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

☐ **Interim** ☒ **Final**

Date of Report Click or tap here to enter text.

Auditor Information

Name: Kayleen Murray	**Email:** kmurray.prea@yahoo.com
Company Name: Click or tap here to enter text.	
Mailing Address: P.O. Box 2400	**City, State, Zip:** Wintersville, Ohio 43953
Telephone: 740-317-6630	**Date of Facility Visit:** March 4-8, 2019

Agency Information

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

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

Agency Website with PREA Information: www.orianahouse.org

Agency Chief Executive Officer

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

Agency-Wide PREA Coordinator

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

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

Facility Information

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

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Facility Website with PREA Information: www.orianahouse.org

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

Director

Name: Rebecca Krezimski	**Title:** Program Administrator
Email:	**Telephone:**

Facility PREA Compliance Manager

Name: Rebecca Krezimski	**Title:** Program Administrator/Facility PREA Compliance Manager
Email: rebeccajkreminski@orianahouse.org	**Telephone:** 330-996-7596 x3106

Facility Health Service Administrator

Name: N/A	**Title:** N/A

Email: N/A		**Telephone:** N/A	
Designated Facility Capacity: 69		**Current Population of Facility:** 64	
Number of residents admitted to facility during the past 12 months			380
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			1
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			240
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			336
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	☒ Adults Male = 22-67; Female = 21-49	☐ Juveniles N/A	☐ Youthful residents N/A
Average length of stay or time under supervision:			
Facility Security Level:			Minimum
Resident Custody Levels:			minimum
Number of staff currently employed by the facility who may have contact with residents:			18
Number of staff hired by the facility during the past 12 months who may have contact with residents:			20
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			10
Physical Plant			
Number of Buildings: 1		**Number of Single Cell Housing Units:** 0	
Number of Multiple Occupancy Cell Housing Units:		2 housing units/12 dorms	
Number of Open Bay/Dorm Housing Units:		0	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): DVRs in server rooms with 30 day retention period.			
Medical			
Type of Medical Facility:		N/A	
Forensic sexual assault medical exams are conducted at:			
Other			
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:			24 contractors/26 volunteers

Number of investigators the agency currently employs to investigate allegations of sexual abuse:	2

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 Residential Correctional Center (RCC) Halfway House, 222 Power Street, Akron, Ohio, was conducted on March 4-8, 2019. The facility is a part of Oriana House, Inc. operated community confinement programs. The goal of the audit is to ensure operational compliance with the Prison Rape Elimination Act standards for community confinement facilities. RCC is receiving this audit in conjunction with another Oriana House, Inc. operated facility (Residential Institutional Probation Program) also located in Akron, Ohio. The facilities operated under the same policies and procedures, and have the same administrative staff oversite. The auditor was able to interview administrative staff (Human Resource Director, Administrative Investigators, PREA Coordinator, PREA Compliance Specialist, and Agency Head) for both facilities during the onsite visit for both facilities. All other interviews are specific to the facility.

The facility elected to use Power DMS to upload documentation relevant to showing compliance with each standard. The auditor received notification that the information was available approximately four weeks prior to the onsite visit. The information included the pre-audit questionnaire, policy and procedures, MOUs, facility staffing plan, table of organization, job descriptions, and post orders. The auditor received photos showing proof of audit notices posted in client and staff areas six weeks prior to the onsite visit. The auditor was met with agency and facility staff prior to the onsite visit and discuss the audit schedule, changes since the last PREA audit, and additional information/documentation needed by the auditor. The auditor has conducted the audits for this agency in the past, including RCC's initial audit in 2016. The auditor reviewed the prior final audit report and previous documentation for comparison to the current audit.

The audit notice posting photographs sent to the auditor, showed the dates of the onsite visit; the name, address and email address of the auditor; and the availability to have private correspondence with the auditor. The auditor did not receive any correspondence

from clients or staff prior to the onsite visit. The auditor had three clients request for an interview during the onsite visit. All three clients wanted to discuss their issue with the facility removing the shower curtains. The auditor was able to view all bathrooms during the onsite visit, and the shower stalls provided privacy without the need of a shower curtain.

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

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

The auditor selected sixteen clients to interview based on the population of sixty-four (64) during the onsite visit. The clients were based on the requirements of the PREA Resources Center's Auditor's Handbook. The clients were selected based on their housing unit, targeted interview status, risk assessment screening, intake dates, and commitment status. The auditor conducted the following client interviews:

- Random = 10
- Targeted = 3
- Requested = 3

The breakdown of the number of targeted interviews is as follows:
Clients that identify as lesbian, gay, or bisexual = 12
Clients that have a physical or cognitive impairment = 3
Clients that have reported prior sexual victimization during risk screening (in the community) = 8

*Where there are multiple clients in targeted categories, only one is being counted toward the targeted interview. The other clients in those categories were counted as random interviews.

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

The facility has eighteen (18) staff members, including the Program Administrator. The auditor was able to talk with agency leadership during the onsite visit, which includes:

- Mary Jones, PREA Coordinator
- Lori Schoenfelder, PREA Compliance Specialist

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

- Human Resource Director, Jodi Glitzenstein
- Administrative Investigators, Denny Sizemore and Jim McFarland
- Program Administrator, Rebecca Krzeminski
- Risk of Victimization/Abusiveness screener
- Retaliation monitor
- SART team members
- First Responders (security and non-security)
- PREA education facilitator

The random staff interviews include Resident Supervisors (RS) and Programing staff. The auditor interviewed security staff from all three shifts. Due to the limited number of staff, the auditor was unable to interview the required twelve random staff members. Several staff members were responsible for more than one specialized area. All staff interviews, random and specialized, were conducted using the PREA Compliance Audit Instrument Interview Guide and the PREA Auditor Handbook's Effective Strategies for Interviewing Staff and Client Guide. The auditor was able to ask questions on the

agency's zero tolerance policy, training, reporting protocols, first responder duties, coordinated response plan, grievance procedures, investigation protocols, confidentiality, retaliation monitoring, risk screening, protection from abuse, LGBTI policies and procedures, data collection, annual reports, staffing plans, electronic surveillance, reporting to other confinement facilities, disciplinary procedures, searches, knock and announcements, cross-gender supervision policies.

The auditor reached out to community resources via phone to confirm the MOU's and scope of services. These community partners include the SANE nursing coordinator from Akron City Hospital and a representative from Rape Crisis Center of Medina and Summit Counties. The auditor was able to confirm the services each agency would provide to RCC free of charge.

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

Facility Characteristics

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

Residential Correctional Center is a halfway house facility in Akron, Ohio that serves female offenders. The facility is a three story brick building built in the 1930's that can house sixty-nine (69) offenders. The annual average daily number of clients is reported at fifty-four (54) offenders and during the onsite visit, the client population was sixty-four (64). To access the facility one must be let into the building by staff and report to the lobby area where all residents, staff, and/or visitors must be signed in. Residents will receive a pat down that is visible by video surveillance or residents may receive an enhanced pat down (residents receiving an enhanced pat down will be moved to a room where they will strip down to their underclothes) which is also visible by video surveillance (see standard 115.215 for a detailed description of a pat and enhanced pat search).

RCC is a three story brick building. Client living areas are on the first and second floors as well as staff offices and posts. Staff offices, one client lounge, classrooms, storage closets and the laundry room are located in the basement. An exterior recreation yard is

enclosed with fencing. The hallways on the third and second (main) floors have bulletin boards with PREA postings. These posting include in-house and outside reporting information (toll-free hotline numbers, email addresses, and mailing addresses), local, state, and national rape crisis organization contact information, and ways one can report an allegation of sexual harassment or sexual abuse. The hallways on these floors also have pay phones that allow for free calling to reporting and rape crisis agencies. Clients are allowed to have personal cell phones. Clients can use their cell phones to contact reporting or rape crisis agencies.

All rooms, offices, and classrooms within the facility have windows in the doors to offer good line of site views and the use of mirrors to capture areas that are not immediately seen by looking through the window. While there are two stairwells in the facility, the clients are only allowed to use one. This stairwell is equipped with security mirrors on each landing. The laundry room is located in the basement area and is locked. Staff are required to open the door for clients, but do not enter in the room with them. Staff can visually see clients in the laundry room with the use of a security mirror.

The auditor entered all dorm rooms. Dorm #1 can house up to 6 residents, dorm #2 can house up to 9 residents, dorm #3 can house up to 12 residents, dorm #4 can house up to 2 residents, dorm #5 can house up to 2 residents, dorm #6 can house up to 2 residents, dorm #7 can house up to 9 residents, dorm #8 can house up to 6 beds, dorm #9 can house up to 9 residents and dorm #10 can house up to 6 residents. The two bed-rooms have a toilet and sink inside the room.

The dorms are set up with the beds and lockers around the perimeter of the room. The room design and security mirrors provide for clear line of site views from the doorway. The auditor noted the dorm room assigned to clients who may need increased monitoring from Resident Security staff. Staff are aware of any client that may need more monitoring for any reason by the number of required “whereabout” checks list on the daily count sheet.

There are four bathrooms for clients in the main housing unit. There is a solid door at the entrance of all bathrooms and each is set up to provide clients an appropriate level of privacy (see standard 115.215 for detailed bathroom descriptions). Staff members are required to increase the number of circulation checks in the bathrooms due to it being designated a blind spot area.

The outdoor recreation yard for the main housing unit is surrounded by a 10-foot fence. The area has a section that is blocked off due to this area being designated a blind spot. The clients have free access to the recreation yard during open hours (6am – dusk).

The dining hall/multipurpose room has cameras and a wall of glass that separates the room from the hallway across from the main post. Clients have access to the dining hall at all times. Off the dining hall is a serving room. This room is used for the setup of all meals. Aramark staff deliver meals to the facility under the supervision of RS staff.

The facility has sixteen (16) cameras with the camera at the main post having the ability to record audio. The cameras can record and playback up to thirty days. Security staff have access to these cameras at the main post. Administrative staff can access the cameras from their desktop computers.

Summary of Audit Findings

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

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

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

115.231

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

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

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

N/A

Summary of Corrective Action (if any)

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

PREVENTION PLANNING

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

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

115.211 (a)

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

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

According to the agency's table of organization, the agency wide PREA Coordinator is the agency's Vice President of Administration and Legal Counsel, and reports directly to the agency's executive Vice President of Administrative Services and Business Relations. During an interview with the PREA Coordinator, she indicated that the bulk of her responsibilities are to ensure that each facility under the Oriana House umbrella complies with the standards. She indicated that she has enough time and authority to develop, implement, and oversee the agency's efforts to comply. The PREA Coordinator supervises the agency's PREA Compliance Specialist, as well as each facility's PREA Compliance Manager.

The agency has a PREA Compliance Specialist that acts as a liaison between the PREA Coordinator and the facility's PREA Manager. The PREA Compliance Specialist helps with implementing PREA strategies at each facility. She also develops the training curriculum for required monthly PREA training at each facility. During an interview with the PREA Compliance Specialist, she discussed providing facilities guidance and assistance in complying with the standards. She is a Department of Justice Certified PREA Auditor and reports directly to the PREA Coordinator.

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, and 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 Administrator works directly with the Compliance Specialist and 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.

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's job description
Agency table of organization
Interview with PREA Coordinator
Interview with PREA Compliance Specialist
Interview with PREA Manager

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable

attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

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

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

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

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

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The facility provided the auditor with their most recent staffing plan. The staffing plan reviewed the availability of video surveillance (sixteen 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 24 hours a day, seven days a week, three hundred sixty-five days per year. The plan also identified the minimum number of staff for each shift:

1st Shift from 7am to 3pm: 2 Resident/Shift Supervisors
2nd Shift from 3pm to 11pm: 2 Resident/Shift Supervisors
3rd Shift from 11 pm to 7am: 2 Resident/ Shift Supervisors

There are no vacant positions listed on the staffing plan and the Program Administrator states that the facility has not deviated from the staffing plan.

The floor plans provided to the auditor include locations that have video surveillance (16 cameras), audio surveillance (at main post only), security mirrors (26), 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 building is also equipped with an intercom system. 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, and ensure the intercom system works. The facility has not identified on its staffing plan the need for increased video monitoring systems.

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

health issues are required to have six whereabout checks. 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 allegation of client-to-client sexual abuse and one allegation of staff-to-client sexual abuse during the past twelve months. Both allegations were determined to be substantiated. The auditor discussed the allegations reported at this facility with the agency investigators. The investigators state that a camera was moved based on an allegation along with procedural changes to transports and staff supervision in areas that do not have cameras or clear lines of site views.

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

Review:
Policy 1080
Staffing Plan
Floor plan
Video monitors
Deviation report
Interview with Program Administrator
Interview with agency investigators
Building tour

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

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

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

115.215 (c)

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

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

115.215 (d)

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 8089 outlines Oriana House's agency search procedures. The policy does not allow for strip or body cavity searches. The policy also does not allow cross-gender pat searches. The policy states that pat (a search overtop the first level of street clothing) or enhanced pat (a search overtop underclothing) searches will be completed by a member of the same gender in a professional and respectful manner. This is a female only facility. Male staff members are not allowed to search female clients, per policy.

During the onsite visit, the auditor was able to view the room that is used for pat searches and the room used for enhanced pat searches. Both searches will be conducted in rooms that have video surveillance. The PREA Coordinator and PREA Compliance Specialist both explained the process for conducting an enhanced pat search. Two staff members of the same gender as the client will perform the search. The monitor that can view into that specific room will be blacked out from the monitoring station. The camera will record the session in case an allegation would arise from the search.

The auditor watched a pat search while at the onsite visit. The search was conducted in accordance with agency policy 8089. In the pat search area are posted notices of the expected steps for a pat search. Clients 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 clients. The policy does not allow for transgender/intersex clients to be searched

for the sole purpose of determining a client's genital status. Searches are to be conducted in a professional and respectful manner and in the least intrusive manner possible. The agency will meet with a transgender/intersex client before placement and determine the gender of the staff that will conduct searches. Each determination will be done on a case-by case basis. A duel search (one male staff and one female staff) of a transgender/intersex client is strictly prohibited. All searches of a transgender client are required to be documented in the agency's client database system.

RCC Halfway House would house a transgender/intersex client. There facility did not have a transgender/intersex client during the onsite visit. The facility has, in the past, housed a transgender client. The auditor interviewed the Program Administrator about the management of those specialized clients. During the interviews it was reported that no transgender or intersex client has been searched in an effort to determine his/her genital status, all searches have been conducted in a professional and respectful manner, and the client was allowed to voice his/her preference on the gender of staff that completed the searches.

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

The auditor was able to interview random and targeted staff during the onsite visit. All security staff interviewed where asked about their training concerning transgender/intersex clients. All staff reported to the auditor that they were comfortable with the training provided, and felt they could conduct searches in a respectful and professional manner based on their training. The staff reports that male RS staff are only allowed to operate the main post. They do not do circulations, whereabout checks, or searches. The lead resident supervisor discussed with the auditor her practice of reviewing pat searches either in person or reviewing video footage in order to ensure pat searches are completed according to policy and make correction if necessary.

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

The building has two housing units and four bathrooms. The bathroom has a solid door at the entrance. There are two toilet stalls with custom made doors that allow for privacy but also visibility for security staff. There are three sinks with mirrors above. The shower area is at the back of the bathroom. There are two shower stalls, one on the right and one on the left, with a middle area that is open to the bathroom. Upon entering the bathroom, one cannot see into the showers unless they walk into the middle area. Clients in the shower can view the client in the other shower because there are no shower curtains covering each entrance. There is a private single use bathroom next to the main post that is used for urinalysis and enhanced pat searches. If requested, transgender/intersex clients would have use of this private bathroom.

The auditor was able to interview sixteen clients during the onsite visit. The clients were asked about privacy for changing, showering, and performing bodily functions. All clients stated that all staff announce themselves before entering the bathroom, they knew the facility's dress policy concerning changing only in bathrooms, and did not encounter an incident of cross-gender viewing.

The Program Administrator reports that there are no documented incidents of cross-gender viewing.

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

Review:
Policy 1080
Policy 8089
Facility tour
2015 PREA audit report
Interview of target clients
Interview of random clients

Interview of staff
Interview of PREA Coordinator
Interview of Program Manger
Interview of PREA Compliance Specialist

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

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

The auditor interviewed any client that identified as having a reading or cognitive disability. No client in this targeted category were in need of any additional services in order to benefit from the agency's effort to prevent, detect, or respond to sexual abuse or sexual harassment. All clients interviewed were capable to describing the facility's zero tolerance policy, reporting options, and services that are provided free of charge to any client that request such services. The facility did have clients that were identified as English as their second language; however, these clients were not limited English proficient. The auditor interviewed these clients and verified that they understand

English and had no issues understanding the facilities rules and regulations concerning the PREA standards.

During the onsite visit the auditor interviewed the Program Administrator on the facility's policy to accommodate clients that may have reading, cognitive, sensory, or English proficiency limitation. The Administrator reports that should a client be in need of services, it would be documented in the facility's client database system along with the type of assistance needed. The Administrator indicated that an appropriate staff member may be tasked with providing assistance to the client during their stay or the facility would provide auxiliary items or interpreter services should it be necessary.

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

Review:
Policy 1080
Policy 8004
PREA Plan to Assist Residents with Disabilities
Client intake materials
Interviewed target clients
Interviewed Program Administrator

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

During the staff file review. The Human Resource Director provided the auditor with the file of a staff member who was terminated because of failing to report an arrest. The arrest did not involve sexual abuse or sexual harassment. The Director reports that during the five year background check, it was discovered that the staff member had been arrested earlier that year, but failed to report the arrest to the supervisor.

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

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

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

The auditor conducted a review of twelve 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

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The Program Administrator 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 Administrator 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 not made any changes to its video monitoring system since the last PREA audit.

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

Review:
Floor plan with additional camera placement
Video monitoring station
Interview with Program Administrator

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

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

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination

issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The PREA Coordinator states that any allegation of sexual abuse or sexual harassment will be administratively investigated by a trained internal PREA investigator, and when necessary, criminally investigated by the agency with legal authority to conduct such investigation. The agency has shown the auditor a request to enter into a formal MOU with the Akron Police Department to investigate any allegation of criminal sexual abuse and/or sexual harassment at RCC. The deputy chief of police has sent the agency an email where he agrees that the department has jurisdiction to investigate any criminal activity and has responded to request for a criminal investigation for Oriana House, Inc. facilities in the Akron city limits. 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

A review of the allegations at RCC for the past twelve month indicates that one allegation of staff-to-client sexual abuse was referred to the Akron Police Department for a criminal investigation. The department conducted a criminal investigation in conjunction with an allegation from a non-RCC client. The department chose not to refer the case for prosecution from the RCC client; however, the client did testify against the staff member during the other case.

Clients that are in need of a forensic medical examination will be taken to SUMMA Health System in Akron, Ohio. The auditor spoke with the SANE Nurse Coordinator who stated that hospital would provide Sexual Assault Nurse Examiners to any client from the Oriana House when necessary free of charge. The hospital employs SANE nurses at SUMMIT- Summa and SUMMIT-Akron General. The Coordinator reports that SANEs are on duty for most shifts; however, should one not be available, the hospital would make the on-call nurse available. The supervisor states that the hospital has never provided SANE services to any client at RCC.

The facility provided the auditor with documentation of a MOU with Rape Crisis Center of Medina and Summit Counties. Services in the MOU include a toll-free hotline number, emergency room advocates, emotional support, crisis intervention, community resource referrals, and assistance during law enforcement interviews and/or court proceedings. The auditor spoke with a representative from the organization who has confirmed the services offered to the clients at RCC and these services are free of charge to the clients. The representative states that no one from the facility has requested any of these services.

The PREA Coordinator states that every effort is made to provide a victim advocate from rape crisis agency; however, should one not be available, the facility's Crisis Counselor has been trained by Ohio Department of Rehabilitation and Correction to serve as an emotional support person.

The facility offers emotional supportive services for all clients that report sexual harassment or sexual abuse. During the past twelve months, one client has received services from the emotional supportive staff member.

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

Review:
Policy 1080
Rape Crisis Center of Medina and Summit Counties MOU
Akron Police Department MOU request
Akron Police Department email
Interview with SANE Nursing Coordinator
Interview Rape Crisis Center representative
Training certificates
Investigation reports

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

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

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

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

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The auditor reviewed the agency's website (www.orianaouse.org//accreditations/prea/prea.php) to ensure that the investigative policy for PREA allegations was posted. The website advises that all allegations of sexual abuse will be referred to the local legal authority for a criminal investigation. The

website also gives notice that all allegations (criminal or not) will have an administrative investigation conducted by a trained investigator. Sexual abuse allegations will receive an administrative investigation at the conclusion of a criminal investigation. The criminal investigatory agency will make referral to the local prosecutor for any allegation deemed appropriate according to their agency policy.

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

Investigation #1: A client made a verbal report of client-to-client sexual harassment and abuse. The client reported to staff members that another client was making unwanted sexual gestures and verbal comments towards her and then escalated to touching her breast. The allegation was administratively investigated and determined to be substantiated. The clients were separated and placed on watched during the investigation. The investigators were able to interview a witness who corroborated the allegation and the abuser admitted to the behavior. The abuser was terminated from the facility; however, the allegation did not reach the level of criminal behavior and was not referred for criminal investigation.

Investigation #2: The facility received a third-party report from a judge that a staff member maybe having a sexual relationship with a client. The staff member was not assigned to RCC but was filling in. The staff member was stopped from working at RCC during the investigation. The staff member was accused by a non-RCC client of sexual assault. During the investigation, the relationship with the current client was discovered. Akron Police Department's Detective Brown conducted a criminal investigation into the allegation. The RCC client admitted to sexual activity inside a closet at the facility. The camera coverage for that area shows the client and staff member entering the closet, but not what happens once inside. The staff member was arrested and terminated from the facility. The prosecutor's office did not take the RCC client's case to trial; however, the RCC client did testify against the staff member at the non-RCC client's trial. Another RCC client came forward later and stated that this staff member also groped her on the way to an NA/AA Meeting. The staff member was convicted and sentenced to one year in prison, five years probation, and fifteen years sex offender registry.

Review:
Policy 1080
Agency website
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 juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

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

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

During staff interviews, most commented on using role-plays and games to remember agency policies, procedures, and practices. The Program Administrator is responsible for conducting monthly PREA training. The Program Administrator states that should a staff member miss a training, she will try to provide a brief one-on-one summery of the training along with the material, or provide the material and ensure the staff member is responsible for knowing the information.

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

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

Review:
Policy 1080
PREA training power point
Training records
Interview with Human Resource Director
Interview with Program Administrator
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 clients receive training on the agency's policies and procedures relating to sexual abuse and sexual harassment. The level and type of training provided will be based on the services provided and amount of contact with the clients. Minimally, all contractors and volunteers will be informed of the agency's policies and how to report allegations.

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

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

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

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

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

Standard 115.233: Resident education

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

115.233 (a)

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

115.233 (b)

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

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

During the onsite visit, the auditor noted various posters in English and Spanish throughout the facility. The posters provided information to clients, visitors, and staff on how to report allegations and phone numbers and address to reporting agencies. The auditor used the payphone in the dayroom to call the outside reporting agency. The phone number listed connected the auditor with a PREA hotline recorded message that requested certain information in order to investigation the allegation. The recording reminded the caller that they could report anonymously and that all allegations would be investigated. The 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 Program Administrator is responsible for providing clients with PREA education during orientation. The Program Administrator states that during orientation, the clients will be shown a video produced by Just Detention. She will then provide the clients with facility specific information and answer questions.

The auditor interviewed sixteen clients (targeted and random) during the onsite visit. The clients interviewed stated that at intake the staff member read all the intake packet material, they received a tour where reporting information was pointed out to them, and they have a client handbook that contains the information reviewed at intake. The clients also talked about PREA education during orientation group. Clients stated that staff showed them the "PREA video" and reviewed what behavior is considered violations of the zero tolerance policy.

Review:
Policy 1080
Client intake packet
Client handbook
PREA posters
PREA reporting phone numbers
Client files
Interview with clients
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 have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 two investigators as well as the PREA Compliance Specialist who received in-person training from the Moss Group. The training provided includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garity warnings, evidence collection in a confinement setting, and required evidence to substantiate a case for administrative action or criminal referral. The agency retains completion of training certificates as proof of training.

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

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

Review:
Policy 1080
Training curriculum and material
Training certificates

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

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

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

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

RCC does not have employed or contact medical staff at the facility. All forensic exams would take place at a SUMMA Health System facility.

The facility does not employ nor contract with mental health practitioners. The PREA Coordinator states that all clients needing mental health care will be referred to a community practitioner (Portage Path or Summit Psych). The agency does employ crisis counselors. These counselors provide crisis intervention and make referral to community resources. The counselors receive the mandated employee training as well as the PREA mental health professionals training.

Review:
Policy 1080

Training Certificate
Interview with PREA Coordinator

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

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

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

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

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

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

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

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

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

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

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

a. Whether the client has a mental, physical, or developmental disability
b. The age of the client
c. The physical build of the client
d. Whether the client has a prior conviction for sex offenses against an adult or child

e. Whether the client is or is perceived to be gay, lesbian, bisexual, transgender, gender non-conforming, or intersex
f. Whether client has previously experienced sexual victimization
g. The clients own perception of vulnerability
h. Prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse

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

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

The auditor was given a copy of the risk assessment instrument. After the screening is complete, the screener will score the instrument based on the client's answers. The client can receive a classification of susceptible, highly susceptible, abusive, highly abusive, or no risk. The Resident Supervisors interviewed stated that they are allowed to override the score based on the interview.

The auditor interviewed two case managers who states that they completes a quality assurance check on initial screenings. The case managers are able to add information to the screening based on additional information that the Resident Supervisor would not have access. The Program Coordinator also performs a quality assurance check on initial and reassessment. She states that once screenings are complete, the classification is entered into the client database system while the paper form is placed in a client's file and if a client has an assessment classification of highly susceptible or highly abusive, they will be automatically reassessed before 30-days. All other assessment classifications are only reassessed due to new information, referral, request, or incident of sexual abuse. This reassessment can happen at any time during the client's stay. The reassessment will be conducted by the client's case manager.

The auditor interviewed sixteen clients during the onsite visit, including clients that have received both an initial and reassessment. All clients interviewed stated that they

received an initial assessment the day they reported to the facility. All clients understood the purpose of safety for the assessment.

The auditor also reviewed ten client files during the onsite visit. Each file contained the client's completed risk assessment, signature of quality assurance check, and date of reassessment if necessary. If the client needed a reassessment, the form was also contained in the file. During the past twelve months, the facility completed Three hundred thirty-six (336) initial risk assessments and thirty-six (36) reassessments. All assessment information is kept in the client's file which only limited staff have access.

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

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing:

transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

statuses will receive six whereabout checks per shift. Only the Program Administrtor or the Lead Resident Supervisor can remove a client 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 agency has developed a team that includes the PREA Coordinator, PREA manager, admissions personnel, crisis counselor, and the offender that will address issues that come with the placement of a transgender client. The PREA Coordinator states that the team will meet prior to meeting with the client to discuss which facility under the Oriana House umbrella is the best facility for placement. The client will be interviewed and have an opportunity to voice concerns to their own safety, opportunities to shower separately, and program assignments. The review team will consider the ability of the facility to ensure the client's health and safety, and whether the placement would present management or security problems.

There were no clients that identified as transgender/intersex during the onsite visit; however, the facility has housed transgender clients in the past. The auditor was able to interview staff who have experience working with transgender clients. The staff reported to the auditor that their training appropriately prepared them for working with this specialized client. They report that the client was placed in a room closer to a staff office, had increased whereabouts, and private shower time opportunities. No staff member reported any issues while working with this client.

Review:
Policy 1080
Interview with Case managers
Interview with PREA Coordinator
Interview with staff

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

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

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

During the onsite visit, the auditor was able to see various postings in English and Spanish informing clients on the ways to report sexual abuse, sexual harassment, or retaliation. The postings included the phone numbers, website address, and email address. The auditor called the phone numbers posted as ways to report an allegation using the client payphones. Both the Oriana House hotline and the outside third party hotline could be reached toll-free and consisted of a recording message asking the caller to leave a message with the details of the allegation and that if the caller wished, could remain anonymous. The auditor received a return phone call from the outside hotline agency. The agency representative confirmed they would report all allegations to the PREA Coordinator. The auditor also sent an email to the email address posted. The auditor received a return message from the agency administrative investigator within two hours from the auditor's initial email. The auditor reviewed the agency website and the links for complete a report for an allegation of sexual abuse or sexual harassment. The links lead to a Client Sexual Abuse/Harassment Reporting Form and instructions to

complete the form and return to the email listed on the form (SexualAbuseReporting@orianahouse.org)

During the past twelve months, the facility has received a total of two allegations. One of the allegations was a client verbal report to staff. The other allegation report was a third party report. The verbal report from the client to staff was documented on the Client Sexual Abuse/Harassment Reporting Form and forwarded to the PREA Coordinator and administrative investigators. The auditor was able to review all allegations with the administrative investigators.

During the onsite visit, the auditor interviewed a total of sixteen clients. The clients were asked questions in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Clients. This includes questions on ways a client can report, private and anonymous reporting, and how clients received this information. Out of the sixteen clients interviewed, all sixteen agreed that they received PREA reporting information at intake, that the reporting phone numbers and email address were listed in the client handbook, they knew the location of PREA posters which contained the information, and that they could report an allegation privately to any staff member, contractor, or volunteer verbally or writing.

During staff interviews, the auditor was able to discuss reporting methods with both targeted and random staff. All staff interviewed were able to describe the reporting process should a client give them a verbal or written allegation of sexual abuse or sexual harassment. The staff was asked about privately reporting allegations or suspicions of sexual abuse or sexual harassment. All staff interviewed stated that the Facility Director is available for private reporting of allegations or suspicions of sexual abuse or sexual harassment. Staff interviewed also stated that they could privately report by calling or emailing the PREA Coordinator or administrative investigators directly.

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

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

☐ **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 client grievance regarding sexual abuse. The agency has an explicit policy and procedure (policy 1080: Client Sexual Abuse and Sexual Harassment Prevention) that addresses all aspects of the agency's compliance with the PREA standards. The Coordinator states that should a client file a grievance alleging sexual abuse or sexual harassment, the allegation will be investigated under agency policy 1080.

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The facility has placed posters in English and Spanish around the building in conspicuous places that provide the telephone number and address to the local victim advocate and

emotional supportive services agency. A review of the client handbook shows a listing of the addresses and telephone numbers to state and national victim advocate agencies.

RCC has an MOU with Rape Crisis Center for Medina and Summit Counties. The MOU states that facility has the agency's permission to provide clients at RCC the organization's toll-free hotline number and address, and that agency agrees to provide the clients emotional supportive and rape crisis services. The auditor was given a copy of the MOU to review.

After the onsite visit, the auditor contacted Rape Crisis Center of Medina and Summit Counties. The organization's representative was able to confirm that the agency would provide rape crisis and emotional supportive services to any client at RCC who has experienced sexual abuse. The representative confirmed the hotline number and the address provided to the clients would in fact contact a client with an agency advocate.

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

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

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

Review:
Policy 1080
PREA Postings
Rape Crisis Center MOU
Client Handbook
Interview with Rape Crisis Center representative
Staff interviews

Client 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 within two hours 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 client. The notices include toll-free hotline numbers and the email address that is listed on the agency website.

The agency received one outside third-party report. The allegation was administratively and criminally investigated.

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

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

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

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

During staff interviews, staff stated that they understood the reporting process, who they are required to report allegations of sexual abuse, sexual harassment, or retaliation to, and that all allegations must be investigated by a trained investigator. All staff interviewed could tell the auditor the location of the "PREA Book" that contains the proper forms, instructions, and reporting phone numbers. When asked about private reporting, staff stated that they have access to the PREA Coordinator, Administrative Investigators, or PREA Compliance Specialist and could make a private report with any of those people.

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

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

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

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

Review:
Policy 1080
Policy 1005
Policy 1027
Employee files
Client files
Intake interview
Interview with PREA Compliance Specialist
Interview with staff

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

In reviewing the administrative investigations from the past twelve months, the facility has placed the staff member on restriction from working in this facility during the initial stages of the administrative investigation. As the investigation progressed the staff member was placed on administrative leave during the investigation. The facility separated and increased whereabout watches (every 15 minutes) on an alleged client abuser during the administrative investigation and the abuser was terminated from the facility once the allegation was determined to be substantiated.

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

Review:
Policy 1080
Investigation reports
Interview with PREA Coordinator

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

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

During the onsite visit, the auditor interviewed both agency investigators. The investigators reviewed all allegations from the past twelve months with the auditor.

There were no investigations that were conducted based on an allegation reported from another confinement facility.

During an interview with the PREA Coordinator, she reports that the process outlined in the policy is the current facility practice. She states that she would receive a copy of any writing report sent to another confinement facility due to an allegation reported, and she would also be notified should another confinement facility report an allegation that occurred in RCC. 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

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

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

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

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

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

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

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

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

The facility has had two allegations of sexual abuse during the past twelve months. Neither allegation call for staff members to request medical assistance. Both clients were offered counseling, emotional support, and rape crisis services. One client met with the

emotional supportive services staff member but all other services from both clients were declined.

Review:
Policy 1080
PREA Book
Interviews with staff
Investigation report

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 1080 list the coordinated response plan as the following:

- Staff shall immediately notify, by telephone, Management staff following the internal chain of command and shall notify by telephone the Clinical Director.

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

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

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

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

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

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

Clients that are on 90-day retaliation monitoring will also be placed on the facility "whereabout" checklist at an increased rate.

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

The Program Administrator reports that no client 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

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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 Akron 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 client, or is employed by Oriana House, plus five years. The Oriana House Investigative Form includes the following information:

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

The auditor reviewed the training curriculum and certificates for completion for both administrative investigators. The PREA Coordinator and PREA Compliance Specialist have also received administrative investigator training. The training was conducted by the Moss Group and included techniques for interviewing sexual abuse victims, proper

use of Miranda and Garity warnings, sexual abuse evidence collection in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

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

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

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

The administrative investigators reviewed two allegations reported at the facility during the past twelve months (see standard 115.222). Only one allegation was referred to the Akron Police Department for a criminal investigation based on the allegation information.

The investigators state that they are not to question a suspected abuser during a criminal investigation. The administrative investigation would only begin at the conclusion of the criminal investigation or with the permission of the legal authority. The investigators report that they are responsible for maintaining and securing investigation reports for as long as the abuser is incarcerated or in the case of staff abusers until the employee in no longer employed, plus five years for both cases.

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

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Review:
Policy and procedure 1080

Interview with PREA Coordinator

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

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

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

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

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the

alleged abuser has been indicted on a charge related to sexual abuse within the facility?
☒ Yes ☐ No

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

- The agency learns that the alleged client abuser has been convicted on a charge related to sexual abuse in the facility

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

The facility had one allegation of client-to-client sexual abuse and one allegation of staff-to-client sexual abuse during the past twelve months. The staff-to-client allegation was administratively investigated and referred to the Akron Police Department for a criminal investigation. The Department did not file charges. The administrative investigation determined that the allegation was substantiated. The client-to-client allegation was only administratively investigated and determined to be substantiated.

The auditor received a copy of the notification form that was signed by the client acknowledging that they received notification of the investigation determination. The notification included the fact that the staff member had been arrested on sexual battery charges (for a different victim).

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 client 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 the investigations that took place during the past twelve months at the facility. The auditor noted that in the case where a staff member's allegation was substantiated the employee was terminated from the agency. The allegation was also referred to the Akron Police Department for a criminal investigation. During a file review, the auditor was able to verify the employee's termination letter along with a letter of notification to the Chemical Dependency Counselor licensing board.

Review:
Policy 1080
Policy 3037
Employee Handbook
Investigation reports
Employee file
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 has be prohibited from contact with clients and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The agency will take appropriate remedial measure, and shall consider whether to prohibit further contact with clients, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

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

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

Review:

Policy 1080
Investigation reports
Interview with Human Resource Director

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

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

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

In reviewing the investigations conducted at the facility during the past twelve months, the facility disciplined one client that had a substantiated sexual abuse allegation. The client was terminated from the facility. The discipline was in line with agency policy.

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

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

Review:
Policy 1080
Client Handbook
Investigation reports
Interview with PREA Coordinator

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

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

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

Clients are informed of the rights to these services free of charge during PREA education at intake.

The facility has received two allegations of sexual abuse during the past twelve months. The alleged victims were offered rape crisis, medical, and mental health counseling. One client accepted emotional supportive services while the other declined.

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

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

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

115.283 (e)

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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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.

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

During a mandatory monthly PREA training. Staff are notified of the agency's PREA Medical Response Plan. The auditor reviewed the Medical Response Plan. The plan outlines how staff is to offer unimpeded access to both emergency and ongoing medical and mental health care. The PREA Compliance Specialist states that all ongoing medical or mental health care will be at the discretion of the medical provider and is at no cost to

the client. The specialist reviews the plan annually to ensure that all service provider information is current and that the range of services are still available.

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

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

The facility has not received a report of a client being sexual abused while in a jail, lockup, or juvenile facility prior to intake at this facility during this audit cycle. The facility has received an allegation of client-to-client sexual abuse during the past twelve months at this facility. The alleged victim was offered rape crisis, medical, and mental health counseling. The alleged victim met with the Emotional Supportive staff member (Agency Crisis Counselor) and agree to wait until she got home to seek counseling if she felt it necessary. She states that she is not currently in need of these services based on the allegation. The facility also had a staff-to-client allegation of sexual abuse during the past twelve months. This client was also offered services. This client declined services.

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

Review:
Policy 1080
Medical Response Plan
Interview with PREA Compliance Specialist
Investigation reports

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 (PREA Coordinator) who will be responsible to distribute the final report to the Executive Team. The Executive Team will review and determine (with the input

of the PREA Coordinator) which recommendations will be implemented or will document the reasons for not doing so. The regional Vice President of Corrections will be responsible for distribution the report to facility management and overseeing the implementation of the approved recommendations.

The auditor interviewed the Program Administrator on her 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. As far as implementation of recommendations, she would ensure facility staff had the resources to comply with the recommendations and report to the PREA Coordinator after implementation.

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

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 were two allegations of sexual abuse during the past twelve months at the facility. The recommendations from the SART were implemented at all Oriana House facilities. The first recommendation is to no longer allow cross-gender transports. The second recommendation is to no longer allow staff to enter into closets or storage rooms with clients. Staff must remain outside the room where they can be seen on camera. The third recommendation is that when clients are placed on PREA watch where they must be observed every fifteen (15) minutes, the minimum staffing level should increase from two to three. A recommendation specific to this facility was to move a camera for better supervision in the area where the PREA incident took place.

Review:
Policy 1080
Client Sexual Abuse/Harassment Review form
Interview with PREA Coordinator

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

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

Standard 115.288: Data review for corrective action

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

115.288 (a)

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

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

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

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The auditor reviewed the report and ensured that the report compares the current year's data with those of previous years and includes updates made from previous year's reports. The report states that the agency has:

- 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 client 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 clients, staff, or facility.

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

Review:
Policy 1080
PREA annual report (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 three-year period starting on August 20, 2013, and during each three-year period thereafter, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once.? (N/A before August 20, 2016.) ☒ Yes ☐ No ☐ NA

115.401 (b)

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency post all final PREA reports of each of its facilities on the agency website. The auditor reviewed the agency website to ensure that during the first year of the audit cycle the agency ensured that one-third (1/3) of its facilities had been audited. The agency has a total of twelve facilities that require PREA audits (one facility has just opened and will have its initial PREA audit after one year of operation). During year one of the audit cycle, the agency had four facilities audited, and during year two, the agency had five facilities audited. The last two facilities, RCC and RIPP, are currently being audited.

The auditor was given full access to the facility during the onsite visit. The Program Administrator, Lead Resident Supervisor, PREA Compliance Manager, and PREA Coordinator escorted the auditor around the facility and opened every door for the auditor. The facility provided the auditor a private room in order to conduct staff and resident interviews. The auditor received documentation on the agency and facility prior to the onsite visit through Power DMS web based audit system. The auditor was also provided requested documentation during the onsite visit.

The auditor reviewed electronic documentation during the onsite visit. This includes camera views, ORION client database system, and intercommunication system. The auditor reviewed ten client files and twelve staff files for additional documentation and confirmation of reported information.

Appropriate audit notices were posted in conspicuous areas throughout the facility. These places included areas client, staff, and visitors would frequent. The notices included the auditors mailing and email addresses. The PREA Compliance Specialist sent the auditor photographic proof of the notices being posted approximately six weeks prior to the onsite visit. During the onsite visit, three client requested to speak to the auditor. All three clients wish to voice their concerns about the removal of the shower curtains. The auditor was able to view the bathrooms during the onsite visit. The bathrooms are designed to provide privacy in the shower area without the need for shower curtains. For a complete description of the bathrooms, please see standard 115.215. The auditor relayed the clients' concerns to the Program Administrator. The auditor did not receive any correspondence with a staff or client prior to or after the onsite visit.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The agency has published on its agency website the final PREA reports for all Oriana House operated facilities. The final PREA report for RCC from the previous audit is currently posted. The auditor reviewed the agency website and verified that the facilities that were audited during year one and year two of this audit cycle, had their final reports posted, and the facilities that have already been audited during year three have been posted. RCC and RIPP are the final two audits to be completed for this audit cycle. The PREA Coordinator states that she understands the requirement of having all final reports posted, and that the Ohio Department of Rehabilitation and Correction Bureau of Community Sanctions also post final PREA reports on their agency website for any facility that houses offenders for the state of Ohio. The auditor also reviewed ODRC agency website and found final PREA reports for Oriana House facilities posted.

AUDITOR CERTIFICATION

I certify that:

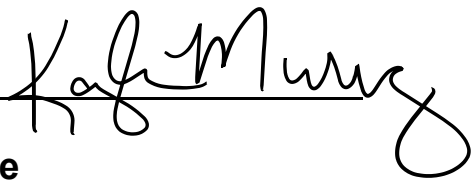
☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Kayleen Murray  April 22, 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.