clients unit; no longer employed at the facility; has been indicted on a charge related to the sexual abuse within the facility; or has been convicted on a charge related to sexual abuse within the facility. The notice includes whether the abuser, if another resident, has been indicted on a charge related to sexual abuse within the facility or has been convicted on a charge related to sexual abuse within the facility.

The facility has not had an allegation of sexual abuse. Sample documentation was reviewed.

Review:
Policy and procedure
Sample notice
Interview with Program Manager
Interview with Program Administrator

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Oriana House 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 resignations by staff will not void an investigation and any criminal activity will be reported to the legal authority and to any relevant licensing agency. Policy also indicates that the agency will notify law enforcement or any relevant licensing boards of any terminations or resignations based upon violations of the agency's client sexual abuse and sexual harassment prevention policy when such behavior is criminal in nature.

All staff interviewed understood that anyone engaging in sexual harassment will be disciplined according to agency policy and that they would be terminated for participating in sexual abuse. Staff indicated that they are required to report any suspicion to their immediate supervisor and that they would not have any issue reporting a coworker for violation of the zero tolerance policy. The staff-to-resident allegation was a staff report.

The substantiated staff-to-resident sexual abuse allegation resulted in the staff member being terminated for violations to Oriana House's Client Sexual Abuse and Sexual Harassment Prevention Policy.

The auditor reviewed agency policy, the employee handbook, and interviewed the Agency Administrator, PREA Coordinator, and Human Resource Manager to confirm the disciplinary process for employees found to have substantially engaged in sexual harassment or sexual abuse against residents. All agency leadership stated that any employee found to have engaged in sexual abuse will be immediately terminated from the facility and law enforcement would be notified.

Review:
Policy and procedure
Employee handbook
Code of ethics
Investigation report
Termination letter
Interview with Human Resource Manger
Interview with Administrative Investigators
Interview with random staff members
Interview with PREA Coordinator

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

All contractors and volunteers are made aware of the agency's zero tolerance policy toward sexual abuse and sexual harassment. Each must participate in PREA training where they will be taught how to prevent, detect, respond, and report sexual harassment and sexual abuse. They will also learn the consequences of participating in any type of sexual misconduct. Contractors and volunteers sign an agreement that they could be removed from the facility for any acts of sexual abuse or sexual harassment.

The auditor has reviewed the contractor/volunteer training and documentation of compliance with training.

Any person (contractor, vendor, volunteer, or visitor) must read and sign an acknowledgment form stating that they have read and understand the agency's Zero Tolerance Policy and agree to abide by the rules set forth by the agency before entering the facility. The auditor was also required to sign the acknowledgment form each time she entered the building.

The agency contracts with AraMark for its food services. These employees receive the same PREA training an Oriana House new employee would receive at orientation due to the amount of time these contractors spend in the building and interact with the residents.

The facility has not removed any contractor or volunteer for a PREA issue.

The PREA Coordinator discussed how contractors/volunteers are trained and the process for ensuring everyone is aware of the Zero Tolerance policy.

Review:
Policy and procedure
Contractor/vendor acknowledgement form
Contractor/vendor training curriculum
Interview with PREA Coordinator

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

A review of the client handbook shows how it outlines resident conduct and prohibits all sexual activity between residents and disciplines residents for such activity. Residents are given a handbook at intake and the contents are reviewed with the resident.

During resident interviews, all residents affirmed that they received a handbook at intake and the rules and discipline policies regarding sexual abuse and sexual harassment were reviewed with them. All residents interviewed understood fully the seriousness of the agency's Zero Tolerance Policy and the consequences of participating in sexual misconduct.

The facility's resident on resident allegation was found unsubstantiated. There was no evidence to determine the allegation substantiated however, the facility was concerned about reports on the behavior of the alleged abuser. A review was completed with facility management and a determination to remove the resident was made.

Review:
Policy and procedure
Resident handbook
Interviews with residents
Interview with Administrative Investigators

Interview with Program Manager
Interview with Program Administrator

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy indicates the types of service offered free of charge to an alleged victim of sexual assault. It is documented which types of services where rendered and or declined by the alleged victim on the investigation form. Residents are offered timely information about and timely access to sexually transmitted infection infections prophylaxis. There are no females housed at this facility.

If services are necessary, the Counselor will provide appropriate referrals to community resources and notify the case manager assigned to the resident. The scope of services provided will be determined by the licensed practitioner.

Staff have been notified of the Agency's PREA Medical Response Plan. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. Ongoing medical or mental health care will be at the discretion of the medical provider and is again at no cost to the resident.

The Medical Response Plan is reviewed annually to ensure that all service provider information is current and that the range of services is still available.

Investigation forms indicate if services were offered and accepted or declined.

Resident are informed of their right to free services during PREA education at orientation.

The facility has not had a sexual abuse/sexual assault allegation.

Review:
Policy and procedure
Medical Response Plan
Investigation reports
Interview with PREA Coordinator
Previous interview with Turning Point Coordinator
Previous interview with Crisis Counselor

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

This facility offers community medical and counseling services for residents who have been sexually abused in jail, lockup, or juvenile facility. This treatment includes testing for sexually transmitted disease. Treatment is offered to all known residents on resident abusers within in 60 days of learning such history. All treatment offered is free of charge.

Staff have been notified of the Agency's PREA Medical Response Plan. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. Ongoing medical or mental health care will be at the discretion of the medical provider and is again at no cost to the resident.

The Medical Response Plan is reviewed annually to ensure that all service provider information is current and that the range of services is still available.

The facility has not had a report of any known resident on resident abuser.

A review of the investigation form shows how staff indicates whether services were offered and accepted or declined. The PREA initial screening form indicates whether a resident has abused others while in a correctional setting. If a resident indicates that he has in fact abused another resident while in a corrections setting, the agency's Crisis Counselor will meet with the resident to make a determination if additional treatment or referrals for community treatment is necessary.

The facility had not a report of a resident being sexually abused while in a jail, lockup, or juvenile facility.

The PREA Coordinator has confirmed the process and practice of how staff will provide unimpeded access to necessary emergency and/or ongoing medical and mental health services. The Agency's PREA Compliance Specialist reviews the information annually.

Review:
Policy and procedure
Medical Response Plan
PREA initial assessments
Investigation reports
Previous interview with Crisis Counselor
Previous interview with Turning Point Coordinator
Interview with PREA Coordinator

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Oriana House has an agency policy on a review of all substantiated or unsubstantiated allegations of sexual abuse within 30 days of the conclusion of the investigation. The review team includes the assigned regional Vice President, an upper management designee, Admissions Manager, input from a designated Resident Supervisor and/or Caseworker, Internal Investigator, and any other employee deemed appropriate.

The team, per policy, considers whether a change in policy or practice will better prevent, detect, or respond to sexual abuse; if the incident or allegation was motivated by race, ethnicity, gender identity, gang affiliation, or any other group dynamic; if any physical barriers in the area enabled the abuse; adequacy of staffing levels; and whether monitoring technology should be deployed or augmented to supplement

supervision by staff.

RIPP has no allegations of sexual abuse or sexual assault that would require a SART review during this audit cycle, but the auditor has reviewed the incident review form and it covers all required areas. Interview with PREA Coordinator and PREA Manager indicates that all executive approved recommendations will be sent to the Regional Vice President and the facility will document implementation.

Review:
Policy and procedure
SART review requirements
Interview with PREA Coordinator

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Oriana House has an agency policy for data collection and statistical reporting of all necessary information in the most recent version of the Survey of Sexual Violence. The auditor reviewed the most recent information collected by the agency and has confirmed that the agency collects the appropriate data on all allegations of sexual abuse and aggregates this information annually. The two previous years SSV report information was also reviewed.

The agency's PREA Coordinator collects the information for each of Oriana House facilities.

The agency has not received a request to supply the Department of Justice with this information.

Review:
Policy and procedure
PREA data collection and statistical reporting information
Interview with PREA Coordinator

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency uses information collected in 115.287 to make improvements in how the agency prevents, detects, and responds to incidents of sexual abuse and sexual harassment. The report compares the current year's data with those of previous years, and includes the updates

made from previous years reports. The information contained in the report is based on a calendar year and the report with this information can be found on the agency's website.

The information in the report has been reviewed and approved by the President and CEO of Oriana House, Inc.

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

Auditor verified that the reported was posted on the agency's website (www.orianahouse.org) and that the report contained all required information.

Review:
Policy and procedure
PREA annual report
Oriana House website
Interview with Executive Vice President of Administrative Services and Business Relations
Interview with PREA Coordinator

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All data collected in sexual abuse cases are securely maintained by the PREA Coordinator for a minimum of 10 years. The PREA Coordinator confirmed the retention schedule.

The aggregated information from each of Oriana House facilities was posted on its website.

There is no information in the report that would identify any individual or jeopardize the safety or security of the facility.

Review:
Policy and procedure
PREA annual report
Oriana House website
Interview with PREA Coordinator

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 inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Kayleen Murray August 9, 2016

Auditor Signature Date