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

☐ **Interim** ☒ **Final**

Date of Report

Auditor Information

Name: Kayleen Murray	**Email:** kmurray.prea@yahoo.com
Company Name: Click or tap here to enter text.	
Mailing Address: P.O. Box 2400	**City, State, Zip:** Wintersville, Ohio 43953
Telephone: 7403176630	**Date of Facility Visit:** September 16-17, 2019

Agency Information

Name of Agency: Oriana House, Inc		**Governing Authority or Parent Agency** *(If Applicable)*: Board of Directors	
Physical Address: 885 Buchtel Ave		**City, State, Zip:** Akron, Ohio 44305	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency Website with PREA Information: www.orianahouse.org

Agency Chief Executive Officer

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

Agency-Wide PREA Coordinator

Name: Lori Schoenfelder	
Email: lorischoenfelder@orianahouse.org	**Telephone:** 330-535-8116
PREA Coordinator Reports to: Mary Jones, Vice President of Administration and Legal Counsel	**Number of Compliance Managers who report to the PREA Coordinator:** 12

Facility Information

Name of Facility: McDonnell Center Community Based Correctional Facility (MCCBCF)			
Physical Address: 3510 Croton Avenue		**City, State, Zip:** Cleveland, Ohio 44115	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: https://www.orianahouse.org

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

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

☐ ACA

☐ NCCHC

☐ CALEA

☒ Other (please name or describe: Bureau of Community Sanctions

☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: Click or tap here to enter text.

Facility Director

Name:	Ashly Wells		
Email:	Ashlywells@orianahouse.org	**Telephone:**	216-202-1017

Facility PREA Compliance Manager

Name:	Pamela Cardinal		
Email:	pamelacardinal@orianahouse.org	**Telephone:**	216-202-1017

Facility Health Service Administrator ☒ N/A

Name:	Click or tap here to enter text.		
Email:	Click or tap here to enter text.	**Telephone:**	Click or tap here to enter text.

Facility Characteristics	
Designated Facility Capacity:	180
Current Population of Facility:	160
Average daily population for the past 12 months:	122
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	20-61
Average length of stay or time under supervision	175 days
Facility security levels/resident custody levels	Minimum/minimum

Number of residents admitted to facility during the past 12 months	538
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	527
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	493
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☒ Yes ☐ No

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

Number of staff currently employed by the facility who may have contact with residents:	55
Number of staff hired by the facility during the past 12 months who may have contact with residents:	17

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	16
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	96
Number of volunteers who have contact with residents, currently authorized to enter the facility:	1
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	3
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	11
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

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

Investigations

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

Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	3
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☐ Facility investigators ☒ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative

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

The PREA onsite visit for McDonnell Center Community Based Correctional Facility (MCCBCF) occurred on September 16-17, 2019. The facility is part of the Oriana House, Inc. operated community confinement facilities. The facility is receiving this audit in conjunction with another Oriana House community confinement facility, Fannie M. Lewis Community Correction and Treatment Center. The agency policies and procedures were reviewed for both facilities as well as the administrative staff interviews. All other interviews and document reviews are facility specific. The goal of the audit is to ensure operational compliance with the Prison Rape Elimination Act (PREA) standards for community confinement facilities.

The facility elected to use Power DMS to upload documentation relevant to showing compliance with each standard. The auditor received notification that the information was available approximately four weeks prior to the onsite visit. The information included the pre-audit questionnaire, policy and procedures, MOUs, facility staffing plan, table of organization, job descriptions, and post orders. The auditor received photos showing proof of audit notices posted in resident and staff areas six weeks prior to the onsite visit. The auditor met with agency and facility staff prior to the onsite visit and discuss the audit schedule, changes since the last PREA audit, and additional information/documentation needed by the auditor. The auditor has conducted the audits for this agency in the past, including MCCBCF's last audit in 2017. The auditor reviewed the prior final audit report and previous documentation for comparison to the current audit.

The audit notice posting was sent to the auditor showed the dates of the onsite visit; the name, address, and email address of the auditor; and the ability to have confidential correspondence with the auditor. The auditor did not receive any correspondence from residents or staff prior to the onsite visit. The auditor did not receive any request to speak with the auditor during the onsite visit.

In addition to the documentation sent prior to the onsite visit, the auditor reviewed ten resident files, twenty staff files, staff and resident training records, risk for abusiveness screenings and re-screenings, agency website, acknowledgement forms, posters, brochures, floor plan with camera locations, volunteer/contractor information, and coordinated response plan during the onsite visit.

The onsite visit was conducted over two days where the auditor received a complete tour of the facility and perimeter areas. The tour included observations of the housing units, dorm rooms, bathrooms, closets/storage rooms, administration area, and outdoor recreation area. During the walkthrough, the auditor was able to have informal conversations with both staff and residents. The auditor made notes of cameras, security mirrors, blind spot areas, and staff/resident interaction. The auditor was provided a private office to conduct formal interviews with staff and residents.

The auditor interviewed twenty residents based on the population of one hundred-sixty residents during the onsite visit. The residents selected were based on the requirements of the PREA Resource Center's Auditor Handbook guidelines. The residents were selected based on their housing unit, targeted interview status, risk assessment screening, intake dates, and commitment status. The auditor conducted the following interviews:

- Random = 17
- Targeted = 3

The breakdown of the number of targeted interviews is as follows:

- Residents that identify as lesbian, gay, or bisexual = 3
- Residents that have a physical or cognitive impairment = 1
- Resident that reported prior sexual victimization during risk screening (in the community) = 1

*Some targeted residents fit into more than one targeted category and was interviewed on all specialized and random interview protocols.

The auditor conducted the interviews in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Residents. The auditor explained the interview process to each resident and that they were under no obligation to answer questions. The auditor asked questions concerning the resident's experience with PREA education, allegation reporting requirements, retaliation, staff communication, grievance reporting, knock and

announcements, searches (pat, enhanced pat, strip, body cavity, and cross-gender), housing unit concerns, limits to confidentiality, outside supportive services, disciplinary sanctions, and other PREA related concerns.

The facility has twenty-six full and part-time staff members including the Program Director. The auditor was able to talk with agency leadership, specialized interviews, and random staff members during the onsite visit, which includes:

- Ashley Webb, Program Director
- Pamela Cardnial, PREA Manager
- Lori Schoenfelder, PREA Coordinator
- Mary Jones, VP of Administration and Legal Counsel
- Illya McGee, Regional VP of Programs Cuyahoga County

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

- Human Resource Director, Jodi Glitzenstein
- Administrative Investigators
- Risk of Victimization/Abusiveness screener
- Retaliation monitor
- SART team members
- First Responders (security and non-security)
- PREA education facilitators
- Medical (Nurse)

The auditor also interviewed seven random staff members from both programming and security. Security staff from all shifts were interviewed. Due to the staff size, the auditor was unable to interview the required twelve random staff members. Several staff members were responsible for more than one specialized area.

All staff interviews, random and specialized, were conducted using the PREA Compliance Audit Instrument Interview Guide and the PREA Auditor Handbook's Effective Strategies for Interviewing Staff and Resident Guide. The auditor was able to question staff on the agency's zero tolerance policies, trainings, reporting protocols, first responder duties, coordinated response plan, grievance procedures, investigation protocols, confidentiality, retaliation monitoring, risk screening, protection from abuse, LGBTI policies and procedures, data collection, annual reports, staffing plans, electronic surveillance, reporting to other confinement facilities, disciplinary procedures, knock and announcements, cross-gender supervision polices, and transgender/intersex accommodations.

The auditor reached out to the facility's community resources by email to confirm the MOUs and scope of services. These community partners include representatives from Cleveland Rape Crisis Center and Cleveland Metro Hospital. The auditor was able confirm the services they would provide to residents free of charge.

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

Facility Characteristics

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

McDonnell Center CBCF is a community based correctional facility located in Cleveland, Ohio that serves both male felony offenders.

The facility is a one story building that can house up to 220 offenders. The facility has two access points, one for residents and one for administration. In order to access the secure perimeter of the facility one must report to the same door as the resident's entrance/exit ring a door buzzer and pass through a body image scanner (PRO ATD). Everyone, including staff, must pass through the body image scanner before entering the secured area. As a person passes through the scanner, a "ginger bread" like image will show on a screen attached to the scanner. If the scanner identifies an area that needs to be search more thoroughly, staff will pull up a more invasive image on the desk top computer located in the room. Only members of the same gender can look at the more invasive image. In addition to receiving a scan, residents will also be pat-searched by a member of the same gender. Residents can also be subject to an enhanced pat-search. An enhanced pat down will be moved to a room where they will strip down to their underclothes with two same gender staff members present. After the search, one would then proceed to the lobby area where all residents, staff, and/or visitors must be signed in. and sign an acknowledgment of Oriana House's zero tolerance policy

The facility has four separate housing units, but is currently only occupying three. The three units are set up by phase and the fourth unit has been turned into an area for family

programming. Each housing unit has a manned housing desk, laundry room, day room, pay phones, bathroom, and recreation yard. Residents are not allowed in their rooms during program hours. Phase one housing unit has three dorms, each with security mirrors in the back of the room, glass in the door, and a two-way intercom button that buzzes to central control. The other housing units are set up in the same manner. All have cameras in the dayroom, laundry area, and recreation yard. The recreation yard is attached to the units and a staff member must open the door for access and will supervise residents while they are on the yard. The yard is enclosed by a 10ft fence with razor wire. Phase two housing is the only unit without an attached rec yard. These residents will be escorted to the rec yard by staff. The bathroom on the units have an open doorway and have four toilet stalls with custom made half doors; two urinals that sit back and have a partition so that they cannot be viewed from the doorway; and five shower stalls with curtains for privacy. The mirrors in the bathroom are non-reflective. For a complete bathroom description please see standard 115.215.

The facility has identified dorms and beds (easily visible to the housing desk) for residents who have been identified as highly abusive or highly vulnerable for each of the housing units. Should the facility house a transgender/intersex resident, the facility can offer private showers in the phase four bathroom.

The facility has windows in all the doors (group rooms, classrooms, staff offices, kitchen area including the freezers, and clinic) for clear line of site views into all rooms. MCCBCF's electronic surveillance program includes 45 cameras placed throughout the facility (interior and exterior) that have the capability to record and playback up to 30 days. Camera footage viewed by Resident Supervisor staff assigned to central control post. Supervisors review live and recorded footage at least one time per week. The Program Administrator, Lead Resident Supervisor, and Program Director have access to the facility camera system on their office desk top computer.

Resident supervisor staff also are required to conduct "whereabouts" 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 "whereabouts". During a "whereabout" staff must document physically seeing each resident. Along with "where abouts", Resident Supervisor staff circulate throughout the whole facility once every 30 minutes. Identified blind spot areas have increased circulation. The facility has placed surveillance mirrors in most of the rooms in order to capture areas that are not immediately visible when looking through the window, and in the hallways to cover corners and other hidden areas.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

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

Standards Exceeded

Number of Standards Exceeded: 1
List of Standards Exceeded: 115.231

Standards Met

Number of Standards Met: 42

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

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: Click or tap here to enter text.

PREVENTION PLANNING

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

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House has an agency wide zero tolerance policy. Policy 1080 mandates zero tolerance on all forms of sexual abuse and sexual harassment as defined by the Prison Rape Elimination Act of 2003 Community Confinement Standards. The policy requires each facility under the Oriana House umbrella to implement a systematic means of

monitoring, identifying, reporting, and investigating employee and resident sexual misconduct in an effort to provide a safe environment. The policy includes definitions of prohibited behavior, sanctions for those found to have participated in sexual abuse or sexual harassment, and appropriate strategies to prevent, detect, and respond to allegations. These strategies include having adequate staffing levels, an electronic monitoring system, and educating both residents and staff on the agency's zero tolerance policy and all ways to report an allegation.

According to the agency's table of organization, the agency wide PREA Coordinator is the agency's PREA and Wellness Coordinator, and reports directly to the agency's Vice President of Administration and Legal Counsel. This is a promotion for the Coordinator who previously served as the agency PREA Compliance Specialist. During the onsite interview, she states she continues to assist with implementing PREA strategies at each facility. She also develops the training curriculum for required monthly PREA training at each facility and provides facilities guidance and assistance in complying with the standards. She is a Department of Justice Certified PREA Auditor and had extensive experience in interpreting the scope and intent of each standard. She indicated that she has enough time and authority to develop, implement, and oversee the agency's efforts to comply. The PREA Coordinator supervises the agency's PREA Compliance Specialist, as well as each facility's PREA Compliance Manager.

The job description for the PREA and Wellness Coordinator states her PREA responsibilities include:

- Develops and maintains Agency-wide PREA operating procedures; monitors responsibilities of each facility's PREA Manager; provides technical guidance, assistance, and feedback agency-wide to ensure compliance is met
- Serves as the primary contact and resource for management on PREA-related inquires and procedural questions
- Monitors and provides PREA-related program services, educational material, and training to facility PREA Managers and staff. Oversees the development of educational materials, staff guides, and education to residents regarding PREA procedures and reporting.
- Assist the VP of Administration and Legal Counsel with responding and submitting PREA reports to regulatory bodies regarding PREA-related issues
- Reports to the State's Intelligrants System regarding PREA incidents in an accurate and timely manner
- Submits quarterly reports to the Ohio Department of Rehabilitation and Correction (ODRC) in an accurate and timely manner

- Assists facilities' PREA Managers with PREA audit preparation including, but not limited to : completing facility walkthroughs, conducting employee and resident interviews and training, completing PREA assessments and questionnaire, and submitting audit documentation and assessments to the PREA auditor assigned to the facility

The auditor interviewed the VP of Administration and Legal Counsel during the onsite visit. She states that she has full confidence in the new PREA Coordinator and provides her the support and assistance when needed to ensure each facility is in compliance with the standards. She states that she is still involved in determining the outcome of administrative investigations and is a part of the SART review.

The auditor was also able to interview the Regional Vice President during the onsite visit. He states that he provides budget approval for PREA-related needs and ensures that recommendations are implemented which includes follow-up to ensure compliance. He states that the PREA Coordinator has enough latitude to enforce compliance at each facility.

The PREA Manager is the facility's Program Administrator. The Program Administrator reports directly to the PREA Coordinator for anything related to complying with the PREA standards. The auditor was able to review the Program Administrator's job description which includes:

- Conducting quality assurance monitoring for PREA standards
- Ensuring facility walkthroughs in order to address any safety issues
- Overseeing the day-to-day PREA facility issues
- Ensures staff meet PREA training requirements.

The Program Administrator discussed her process with the auditor for ensuring the facility is meeting all required standards. The Manager works directly with the PREA Coordinator to ensure staff have the proper training, material, and guidance. She reports that she has enough time to ensure compliance with the standards. She would be informed of all PREA allegations and assist in assuring resident and staff safety.

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

Review:
Policy 1080

Program Administrator job description
PREA and Wellness Coordinator job description
Agency table of organization
Interview with PREA Coordinator
Interview with VP of Administration and Legal Counsel
Interview with PREA Manager
Interview with Regional Vice President

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

N/A: The PREA Coordinator reports to the auditor that the agency is a private not for profit agency and does not contract with other facilities to house offenders on behalf of the Oriana House.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- ☒ Yes ☐ No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

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

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The facility provided the auditor with their most recent staffing plan. The staffing plan reviewed the availability of video surveillance (forty-four cameras strategically placed throughout the interior and exterior of building), security mirrors, and identified blind spot areas. The staffing levels noted on the plan includes availability of security staff

twenty-four hours a day, seven days a week, three hundred sixty-five days per year. The plan also identified the minimum number of staff for each shift:

- 1st Shift Mandatory Minimum 6 security staff
- 2nd Shift Mandatory Minimum 6 security staff
- 3rd Shift Mandatory Minimum 5 security staff

It is the policy of Oriana House (policy 3002), that facilities be staffed so as to maximize the use of personnel in conjunction with the needs of our residents including how best to protect residents against sexual abuse. The facility employs enough security staff members to cover each shift which does not include supervisory staff to meet these staffing requirements.

The PREA Coordinator reports that while the facility has recently experienced a few security staff vacancies, there have been no deviations from the staffing plan. The Program Administrator states that all vacant shift are filled through overtime until replacements can be hired and trained.

The floor plans provided to the auditor include locations that have video surveillance, audio surveillance, and security monitors. During the onsite visit, the auditor toured the building. The auditor noted camera placement, security mirror placement, and blind spot areas. The video surveillance cameras have the capability to record and playback up to thirty days. The camera at the main post also records audio. The auditor viewed the video monitors to inspect the views from each camera, confirm coverage and blind spot areas. The staffing plan requires management staff to view live camera footage six times per shift. The agency IT staff and administrative investigator states that the agency is in the process of upgrading the camera system and is in search of a new vendor. The facility has also installed an intercom system on all external doors to facilitate movement. The system has the capability of providing two-way communication with RS staff at the main post desk. The facility has installed the intercom systems in the bathrooms, dorm rooms, recreation yards, and classrooms; however, the camera feature has been disabled. The system has an automatic volume feature that will alert the main post desk any time the volume in that area reaches a certain level. During the onsite visit, the auditor was able to test the system.

Security checks are conducted by resident supervisor staff and shift supervisors. The staffing plan requires three whereabout checks per shift. Whereabout checks require the staff member to visually identify a resident and document on form that the resident was seen. Residents that have been identified as being vulnerable, abusive, or have mental

health issues are required to have six whereabout checks per shift. Along with whereabout checks, security staff will also conduct circulations at minimum three times per hour. Circulations are complete facility walk-throughs. Staff will conduct more frequent circulations in designated blind spot areas.

The facility had one unsubstantiated allegation of sexual abuse during the past twelve months. Agency leadership team did not approve the SART review recommendation of placing cameras in the dorms. The facility will instead increase the number of circulations in the dorm areas.

The plan reviewed the composition of resident population, prevalence of substantiated and unsubstantiated sexual abuse allegations, and other relevant factors. The facility previously had four housing units, but due to the reduced number of residents, has changed its use to providing family related programming.

During interviews with agency and facility leadership, they discussed their ongoing process of reviewing each facility for ways they can prevent, detect, and respond to incidents of sexual abuse and sexual harassment. The staff spoke of applying for grants from the State of Ohio as well as Impact Justice's TIPS grant. These opportunities have allowed the agency to provide facilities with more training, electronic monitoring, and informational material for staff and residents.

The annual staffing plan is completed annually by the Program Director. The leadership team will review the staffing plan and address any recommendations.

Review:
Policy and procedure
Staffing plan 2018 & 2017
Floor plan
Camera monitors
Building tour
Interview with agency investigators
Interview with PREA Coordinator
Interview with Program Director
Interview with VP of Administration and Legal Counsel
Interview with Regional Vice President
Interview with PREA Manager

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

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

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) ☒ Yes ☐ No ☐ NA

115.215 (c)

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

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

115.215 (d)

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

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Anyone who wants to enter into the secure perimeter of the facility must pass through a body image scanner (PRO ATD). The resident will buzz the main post to gain access into the building. A staff member will permit entrance into a search room area. They will remove all clothing down to the first layer of outerwear and empty out pockets. The will be directed to step into the scanner and raise their hands above their heads. The scanner will show a gingerbread image on a monitor attached to the machine. The system will highlight areas that detect anonymities. The staff member can see a more invasive image on a computer should the system detect possible contraband. Only staff members of the same gender may view the more invasive image.

After passing through the scanner, a resident will receive a pat search or an enhanced pat search. Both searches are conducted on camera; however, the enhanced pat search will be conducted in a private room with two staff members of the same gender. The monitor that can view into that specific room will be blacked out from the monitoring station. The camera will record the session in case an allegation would arise from the search.

The auditor watched several pat searches while at the onsite visit. The searches were conducted in accordance with agency policy 8089. In the pat search area are posted notices of the expected steps for a pat search. Residents also sign a Search of Person Acknowledgement. The acknowledgment form list what is to be expected for pat and enhanced pat searches, when searches may be conducted, and refusal of searches can be cause for termination. The ten files reviewed by the auditor had signed and dated acknowledgments.

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

As part of supportive documentation sent prior to the onsite visit, the auditor received and reviewed the training curriculum provided to staff members who are responsible for conducting pat searches. The training included instructions on appropriate pat search techniques for cross-gender and transgender searches, respectful communication with

LGBTI residents. These training also include instructions on who to conduct a pat search in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs. The auditor also reviewed staff training completions sheets for searches.

The facility allows residents to shower, perform bodily functions, and dress in areas not viewable to staff. The facility has a restroom in each of the housing units for residents to be able to shower and use the toilets. Policy 1080 requires all staff to announce their presence when entering an area where residents shower, perform bodily functions, and change clothing. All non-medical staff are prohibited from viewing a resident's breast, buttocks, or genitalia except in exigent circumstances or when such viewing is incidental to routine security checks. The facility requires all residents to change in the bathroom in order to ensure the most private space for changing clothing.

The bathroom in the Phase 1 Dorm has a large open entrance from the dayroom area. There are two urinals with a partition between. There is a covering over the first urinal to prevent viewing from the entrance. Next to the urinals are four toilet stalls with custom 1/3 doors. Directly across from the toilets are sinks with stainless steel mirrors (does not reflect the toilet area). There is a shower area with a medical curtain to cover the changing area. There are five individual showers with curtains that have clear tops and bottoms. The Phase 2 Dorm bathroom also has a large open entrance from the dayroom area. There are two urinals with a partition between. There is a wall that protects the view from the dayroom area. Next to the urinals are four toilets with custom 1/3 doors. Across from the toilets are sinks with stainless steel mirrors. At the back of the bathroom is the shower area. There is no curtain at the entrance, but the showers are tucked into an alcove where there is no visibility outside this area. There are seven individual showers but only showers close to the entrance of the shower area have curtains. The Phase 3 Dorm bathroom is set up identical to the Phase 2 bathroom.

During the onsite visit, the auditor was able to interview twenty (20) residents. The auditor inquired about searches as well as cross-gender announcements. All of the residents interviewed have received at least one pat search during their stay at the facility. The residents have had a security wand used on them by a female staff member but never an actual pat search. They stated that all hands-on searches were conducted by a male staff member. The residents did not report any unprofessional pat or enhanced pat searches. When asked about cross-gender announcements, all residents stated that anytime a female staff enters the bathroom she announces herself before entering into the room. None of the male residents interviewed reported any incidental viewing from a member of the opposite sex. The male dorm has glass windows in the door that allow for

clear line of site views into the room. Because of this, residents are not allowed to change in the dorms. Opposite gender staff still have to knock when entering dorm rooms. During the tour portion of the onsite visit, the auditor was able to view the knock and announce practice.

The auditor conducted six (6) Resident Supervisor (RS) interviews. All staff interviewed indicated that they received annual training on how to conduct proper pat searches and to use the security wand to perform a pat search on a member of the opposite gender. The RS staff report that it is not the practice of the facility to conduct cross gender pat searches. The all state that at no time do they conduct strip or body cavity searches. The staff report that while everyone must pass through the body scanner, they are still required to conduct, at a minimum, a pat search on all residents entering the facility.

The auditor interviewed the Program Administrator during the onsite visit. The Administrator was questioned regarding the training and ongoing reviews of various pat searches. The Program Administrator states that a specialized team conducts a training annually on same gender, cross-gender, and transgender/intersex pat searches as well as urinalysis. She states that she is required to view a specific number of video footage each week. During these reviews, she inspects pat searches and conduct additional training when necessary.

The facility does not currently have a transgender or intersex resident, but has in the past. The agency has implemented a policy addressing the proper housing, search, and showering of any transgender or intersex resident. The housing units are set up by phase levels and the dorms within each unit are set up based on the Ohio Risk Assessment System (ORAS) score. Each housing unit has dorms where residents who are identified as highly vulnerable or highly abusive would be housed and in beds that are easily viewable to staff. A transgender or intersex resident would be offered showering options such as showering at different times or in the clinic area in order to protect privacy and offer safety. The policy does not allow staff to physically examine a transgender or intersex resident for the sole purpose of determining genital status.

The auditor spoke with the PREA Coordinator, Program Administrator, and the Program Manager on the process of addressing the needs of a transgender resident before placement. They state the agency will convene the Transgender Review Committee before placement in order to identify which Oriana House operated facility will be best for the safety, security, and manageability of the residents. The committee will provide options for providing private shower times, dorm and bed placement, and an appropriate

case manager. The Program Administrator states that transgender/intersex residents are able to use the bathroom in the housing unit that is not currently being used. The PREA Coordinator states that all staff will be given refresher training on how to complete a pat and enhanced pat search of a transgender individual whenever a transgender resident is placed at the facility. The staff were also questioned on their comfortability on performing pat searches, enhanced pat searches, and urinalysis testing on transgender residents. No staff member voiced concerns or comfortability with the process.

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

Review:
Policy 1080
Policy 8089
Facility tour
Interview of target residents
Interview of random residents
Interview of staff
Interview of PREA Coordinator
Interview of Program Administrator
Interview of Program Director

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 8004 states that Oriana House facilities must ensure that all residents understand the program rules, regulations, and guidelines. This includes ensuring that residents who have disabilities and are limited English proficient have equal opportunity to participate and benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

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

The policy also states:

- Telecommunications device for the deaf (TDD), shall be provided as needed with no cost to residents, family members, and/or significant others. Mobile units are stationed at the Administrative Office and the Detox facility. The Admissions Manager, or designee, will coordinate with the Communications Specialist to install the unit at the requested facility
- If an interpreter is needed for continuing case management services, the Program Manager or designee should utilize the contact list for these services
- When a translator (i.e., Spanish, Vietnamese, etc.) is needed for prospective residents, the Admissions Manager or designee will make arrangements through The International Institute
- Once a resident is placed in a program, a Program Manager or designee should arrange for ongoing services
- The Program Manager/designee in the facility where the resident is placed can utilize the contact list during standard business hours and off-hours
- There are no fees to residents, family members, and/or significant others with regard to language barrier/literacy services. The Agency has signed agreements and/or billing guidelines set up with the contacts listed
- Should an employee offer/be directed to provide in-house services, his/her supervisor must authorize him/her to leave his/her regular duties during the time in which he/she is interpreting
- Any request by a resident to have a family member or friend interpret, following the Agency's offer to provide an interpreter, must be documented in the resident's file. The resident's request will be honored unless the Admissions Manager and/or facility's Program Manager feels the person the resident is requesting is not sufficiently qualified and, in such cases, must provide the resident an interpreter from the contact list. Documentation must include a written statement signed by the resident

The policy does not allow for the use of resident interpreters unless circumstances are such as where an extended delay in interpretation could compromise a resident's safety, the performance of first-responder duties, or the investigation of the resident's allegation of sexual abuse or sexual harassment. If a resident interpreter or reader is used, this must be documented in a resident log.

The auditor was give the materials given to residents during intake. All material provided is at a 9th grade reading level and all residents must read a passage to ensure that they are capable of reading all provided materials and instructions.

The auditor was able to interview the RS staff member that performs resident intakes during the onsite visit. The RS states that during intake he shows the new residents the PREA video produced by just detention. After the video he will give them facility specific information regarding PREA and how to report allegations and answer any questions. He reports that he makes the residents read a section of the paperwork to ensure the resident can read and understand the material. If the resident cannot read, has limited reading ability, or has comprehension issues, the RS states he will read the entire intake packet and explain each section. For residents that are capable of reading and understanding, he will review all the PREA information, grievance procedures, and facility rules while hitting the highlights of areas the resident can read on his own. The RS reported enlisting the services of interpreters in the past but does not currently have a resident that is limited English proficient.

The auditor interviewed any resident that identified as having a reading or cognitive disability. No resident in this targeted category were in need of any additional services in order to benefit from the agency's effort to prevent, detect, or respond to sexual abuse or sexual harassment. All residents interviewed were capable to describing the facility's zero tolerance policy, reporting options, and services that are provided free of charge to any resident that request such services.

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

Review:
Policy 8004
PREA Plan to Assist Residents with Disabilities
Resident intake materials
Interviewed target residents
Interviewed Program Administrator
Interviewed PREA resident educator

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

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

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

Policy 3006 requires the agency to conduct background check for all prospective employees, including temporary employees, independent contractors, volunteers, and student interns or required the contractor, vendor, volunteer to provide a background check. Record checks are completed every five years. The auditor interviewed the Director of Human Resources during the onsite visit. The director states that every five years the Human Resource Department will run background checks on the entire facility regardless when a person was hired in order to guarantee all staff received the required updated check. The updated background check will be stamped with a red PREA label to signify that the employee has received an updated background check as required by the standard. All employees, independent contractors, volunteers, and interns are required by policy 1080 to immediately report to their supervisor any arrests, citations, and complaints to professional licensing boards. Employees document this continued affirmation during annual personnel evaluations. All successful applicants are notified of the PREA background check requirement and that any omission regarding sexual misconduct is grounds for termination. Employees are required to document their adherence to this policy.

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

The Director also reports the Human Resource Department conducts referral checks for all new hires and specifically documents whether or not a potential employee has been

found to have substantially sexually abused an offender or resigned during a pending investigation of an allegation of sexual abuse.

The agency documents any request from outside confinement facilities requesting PREA reference checks on potential employees. The Director reports no request at this time.

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

The auditor conducted a lengthy interview with the Director of Human Resources who took the auditor systematically through the hiring and promotion process. The Director states that during the hiring process, applicants are questioned about criminal or administrative sexual misconduct allegations on the application, during the telephone interview, and during the in person interview. Once hired, all new employees are provided the agency's zero tolerance policy 1080 and continued affirmation policy 3009 to disclose misconduct. Employees document their acknowledgment of this annually. The Director reports that to be eligible for a promotion, all interested employees must submit a letter of interest to the Human Resource Department. The department will review the employees file including disciplinary actions. Employees with disciplinary action that includes sexual misconduct are not eligible for promotion.

The Director reports no new changes to the hiring process since the last PREA audit. The auditor has been able to interview the Director for all Oriana House, Inc. community confinement facility audits.

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

Review:
Policy 1080
Policy 3006
Policy 3009
Employee files
Continued affirmation
Prior institutional referral

Applicant interview questions
Background checks
Promotion documentation
Disciplinary records
Interview with Director of Human Resources

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The Program Director reports that the facility has not acquired any new facility nor is it planning any substantial expansion or modification to the current facility.

The Program Director reports that she, along with facility management during the annual staffing plan review will assess the needs to its video monitoring system. This includes taking into consideration how such technology may enhance its ability to protect from sexual abuse. The facility has recently installed fifty (50) push button wall mounted two way intercoms throughout the facility, including all restrooms, all resident dorms, and outside recreation areas. While these intercoms have video capabilities, the facility has chosen not to make them operable in restrooms and dorm rooms. The intercoms ring directly into the central control area and are equipped with automatic volume activation feature. Anytime sound reaches a certain volume, the system will automatically alert the central control desk. The auditor tested the system during the onsite visit.

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

Review:
Intercom system
Interview with Program Director

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

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

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

115.221 (e)

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

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

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a)

through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The PREA Coordinator states that any allegation of sexual abuse or sexual harassment will be administratively investigated by a trained internal PREA investigator, and when necessary, criminally investigated by the agency with legal authority to conduct such investigation. The agency has provided the auditor with certificates for the administrative investigator training for all three agency investigators. The agency has shown the auditor a request to enter into a formal MOU with the Cuyahoga County Police Department to investigate any allegation of criminal sexual abuse and/or sexual harassment at MCCBCF.

The Regional VP has provided a documented request for the Cuyahoga County Police Department to investigate all criminal incidents of sexual abuse or sexual harassment at the facility. The department responded by stating that do not enter into MOU's but will answer calls of any issues as required. The agency has request the criminally investigative agency to:

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

At facility had one resident-to-resident sexual abuse allegation in the past twelve months. The allegation was reported to the facility by a third-party. The administrative investigators could not review camera footage due to the amount of time that past before the allegation was reported. Because the allegation alleged sexual abuse, the facility reported the incident to the Cuyahoga County Police Department. The department collected the information but could not investigate the allegation because the alleged victim would not contact the department. The facility tried to facilitate a meeting but the alleged victim or his family members would not cooperate in the investigation.

The facility does not provide forensic medical exams. Any resident in need of a forensic medical exam will be taken to Cleveland Metro Health Hospital. The hospital has certified Sexual Assault Nurse Examiners (SANE) who receive training by the International Association of Forensic Nursing an accredited provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. The hospital collaborates with Cleveland Rape Crisis Center and provides services free of charge.

The facility provided the auditor with documentation of a MOU with Cleveland Rape Crisis Center. The Center agrees to:

- Accompany and support the victim through the forensic examination process
- Accompany and support the victim through investigatory interviews at the hospital or institution
- Provide emotional support
- Provide crisis intervention services
- Provide information on community resources
- Provide contact information to include telephone number and address for victims needing emotional support
- Provide contact information to include a telephone number that any resident can call to anonymously report sexual abuse

The PREA Coordinator states that every effort is made to provide a victim advocate from rape crisis agency; however, should one not be available, the facility has access to two Crisis Counselors that have been trained to serve as an emotional support person. The auditor was provided training certificates for both Crisis Counselors.

The auditor contacted the director of Cleveland Rape Crisis Center after the onsite visit. The Director was able to confirm the services provided to the residents as listed in the MOU and that the services are provided free of charge.

The PREA Manager reports that no resident has requested services of the Cleveland Rape Crisis Center or emotional support services from trained staff.

Review:
Policy 1080
Cleveland Rape Crisis Center MOU
Email to Cuyahoga County Police Department
Cleveland Metro Health Hospital website

Administrative investigation report
Interview with administrative investigators
Telephone interview with Cleveland Rape Crisis Center Director

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

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

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

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

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The facility has had one allegation reported during the past twelve months. During the onsite visit, the auditor reviewed the investigation with the administrative investigators.

Investigation #1: The facility received a third-party report that a resident that went AWOL did so because he was being sexually abused by another resident while at the facility. The administrative investigators could not find any corroborating evidence to substantiate the allegation. The allegation was not reported in enough time to retrieve any video evidence. Because the report alleged sexual abuse and the alleged victim was of limited mental capacity, the investigator reported the allegation to the Cuyahoga County Police Department. The department and the facility tried to work together to investigate the allegation. The department closed the investigation due to the alleged victim not participating in any part of the investigation. The department reported to the facility that should the alleged victim or his family participate in the allegation they would re-open the case. The facility reported this information to the family and the

alleged victim's probation officer. The administrative investigation was determined to be unsubstantiated.

Review:
Policy and procedure
Agency website
Investigation report
Interview with administrative investigators

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

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

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The agency has trained staff on the agency zero tolerance policy, employee responsibilities, residents rights to be free from sexual abuse and sexual harassment and be free from retaliation from reporting sexual abuse and sexual harassment, common

reactions for males and females, dynamics of sexual abuse and sexual harassment in a confinement setting, detecting and responding to incidents of sexual abuse and sexual harassment, avoiding inappropriate relationships, effective communication with LGBTI residents, and compliance with mandatory reporting laws. These training topics are taught to new employees during the onboarding process. All staff are required to attend this training before the employee can work directly with residents.

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

In addition to the required training dictated by the standard, the facility also provides training on the following related topics:

- Policy and procedure
- Code of Ethics
- Client civil rights and grievance procedures
- Employee discipline
- Harassment
- Relationships with residents, former residents, and notification requirements
- Notifying supervision of arrest, citation or complaints to professional licensing board

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

January: Common reactions of sexual abuse and sexual harassment victims (male and female)
February: How to detect and respond to signs of threatened and actual sexual abuse
March: How to avoid inappropriate relationships with residents
April: How to communicate effectively and professionally with LGBTI residents; Oriana House policy 8089
May: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities

June: Pat down training; policies, procedures, and practice for conducting proper pat searches (all pat search types are reviewed)
July: PREA screening policies and procedures
August: Agency zero tolerance policy; Oriana House policy 1080
September: Prevention, detection, reporting, and response to sexual abuse and sexual harassment (part 1)
October: Prevention, detection, reporting, and response to sexual abuse and sexual harassment (part 2)
November: Right of residents and employees to be free from sexual abuse and sexual harassment and from retaliation for reporting sexual abuse and sexual harassment
December: Dynamics of sexual abuse and sexual harassment in a confinement setting.

During staff interviews, staff stated they receive plenty of training on PREA standards and practices. They state the monthly trainings include a power point presentation, a game, and role plays. Monthly trainings are supplemented with the information from the training being displayed on a video monitor in the staff office. The auditor was able to view the monitor and information during the onsite visit. The staff also discussed a PREA Staff Guide Book that is located at all post desk. The auditor reviewed the contents of the book. It includes:

- First responder duties
- Reporting duties
- Coordinated respond plan with contact names and phone numbers
- PREA policies and procedures
- Assisting residents with disabilities
- Transgender safety plans
- Medical response plan
- PREA definitions
- Staffing plan
- Logging cross-gender views

During intake RS and case manager interviews, they state that in addition to the monthly training sessions, they received training on completing and interpreting the PREA risk assessment tool.

The Human Resource Director discussed the agency's training practices. She states that the agency cross trains all staff concerning PREA gender specific topics because staff can work with male and/or female residents. The agency also offers staff gender specific

training on PREA related topics. Each facility will provide training on building specific issues related to PREA. These topics can include: transgender residents, PREA assessment interview, coordinated response plan, and first responder duties.

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

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

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

The auditor was able to discuss contractor training with the Aramark Kitchen Manager during the onsite visit. She states that all Aramark staff receive Oriana House full PREA training prior to being assigned to a facility. She states that she is updated on any changes or new policies and procedures and ensures her staff are updated on those procedures.

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

Standard 115.233: Resident education

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

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

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

115.233 (c)

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

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

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

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

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

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 states that during the intake process, all residents shall receive information explaining the agency's zero tolerance policy regarding all forms of sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. The policy also states that residents that are transferred into the

facility will receive refresher training which includes the location of PREA posters and information on how to report allegations or suspicions of sexual abuse or sexual harassment.

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

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

During the onsite visit, the auditor noted various posters in English and Spanish throughout the facility. The posters provided information to residents, visitors, and staff on how to report allegations and phone numbers and address to reporting agencies. The auditor used the payphone in the Phase 1 dayroom to call the outside reporting agency. The phone number listed connected the auditor with a PREA hotline recorded message that requested certain information in order to investigation the allegation. The recording reminded the caller that they could report anonymously and that all allegations would be investigated. The agency in charge of the hotline number returned the auditor's phone call and ensured the auditor that regardless of who calls the hotline number, that all allegations would be reported the agency's PREA Coordinator. The auditor also called the agency hot line number from the same payphone and received a call back from the agency administrative investigator.

The Intake RS is responsible for providing residents with PREA education during intake and the Program Administrator conducts resident orientation. The RS shows the residents a PREA education video produced by *Just Detention* and provides facility specific information for reporting allegations; accessing medical, mental health, and rape crisis organizations; and locations of PREA information posted throughout the facility. The Program Administrator reports to the auditor that during orientation she reviews resident expectations, what to expect, how to complete various forms, role clarification, disciplinary procedures, phase rules, and PREA info sheet. The PREA info sheet

contains information on reporting options, phone numbers and addresses for outside emotional support agencies, grievance procedures, limits to confidentiality, mandatory reporting, and keeping themselves safe. The sheet also details good faith and bad faith (false or misleading) allegations. Residents are able to ask questions and receive private consultation for any questions at a later time.

The auditor interviewed twenty residents (targeted and random) during the onsite visit. The residents interviewed stated that at intake they received a handbook, resident intake packet, and watched a "PREA" video at intake. The residents state that they also received PREA information from the case manager and during orientation group. Most residents were asked to clarify what information was given to them by Oriana House due to them also receiving PREA education while confined at Ohio Department of Rehabilitation and Correction facilities. All residents had some level of understanding and stated that should they need to report; they have the information necessary to do so.

Review:
Policy 1080
Resident intake packet
Resident handbook
PREA posters
PREA reporting phone numbers
Resident files
Interview with residents
Interview with Intake RS
Interview with Program Administrator

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires all administrative investigators to receive specialized training. The agency has three investigators as well as the PREA Coordinator who received in-person training from the Moss Group. The training provided includes

techniques for interviewing sexual abuse victims, proper use of Miranda and Garity warnings, evidence collection in a confinement setting, and required evidence to substantiate a case for administrative action or criminal referral. The agency retains completion of training certificates as proof of training.

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

The administrative investigators were able to discuss the training they received on trauma informed care, evidence collection as it relates to administrative investigations in a confinement setting, proper documentation, and how to determine an appropriate finding to an investigation. All three investigators are former police officers and have extensive experience in investigating crimes. The investigators understand Garity; however, this is a private non-profit organization and Garity warnings do not apply. All three investigators are previous members of the Akron Police Department and report having a good working relationship with the department.

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

Review:
Policy 1080
Training curriculum and material
Training certificates
Administrative investigator interviews

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of

sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☒ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.235 (b)

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

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.235 (d)

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

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The facility does have onsite medical practitioners; however, these practitioners would not complete a forensic medical exam should a resident be a victim of sexual abuse or sexual harassment. All residents would be seen by a SANE at Cleveland Metro Health.

The auditor was able to interview a nurse practitioner during the onsite visit. The practitioner states that she has received both employee annual PREA training and has completed specialized training for Medical and Mental Health Professionals provided by NIC. The practitioner discussed understanding the signs of sexual abuse and her mandatory reporting obligation. The practitioner states that all medical staff are required to complete the agency's employee training, specialized training, and outside medical continuing education credits. She is well versed on working with residents who have experienced trauma.

The practitioner states that she has not had a resident at the facility report an allegation to her.

The Crisis Counselor at the facility states that while she does not provide mental health services for the residents at MCCBCF, she has completed the specialized training for Medical and Mental Health Professionals provided by NIC. The counselor states that residents will go into the community for mental health services and for residents that are not eligible for community access, professionals from Recovery Resources will meet with the residents at the facility.

Review:
Policy and procedure
Interview with Crisis Counselor
Interview with Nurse Practitioner

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

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

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

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

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

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

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

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

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

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

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

a. Whether the resident has a mental, physical, or developmental disability
b. The age of the resident
c. The physical build of the resident
d. Whether the resident has a prior conviction for sex offenses against an adult or child
e. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, gender non-conforming, or intersex
f. Whether resident has previously experienced sexual victimization

g. The residents own perception of vulnerability
h. Prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse

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

The auditor was given a copy of the risk assessment instrument. The assessment not only documents the residents answers to the required questions, but also identifies sources of additional information, areas of concern or other considerations, and reasons for a professional override to the score. After the screening is complete, the screener will score the instrument based on the resident's answers. The resident can receive a classification of susceptible, highly susceptible, abusive, highly abusive, or no risk. During the past twelve months the facility has conducted 527 initial risk assessments.

The auditor conducted an interview with the Intake RS during the onsite visit. The RS reviewed his process for conducting risk assessments. The RS states that he reads each question to the resident explaining as he goes. He ensures to define words and give examples so that the resident has a clear understanding of each question. The RS states that before starting the assessment he explains the purpose of the assessment and ensures that the resident knows the information is confidential. The RS says he documents on the form if he notices any attitude, body language, or mannerisms that would impact the risk assessment score or his perceived gender or sexual identity. He states that he has only had one resident refuse to answer questions. The RS states at the completion of the assessment, he provides the form to the Program Administrator who conducts quality assurance.

The Program Administrator reports that all residents that have an initial risk assessment classification of highly abusive or highly susceptible will be automatically reassessed before 30-days. All other assessment classifications are only reassessed due to new information, referral, request, or incident of sexual abuse. The reassessment will be conducted by the case manager. The Program Administrator states she conducts a quality assurance review on a random sample of assessments and reassessments to ensure the instrument is begin completed properly. The Program Administrator states that all assessments are kept in the residents file with limited assess. The resident's classification status only will be documented in the resident database system.

*The auditor discussed with the PREA Coordinator, Program Director, and Program Administrator that the facility must do an affirmative check on all assessments to

document that no new information has been discovered and/or the resident does not report information different than the initial report. The facility understands the requirement and have made adjustment to the reassessment form and procedure. All case managers will now complete the new reassessment form on all residents regardless of the initial classification.

The auditor interviewed two case managers. The case manager state that after the forms are reviewed by the Program Administrator for quality assurance, they receive the form and do another review to ensure the information reported matches information they have received. One case manager stated that at times Pre-Sentence Investigation Reports will be received after placement and information can be discovered and a new assessment will be conducted. Both case managers state that all residents that are classified as highly abusive or susceptible will receive another assessment within 30-days of placement. The case managers also state that any resident that is involved in a sexual abuse allegation will complete another assessment.

The auditor interviewed twenty residents during the onsite visit. The residents were questioned on the risk assessment and reassessment. All residents interviewed stated that they received an initial assessment upon arrival to the facility. They state that they understand the need for the assessment and answered as honestly as possible. When questioned about a reassessment conducted with their case manager, some residents remembered having a reassessment while others were unsure. All residents reported feeling safe in the facility.

The auditor also reviewed ten resident files during the onsite visit. Each file contained the resident's completed risk assessment, signature of quality assurance check, and date of reassessment if necessary. If the resident needed a reassessment, the form was also contained in the file.

UPDATE:
On October 29, 2019, the facility sent the auditor a draft copy of the new re-screen tool. The case managers at all Oriana House facilities will be required to conduct a rescreen on all residents between 15-29 days into their stay. The assessment tool is different from the initial tool, but addresses changes in classification based on new information, resident concerns, or a sexual abuse or sexual harassment incident.

Review:
Policy and procedure
Risk assessments (initial and reassessments)

Resident files
Interview with Intake RS
Interview with Case managers
Interview with Program Administrator
Interview with PREA Coordinator
Interview with residents

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents

to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The policy states that residents with a highly susceptible or highly abusive PREA status will have increased whereabout checks. Residents with no status or a status of susceptible or abusive receive three whereabout checks per shift while residents with highly PREA statuses will receive six whereabout checks per shift. Only the Program Administrator or the Lead Resident Supervisor can remove a resident from the increased whereabout checks.

During the onsite visit, the auditor was shown the whereabout check sheet and verification of increased checks for those with PREA statuses. The auditor was also able to view the designated PREA rooms/beds from the main post. Room set up along with security mirrors strategically placed assist staff into having clear views into most areas of these rooms. The bathrooms and rooms are also equipped with a two-way intercom system that allows residents to speak directly with staff at the main post.

Oriana House policy 1080 also requires the facility to address the underlying reasons and motivations for susceptibility or abusiveness. The information from the screening will be used to develop targeted Individual Program Plan (IPP) goals and objectives to address the identified risk and needs assessment indications. The counselor will then make the

appropriate referral to an outside professional to address and correct the underlying reasons and motivations for susceptibility or abusiveness.

The auditor interviewed case managers as well as the crisis counselor during the onsite visit. Case managers discussed meeting with residents after reviewing assessment information along with other information (Pre-Sentence Investigation) to develop an IPP. If the resident has been identified as being highly susceptible or abusive, the case manager will work with the resident to include programming that will address those issues such as trauma group or anger management. Residents that have experienced past sexual abuse and wish to seek mental or emotional health counseling will be referred to community agencies that specialize in those areas. The crisis counselor states that she is available for immediate needs but long term case will be referred to community agencies.

The agency has developed a plan to ensure the safety of transgender/intersex residents while in Oriana House facilities. The plan includes a review of the perspective resident by the PREA Coordinator, PREA manager, admissions personnel, and crisis counselor that will address issues that come with the placement of a transgender resident. Once an appropriate facility has been identified, the intake department will notify supervisory staff at the proposed facility. In order to ensure placement decisions are on an individualized case-by-case basis, the facility will collect information into consideration the transgender resident's concerns in terms of safety- housing placement and programming, name, pronoun, shower, preference, and searches. The resident will be asked:

- What gender do you identify with
- What is your preferred name
- How do you prefer to be addressed
- Have you had any medical consolation regarding your gender identity
- Are you willing to provide a medical release of information for verification of medical consultation
- Are you in the process or have you undergone any gender affirmation surgery or hormonal therapy
- How long with you been living as your identified gender
- Who are you attracted to
- Do you prefer male or female housing
- Do you have any specific safety concerns in regards to you placement
- Are you comfortable with communal showering or would you prefer accommodations be made for you to shower separately

- What gender would you feel most comfortable conducting a pat-down search and UDS

The PREA Coordinator reports that once the transgender assessment is completed, the facility will forward the results to the review committee. She reports that the resident's preferences will not be the sole determining factor for placement and handling but will be given serious consideration, along with the safety, security, and staffing of the facility. Once the review and placement decision is made, the facility will notify and prepare staff for the safe management of the resident.

There were no residents that identified as transgender/intersex during the onsite visit.

Review:
Policy 1080
PREA screens memo
Plan to ensure transgender safety in facilities
Transgender risk assessment
Interview with Case managers
Interview with PREA Coordinator
Interview with Crisis Counselor

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

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

115.251 (b)

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

115.251 (c)

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

Each housing unit is equipped with several payphone that resident are able to use in order to report (including anonymously) sexual abuse and sexual harassment. Residents are also able to report allegations directly to any staff member, contractor, volunteer, or to/on behalf of a third party. Residents are reminded during intake, orientation, and during case manager meetings that all reports will be taken seriously and investigated.

During the tour portion of the onsite visit, the auditor used a payphone in the Phase 1 housing unit. The auditor called the hotline numbers for both the agency and outside reporting agency. The agency hotline is answered by an answering machine. The message on the machine reminds callers of the obligation of the facility to investigated all allegations and that there is no retaliation for reporting any incidents. The message request callers to leave as much detailed information about the incident but if the caller wishes they can remain anonymous. The outside reporting agency's hotline number is also answered by a machine. The message also request the caller leave detailed information about the incident and that if they so choose, they can remain anonymous.

The auditor received a return phone call from an agency administrative investigator and from the Bureau of Community Sanctions PREA Liaison on the same day the call was placed.

The residents have access to a computer where they can report allegations of sexual abuse or sexual harassment from the agency website. The website has links for the Client Sexual Abuse/Harassment Reporting Form and instructions on how to complete the form and return to the email listed on the site. The auditor left a test message and received a return email from an agency administrative investigator.

During the tour, the auditor noticed several postings in conspicuous places that listed reporting information for local, state, and national organizations. The information includes the name, phone number, and address for all organizations listed.

During the onsite visit, the auditor interviewed a total of twenty residents. The residents were asked questions in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Residents. This includes questions on ways a resident can report, private and anonymous reporting, and how residents received this information. Residents discussed the information they received during intake and watching the "PREA" video. Residents understood their ability to report to any staff member and could make mention of a staff member they felt comfortable reporting allegations. Four residents understood their ability to report and stated they felt more comfortable reporting anonymously should an incident of sexual harassment or sexual abuse occur at the facility. While not all the residents agreed that they would report, they did all know that they could report and the ways that were available. All residents stated they received a handbook during intake and that reporting options and phone numbers were listed in the handbook. Most of the residents interviewed seem to think that sexual abuse or sexual harassment would not happen to them while at MCCBCF.

The auditor interviewed both targeted and random staff members and inquired about reporting options and obligations. All staff reported that all information they received concerning an incident or report of sexual abuse or sexual harassment they are to immediately report to their supervisor and document on a Client Sexual Abuse/Harassment Reporting Form and email the form to administrative investigators. The staff was able to identify the Program Administrator as the PREA Manager and that they could make a private report to her.

Review:

Policy 1080
Client Sexual Abuse and Sexual Harassment Reporting Form
Agency website
Reporting hotline numbers
Interview with Administrative investigators
Interview with staff
Interview with residents

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the

90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

MCCBCF has a MOU with Cleveland Rape Crisis Center for its Cuyahoga County locations. The MOU permits the agency to provide its residents the telephone number and address to the Center and to offer all residents emotional supportive services. A copy of the MOU was provided to the auditor.

After the onsite visit, the auditor contacted the Center via email to the Chief Program Officer listed on the MOU. The Officer confirmed the hotline number and address and that the advocates at the center will provide emotional supportive services to all residents at MCCBCF. The Officer states that at the initiation of services, advocates inform residents that all information reported is confidential except in case where they are mandated to report.

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

During interviews with residents and case managers, both stated that during the role clarification meeting, residents are given information on the limits to confidentiality and information that would be immediately reported to proper authorities.

*The national rape crisis advocacy organization, RAINN, does not keep record of calls into the center. All calls are anonymous and callers are forwarded to their local rape crisis agency.

Review:
Policy 1080
PREA Postings
Cleveland Rape Crisis Center MOU
Resident Handbook
Email with Rape Crisis Center representative
Staff interviews
Resident interviews

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires the posting of information on how a third-party can report sexual abuse or sexual harassment on behalf of a resident on the agency website. The auditor reviewed the agency website (www.orianahouse.org//accreditations/prea/prea.php) and was able to see the posted

information on how to report an allegation. The auditor tested the reporting method posted and received a reply from an administrative investigator on the same day of the auditor's initial email.

The auditor also called the outside agency hotline number. A representative from the outside agency returned the auditor's phone call and confirmed that they are a reporting agency and would report all allegations to the PREA Coordinator.

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

The agency received one resident third-party report. The facility received a phone call from a resident's family explaining that the resident went AWOL due to being sexually abused. The facility also received a report pertaining to the allegation from the resident's probation officer. The allegation was administratively investigated and determined to be unsubstantiated.

Review:
Policy 1080
Agency website
Investigation reports
PREA notices
PREA hotline number

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

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

115.261 (b)

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

115.261 (c)

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

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

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

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

A review of the PREA Staff Guide Book provides instructions to staff on how to report resident sexual abuse or harassment. The guide speaks to the agency's responsibility of creating a culture where residents feel safe to report sexual abuse or sexual harassment

without the fear of retaliation. The book provides a phone number, email address, and required reporting form.

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

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

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

The auditor interviewed programming, security, and administrative staff during the onsite visit. The staff were interviewed on agency reporting protocols and expected practice. All staff were capable of listing the reporting options available to residents, staff, and outside sources. The staff were aware that residents were allowed to verbally report and report anonymously. The auditor interview two staff members who stated that have reporting allegations in the past. When asked about reporting suspicions, the staff state they have been trained to report all suspicions without investigating their suspicions. Some staff stated if they had suspicions or witnessed some red flags or questionable behavior, they would address their concerns with the staff member along with reporting the behavior. All staff stated they will report and can be disciplined for receiving information, having knowledge, or suspecting sexual abuse or sexual harassment and not immediately reporting that information to their supervisor or the manager on call.

Review:
Policy and procedure
Employee files
Resident files
PREA staff guide book
Interview with staff
Interview with PREA Coordinator

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The auditor reviewed the one allegation reported during the past twelve months. The allegation was reported after the resident was no longer housed at the facility; therefore, no protection measures were deployed.

The auditor spoke with the Program Director and the Program Administrator who state that alleged abusers are separated from a victim during investigations. The facility is able to separate by dorm, housing unit, and facility if necessary. They state that alleged abuser and victims will be placed on increased whereabouts until the conclusion of the

investigation. They will determine if increased whereabout need to continue to monitor for retaliation at the end of the investigation.

No resident has reported to the facility that they were in fear of imminent sexual abuse.

Review:
Policy and procedure
Investigation reports
Interview with administrative investigators
Interview with Program Director
Interview with Program Administator

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

Policy 1080
Interview with Administrative Investigators
Interview with PREA Coordinator

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

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

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

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

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

- First responder duties
- Reporting duties
- Coordinated respond plan with contact names and phone numbers
- PREA policies and procedures
- Assisting residents with disabilities
- Transgender safety plans
- Medical response plan
- PREA definitions
- Staffing plan
- Logging cross-gender views

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

During staff interviews, staff were able to dutifully repeat the first responder duty steps of:

- Separating the abuser and victim
- Protecting the scene
- Requesting and ensuring the victim and abuser do not do anything to destroy evidence
- Contact all parties listed on the phone tree

The staff state that other than having to separate the alleged abuser and victim, they have not had to employ the first responder step duties. All staff report feeling comfortable deploying the steps should an incident of sexual abuse take place.

The facility has had one allegation of sexual abuse during the past twelve months. The allegation was not reported until the alleged victim was no longer housed in the facility.

Review
Policy and procedure
Interview with staff
Investigation report

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 list the coordinated response plan as the following:

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

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

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

- Enact first-responder duties
- Management staff shall contact law enforcement
- First responders will notify in-house mental health staff if available and call 9-1-1 to arrange for immediate access to emergency medical and/or mental health services
- Offer to contact rape crisis services, at 330-434-7273, for victim advocate services
- Document incident as a violation report
- Follow all directives of law enforcement

The auditor was given a copy of the coordinated response plan and viewed the posted plan during the onsite visit. Staff interviewed could note the location of the plan.

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

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Review:
Interview with Human Resource Director

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

Residents that are on 90-day retaliation monitoring will also be placed on the facility "whereabout" checklist at an increased rate. The auditor was shown the process and the facility whereabout checklist and identified high risk residents with increased whereabout checks.

The auditor was able to interview the Crisis Counselor during the onsite visit. She states that she has an open door policy for all residents. She will meet with any resident by

request or if they were a witness or victim of a substantiated or unsubstantiated allegation of sexual abuse. The Counselor states that she is trained on providing services to residents who had experienced trauma and can provide these services in addition to conducting weekly status checks.

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

The Program Administrator reports that no resident has reported an incident of retaliation.

Review:
Policy 1080
Whereabout checklist
Interview with Program Administrator

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

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

115.271 (b)

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

115.271 (c)

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

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

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

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 requires an administrative investigation on any allegation on sexual harassment and sexual abuse. This includes allegations received through third-parties or anonymous reports. If the allegation is of sexual abuse/assault or appears to be criminal in nature, the Sexual Abuse Response Team will promptly refer the allegation to the Cuyahoga County Police Department. In instances of sexual abuse or sexual harassment that are not criminal in nature, the facility shall gather and preserve direct and

circumstantial evidence, including any physical and electronic data; interview alleged victims, suspected perpetrators, and witnesses; and review prior complains, and reports of sexual abuse/sexual harassment involving the suspected perpetrator.

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

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

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

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

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

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

The administrative investigators reviewed the one allegations reported at the facility during the past twelve months (see standard 115.222). The allegation was referred to the Cuyahoga County Police Department for a criminal investigation. The administrative investigation determined the allegation unsubstantiated. Due to the length of time that past between the incident and the allegation, the facility was not able to recover any evidence nor were there any witness or alleged abuser to interview. The administrative investigators stayed in contact with the criminal investigators who report that the alleged victim and family did not return any attempts to contact them in order to conduct an investigation. The department closed the investigation until the victim or his family comes to make a report of the allegation. The administrative investigator tried to facilitate a meeting between the victim and the police department but was unsuccessful.

The investigators state that they are not to question a suspected abuser during a criminal investigation. The administrative investigation would only begin at the conclusion of the criminal investigation or with the permission of the legal authority. The investigators

report that they are responsible for maintaining and securing investigation reports for as long as the abuser is incarcerated or in the case of staff abusers until the employee in no longer employed, plus five years for both cases.

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

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 states that the agency imposes a standard of preponderance of evidence or 51% to substantiate an allegation of sexual abuse or sexual harassment.

The auditor interviewed the facility's administrative investigators on the standard of proof used when making allegation determinations. All report using 51% as the measure to substantiate an allegation. The VP of Administration and Legal Counsel will make the final outcome determination.

The auditor reviewed the allegation from the past twelve months to verify the standard of proof used. The allegations were determined with that standard.

Review:
Policy and procedure
Investigation report
Interview with PREA administrative investigators

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

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

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the

resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

The facility had one allegation of resident-to-resident sexual abuse during the past twelve months. The resident-to-resident allegation was administratively investigated and referred to the Cuyahoga County Police Department for a criminal investigation. The Department did not file charges based on the victim not providing any information or participating in the investigation. The administrative investigation determined that the allegation was unsubstantiated.

The auditor received a copy of the notification form and the notification included information included all required information. The facility was not required to notify the victim due to the victim no longer being housed at the facility. The resident was verbal told the outcome when the administrative investigator was trying to persuade the victim to cooperate with the criminal investigation.

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

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The agency outlines its progressive disciplinary plan in its employee handbook. A review of the handbook states that any staff member found to have engaged in sexual abuse will be terminated. Termination or resignation by a staff member who otherwise would have been terminated for violations of the Client Sexual Abuse and Sexual Harassment Prevention, will be reported to law enforcement agencies and any relevant licensing bodies. The handbook also states that employees who have knowledge of resident victimization and do not report it will be terminated.

The auditor interviewed the Human Resource Director during the onsite visit. The Human Resource Director reports that it is agency practice to place a staff member on administrative leave during the course of an investigation. She states the agency enforces their strict zero tolerance policies by terminating employees found to be in violation of the policy, and terminating employees whose allegation was determined to be unsubstantiated but a major violation of the boundaries/integrity policy has been committed.

The auditor reviewed twenty employee files. All files contained acknowledgements of receiving the employee handbook and the agency's zero tolerance policy. Employees who have been disciplined by the agency had a Notice of Employee Disciplinary Action. The documentation listed the disciplinary charge, appeal, information, and sanction. None of the disciplinary charges reviewed were related to PREA. The auditor spoke to the Director about disciplinary action for actions that do not quite meet the definition of sexual abuse or sexual harassment. She states that the agency will terminate all employees that have boundary issues with residents. She also states that employees that are in the orientation phase of employment cannot appeal a disciplinary sanction.

The facility did not have an allegation of sexual abuse or sexual harassment against a staff member during this audit cycle.

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

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

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

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

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

Review:
Policy 1080
Investigation reports
Interview with Human Resource Director

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 requires all residents to face disciplinary action up to and including termination from the program following a substantiated allegation of resident to resident sexual abuse and sexual harassment or a criminal finding of guilt for resident to resident sexual abuse. The policy requires the agency to consider whether a resident's mental disabilities or mental illness contributed to his/her behavior, the resident's

disciplinary history and sanctions imposed for comparable offenses by other residents with similar histories, when determining what type of sanction, if any, should be imposed.

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

The policy also does not allow for offenders to have consensual sexual contact; however, such conduct will not be defined as resident sexual abuse. The policy also does not allow for the discipline of offenders for resident sexual contact with staff unless the staff member did not consent to such contact.

In the resident handbook, the facility has listed Physical assaults/sexual assaults by residents or threats of assault and sexual harassment are not tolerated. The handbook also states that the agency prohibits all sexual activity between residents, which includes hugging, kissing, or touching any body part. Specifically, under the *Client sexual abuse and Sexual Harassment Prevention Guide* in the handbook, the agency details what is considered sexual abuse, sexual harassment, and retaliation. The handbook states that violations of the zero tolerance policy will result in disciplinary sanctions and/or criminal charges.

The PREA information sheet given to residents during orientation group. The sheet gives the residents a clear understanding of what is a good faith report of sexual abuse or sexual harassment versus a bad faith or false/misleading report. The sheet states that residents can be charged with a level three sanctions for falsification.

The Program Administrator reports that termination is the sanction for all resident found to have sexually abused another resident. All other substantiated allegations of sexual harassment will be disciplined according to the agency's progressive discipline policy. She states that the facility has not had a false allegation report during this audit cycle.

The facility had one allegation of resident-to-resident sexual abuse during the past twelve months. The alleged abuser and victim were no longer at the facility when the allegation was reported. The allegation was turned over to the Cuyahoga County Police Department due to the facility not having any evidence to corroborate the allegation.

During resident interviews, all residents were aware of the facility's zero tolerance policy, received a handbook during intake, participated in orientation group and

understood the facility's disciplinary policies. When questioned on the possible sanction for a violation of the policy, all residents stated that termination from the facility would be the consequence for a PREA violation.

Review:
Policy and procedure
Resident handbook
PREA information sheet
Interview with Program Administrator
Interview with residents
Investigation report
Interview with administrative investigators

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The PREA Coordinator reports that residents who experience sexual victimization would be offered services provided by the agency's crisis counselor. The counselor would be available for immediate crisis intervention or to complete weekly status checks. The agency would refer sexual abuse victims to community rape crisis counseling or other appropriate community resources. The counselor also provides trauma response training to Oriana House staff. This training better prepares staff to assist abuse victims.

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

- In the event a resident is a victim of sexual abuse in our facility, the resident will be provided with unimpeded access to both emergency and ongoing medical and mental health care at no cost to the resident
- Once staff become aware of an incident involving the sexual abuse of a resident, the will follow the initial staff first responder duties
- The alleged victim will be afforded unimpeded and timely access to emergency medical and/or mental health services
- The alleged victim will be taken (if necessary) to a hospital that provides SAFE/SANE services. Services will be at no cost to the resident
- The name, address, and telephone number for local medical, mental health, and SANE providers must be listed in the facility's binder that contains emergency phone numbers
- Ongoing medical and/or mental health services that are related to incidents of sexual abuse, will be provide to the resident at no cost

The Coordinator states that the facility is responsible for reviewing the PREA Medical Response Plan annually to ensure that all service provider information is current and that the range of services are still available. Residents are informed of the rights to these services free of charge during PREA education at intake.

The facility has not had an allegation during this audit cycle that required medical or mental health services.

Review:
Policy 1080
Medical Response Plan
Interview with PREA Coordinator

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

During a mandatory monthly PREA training. Staff are notified of the agency's PREA Medical Response Plan. The auditor reviewed the Medical Response Plan. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. The PREA Coordinator states that all ongoing medical or mental health care will be at the discretion of the medical provider and is at no cost to the resident. The facility is responsible for reviewing the plan annually to ensure that all service provider information is current and that the range of services are still available. To see the details of the plan, please see standard 115.282.

The PREA Crisis Counselor states that the agency has not been notified of any known resident-to-resident abuser. This information would be collected at intake in documentation provided to the facility from the resident's parent agency or a resident could self-report during risk assessments. Should the facility become aware that a resident has previously abused another resident, the Crisis Counselor would meet with the resident to assess how to address any underlying issues. The facility does not provide treatment for known abusers. Any available services would be provided by community agencies.

The policy also states that should a pregnancy result from sexually abusive penetration while incarcerated, timely and comprehensive information about and timely access to all

lawful pregnancy related medical services will be offered; however, the facility does not house female residents.

The facility has not received a report of a resident being sexual abused while in a jail, lockup, or juvenile facility prior to intake at this facility during this audit cycle.

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

Review:
Policy 1080
Medical Response Plan
Interview with PREA Coordinator
Interview with Crisis Counselor

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

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

115.286 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

The auditor interviewed the Regional Vice President, VP of Administration and Legal Counsel, PREA Coordinator, Program Administrator and the Program Director on their role on the SART. The Administrator reports that she would report on the facility dynamics that might have contributed to the report, conduct a review of the physical plan to see if there are physical barriers that may have led to the incident, and collect reports from facility staff that may assist in discerning whether the facility could have prevented the incident. The Program Director would ensure facility staff had the resources to comply with the recommendations and report to the PREA Coordinator after implementation. The Program Director will also discuss with the PREA Coordinator any barriers to implementation and possible solutions.

The Regional Vice President and the VP of Administration and Legal Counsel states that they participate in the Executive Team's review of the report and makes recommendations based on the PREA standards.

The facility provided the auditor with the Client Sexual Abuse Review form. The form list a summary of the allegation and findings, the considerations of the committee as listed above, collateral information, and committee recommendations. The second section of the form is completed by the Executive Team. This section lists the approved recommendations, reasons for not approving recommendations, and the implementation plan.

There was one allegation of sexual abuse that was reviewed by the SART during the past twelve months. The allegation was determined to be unsubstantiated. The team who reviewed the report was the VP of Programs for Cuyahoga County, Program Manager Admissions, Administrative Investigators, Clinical Manger, and the Program Manager. The review determined that because the incident happened in the dorm room, the staff was unable to monitor that location from surveillance cameras. The SART made a recommendation to place cameras in all dorms. The Executive Staff Review did not

approve the recommendation. The team felt as if placing cameras in dorm areas went against Oriana House philosophy and felt that cameras could possibly create more problems. The recommendation was not implemented. The Program Director states that while the cameras were not placed in the dorms, the facility has increased the number of circulations in all blind spot areas.

Review:
Policy 1080
Client Sexual Abuse/Harassment Review form
Interview with PREA Coordinator
Interview with VP of Administration and Legal Counsel
Interview with Regional Vice President of Programs
Interview with Program Director
Interview with Program Administrator

Standard 115.287: Data collection

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

115.287 (a)

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

115.287 (b)

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

115.287 (c)

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

115.287 (d)

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

115.287 (e)

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

115.287 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires the tracking of accurate, uniform data for every allegation of sexual abuse in all Oriana House facilities and that information will be aggregated at least annually. The PREA Coordinator reports that the information is collected, reviewed, and retained from all PREA related reports. The agency is using Ohio Department of Rehabilitation and Corrections PREA reporting form as their collection instrument.

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

The information on the form is aggregated and listed in the agency's annual PREA report. The report is posted on the agency's website, http://www.orianahouse.org/accreditations/prea/prea.php. The auditor accessed the agency's website and reviewed the 2018 annual report. The report contains the aggregated sexual abuse and sexual harassment allegation data from all Oriana House, Inc. operated facilities.

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

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

Standard 115.288: Data review for corrective action

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

115.288 (a)

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

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

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

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The auditor reviewed the report and ensured that the report compares the current year's data with those of previous years and includes updates made from previous year's reports. The report states that the agency has:

- Installation of camera equipment to cover additional areas of concern and an increase of staff supervision in the identified areas of concern
- Increase awareness of internal and external victim advocates which entailed: 1) identifying the facility's victim advocate and the external victim advocate contacts; 2) every external advocated provided signage to be posted in the facility to increase resident access to information; 3) PREA Staff Guide manuals where updated with the internal and external advocate contact information; 4) all staff are receiving additional training on who the internal advocate is for their facility through the monthly PREA Refresher Trainings.

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

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

Review:
Policy 1080
PREA annual report (2018)
Oriana House website

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

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

115.289 (b)

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

115.289 (c)

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

115.289 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The auditor accessed the agency's website, www.orianahouse.org/accreditations/prea/prea.php, to ensure that the agency has posted its annual report. The annual reports are completed based on a calendar year and the agency has posted the 2018, 2017, 2016, 2015, and 2014 annual reports. The information in the report is collected by each facility's PREA Manager and is then submitted to the agency's PREA Compliance Specialist. The agency PREA Compliance Specialist aggregates the information and prepares the information for the annual report. The report is then submitted to the PREA Coordinator for approval.

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

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

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

Review:
Policy 1080
Oriana House website
PREA annual reports 2014-2018
Interview with PREA Coordinator

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

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

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The agency post all final PREA reports of each of its facilities on the agency website. The auditor reviewed the agency website to ensure that during the previous audit cycle all Oriana House facilities had been audited. The agency has a total of twelve facilities that require PREA audits (one facility has just opened and will have its initial PREA audit after a year of collection documentation). The Audit for MCCBCF is being completed with another Oriana House operated facility, Fannie M. Lewis Community Corrections and Treatment Center. These two audits will be the first two of four to be completed during the first year of the new audit cycle.

The auditor was given full access to the facility during the onsite visit. The Program Director, Program Administrator, Lead Resident Supervisor, and PREA Coordinator escorted the auditor around the facility and opened every door for the auditor. The facility provided the auditor a private room in order to conduct staff and resident interviews. The auditor received documentation on the agency and facility prior to the onsite visit through Power DMS web based audit system. The auditor was also provided requested documentation during the onsite visit.

The auditor reviewed electronic documentation during the onsite visit. This includes camera views and ORION resident database system. The auditor reviewed ten resident files and twenty staff files for additional documentation and confirmation of reported information.

Appropriate audit notices were posted in conspicuous areas throughout the facility. These places included areas resident, staff, and visitors would frequent. The notices included the auditors mailing and email addresses. The PREA Coordinator sent the

auditor photographic proof of the notices being posted approximately four weeks prior to the onsite visit. The auditor did not receive any correspondence with a staff or resident prior to or after the onsite visit. During the onsite visit no resident or staff member requested to speak to the auditor.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has published on its agency website, www.orianahouse.org/accreditations/prea/prea.php, the final PREA reports for all Oriana House operated facilities. The final PREA report for MCCBCF from the previous audit is currently posted. The auditor reviewed the agency website and verified that all the facilities that were audited during cycle two and had their final audit report posted. The PREA Coordinator states that she understands the requirement of having all final reports

posted. In the state of Ohio, all final audit reports are also posted on the Ohio Department of Rehabilitation and Corrections website, https://www.drc.ohio.gov/prea.

AUDITOR CERTIFICATION

I certify that:

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

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Kaylee Murray October 31, 2019

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.