PREA AUDIT: AUDITOR'S SUMMARY REPORT
COMMUNITY CONFINEMENT FACILITIES

FINAL REPORT			
Name of facility: ICCS-PUEBLO			
Physical address: 1901 NORTH HUDSON PUEBLO, CO 81001			
Date report submitted: **November 5, 2016**			
Auditor Information			
Address: PO BOX 732 BENICIA, CA 94510-0732			
Email: eiw@comcast.net			
Telephone number: **(707) 333-8303**			
Date of facility visit: MARCH 9, 2016 TO MARCH 11, 2016			
Facility Information			
Facility mailing address: *(if different from above)*			
Telephone number:			
The facility is:	■	■	■
	■	■	■
	■ Private not for profit		
Facility Type:	■ ■ ■	■ Community based confinement facility ■	■ Other:
Name of Facility Head: BRANDON MATHEWS		**Title: PROGRAM DIRECTOR**	
Email address: bmathews@int-iccs-org		**Telephone number: (719) 569-3020**	
Name of PREA Compliance Manager (if applicable): BRANDON MATHEWS		**Title: PROGRAM DIRECTOR**	
Email address: bmathews@int-iccs-org		**Telephone number:**	
Agency Information			
Name of agency: INTERVENTION COMMUNITY CORRECTION SERVICES (ICCS)			
Governing authority or parent agency: *(if applicable)*			
Physical address: 1651 KENDALL STREET LAKEWOOD, CO 80214			
Mailing address: *(if different from above)*			
Telephone number: (303) 232-4002			
Agency Chief Executive Officer			
Name: GREGG KILDOW		**Title: EXECUTIVE DIRECTOR**	

Email address: gkildow@int-iccs.org	**Telephone number: (720) 544-5523**
Agency-Wide PREA Coordinator	
Name: JOE CLARK	**Title: PREA COORDINATOR**
Email address: jclark@int-iccs.org	**Telephone number: (720) 544-5559**

AUDIT FINDINGS

NARRATIVE:

An audit of the ICCS Pueblo Facility was conducted from March 9, 2016 to March 11, 2016 by a certified PREA Auditor. The following is a summary of the observations noted during the facility review and a description of the audit process:

PRE-AUDIT PHASE:

On January 3, 2016, auditor forwarded pre-audit preparation documentation to the PREA Coordinator. The preparation documentation consisted of the pre-audit questionnaire, pre-audit process map, documentation checklist and instructions for facility PREA audit. January 29, 2016, auditor forwarded the ICCS-Pueblo pre-audit timeline and Notice of Audit to be printed as posters & distributed throughout the general areas of the facility by February 6, 2016. PREA Coordinator provided auditor with dated photographs of Notice of Auditor posting throughout the facility, with location of placement on February 6, 2016. On February 6, 2016, PREA Coordinator provided auditor with Drop-Box access which contained the pre-audit questionnaire, PREA Standard provision supporting documents and MOU's. February 24, 2016, auditor completed the Compliance Tool and submitted an Issue Paper to the PREA Coordinator outlining issues with the PAQ and requested clarification or provision of missing documentation. On February 24, 2016, auditor submitted interview protocol sheet for specialized staff and designated administrative staff. PREA Coordinator returned the completed protocol sheet identifying key staff on March 3, 2016. Auditor requested list of all staff & residents who are currently assigned to the Pueblo facility for random selection for interview during the on-site review. PREA Coordinator provided the list on March 4, 2016.

ON-SITE AUDIT PHASE:

Auditor arrived at the facility on March 9, 2016 to start the audit with an entry briefing with facility command staff, Agency PREA Coordinator, Compliance Administrator Staff Security Supervisor, Program Director, Case Manager Supervisor and Agency head. Auditor explained the audit process and interview protocols. Following the entry briefing, auditor conducted the facility review.

Staff accompanying Auditor during facility review:
Agency PREA Coordinator
Facility Security Supervisor
Program Director
Case Manager Supervisor
Building Engineer

BUILDING A

Pueblo facility is a co-ed residential facility. Total resident population at time of on-site facility review was 82. 22 female residents and 60 male residents.

Female Residential Housing:

The facility review began with Building A. The lobby entry serves as the day room and visiting room for the female residents who are housed on the 1st floor of Building A. The area is directly supervised by the Security Office staff and is covered by 3 cameras and mirrors for surveillance purposes. Security is manned by staff member of both genders on each shift. PREA Signage and Notice of Auditor signage is available throughout the common areas. PREA Signage provides for limits to confidentiality and monitoring with regards to outside reporting and advocacy services. Visitors bathroom is attached to the visiting room. Female residents have access to outside recreation area, which is covered by a camera over the outside door. Recreation area is enclosed on all sides by cement walls. Access is from the day room area through a storeroom area which is monitored by 2 cameras. The storage closets are accessed by staff through a draw-key system. Auditor checked each door and they were all locked per policy. The Security Office has 2 monitoring cameras for surveillance & building cameras are available for surveillance on Security Office monitors and through Management computer feeds. Locked grievance box is in front of the security office along with a multitude of forms so residents are not required to obtain forms from staff or submit to staff for resolution. Only Program Director, Case Manager Lead, Case Manager Supervisor and Security Supervisor has access. Security Office has an intake area, area for PREA education video and the Security Supervisor's office which is locked when he is not on duty. Off from the Security Office is the female resident rooms, laundry room, 2 case manager offices, locked employee bathroom and bathroom down a linear hallway with cameras at each end of the hallway. Resident rooms have Zero Tolerance and PREA Signage behind each entry door. Notice of Auditor posters throughout residential common areas. All resident rooms are similar in design. Auditor observed male staff conducting knock and announce during the facility review. Case Manager offices are locked when managers leave their offices for security purposes. Storage Room mop closet is locked with a Draw Key from security. Middle of the hallway is the laundry room, which is monitored by a camera. At the end of the hallway is an alarmed fire exit door. Before the door is the female bathroom. The shower area is not PREA compliant as it is an open-bay configuration without stalls or curtains to provide privacy for Transgender or Intersex residents. The toilets are open-access separated by a short barrier. Female staff conduct count ordinarily. When male staff conduct count, they announce but do not enter the resident rooms or bathroom area.

Access to Building A male area on bottom floor is through stairwell across from the 1st floor Security area. Stairwell is monitored by cameras and motion sensors. PREA Signage on stairwell, throughout resident common areas to include Notice of Auditor postings. BTS Clinician offices and group counseling rooms are located at the bottom of the stairs. The hallway is monitored by

2 cameras. Rooms are locked when clinician leaves the rooms. Cameras monitor the counseling classrooms. PREA Signage located in each of the BTS Clinician counseling classrooms. After the BTS Clinican Offices, the CEO literacy labs and computer education room is located, monitored by hallway cameras. Monitoring camera is located in the computer room and testing room. Staff bathroom is locked when not in use by staff. PREA Signage located in the CEO Area. Away from the BTS and CEO area is a long linear hallway that houses male residents. Hallway is covered by multiple cameras. Case Manager offices are located at the beginning of hallway and are locked when Case Managers are off duty and when they leave their offices. Day Room is monitored by camera and has PREA signage. All resident rooms are similar in design and has Zero Tolerance and PREA Signage behind each entry door. Boiler room has maintenance only keys for access. Men's shower and toilet rooms are PREA compliant.

BUILDING B

Male Residential Housing

Building B houses male residents only. Entry hallway is covered by cameras and leads to Security Office, which houses security monitors for both buildings A & B surveillance. Locked grievance box is in front of the security office along with a multitude of forms so residents are not required to obtain forms from staff or submit to staff for resolution. Only Program Director, Case Manager Lead, Case Manager Supervisor and Security Supervisor has access. To the right of the Security office are stairs leading to the basement floor and monitored with mirrors and cameras. An elevator is located across from the Security Office, providing direct supervision. Only one resident allowed in the elevator at a time and it is posted. Elevator is used for food transport only as there are no resident rooms in the basement. From the Security Office is a linear hallway that contains male resident rooms. Hallway is monitored through multiple cameras. All resident rooms are similar in design and has Zero Tolerance and PREA Signage behind each entry door. Bathrooms on both sides of hallway are PREA Compliant. Alarmed emergency exit door is at the end of the hallway.

Laundry

Stairs lead to downstairs basement which has posted PREA Signage. Mirror located at bottom of stairs with hallway camera to entrance of dining room. C-22 and C-23 Storage rooms are covered by cameras as is the elevator access doors. Access keys are master Draw Keys. No residents are allowed in either room per Policy. Laundry room is monitored by camera and only one resident is allowed to use the laundry at a time.

Dining Room

The Dining area is covered by approximately 6-8 cameras. This area is used for eating the evening meal and supervised visiting. Residents are allowed in this area with approval of the security office to obtain ice when feeding is not occurring.

Kitchen

The kitchen is only used for serving the evening meal. Other meals are sack breakfast & lunch. Trinity Food Service Contractors provides prepared foods from the Jail. Food is served by clients under staff supervision. During facility review, auditor observed the scullery area to be an entire

blind spot. There is 1 camera over serving area, 1 camera over prep area. Blind spot identified on side of locked reefer in the back of the kitchen near the alarmed back exit door. Back office near back exit door is used as a storeroom, but is locked and has a window for viewing by video surveillance. Mop/sink room entry by master key and covered by camera. File room and Mechanical rooms are covered by camera and access is only via maintenance and Administration. No residents allowed in that area at any time. Blind spot also observed in area next to serving line where toiletry items are stored.

Courtyard/Recreation

Courtyard area between Building A and Building B is monitored by 3 cameras. Review of camera monitors by auditor revealed the employee smoking area was a blind spot due to staff vehicles parked in stalls which blocked video monitoring of that area. Back patio of Building B camera was found to be defective as auditor found it to be unviewable on the monitors.

Documentation Review and Interviews – Following the on-site review, Auditor conducted interviews with 14 Specialized Staff, 1 Volunteer, 2 Contractors, 12 random sampling of staff and 12 random sampling of residents to determine Agency & Facility compliance with the PREA Standards. Auditor conducted a review of 12 random sampling of residents screening files, 12 random sampling of staff personnel files, 4 random sampling of volunteer/contractor files and 3 Investigative files to determine compliance with the PREA Standards.

Upon completion of the On-Site Facility Review, Interviews and Document Review. Auditor conducted the exit briefing with Management and Administrative staff in attendance. Auditor discussed the On-Site Audit process and general findings during the review of the facility, interviews and document review. The Post Audit phase of the audit was also discussed. There was a question and answer period after which the exit briefing concluded.

POST AUDIT PHASE:

Auditor departed the Pueblo facility on March 11, 2016 to begin transferring data gleaned from the on-site audit to the PREA Compliance Tool. Auditor maintained constant communication with the PREA Coordinator to assist with Standards clarification and compliance issues and requesting additional data to clear deficient Standard provisions. Auditor submitted the Interim Report to both Agency Head and Agency PREA Coordinator on April 11, 2016

DESCRIPTION OF FACILITY CHARACTERISTICS:

ICCS-Pueblo is located at 1901 N. Hudson Pueblo, Colorado and serves both male and female residents. Facility is positioned within walking distance to public transportation. A parking lot is located on the ICCS sight with sufficient parking for services and populations served.
The Pueblo facility includes two buildings (Building A and Building B), both are two-story buildings. Building A has residential rooms on the first and second floor and Building B has residential rooms on the first floor, both possess handicap accessibility to the entryway, toilets

and showers. Adequate ingress and egress is available for handicapped individuals. An elevator provides access to each level of building A. Handicap accessible restrooms are available on all floors. In addition, each residential floor has rooms that provide handicap accessible showers. The facility is in compliance with the Colorado Community Corrections Standards.
Clients are afforded roommate style living arrangements in sleeping rooms accommodating two to eight clients. ICCS has provided residential and non-residential community corrections services to the 19th Judicial District since July 2008.

Programs Offered at this Facility

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

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

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

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

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

INTERIM REPORT AUDIT FINDINGS	FINAL AUDIT REPORT FINDINGS
EXCEEDS STANDARDS - **1**	EXCEEDS STANDARDS - **2**
MEETS STANDARDS - **26**	MEETS STANDARDS - **36**
DOES NOT MEET STANDARDS - **11**	DOES NOT MEET STANDARDS - **0**
NOT APPLICABLE - **1**	NOT APPLICABLE - **1**

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #160 INCORPORATES ZERO TOLERANCE TOWARDS SEX ABUSE & SEX HARASSMENT, OUTLINES IMPLEMENTATION OF AGENCY'S APPROACH TOWARDS PREVENTING, DETECTING AND RESPONDING TO SEX ABUSE/HARASSMENT. POLICY PROVIDES DEFINITIONS OF PROHIBITED BEHAVIORS & SANCTIONS FOR THOSE FOUND TO HAVE PARTICIPATED IN PROHIBITED BEHAVIORS TO INCLUDE DESCRIPTION OF AGENCY STRATEGIES TO REDUCE AND PREVENT SEXUAL ABUSE/HARASSMENT.
b) PREA COORDINATOR IS PLACED 2ND LEVEL DOWN FROM THE EXECUTIVE DIRECTOR OF THE AGENCY, COMPLIANT WITH PROVISION 115.211(b). INTERVIEW WITH PREA COORDINATOR VERIFIES HE HAS SUFFICIENT TIME & AUTHORITY TO DEVELOP AND OVERSEE AGENCY EFFORTS TO COMPLY WITH THE PREA STANDARDS IN ALL OF ITS COMMUNITY CONFINEMENT FACILITIES.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.211.

115.212	Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

■ Not Applicable

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

N/A - STANDARD 115.212 DOES NOT APPLY AS AGENCY HAS NOT ENTERED INTO A CONTRACT WITH ANY OTHER AGENCY OR ENTITY FOR THE CONFINEMENT OF RESIDENTS PER AGENCY CONTRACT ADMINISTRATOR. AUDITOR HAS DETERMINED THE STANDARD NOT APPLICABLE TO THIS AGENCY/FACILITY.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.212.

115.213	Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) 2016 STAFFING PLAN SPECIFIC TO THE PUEBLO FACILITY. PLAN INCLUDES BLIND-SPOT IDENTIFICATION, DEVIATIONS FROM STAFFING PLAN, COMPOSITION OF RESIDENT POPULATION, PREVALENCE OF SEXUAL ABUSE INCIDENTS AND PHYSICAL LAYOUT OF FACILITY. INTERVIEW WITH PROGRAM DIRECTOR AND PREA COORDINATOR INDICATE STAFF RATIO IS 1-10 WITH NO LESS THAN 3 PEOPLE IN SECURITY AT ANY GIVEN TIME. PROVIDED MORE STAFFING THAN OTHER FACILITIES AS PUEBLO HAS TWO BUILDINGS WITH ONE BUILDING HOUSING BOTH MALE AND FEMALE RESIDENTS. FEMALE STAFF ASSIGNED TO EACH SHIFT. PROGRAM DIRECTOR MONITORS FOR COMPIANCE VIA ROUNDS AND VIDEO MONITORING. PART-TIME STAFF AVAILABLE TO FILL IN GAPS IN THE EVENT STAFFING COULD FALL BELOW THE MINIMAL STAFFING THRESHHOLD. THERE HAVE BEEN NO DEVIATIONS FROM THE STAFFING PLAN OVER THE PAST 12 MONTHS.

DURING ON-SITE AUDIT REVIEW, AUDITOR OBSERVED THE FOLLOWING BLIND SPOTS THAT WERE NOT CONSIDERED ON THE STAFFING PLAN PROVIDED PRE-AUDIT REVIEW:

a. DINING ROOM KITCHEN – SCULLERY AREA ON LEFT SIDE AS YOU ENTER KITCHEN.
b. BACK OF KITCHEN ON BACK SIDE OF REEFER NEAR BACK DOOR.
c. AREA NEXT TO SERVING LINE WHERE TOILETRY ITEMS ARE STORED.
d. BACK PATIO AREA OF BUILDING B – INSTALLED CAMERA WAS DEFECTIVE WHEN AUDITOR REVIEWED, NEEDS TO BE FIXED.
e. EMPLOYEE SMOKING AREA IN COURTYARD BETWEEN BUILDINGS CANNOT BE SEEN BY THE COURTYARD CAMERAS WHEN CARS ARE PARKED IN FRONT OF THAT AREA.

b) N/A - THERE HAVE BEEN NO DEVIATIONS FROM THE STAFFING PLAN OVER THE PAST 12 MONTHS.

c) THIS IS FACILITY'S 1ST PREA AUDIT. NO PREVIOUS STAFFING PLAN OR ANNUAL REVIEWS CONDUCTED PRIOR TO THIS AUDIT. POLICY #400-B INCORPORATES CRITERIA AS IDENTIFIED IN PROVISION 115.113(c). STAFFING PLAN DATED MAY 2015, PROVIDED BY AGENCY EXHIBITS IMPLEMENTATION OF THE CONSIDERED CRITERIA. INTERVIEW WITH PREA COORDINATOR INDICATES THE STAFFING PLAN WILL BE REVIEWED ANNUALLY GOING FORWARD IN ACCORDANCE WITH POLICY #400-B.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.213 AS PROVISION 115.213(a) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.213(a): AGENCY TO IMPLEMENT MONITORING SYSTEM(S) TO REMOVE BLIND SPOTS FROM THE FOLLOWING AREAS:

a. DINING ROOM KITCHEN – SCULLERY AREA ON LEFT SIDE AS YOU ENTER KITCHEN.
b. BACK OF KITCHEN ON BACK SIDE OF REEFER NEAR BACK DOOR.
c. AREA NEXT TO SERVING LINE WHERE TOILETRY ITEMS ARE STORED.
d. BACK PATIO AREA OF BUILDING B – INSTALLED CAMERA WAS DEFECTIVE WHEN AUDITOR REVIEWED, NEEDS TO BE FIXED.
e. EMPLOYEE SMOKING AREA IN COURTYARD BETWEEN BUILDINGS CANNOT BE SEEN BY THE COURTYARD CAMERAS WHEN CARS ARE PARKED IN FRONT OF THAT AREA.

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: OCTOBER 6, 2016.

CORRECTIVE ACTION COMPLETION 11/3/16:

AGENCY PROVIDED AUDITOR WITH CAMERA/BUILDING SCHEMATICS TO VERIFY PLACEMENT OF CAMERA IN BUILDING B KITCHEN - SCULLERY AREA. MIRRORS AND CAMERAS HAVE BEEN INSTALLED IN THE BACK OF KITCHEN IN REEFER AREA BACK DOOR, MAIN KITCHEN AREA AND AREA ADJACENT TO SERVING LINE WHERE TOILETRY ITEMS ARE STORED. DEFECTIVE CAMERA WAS REPLACED IN BACK PATIO OF BUILDING B. EMPLOYEE SMOKING AREA BLIND SPOT HAS BEEN ADDRESSED WITH FENCE ENCLOSURE AND CAMERA ON TOP OF BUILDING A OVERLOOKING THE AREA. AGENCY INSTALLED ADDITIONAL CAMERAS IN THE CEO TESTING ROOM AND SMALL GROUP ROOM IN THE DOWNSTAIRS OF BUILDING A AND OUTSIDE THE CASE LOAD AIDE OFFICE UPSTAIRS IN BUILDING B ALL TO ENHANCE RESIDENT SAFETY. PRIVACY SCREENS HAVE BEEN INSTALLED IN THE BUILDING A WOMEN'S BATHROOM. AGENCY HAS COMPLIED WITH STANDARD PROVISION 115.213(a).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.213

115.215	Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #450 COMPLIANT WITH STANDARD AS IT AUTHORIZES STRIP SEARCHES WITH AUTHORIZATION OF EXECUTIVE DIRECTOR OR PROGRAM DIRECTOR. THE PRESENCE OF TWO SAME-SEX STAFF MEMBERS ARE REQUIRED, ONE OF WHICH MUST BE A SUPERVISOR. UNDER EXIGENT CIRCUMSTANCES IF A CROSS-GENDER STRIP SEARCH IS CONDUCTED THE SEARCH MUST BE DOCUMENTED & FOWARDED TO THE PREA COORDINATOR OR DESIGNEE. BODY CAVITY SEARCHES ARE NOT ALLOWED. NO NON-MEDICAL STAFF INVOLVED IN CROSS-GENDER OR VISUAL SEARCHES. NO CROSS GENDER STRIP OR CROSS GENDER BODY CAVITY SEARCHES CONDUCTED IN PAST 12 MONTHS

b) POLICY #450 STATES THAT ONLY STAFF OF SAME SEX IS ALLOWED TO CONDUCT PAT-DOWN SEARCHES. THIS IS AN ALL MALE FACILITY & STANDARD DOES NOT APPLY TO THIS FACILITY. THIS IS THE FACILITY'S INITIAL PREA AUDIT. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATES CROSS-GENDER PAT-DOWN SEARCHES ARE PROHIBITED EXCEPT DURING EXIGENT CIRCUMSTANCES. RANDOM SAMPLE OF RESIDENTS RESPONDED THERE HAVE BEEN NO INSTANCES OF CROSS-GENDER PAT DOWN SEARCHES

c) POLICY #450 MANDATES CROSS-GENDER STRIP SEARCHES ARE CONDUCTED ONLY UNDER EXIGENT CIRCUMSTANCES AND ARE DOCUMENTED. VISUAL BODY CAVITY SEARCHES ARE PROHIBITED. THERE IS NO DOCUMENTATION OF CROSS-GENDER STRIP OR CROSS –GENDER VISUAL BODY CAVITY SEARCHES OF RESIDENTS.

d) POLICY 45O MANDATES WHEN ENTERING CLIENT ROOMS OR RESTROOMS WHERE CLIENTS MAY BE CHANGING CLOTHING, SHOWERING, PERFORMING BODILY FUNCTIONS, STAFF WILL ANNOUNCE THEIR PRESENCE USING THE "KNOCK-AND-ANNOUNCE" SYSTEM, STATING "FEMALE STAFF". OBSERVATION OF SHOWERS & BATHROOM IN RESIDENTIAL BUILDING A, WHICH HOUSES THE FEMALES IN THE TOP FLOOR AUDITOR FOUND OPEN BAY SHOWERS AND OPEN TOILET STALLS. RESIDENTIAL BUILDING A DOWNSTAIRS HOUSES MALE RESIDENTS. BATHROOM AND SHOWERS ENABLE RESIDENTS TO SHOWER, CHANGE AND CONDUCT BODILY FUNCTIONS WITHOUT CROSS-GENDER VIEWING. RESIDENTIAL BUILDING B DOWNSTAIRS HOUSE MALE RESIDENTS AND THE BATHROOM & SHOWERS ENABLE RESIDENTS TO SHOWER, CHANGE AND CONDUCT BODILY FUNCTIONS WITHOUT CROSS-GENDER VIEWING. CROSS GENDER STAFF DO NOT ENTER THE BATHROOMS, BUT CALL OUT FOR NAMES & INSTRUCT THE RESIDENTS TO REPORT TO SECURITY FOR COUNT AS VERIFIED

THROUGH RESIDENT INTERVIEWS, BOTH MALE & FEMALE. 10 OUT OF 12 RANDOM SAMPLE OF RESIDENTS INTERVIEWED, BOTH MALE & FEMALE, INDICATE STAFF ANNOUNCE WHEN COMING ON THE FLOOR OF THE HOUSING UNIT OR KNOCK & ANNOUNCE WHEN ENTERING RESIDENT ROOMS. AUDITOR OBSERVED STAFF KNOCK AND ANNOUNCE AT EVERY OPPORTUNITY DURING THE ON-SITE REVIEW.

e) POLICY #450 MEETS STANDARD PROVISION IN PROHIBITING STAFF FROM SEARCHING OR PHYSICALLY EXAMINING A TRANSGENDER OR INTERSEX RESIDENT FOR THE SOLE PURPOSE OF DETERMINING THE RESIDENT'S GENITAL STATUS. POLICY MANDATES THAT IF STATUS IS UNKNOWN, IT MAY BE DETERMINED VIA REVIEW OF MEDICAL RECORDS OR PART OF A BROADER MEDICAL EXAMINATION CONDUCTED BY A PRIVATE MEDICAL PRACTITIONER. THERE ARE NO TRANSGENDER OR INTERSEX RESIDENT AT THE FACILITY. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATE THEY ALL KNOW THE POLICY PROHIBITING SEARCHING A TRANSGENDER/INTERSEX INMATE FOR THE SOLE PURPOSE OF DETERMINING THE GENITAL STATUS.

f) SECURITY TRAINING CURRICULUM IDENTIFIES PAT DOWN SEARCHES OF A CLIENT, PERSON & PROPERTY SEARCHES. CURRICULUM PROVIDED IS A CHECKLIST OF TOPICS ONLY WITH INSTRUCTIONS FOR STAFF/CLIENTS TO INITIAL AND SIGN. FULL TRAINING PPT PROVIDED WHICH MEETS STANDARD 115.215(F). POLICY #450 A-9 INDICATES BEFORE A TRANSGENDER OR INTERSEX RESIDENT IS SUBJECT TO A PAT SEARCH, THEY SHOULD BE ASKED WHICH GENDER OF STAFF THEY WOULD FEEL MOST COMFORTABLE IN CONDUCTING THE SEARCH. POLICY #450 HAS NARRATIVE WHICH MANDATES ALL PAT-DOWN SEARCHES WILL BE CONDUCTED IN A PROFESSIONAL AND RESPECTFUL MANNER. SEARCH VIDEO PROVIDED BY AGENCY MEETS STANDARD PROVISION 115.215(f). INTERVIEW WITH RANDOM SAMPLE OF 12 STAFF INDICATE THEY RECEIVED THE FULL PREA TRAINING UPON HIRE IN 2015 AND REFRESHER TRAINING EITHER JANUARY OR FEBRUARY 2016. BOTH TRAININGS INCLUDED CROSS-GENDER PAT DOWN SEARCHES & SEARCHES OF TRANSGENDER AND INTERSEX RESIDENTS. REVIEW OF TRAINING LOGS & TRAINING CURRIRULUM PROVIDED DURING ON-SITE REVIEW VERIFY ALL STAFF HAVE BEEN TRAINED ON SEARCHING PROTOCOL.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.285.

115.216	Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICIES #160 & #450 ESTABLISHES PROCEDURES TO PROVIDE EFFECTIVE COMMUNICATION AS IT RELATES TO PREA FOR ALL DISABLED & LEP RESIDENTS TO INCLUDE WRITTEN DOCUMENTATION IN ENGLISH & SPANISH, VOIANCE CONTRACT FOR INTERPRETERS PROVIDED. STAFF TRAINING CURRICULUM DOES NOT PROVIDE COMPLIANCE PRACTICES FOR RESIDENTS WITH DISABILITIES. POLICY 405 MANDATES STAFF TO DETERMINE COMMUNICATION ABILITIY OF RESIDENT & PROVIDE INTERPRETERS IF RESIDENT IS LEP & PROVIDE MATERIALS IN MULTIPLE FORMATES TO ENSURE EFFECTIVE COMMUNICATION WITH RESIDENTS WHO HAVE INTELLECTUAL DISABILITIES, LIMITED READING SKILLS, OR WHO ARE BLIND & LOW VISION. THESE FORMATS WILL INCLUDE, BUT NOT LIMITED TO, WRITTEN MATERIAL AND VERBAL COMMUNICATION. NO WRITTEN MATERIAL TO ASSIST COMMUNICATION WITH RESIDENTS WITH INTELLECTUAL DISABILITIES OR LIMITED READING SKILLS, BLIND OR LOW VISION PROVIDED. REVIEW OF VOIANCE CONTRACT PROVIDES INTERPRETER SERVICES FOR A MULTITUDE OF LANGUAGES TO INCLUDE AMERICAN SIGN FOR THE DEAF. INTERVIEW WITH AGENCY HEAD DESIGNEE INDICATES AGENCY HAS RESOURCES TO PROVIDE EFFECTIVE COMMUNICATION. CONTRACT WITH VOIANCE PROVIDES LANGUAGE INTERPRETATION FOR RESIDENTS IN THIS FACILITY.

b) POLICIES #160 & #450 ESTABLISHES PROCEDURES TO PROVIDE EFFECTIVE COMMUNICATION AS IT RELATES TO PREA FOR ALL DISABLED & LEP RESIDENTS TO INCLUDE WRITTEN DOCUMENTATION IN ENGLISH & SPANISH, VOIANCE CONTRACT FOR INTERPRETERS PROVIDED. STAFF TRAINING CURRICULUM DOES NOT PROVIDE COMPLIANCE PRACTICES FOR RESIDENTS WITH DISABILITIES. POLICY 405 MANDATES STAFF TO DETERMINE COMMUNICATION ABILITIY OF RESIDENT & PROVIDE INTERPRETERS IF RESIDENT IS LEP & PROVIDE MATERIALS IN MULTIPLE FORMATES TO ENSURE EFFECTIVE COMMUNICATION WITH RESIDENTS WHO HAVE INTELLECTUAL DISABILITIES, LIMITED READING SKILLS, OR WHO ARE BLIND & LOW VISION. THESE FORMATS WILL INCLUDE, BUT NOT LIMITED TO, WRITTEN MATERIAL AND VERBAL COMMUNICATION. NO WRITTEN MATERIAL TO ASSIST COMMUNICATION WITH RESIDENTS WITH INTELLECTUAL DISABILITIES OR LIMITED READING SKILLS, BLIND OR LOW VISION PROVIDED. REVIEW OF VOIANCE CONTRACT PROVIDES INTERPRETER SERVICES FOR A MULTITUDE OF LANGUAGES TO INCLUDE AMERICAN SIGN FOR THE DEAF. INTERVIEW WITH RESIDENT WHO WAS LISTED AS DISABLED INDICATED HER CONGNITIVE ABILITIES WERE INTACT, SO SHE DID NOT REQUIRE ASSISTANCE FROM

STAFF TO READ OR UNDERSTAND THE PREA MATERIAL. INTERVIEW WITH INTAKE STAFF INDICATES THEY WILL READ DOCUMENTATION REGARDING RESIDENT PREA RIGHTS IF THEY CANNOT UNDERSTAND OR READ THE MATERIAL.

c) POLICY #450 MANDATES THE USE OF CONTRACT INTERPRETERS OR STAFF INTERPRETERS. RESIDENT INTERPRETERS OR READERS MAY BE USED IN LIMITED CIRCUMSTANCES WHERE AN EXTENDED DELAY IN OBTAINING EFFECTIVE INTERPRETERS COULD COMPROMISE THE RESIDENT'S SAFETY. INTERVIEW WITH RANDOM SAMPLE OF STAFF VERIFY THEIR TRAINING & KNOWLEDGE REGARDING THE POLICY PROHIBITING USE OF RESIDENT INTERPETERS. ALL KNOW THEY CAN EITHER CONTACT THE CONTRACTED INTERPRETER SERVICES COMPANY OR USE BI-LINGUAL STAFF AS INTERPRETERS. A NUMBER OF STAFF USE AMERICAN SIGN LANGUAGE, ALSO. THERE ARE NO RESIDENTS WITH LEARNING DISABILITIES OR LIMITED ENGLISH PROFICIENT AVAILABLE.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.216 AS PROVISIONS 115.216(a) & 115.216(b) ARE NON-COMPLIANT

CORRECTIVE ACTION:

115.216(a): PLEASE PROVIDE WRITTEN MATERIAL OR NARRATIVE IN SUPPORT OF POLICY #405 C-3, WHICH OUTLINES THE METHOD OR PROCEDURE UTILIZED BY INTAKE STAFF SHOULD A RESIDENT EXHIBIT INTELLECTUAL DISABILITIES (DEVELOPMENTALLY DISABLED), LIMITED READING SKILLS, BLIND OR LOW VISION.

115.216(b): AGENCY TO DEVELOP STAFF TRAINING CURRICULUM TRAINS PROVIDES STAFF ON COMPLIANT PRACTICES FOR RESIDENTS WITH DISABILITIES.

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: OCTOBER 6, 2016.

CORRECTIVE ACTION COMPLETION 9/23/16:

AGENCY PROVIDED AUDITOR WITH COPY OF "ENDING SILENCE" COMIC BOOKS FOR MALE, FEMALE AND TRANSGENDER EFFECTIVE COMMUNICATION. THESE BOOKS WERE CREATED BY THE UNIVERSITY OF WASHINGTON COLLEGE OF LAW IN COLLABORATION WITH THE PREA RESOURCE CENTER AND BUREAU OF JUSTICE ADMINISTRATION. THE BOOKS PROVIDE A METHOD TO COMMUNICATE WITH RESIDENTS WHO ARE DEVELOPMENTALLY DISABLED AND THOSE WITH LIMITED READING SKILLS. CASE MANAGERS WILL READ THE INMATE RIGHTS AND SEXUAL ABUSE/HARASSMENT REPORTING INFORMATION TO RESIDENTS WHO ARE BLIND OR HAVE LOW VISION PER UPDATED POLICY 600. ALL CASE MANAGERS HAVE SIGNED ACKNOWLEDGEMENT THAT THEY HAVE REVIEWED THE UPDATED

POLICY AND UNDERSTAND THE INFORMATION.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.216

115.217	Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #220 INCLUDES ALL 3 CRITERIA REGARDING THE HIRING OR PROMOTIONS AS OUTLINED IN STANDARD PROVISION 115.217(a). REVIEW OF 12 RANDOMLY SELECTED EMPLOYEE FILES INDICATE BACKGROUND CHECKS WERE CONDUCTED USING CCIC/FBI/CBI. 1 OUT OF THE 12 STAFF EMPLOYEE FILES WAS MISSING APPLICATION DOCUMENTS WHICH INCLUDED QUESTIONS IDENTIFIED IN STANDARD PROVISION 115.17(a).

b) POLICY #220 CONTAINS NARRATIVE COMPLIANT WITH STANDARD PROVISION REGARDING THE CONSIDERATION OF ANY INCIDENTS OF SEXUAL HARASSMENT IN DETERMINING WHETHER TO HIRE OR PROMOTE AN APPLICANT. INTERVIEW WITH HUMAN RESOURCES DIRECTOR INDICATES THE AGENCY CONSIDERS INCIDENTS OF SEXUAL HARASSMENT TO DETERMINE WHETHER OR NOT TO HIRE OR PROMOTE OR ENLIST THE SERVICES OF ANY CONTRACTOR WHO MAY HAVE CONTACT WITH RESIDENTS.

c) POLICY #220 MANDATES BEFORE ANY APPLICANT OR CONTRACTOR IS HIRED, A BACKGROUND INVESTIGATION IS CONDUCTED. AGENCY REPORTS THAT IN THE PAST 12 MONTHS 20 BACKGROUND CHECKS WERE CONDUCTED ON STAFF WERE HIRED WHO MAY HAVE CONTACT WITH RESIDENTS. INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR INDICATE CRIMINAL BACKGROUND CHECKS ARE CONDUCTED BEFORE HIRING NEW EMPLOYEES THROUGH CBIC, FBI, CIC AND NCIC. REVIEW OF 12 RANDOMLY SELECTED PERSONNEL FILES WAS CONDUCTED BY AUDITOR. 11 VERIFIED BACKGROUND CHECKS BEING CONDUCTED PER HR ADMINISTRATORS INTERVIEW. 1 STAFF PERSONNEL FILE WAS MISSING COMPLETE BACKGROUND CLEARANCE DOCUMENTATION. A SECOND STAFF PERSONNEL FILE INDICATED THE CCIC CHECK WAS COMPLETED AND CLEARED, HOWEVER, THE CBI/FBI OR NCIC CHECK WAS NOT AVAILABLE.

d) POLICY #220 MANDATES CRIMINAL BACKGROUND CHECK ON ALL APPLICANTS TO INCLUDE CONTRACTORS IN THE NARRATIVE. PAST 12 MONTHS NO CONTRACTS FOR SERVICES, NO CONTRACTOR BACKGROUND CHECKS CONDUCTED FOR CONTRACTORS

WHO MAY HAVE CONTRACT WITH RESIDENTS. AUDITOR CONDUCTED REVIEW OF A RANDOM SAMPLE OF 2 BTS AND 2 CEO CONTRACT STAFF PERSONNEL RECORDS. AUDITOR DETERMINED 3 OF THE 4 CONTRACTOR PERSONNEL FILES POSSESSED THE CCIC CLEARANCE BUT FAILED TO POSSESS THE CBI/FBI OR NCIC CLEARANCE.

e) POLICY #220 SPECIFICALLY MANDATES CRIMINAL BACKGROUND RECORDS CHECKS ON ALL EMPLOYEES AND CONTRACTORS. INTERVIEW WITH HUMAN RESOURCES DIRECTOR INDICATE 5 YEAR FINGERPRING CHECKS ARE CONDUCTED ON ALL CONTRACTORS AND EMPLOYEES. STAFF ARE REQUIRED TO SELF EVALUATE FOR HIRING & PROMOTIONS. STAFF HAVE AN AFFIRMATIVE DUTY TO DISCLOSE SHOULD THEY BE ARRESTED OR HAVE POLICE CONTACT. THE SIGNED ACKNOWLEDGEMENT FORMS ARE LOCATED IN THEIR PERSONNEL FILES. AGENCY ALSO RECEIVE NOTICE THROUGH DEPT. OF JUSTICE IF AN EMPLOYEE IS ARRESTED, WHICH WAS VERIFIED THROUGH PERSONNEL FILE REVIEW BY AUDITOR.

f) POLICY #220 MANDATES THE CRIMINAL HISTORY BACKGROUND CHECK FORM ASKS ALL APPLICANTS DIRECTLY ABOIUT PREVIOUS SEXUAL ABUSE MISCONDUCT. NARRATIVE INCLUDES NARRATIVE FOR HIRING INTERVIEWS OR PROMOTIONS TO INCLUDE A CONTINUING AFFIRMATIVE DUTY TO DISCLOSE SUCH MISCONDUCT. Policy #230 MANDATES STAFF TO COMPLETE A WRITTEN SELF-EVALUATION DURING ANNUAL STAFF EVALUATION REGARDING CRITERIA IDENTIFIED IN STANDARD 115.217(f).

g) INTERVIEW WITH HUMAN RESOURCED DIRECTOR INDICATE CURRENT EMPLOYEES AND INITIAL APPLICANTS HAVE AN AFFIRMATIVE DUTY TO DISCLOSE ANY PREVIOUS SEXUAL ABUSE MISCONDUCT AS IDENTIFIED IN STANDARD PROVISION 115.217(a). DIRECTOR INDICATES HIRING & PROMOTIONAL INTERVIEWS ASK QUESTIONS RELATED TO CRITERIA IDENTIFIED IN STANDARD PROVISION 115.217(a). AUDITOR VERIFIED THE AFFIRMATIVE DUTY TO DISCLOSE FORM DURING PERSONNEL FILE REVIEW.

h) POLICY #220 MANDATES MATERIAL OMISSIONS REGARDING SUCH MISCONDUCT OR THE PROVISION OF MATERIALLY FALSE INFORMATION ARE GROUNDS FOR TERMINATION.

i) POLICY #220 PROVIDES NARRATIVE COMPLIANT WITH STANDARD PROVISION 115.217(h) TO PROVIDE INFORMATION ON SUBSTANTIATED ALLEGATIONS OF SEX ABUSE/HARASSMENT INVOLVING A FORMER EMPLOYEE UPON RECEIVING REQUEST FROM INSTITUTIONAL EMPLOYER FOR WHOM SUCH EMPLOYEE HAS APPLIED TO WORK.

j) INTERVIEW WITH HUMAN RESOURCES DIRECTOR INDICATE ONCE RECEIVING A RELEASE OF INFORMATION SIGNED BY FORMER EMPLOYEE, AGENCY PROVIDES INFORMATION ON SUBSTANTIATED ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.217 AS PROVISIONS 115.217(a), 115.217(c) & 115.217(d) ARE NON-COMPLIANT

CORRECTIVE ACTION:

115.217(a): AGENCY TO PROVIDE AUDITOR WITH COPIES OF BACKGROUND CLEARANCES EMPLOYMENT APPLICATION AND BACKGROUND SOURCE MATERIAL FOR IDENTIFIED STAFF MEMBER WHO IS MISSING THIS DOCUMENTATION FROM THE PERSONNEL FILE. (SEE ATTACHED ISSUE PAPER FOR IDENTIFIER)

115.217(c): AGENCY TO PROVIDE AUDITOR WITH FBI/CBI OR NCIC BACKGROUND CLEARANCE VERIFICATION FOR THE 1 STAFF MEMBER IDENTIFIED (SEE ATTACHED ISSUE PAPER FOR IDENTIFIER)

115.217(d): AGENCY TO PROVIDE AUDITOR WITH FBI/CBI OR NCIC BACKGROUND CLEARANCE VERIFICATION 1 BTS AND 2 CEO CONTRACTORS. (SEE ATTACHED ISSUE PAPER FOR IDENTIFIERS)

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: OCTOBER 6, 2016

CORRECTIVE ACTION COMPLETION 9/23/16:

AGENCY HAS PROVIDED AUDITOR WITH COMPLETED FBI BACKGROUND CHECKS FOR 2 STAFF MEMBERS, 1 BTS CONTRACTOR AND 2 CEO CONTRACTORS WHICH WERE NOT PREVIOUSLY PROVIDED DURING THE ON-SITE REVIEW. THE BACKGROUND SOURCE MATERIAL MISSING FROM THE PERSONNEL FILE FOR THE 1 IDENTIFIED STAFF MEMBER WAS LOCATED AND PROVIDED TO AUDITOR FOR COMPLIANCE VERIFICATION WITH THE STANDARD.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.217

115.218	Upgrades to facilities and technology

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) AGENCY INDICATES NO ACQUISITION OF FACILITY, SUBSTANTIAL EXPANSION OR MODIFICATION TO EXISTING FACILITIES SINCE AUGUST 20, 2012. INTERVIEW WITH AGENCY HEAD & DIRECTOR INDICATE AGENCY HAS NOT ACQUIRED A NEW FACILTY NOR MADE SUBSTANTIAL EXPANSION TO EXISTING FACILITIES SINCE 8/20/12.

b) AGENCY INDICATES NO ACQUISITION OF FACILITY, SUBSTANTIAL EXPANSION OR MODIFICATION TO EXISTING FACILITIES SINCE AUGUST 20, 2012. INTERVIEW WITH AGENCY HEAD & DIRECTOR INDICATE NO ADDITIONAL VIDEO MONITORING INSTALLATION SINCE AUGUST 20, 2012.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.218.

115.221	**Evidence protocol and forensic medical examinations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) AGENCY INVESTIGATORS ARE TRAINED VIA NIC INVESTIGATOR TRAINING FOR SEX ABUSE INVESTIGATION IN A CONFINEMENT SETTING. AGENCY CONDUCTS ONLY ADMINISTRATIVE INVESTIGATIONS. CRIMINAL INVESTIGATIONS ARE HANDLED VIA PUEBLO PD. POLICY 165 B PROVIDES EVIDENCE PROTOCOL TO BE FOLLOWED BY ALL STAFF, CONTRACTORS & VOLUNTEERS FOR CRIME SCENE EVIDENCE & PROTECTION. PUEBLO PD UNSIGNED MOU PROVIDED. INTERVIEW WITH RANDOM SAMPLE OF 12 STAFF INDICATES ADMINISTRATIVE INVESTIGATIONS ARE CONDUCTED IN-HOUSE. SHOULD THE INITIAL INVESTIGATION DETERMINE TO BE CRIMINAL IN NATURE, THE CASE IS HANDLED BY PUEBLO PD. PUEBLO FACILITY INVESTIGATORS WILL ASSIST WITH INVESTIGATION TO OBTAIN & PROVIDE VIDEO MONITORING, INITIAL VICTIM & WITNESS INTERVIEWS ETC.

b) PAQ INDICATES PROTOCOL NOT DEVELOPMENTALLY APPROPRIATE FOR YOUTH, HOWEVER, AGENCY INDICATES PROTOCOL IS GLEANED FROM THE NIC INVESTIGATOR TRAINING WHICH IS DEVELOPMENTALLY APPROPRIATE FOR YOUTH. THIS IS AN ADULT ONLY FACILITY. POLICY 165 B PROVIDES EVIDENCE PROTOCOL TO BE FOLLOWED BY ALL STAFF, CONTRACTORS & VOLUNTEERS. PROTOCOL NOT DEVELOPMENTALLY APPROPRIATE FOR YOUTH, HOWEVER, AGENCY INDICATES THE PROTOCOL USED IS GLEANED FROM THE NIC INVESTIGATOR TRAINING WHICH IS NOT DEVELOPMENTALLY APPROPRIATE FOR YOUTH. THIS IS AN ADULT ONLY FACILITY. POLICY 165 B PROVIDES EVIDENCE PROTOCOL TO BE FOLLOWED BY ALL STAFF, CONTRACTORS & VOLUNTEERS.

c) POLICY 165 MANDATES FORENSIC MEDICAL EXAMINATIONS BE OFFERED TO VICTIMS OF SEX ABUSE WITHOUT FINANCIAL COST. FORENSIC EXAMINATIONS ARE CONDUCTED AT PARKVIEW MEDICAL HOSPITAL. UNSIGNED MOU PROVIDED. AGENCY PROVIDED MOU AND E-MAIL COMMUNICATION BETWEEN ENTITIES WHICH VERIFIES ATTEMPTS TO OBTAIN MOU. DISCUSSIONS FOR MOU RATIFICATION ARE ONGOING. NO FORENSIC EXAMINATIONS OCCURRED OVER THE PAST 12 MONTHS. INTERVIEW WITH SANE NURSE AT PARKVIEW MEDICAL HOSPITAL VERIFIES SHOULD A RESIDENT VICTIM OF SEXUAL ABUSE ARRIVE AT THE HOSPITAL, THE 24/7 ON-CALL SANE NURSE STAFF IMMEDIATELY BEGIN THE FORENSIC PROTOCOLS.

d) POLICY 165 D-2 PROVIDES CONTACT WITH OUTSIDE RAPE CRISIS CENTER FOR VICTIM ADVOCACY. AGENCY IDENTIFIED PUEBLO RAPE CRISIS SERVICES CENTER FOR VICTIM ADVOCACY AND PROVIDED UNSIGNED MOU ACCOMPANIED BY E-MAIL DOCUMENTATION TO INDICATE ATTEMPTS TO OBTAIN MOU FOR ADVOCACY SERVICES. INTERVIEW WITH PREA COORDINATOR & PUEBLO RAPE CRISIS CENTER STAFF VERIFIES FACILITY'S USE OF PUEBLO RAPE CRISIS CENTER FOR VICTIM ADVOCACY. PUEBLO RAPE CRISIS CENTER ADVOCATES WERE AVAILABLE FOR EMOTIONAL SUPPORT DURING PREA AUDIT INTERVIEWS SHOULD THERE BE A NEED.

e) UNSIGNED PUEBLO RAPE CRISIS CENTER MOU PROVIDED WHICH VERIFIED SCOPE OF SERVICES COMPLIANT WITH STANDARD PROVISIONS IN THAT ADVOCATES ACCOMPANY VICTIM THROUGH THE FORENSIC EXAMINATION PROCESS. E-MAIL COMMUNICATION BETWEEN PUEBLO RAPE CRISIS CENTER & ICCS VERIFIES ATTEMPTS TO RATIFY THE MOU FOR ADVOCACY SERVICES. INTERVIEW WITH PREA COORDINATOR VERIFIES FACILITY'S USE OF SAVA CENTER FOR VICTIM ADVOCACY. INTERVIEW WITH DIRECTOR OF THE PUEBLO RAPE CRISIS CENTER INDICATE THEY ARE AVAILABLE THROUGHOUT THE FORNESIC EXAMINATION PROCESS, AFTER FORENSIC EXAMINATION PROCESS, THROUGH THE PROSECUTION PHASE AND MONITORING AFTER THE LEGAL PROCESSES HAVE COMPLETED FOR VICTIMS OF SEXUAL ABUSE.

f) SIGNED PUEBLO PD MOU PROVIDED BY AGENCY. PUEBLO PD AGREES TO PROVIDE STATUS OF INVESTIGATIONS THROUGHOUT THE INVESTIGATIVE PROCESS. INTERVIEW WITH DIRECTOR & PREA COORDINATOR VERIFIES GOOD WORKING RELATIONSHIP WITH PUEBLO PD & ICCS WOULD BE KEPT APPRISED OF STATUS OF INVESTIGATIONS.

g) N/A – STANDARD PROVISION NOT APPLICABLE TO AGENCY/FACILITY PER DOJ

h) N/A – STANDARD PROVISION NOT APPLICABLE TO AGENCY/FACILITY PER DOJ

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.221.

115.222	Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY 165 MANDATES ALL REPORTED ACTS OF SEXUAL ABUSE OR SEXUAL MISCONDUCT WHETHER IT OCCURS IN COMMUNITY CORRECTIONS OR ANY OTHER LOCATION WHERE CLIENTS ARE HOUSED, WORK OR ARE PROVIDED SERVICES WILL BE INVESTIGATED IN ACCORDANCE WITH ESTABLISHED LOCAL LAW ENFORCEMENT AGENCY'S INVESTGATIVE STANDARDS & PROTOCOLS. PAQ ISSUED BY AGENCY REPORTS 5 ALLEGATIONS OF SEX ABUSE/HARASSMENT RECEIVED IN LAST 12 MONTHS. NO ALLEGATION REFERRED FOR CRIMINAL INVESTIGATION & 5 RESULTED FOR ADMINISTRATIVE INVESTIGATION. INTERVIEW WITH AGENCY HEAD INDICATES ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT ARE INVESTIGATED. REVIEW OF ALL 5 CASES INDICATED THEY WERE ALL ADMINISTRATIVELY INVESTIGATED. 2 WERE NOT ALLEGATIONS OF SEX ABUSE/HARASSMENT, BUT ADMINISTRATION STAFF DISCOVERY OF PHONE COMMUNICATION BETWEEN STAFF & RESIDENTS WHICH RESULTED IN STAFF DISMISSAL. 1 INVESTIGATION WAS REGARDING ALLEGATION OF SEXUAL HARASSMENT RESIDENT ON RESIDENT THROUGH BEHAVIORAL TREATMENT STAFF (BTS), WHICH RESULTED IN RESIDENTS BEING SEPARATED VIA REHOUSING & RESIDENT WHO MADE ALLEGATION WAS MONITORED FOR RETALIATION THROUGH BTS. THE 2 INVESTIGATIONS WAS REGARDING STAFF SEARCH OF RESIDENTS, BOTH ALLEGATIONS WERE DROPPED BY BOTH RESIDENTS.

b) POLICY 165 INCORPORATES NARRATIVE CONSISTENT WITH STANDARD PROVISION 115.222(B). INFORMATION IS INCLUDED ON AGENCY WEBSITE.INTERVIEW WITH INVESTIGATION STAFF INDICATE ALLEGATIONS OF SEXUAL ABUSE ARE CONSIDERED CRIMINAL IN NATURE AND IMMEDIATELY REFERRED TO GREELEY PD FOR INVESTIGATION. ADMINISTRATIVE CASES ARE INVESTIGATED VIA IN-HOUSE CERTIFIED INVESTIGATORS.

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

d) N/A – STANDARD PROVISION NOT APPLICABLE TO AGENCY/FACILITY PER DOJ

e) N/A – STANDARD PROVISION NOT APPLICABLE TO AGENCY/FACILITY PER DOJ

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.222.

115.231	Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

1. POLICY #255 MANDATES 40 HOURS OF TRAINING OF ALL STAFF WITHIN 90 DAYS OF EMPLOYMENT. TRAINING CURRICULUM & EMPLOYEE TRAINING PPT MEETS STANDARD PROVISION 115.221(a). INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATE 100% OF THOSE INTERVIEWED RECEIVED INITIAL PREA ORIENTATION VIA PREA VIDEO UPON HIRE & ALL RECEIVED THEIR FULL PREA TRAINING WITHIN 45 DAYS FROM HIRE DATE. REVIEW OF RANDOM SAMPLE OF 12 STAFF TRAINING RECORDS VERIFIED STATEMENTS MADE BY STAFF. MAJORITY OF STAFF INTERVIEWED WERE ABLE TO PROVIDE AUDITOR WITH TOPICS THAT WERE COVERED DURING THE TRAINING.
2. POLICY #255 MANDATES EMPLOYEES REASSIGNED FROM FACILITIES HOUSING THE OPPOSITE GENDER ARE GIVEN ADDITIONAL TRAINING SPECIFIC TO THAT GENDER. TRAINING PPT SPECIFIC TO ALL MALE, ALL FEMALE & CO-ED. REVIEW OF TRAINING RECORDS & TRAINING CURRICULUM VERIFIES STAFF IS TRAINED FOR WORKING IN BOTH MALE & FEMALE UNITS. PUEBLO FACILITY IS A COE-ED FACILITY.
3. AGENCY CLAIMS 100% EMPLOYEE TRAING OR RETRAINING FOR STAFF IN PREA REQUIREMENTS. REFRESHER PPT STAFF TRAINING PROVIDED FOR COMPLIANCE VERIFICATION. REVIEW OF TRANINING RECORDS OF RANDOM STAFF INDICATE 100% OF THOSE INTERVIEWED RECEIVED INITIAL PREA ORIENTATION VIA PREA VIDEO UPON HIRE & ALL RECEIVED THEIR FULL PREA TRAINING WITHIN 45 DAYS OF HIRE.
4. POLICY #265 #F MANDATES ALL STAFF RECEIVING TRAINING WILL SIGN A TRAINING FORM ACKNOWLEDGING THE TRAINING THEY HAVE RECEIVED. STAFF TRAINING ACKNOLWEDGEMENT SHEETS PROVIDED BY AGENCY DURING ON-SITE AUDIT REVIEW.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.231.

115.232	Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

1. POLICY #265-F MANDATES EACH INTERN, VOLUNTEERS AND CONTRACTORS WILL BE TRAINED ON ICCS ZERO TOLERANCE POLICY & HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT. TRAINING WILL BE BASED ON SERVICES THEY PROVIDE AND THE LEVEL OF CONTACT THEY HAVE WITH RESIDENTS. EACH WILL SIGN TRAINING FORM TO ACKNOWLEDGE THE TRAINING THEY HAVE RECEIVED. TRAINNG CURRICULUM PROVIDED AGENCY INDICATES 7 VOLUNTEERS & CONTRACTORS HAVE BEEN TRAINED IN PREA WHICH ACCOUNTS TO 100% OF VOLUNTEERS & CONTRACTORS TRAINED. INTERVIEW WITH RANDOM SAMPLE OF 2 VOLUNTEERS & 2 CONTRACTORS INDICATE PREA TRAINING WAS PROVIDED IN JANUARY AND FEBRUARY 2016 & WAS ABLE TO PROVIDE AUDITOR WITH SOME OF THE TOPICS COVERED THROUGH PROBING QUESTIONS BY AUDITOR. BRINGS INTO QUESTION IF VOLUNTEERS & CONTRACTORS HAVE HAD THE OPPORTUNITY TO DEMONSTRATE & PRACTICE RESPONSIBILITIES REGARDING SEXUAL ABUSE/SEXUAL HARASSMENT TRAINING LEARNED. REVIEW OF SAMPLE TRAINING RECORDS INDICATE ALL BUT 1 BTS CONTRACTOR HAD VERIFIABLE DOCUMENTATION TO PROVE TRAINING WAS CONDUCTED.
2. POLICY #265-F MANDATES EACH INTERN, VOLUNTEERS AND CONTRACTORS WILL BE TRAINED ON ICCS ZERO TOLERANCE POLICY & HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT. TRAINING WILL BE BASED ON SERVICES THEY PROVIDE AND THE LEVEL OF CONTACT THEY HAVE WITH RESIDENTS. EACH WILL SIGN TRAINING FORM TO ACKNOWLEDGE THE TRAINING THEY HAVE RECEIVED. INTERVIEW WITH RANDOM SAMPLE OF 1 VOLUNTEERS & 2 CONTRACTORS VERIFY TRAINING RECEIVED HAS BEEN BASED ON THE SERVICES THEY PROVIDE AND LEVEL CONTACT THEY HAVE WITH RESIDENTS.
3. POLICY #265-F MANDATES EACH INTERN, VOLUNTEERS AND CONTRACTORS WILL BE TRAINED ON ICCS ZERO TOLERANCE POLICY & HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT. EACH WILL SIGN TRAINING FORM TO ACKNOWLEDGE THE TRAINING THEY HAVE RECEIVED.
4. OF THE 1 VOLUNTEER & 7 CONTRACTORS IDENTIFIED BY FACILITY, AUDITOR RECEIVED 1 BTS AND 5 CEO ACKNOWLEDGEMENT PROVIDED DURING THE ON-SITE REVIEW TO INCLUDE TRAINING SIGN-IN SHEETS FOR 7 VOLUNTEER/CONTRACTORS. 1 VOLUNTEER AND 1 BTS CONTRACTOR WAS MISSING PREA ACKNOWLEDGEMENT IN THE TRAINING FILES

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.232 AS PROVISIONS 115.232(a) & 115.232(c) ARE NON-COMPLIANT.

CORRECTIVE ACTION:

115.232(a): AGENCY TO PROVIDE AUDITOR WITH TRAINING ACKNOWLEDGEMENT OF BTS CONTRACTOR. (SEE ATTACHED ISSUE LOG FOR IDENTIFIER)

115.232(d): AGENCY TO PROVIDE AUDITOR WITH TRAINING ACKNOWLEDGEMENT OF VOLUNTEERS (SEE ATTACHED ISSUE LOG FOR IDENTIFIER)

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: OCTOBER 6, 2016

CORRECTIVE ACTION COMPLETION 9/23/16:
AGENCY PROVIDED AUDITOR WITH TRAINING ACKNOWLEDGEMENT FORMS FOR BOTH BTS AND CEO CONTRACTORS THAT WERE NOT AVAILABLE DURING THE ON-SITE AUDIT. BOTH FORMS WERE SIGNED BY THE CONTRACTORS DURING THE APRIL 2016 TRAINING.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.232

115.233	Resident education

■ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #160-A, #160-D-1, #405-C-16 MANDATE RESIDENT RECEIVE ZERO TOLERANCE POLICY, HOW TO REPORT INCIDENTS OF SEX ABUSE/HARASSMENT & RELEVANT PREA POLICIES. RESIDENTS ARE PROVIDED PREA BROCHURE BOTH IN ENGLISH AND SPANISH. AGENCY INDICATES OVER THE PAST 12 MONTHS 333 RESIDENTS HAVE BEEN ADMITTED TO FACILITY & ALL HAVE RECEIVED PREA EDUCATION AT INTAKE. INTERVIEW WITH INTAKE STAFF INDICATE RESIDENTS RECEIVE PREA TRAINING WITHIN 72 HOURS OF INTAKE. STAFF GOAL IS TO PROVIDE PREA EDUCATION ON DAY OF INTAKE. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEY RECEIVE THE PREA VIDEO ON DAY OF INTAKE & ARE PROVIDED HANDBOOK WHICH INCLUDES PREA RIGHTS & REPORTING INFORMATION. REVIEW OF 12 RANDOM RESIDENT SCREENING FILES BY AUDITOR VERIFY ALL RECEIVED PREA INFORMATION AT DAY OF INTAKE.
b) POLICY #160-D MANDATES WHENEVER RESIDENTS TRANSFERRED TO A DIFFERENT FACILITY SHALL BE PROVIDED REFRESHER TRAINING. THERE HAS BEEN ONE INTRA-AGENCY TRANSFER OF RESIDENTS. INTERVIEW WITH INTAKE STAFF VERIFY ANY RESIDENT WHO IS ADMITTED TO FACILITY SHALL GO THROUGH SCREENING AND PREA

TRAINING EVEN IF THEY ARE TRANSFERRED TO ANOTHER FACILITY. OVER PAST 12 MONTHS, NO RESIDENT WAS TRANSFERRED FROM ANOTHER FACILITY TO THE PUEBLO FACILITY.

c) POLICY #160 MANDATES ICCS PROVIDE RESIDENT EDUCATION IN FORMATS ACCESSIBLE TO ALL RESIDENTS INCLUDING RESIDENTS WHO MEET CRITERIA OF THIS STANDARD PROVISION. RESIDENT BROCHURES ARE PROVIDED IN BOTH ENGLISH & SPANISH AND THE RULES OF CONDUCT WHICH IDENTIFIES PREA ON PAGE 15 IS IN BOTH ENGLISH & SPANISH. VOIANCE INTERPRETIVE SERVICES CONTRACT PROVIDED. POLICY 405 MANDATES STAFF TO DETERMINE COMMUNICATION ABILITIY OF RESIDENT & PROVIDE INTERPRETERS IF RESIDENT IS LEP & PROVIDE MATERIALS IN MULTIPLE FORMATES TO ENSURE EFFECTIVE COMMUNICATION WITH RESIDENTS WHO HAVE INTELLECTUAL DISABILITIES, LIMITED READING SKILLS, OR WHO ARE BLIND & LOW VISION. THESE FORMATS WILL INCLUDE, BUT NOT LIMITED TO, WRITTEN MATERIAL AND VERBAL COMMUNICATION. NO WRIITTEN MATERIAL TO ASSIST COMMUNICATION WITH RESIDENTS WITH INTELLECTUAL DISABILITIES OR LIMITED READING SKILLS, BLIND OR LOW VISION PROVIDED.

d) POLICY #160 MANDATES ICCS PROVIDE RESIDENT EDUCATION IN FORMATS ACCESSIBLE TO ALL RESIDENTS INCLUDING RESIDENTS WHO MEET CRITERIA OF THIS STANDARD PROVISION. RESIDENT BROCHURES ARE PROVIDED IN BOTH ENGLISH & SPANISH AND THE RULES OF CONDUCT WHICH IDENTIFIES PREA ON PAGE 15 IS IN BOTH ENGLISH & SPANISH. VOIANCE INTERPRETIVE SERVICES CONTRACT PROVIDED. POLICY 405 MANDATES STAFF TO DETERMINE COMMUNICATION ABILITIY OF RESIDENT & PROVIDE INTERPRETERS IF RESIDENT IS LEP & PROVIDE MATERIALS IN MULTIPLE FORMATES TO ENSURE EFFECTIVE COMMUNICATION WITH RESIDENTS WHO HAVE INTELLECTUAL DISABILITIES, LIMITED READING SKILLS, OR WHO ARE BLIND & LOW VISION. THESE FORMATS WILL INCLUDE, BUT NOT LIMITED TO, WRITTEN MATERIAL AND VERBAL COMMUNICATION. NO WRITTEN MATERIAL TO ASSIST COMMUNICATION WITH RESIDENTS WITH INTELLECTUAL DISABILITIES OR LIMITED READING SKILLS, BLIND OR LOW VISION PROVIDED.

e) POLICY #405-C-16 MANDATES AFTER RESIDENT VIEWS PREA VIDEO HE/SHE WILL SIGN THE TRAINING ACKNOWLEDGEMENT FORM FOLLOWED BY STAFF MEMBER WHO PROVIDED THE TRAINING. THE FORM WILL BE MAINTAINED IN RESIDENTS FILE. AUDITOR REVIEWED SAMPLE OF 12 RESIDENT SCREENING RECORDS & OBTAINED DOCUMENTED ACKNOWLEDGEMENT FORMS WHICH VERIFIES RESIDENT PARTICIPATION IN PREA EDUCATION. WRITTEN MATERIALS AVAILABLE VIA PREA BROCHURES IN BOTH ENGLISH & SPANISH. THE RULES OF CONDUCT WHICH IDENTIFIES PREA ON PAGE 15 WAS PROVIDED IN ENGLISH & SPANISH. ONE DOOR POSTER (ENGLISH ONLY) PROVIDED WHICH IDENTIFIES CONFIDENTIAL REPORTING SOURCES, INDICATES CALL IS NOT MONITORED & PROVIDES LIMITS OF CONFIDENTIALITY. DURING ON-SITE REVIEW, AUDITOR OBSERVED NOTICE OF AUDITOR AND PREA POSTERS PROVIDING EDUCATION ON ZERO TOLERANCE AND REPORTING INSTRUCTIONS AND REPORTING CONTACTS THROUGHOUT THE FACILITY. POSTERS WERE LOCATED BETWEEN THE PHONES ON EACH HALLWAY OF RESIDENTIAL AREAS AND BEHIND THE DOORS OF EVERY RESIDENT ROOM. PREA EDUCATION INFORMATION IS PROVIDED ON ALL ADMINISTRATION, THERAPIST AND CASE MANAGER DOORS. INFORMATION IS PROVIDED IN RESIDENT HANDBOOK & PAMPLETS

UPON INTAKE. AGENCY EXCEEDS STANDARD PROVISION 115.233(e) WITH THEIR CONTINUOUS EDUCATION PRACTICES.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.233 AS PROVISION 115.233(d) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.233(d): AGENCY TO PROVIDE AUDITOR WITH WRITTEN MATERIAL OR METHOD WHICH ASSISTS STAFF IN COMMUNICATION WITH RESIDENTS WITH INTELLECTUAL DISABILITIES, LIMITED READING SKILLS, BLIND OR LOW VISION.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: OCTOBER 6, 2016

CORRECTIVE ACTION COMPLETION 9/23/16:
AGENCY PROVIDED AUDITOR WITH COPY OF "ENDING SILENCE" COMIC BOOKS FOR MALE, FEMALE AND TRANSGENDER EFFECTIVE COMMUNICATION. THESE BOOKS WERE CREATED BY THE UNIVERSITY OF WASHINGTON COLLEGE OF LAW IN COLLABORATION WITH THE PREA RESOURCE CENTER AND BUREAU OF JUSTICE ADMINISTRATION. THE BOOKS PROVIDE A METHOD TO COMMUNICATE WITH RESIDENTS WHO ARE DEVELOPMENTALLY DISABLED AND THOSE WITH LIMITED READING SKILLS. CASE MANAGERS WILL READ THE INMATE RIGHTS AND SEXUAL ABUSE/HARASSMENT REPORTING INFORMATION TO RESIDENTS WHO ARE BLIND OR HAVE LOW VISION PER UPDATED POLICY 600. ALL CASE MANAGERS HAVE SIGNED ACKNOWLEDGEMENT THAT THEY HAVE REVIEWED THE UPDATED POLICY AND UNDERSTAND THE INFORMATION.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.233

115.234	Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

115.234 (a) THRU (c). PUEBLO FACILITY HAS 2 TRAINED STAFF INVESTIGATORS FOR ADMINISTRATIVE INVESTIGATIONS OF SEXUAL ABUSE/HARASSMENT INVESTIGATIONS. VERIFICATION CERTIFICATES NIC INVESTIGATOR TRAINING COMPLETION FOR BOTH INVESTIGATORS PROVIDED. INTERVIEW WITH INVESTIGATIVE STAFF VERIFY COMPLETION OF SPECIAL INVESTIGATOR TRAINNG AND DESCRIPTION OF TOPICS OF SAID TRAINING.

b) POLICY #160 MANDATES THAT BEFORE CONDUCTING ANY ADMINISTRATIVE INVESTIGATION, ALL ICCS SUPERVISORS, PROGRAM DIRECTORS, AND THE PREA COORDINATOR WILL COMPLETE THE INVESTIGATOR TRAINING AS OUTLINED IN 115.234 (a) THRU (c). INTERVIEW WITH INVESTIGATIVE STAFF INDICATE ALL INVESTIGATORS ARE TRAINED THROUGH NIC SEXUAL ABUSE INVESTIGATION COURSE FOR INVESTIGATIONS IN A CORRECTIONAL SETTING. SUCH TRAINING MEETS STANDARD PROVISION 115.234(b).
c) 2 NIC INVESTIGATOR TRAINING COMPLETION CERTIFICATION PROVIDED WHICH VERIFIES COMPLIANCE WITH STANDARD PROVISION 115.234(c).
d) N/A – STANDARD PROVISION 115.234(d) IS NOT APPLICABLE TO AGENCY/FACILITY PER DOJ.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.234

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165, IDENTIFIED TO SUPPORT COMPLIANCE OF THIS STANDARD PROVISION DOES NOT PROVIDE ANY SPECIALIZED TRAINING PROCEDURES SPECIFIC TO MENTAL HEALTH CARE. POLICY #165 MANDATES MENTAL HEALTH WORKERS MUST COMPLETE THE SAME PREA TRAINING AS EMPLOYEES. AGENCY INDICATES 2 BEHAVIORAL TREATMENT SERVICES (BTS) STAFF WHO WORK REGULARLY AT THE FACILITY HAVE RECEIVED TRAINING. THIS ACCOUNTS FOR 100% OF BTS STAFF TRAINED. MENTAL HEALTH STAFF IS CONTRACTED THROUGH BTS TO PERFORM SERVICES AT ICCS & NO MEDICAL STAFF ARE ASSIGNED TO ICCS AS ALL MEDICAL ACTIVITIES ARE CONDUCTED AT PARKVIEW MEDICAL CENTER.

b) INTERVIEW WITH 1 MENTAL HEALTH STAFF (BTS) INDICATE PREA TRAINING RECIEVED ON 12/28/15. STAFF INDICATED ALL TOPICS AS IDENTIFIED IN STANDARD PROVISION 115.235(a) CRITERIA, MOST OF WHICH MENTAL HEALTH STAFF RECEIVE DURING THEIR TRAINING AS MENTAL HEALTH PROFESSIONALS. REVIEW OF BTS STAFF TRAINING RECORDS VERIFIES TRAINING WAS CONDUCTED AS ACKNOWLEDGEMENT DOCUMENTATION WAS PROVIDED. 1 STAFF MEMBER WAS MISSING TRAINING VERIFICATION DOCUMENTATION. NO MEDICAL STAFF HIRED BY AGENCY FOR THIS FACILITY.
c) N/A – STANDARD PROVISION 115.235(b) DOES NOT APPLY TO AGENCY/FACILTY. FORENSIC EXAMINATIONS ARE CONDUCTED AT PARKVIEW MEDICAL CENTER, NOT AT THE FACILITY.
d) AGENCY MAINTAINS TRAINING RECORDS FOR VERIFICATION THAT MENTAL HEALTH PRACTITIONERS HAVE COMPLETED THE REQUIRED TRAINING. NO MEDICAL STAFF EMPLOYED AT FACILITY.
e) ALL STAFF, INCLUDING MENTAL HEALTH PRACTITIONERS, RECEIVE THE SAME PREA TRAINING PER POLICY#165 AS EVIDENCED THROUGH MENTAL HEALTH PRACTITIONER INTERVIEW.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.235 AS PROVISIONS 115.235(b) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.235(b): AGENCY TO PROVIDE AUDITOR WITH PREA TRAINING ACKNOWLEDGMENT FOR MENTAL HEALTH STAFF MEMBER MISSING THE TRAINING DOCUMENTATION FROM THE TRAINING FILE. (SEE ACCOMPANYING ISSUE PAPER FOR IDENTIFIER).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: <u>OCTOBER 6, 2016</u>

<u>CORRECTIVE ACTION COMPLETION 9/23/16</u>:
AGENCY PROVIDED AUDITOR WITH TRAINING ACKNOWLEDGEMENT FORM FOR MISSING MENTAL HEALTH STAFF MEMBER. FORM WAS UNAVAILABLE DURING THE ON-SITE AUDIT AND WAS SIGNED DURING THE MARCH 2016 TRAINING.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.235

115.241	Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #160 & POLICY #600 MANDATES THAT WITHIN 72 HOURS OF ADMISSION, THE CASE MANAGER WILL CONDUCT A RISK ASSESSMENT TO ENSURE THOSE AT HIGH RISK OF BEING SEXUALLY ABUSED ARE NOT HOUSED WITH THOSE WHO ARE AT RISK OF BEING SEXUALLY ABUSIVE. INTERVIEWS WITH RANDOM SAMPLE OF 12 STAFF &12 RESIDENTS INDICATE RESIDENTS ARE SCREENED WITHIN 72 HOURS OF ADMISSION TO THE FACILITY AND SCREENED WHEN TRANSFERRED BETWEEN FACILITIES. THROUGHOUT THE FACILITY TOUR WEEK, AUDITOR OBSERVED CONTINUOUS SCREENING OF RESIDENTS UPON INTAKE.
b) POLICY 600 MANDATES THAT WITHIN 72 HOURS OF ADMISSION, THE CASE MANAGER WILL CONDUCT A RISK ASSESSMENT TO ENSURE THOSE AT HIGH RISK OF BEING SEXUALLY ABUSED ARE NOT HOUSED WITH THOSE WHO ARE AT RISK OF BEING SEXUALLY ABUSIVE. AGENCY INDICATES 100% OF THE 195 RESIDENTS WHO ENTERED THE FACILITY OVER THE PAST 12 MONTHS WHO'S LENGTH OF STAY WAS FOR 72 HOURS OR MORE WERE SCREENED WITHIN 72 HOURS OF INTAKE. INTERVIEW WITH SCREENING STAFF & 12 RANDOM SAMPLE OF RESIDENTS CONFIRM AGENCYFACILITY'S COMPLIANCE WITH STANDARD PROVISION 115.241(b). REVIEW OF RANDOM SAMPLE OF 12 SCREENING RECORDS INDICATE THE 72 HOUR SCREENING WAS CONDUCTED SAME DAY AS DATE OF INTAKE FOR ALL CASES REVIEWED.
c) SCREENING INSTRUMENTS USED FOR ALL RESIDENTS ARE COMPLIANT WITH STANDARD PROVISION 115.241(c).
d) SCREENING INSTRUMENT INCLUDES ALL 9 CRITERIA IDENTIFIED IN STANDARD 115.41(d). INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING INDICATES THE SCREENING CONSIDERS CRITERIA INCLUDED IN STANDARD PROVISION TO INCLUDE BOTH PREDATOR & VICTIM CHARACTERISTICS, HANDICAPPED RESIDENTS WHO MAY BE CONSIDERED VULNERABLE. REVIEW OF OBJECTIVE SCREENING INSTRUMENT VERIFIES IT IS CONSTRUCTED IN A WAY TO PROVIDED YES/NO ANSWERS, GRADED CLASSIFICATION STATUS BASED UPON THE ANSWERS, AREA FOR OVERRIDE AND ADDITIONAL FACTORS SECTION. SCREENING DATA RESULTS ARE LOADED INTO THE ELECTRONIC E-TRAC SYSTEM FOR MANAGEMENT PURPOSES.
e) SCREENING INSTRUMENT CONSIDERS PRIOR ACTS OF SEXUAL ABUSE, PRIOR CONVICTIONS FOR VIOENT OFFENSES AND HISTORY OF PRIOR INSTITUTIONAL VIOLENCE OF SEXUAL ABUSE AS KNOWN TO AGENCY AS IDENTIFIED IN STANDARD PROVISION 115.241(e). INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING INDICATE INSTRUMENT CONSIDERS CRITERIA AS IDENTIFIED IN STANDARD 115.241(e).
f) POLICY #600 MANDATES REASSESSMENT WITHIN 30 DAYS OF INTAKE BASED UPON ADDITIONAL INFORMATION OR ANY RELEVANT INFORMATION RECEIVED AFTER THE INITIAL ASSESSMENT. AGENCY INDICATES THAT 158 RESIDENTS ENTERED THE

FACILITY IN THE PAST 12 MONTHS AND ALL WERE REASSESSED FOR THEIR RISK OF VICTIMIZATION OF BEING SEXUALLY ABUSIVE WITHIN 30 DAYS OF INTAKE. INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING INDICATE RESIDENTS ARE REASSESSED WITHIN 30 DAYS OF ARRIVAL AT FACILITY FOR RISK OF VICTIMIZATION OR ABUSIVENESS IF ADDITIONAL INFORMATION WAS RECEIVED BY FACILITY. RESIDENTS ARE SEEN BY CASE MANAGERS MONTHLY. INTERVIEW WITH 12 RANDOM SAMPLE OF RESIDENTS INDICATE THEY CANNOT READILY VERIFY IF WERE REASSESSED BY SCREENING STAFF WITHIN 30 DAYS OF INTAKE. SMALL MINORITY OF 12 RESIDENTS INTERVIEWED INDICATE THEY CANNOT RECALL PREA QUESTIONS AFTER INTAKE. REVIEW OF 12 RANDOM SAMPLE OF SCREENING RECORDS INDICATE ALL BUT 3 RESIDENTS WERE REASSESSED WITHIN THE 30 DAY REASSESSMENT PERIOD AS MANDATED BY STANDARD PROVISION 115.241(f). RECORDS REVIEW REFLECTED 2 RESIDENTS WERE REASSESSED OVER 2 MONTHS PAST THE 30 DAY PERIOD, 1 WAS REASSESSED 1 YEAR PAST THE 30 DAY PERIOD.

g) POLICY #600 MANDATES REASSESSMENT WITHIN 30 DAYS OF INTAKE BASED UPON ADDITIONAL INFORMATION OR ANY RELEVANT INFORMATION RECEIVED AFTER THE INITIAL ASSESSMENT. INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING INDICATE RESIDENTS ARE REASSESSED WITHIN 30 DAYS OF ARRIVAL AT FACILITY FOR RISK OF VICTIMIZATION OR ABUSIVENESS IF ADDITIONAL INFORMATION WAS RECEIVED BY FACILITY. RESIDENTS ARE SEEN BY CASE MANAGERS MONTHLY. INTERVIEW WITH 12 RANDOM SAMPLE OF RESIDENTS INDICATE THEY CANNOT READILY VERIFY IF WERE REASSESSED BY SCREENING STAFF WITHIN 30 DAYS OF INTAKE. SMALL MINORITY OF 12 RESIDENTS INTERVIEWED INDICATE THEY CANNOT RECALL PREA QUESTIONS AFTER INTAKE. REVIEW OF 12 RANDOM SAMPLE OF SCREENING RECORDS INDICATE ALL BUT 3 RESIDENTS WERE REASSESSED WITHIN THE 30 DAY REASSESSMENT PERIOD AS MANDATED BY STANDARD PROVISION 115.241(g). RECORDS REVIEW REFLECTED 2 RESIDENTS WERE REASSESSED OVER 2 MONTHS PAST THE 30 DAY PERIOD, 1 WAS REASSESSED 1 YEAR PAST THE 30 DAY PERIOD.

h) POLICY 600 PROVIDES NARRATIVE TO PROHIBIT DISCIPLINING A RESIDENT FOR REFUSING TO ANSWER OR NOT DISCLOSING COMPLETE INFORMATION IN RESPONSE TO THE INITIAL SCREENING OR REASSESSEMENT. INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING INDICATE RESIDENTS ARE NOT DISCIPLINED FOR FAILING TO ANSWER RISK SCREENING QUESTIONS.

i) POLICY #600 HAS APPROPRIATE CONTROLS INCORPORATED INTO THE NARRATIVE TO MAINTAIN OR CONTROL DISSEMINATION TO SENSITIVE INFORMATION PROVIDED IN SCREENING RESPONSES. ALL INFORMATION IS ENTERED INTO THE E-TRAC SYSTEM BY THE CASE MANAGER WITHING 72 HOURS OF INTAKE. ACCESS TO SCREENING INFORMATION IS NEED TO KNOW FOR SAFETY PURPOSES. INTERVIEWS WITH BOTH PREA COORDINATOR & STAFF RESPONSIBLE FOR RISK SCREENING INDICATE CASE MANAGERS & SECURITY SHIFT LEAD ARE THE ONLY STAFF TO HAVE CLEARANCE TO VIEW SCREENING INFORMATION. INFORMATION IS MAINTAINED ELECTRONICALLY.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.241 AS PROVISIONS 115.241(f) & 115.241(g) ARE NON-COMPLIANT

CORRECTIVE ACTION:

115.241(f) & (g): AGENCY TO PROVIDE AUDITOR 30 DAY REASSESSMENT SCREENING DOCUMENTATION FOR ALL RESIDENTS ADMITTED TO PUEBLO FACILITY BETWEEN APRIL 11,2016 AND JULY 11,2016 FOR AUDITOR TO CONDUCT RANDOM SELECTION COMPLIANCE REVIEW.

AGENCY TO PROVIDE DOCUMENTATION FOR 90 DAY STATUS REVIEW ON JULY 11, 2016, FOR VERIFICATION OF COMPLIANCE.

COMPLIANCE MUST BE ACHIEVED NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: OCTOBER 6, 2016

CORRECTIVE ACTION 10/4/16:

115.241(f) & (g): AGENCY PROVIDED AUDITOR 30-DAY REASSESSMENT SCREENING DOCUMENTATION FOR ALL RESIDENTS ADMITTED TO PUEBLO FACILITY BETWEEN JUNE 20,2016 AND SEPTEMBER 20,2016 FOR AUDITOR TO CONDUCT RANDOM SELECTION COMPLIANCE REVIEW. AUDITOR RANDOMLY SELECTED 15 RESIDENTS TO CONDUCT THE REVIEW. AUDITOR FOUND ALL 15 HAD 30-DAY REASSESSMENTS CONDUCTED WITHIN THE STANDARD MANDATE. AGENCY HAS COMPLIED WITH STANDARD PROVISION 115.241(f) & 115.241(g).

AUDITOR HAS DETERMINED THAT AGENCY METS STANDARD 115.241

115.242	Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

1. AGENCY USES SCREENING INFORMATION TO SEPARATE VICTIMS, POTENTIAL VICTIMS & PREDATORS DURING HOUSING & PROGRAMMING ASSIGNMENTS. AN OBJECTIVE SCREENING INSTRUMENT IS USED ALONG WITH THE CLASSIFICATION FOR HOUSING DOCUMENT, WHICH IDENTIFIES SPECIFIC HOUSING ASSIGNMENTS AND CHARACTERISTICS GLEANED FROM THE SCREENING TOOL. EACH RESIDENT IS EXAMINED INDIVIDUALLY TO PROVIDE SEXUAL SAFETY IN THE FACILITY. INTERVIEW WITH PREA COORDINATOR & STAFF RESPONSIBLE FOR RISK SCREENING INDICATE THE RISK SCREENING INSTRUMENT PROVIDES THE CORRECT ASSIGNMENT VIA CLASSIFICATION TO ENSURE PROPER PLACEMENT. AT THE BOTTOM OF THE SCREENING INSTRUMENT, NARRATIVE STATES, "RISK FACTOR INFORMATION IS FORWARDED TO STAFF RESPONSIBLE FOR ROOM, WORK, EDUCATION AND PROGRAMMING ASSIGNMENTS, WITH THE GOAL OF KEEPING OFFENDERS THAT ARE AT A HIGHER RISK

FOR BEING VICTIMIZED SEPARATED FROM OFFENDERS THAT ARE AT A HIGHER RISK FOR BEING SEXUALLY ABUSIVE TO THE DEGREE POSSIBLE."

2. POLICY #600 MANDATES AGENCY MAKE INDIVIDUAL DETERMINATIONS ON CASE BY CASE BASIS TO ENSURE SAFETY OF EACH RESIDENT. INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING INDICATE ALL SCREENINGS ARE CONDUCTED IN THE CASE MANAGER'S OFFICE OR OTHER CONFIDENTIAL AREA ON A ONE ON ONE BASIS. THE SCREENINGS ARE INDIVIDUALIZED FOR AN OBJECTIVE PLACEMENT DECISION TO BE MADE FOR EACH RESIDENT.
3. POLICY #600 MANDATES AGENCY MAKE INDIVIDUAL DETERMINATIONS ON CASE BY CASE BASIS TO ENSURE SAFETY OF EACH RESIDENT. INTERVIEW WITH PREA COORDINATOR INDICATES TRANSGENDER OR INTERSEX RESIDENTS HOUSING & PROGRAMMING ARE CONSIDERED ON A CASE BY CASE BASIS. THERE ARE NO TRANSGENDER OR INTERSEX RESIDENTS HOUSED AT THE PUEBLO FACILITY AT THIS TIME.
4. POLICY #160 PROVIDES FOR CONSIDERATION PROVIDED FOR TRANSGENDER OR INTERSEX RESIDENT'S OWN VIEWS WITH RESPECT TO HIS OR HER OWN SAFETY. INTERVIEW WITH STAFF RESPONSIBLE FOR RISK SCREENING INDICATE TRANSGENDER OR INTERSEX RESIDENTS OWN VIEWS WITH RESPECT TO HIS OR HER OWN SAFETY IS GIVEN CONSIDERATION WITH REGARDS TO HOUSING & PROGRAMMING.
5. POLICY #160 PROVIDES FOR TRANSGENDER AND INTERSEX RESIDENTS TO BE AFFORDED THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. INTERVIEW WITH PREA COORDINATOR & STAFF RESPONSIBLE FOR RISK SCREENING INDICATE TRANSGENDER & INTERSEX RESIDENTS SHALL BE PROVIDED THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. AUDITORS OBSERVATION OF PHYSICAL PLANT INDICATE FEMALE SHOWERS IN BUILDING A ARE NOT PREA COMPLIANT TO PROVIDE TRANSGENDER AND INTERSEX RESIDENTS THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. BUILDING A FEMALE SHOWER IS A BAY SHOWER WITH NO STALLS OR SHOWER CURTAINS TO PROVIDE SEPARATION DURING SHOWERS. BUILDING A MALE SHOWERS POSSESSES A SEPARATE SHOWER STALL WHICH COULD BE USED FOR TRANSGENDER AND INTERSEX PRIVACY DOES NOT HAVE VISUAL BARRIER FOR PRIVACY.
6. POLICY #160 PROHIBITS AGENCY FROM PLACING RESIDENTS IN DEDICATED FACILTIES BASED UPON THEIR LGBTI STATUS. THERE ARE NO DEDICATED FACILITIES OR WINGS FOR LGBTI RESIDENTS.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.241 AS PROVISION 115.242(e) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.242(e): 1) AGENCY TO PROVIDE AUDITOR WITH VERIFICATION OF BUILDING A WOMENS SHOWER MODIFICATION TO COMPLY WITH THIS STANDARD PROVISION OR A WRITTEN POLICY/DIRECTIVE WHICH MANDATES SEPARATE SHOWER SCHEDULE FOR TRANSGENDER AND INTERSEX RESIDENTS WITH STAFF SUPERVISION TO PROVIDE THIS SPECIAL POPULATION THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS.

2) AGENCY TO PROVIDE AUDITOR WITH VERIFICATION OF MODIFYING THE MEN'S BATHROOM AREA TO COMPLY WITH THIS STANDARD PROVISION, OR A WRITTEN POLICY/DIRECTIVE WHICH MANDATES SEPARATE SHOWER SCHEDULE FOR TRANSGENDER AND INTERSEX RESIDENTS WITH STAFF SUPERVISION FOR TRANSGENDER AND INTERSEX RESIDENT THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS

AGENCY TO PROVIDE DOCUMENTATION FOR 90 DAY STATUS REVIEW ON JULY 11, 2016, FOR VERIFICATION OF COMPLIANCE.

COMPLIANCE MUST BE ACHIEVED NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: OCTOBER 6, 2016

CORRECTIVE ACTION COMPLETION 11/3/16:

AGENCY PROVIDED PHOTO VERIFICATION OF THE WOMEN'S SHOWER MODIFICATION WHERE PRIVACY SCREENS HAVE BEEN INSTALLED TO PROVIDE THE WOMEN THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. AGENCY PROVIDES METHOD FOR TRANSGENDER MEN TO SHOWER SEPARATELY FROM OTHER RESIDENTS BY SCHEDULING SPECIFIC SHOWER TIME FOR THAT POPULATION WITH STAFF STANDING BY IN DIRECT LINE OF SIGHT OF THE BATHROOM AREA. AGENCY COMPLIES WITH STANDARD PROVISION 115.242(e).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.242.

115.251	Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

1. POLICY #165 PROVIDES FOR MULTIPLE INTERNAL WAYS FOR RESIDENTS TO PRIVATELY REPORT TO AGENCY OFFICIALS ABOUT SEX ABUSE/HARASSMENT. POLICY PROVIDES NARRATIVE REGARDING REPORTING OF RETALIATION BY OTHER RESIDENTS OR STAFF FOR REPORTING SEX ABUSE/HARASSMENT AND INCLUDES REPORTING STAFF NEGLECT OR VIOLATION OF RESPONSIBILITIES THAT MAY HAVE CONTRIBUTED TO SUCH INCIDENTS. PREA BROCHURE IN BOTH ENGLISH AND SPANISH INCLUDES VERBIAGE RELATED TO RETALIATION IN COMPLIANCE WITH STANDARD PROVISION. ZERO TOLERANCE DOOR POSTER FOR WELD FACILITY INCLUDES CONFIDENTIAL REPORTING CONTACT NUMBERS AND INCLUDES RETALIATION AS A REPORTING CRITERIA. CONTACT NUMBER INFORMATION IS PROVIDED IN BOTH ENGLISH AND SPANISH TO

PROVIDE FOR EFFECTIVE COMMUNICATION. INTERVIEW WITH RANDOM SAMPLE OF 12 STAFF INDICATE RESIDENTS CAN REPORT THROUGH WRITING, ANNONYMOUSLY, 3RD PARTY, CALL PUEBLO RAPE CRISIS CENTER OR DOC TIP LINE. RANDOM SAMPLE OF 12 RESIDENTS INDICATES THEY COULD REPORT TO STAFF, SPECIFICALLY CASE MANAGERS, GRIEVANCE SYSTEM AND DIRECTOR

2. POLICY #165 DOES PROVIDES A METHOD FOR RESIDENTS TO REPORT ABUSE OR HARASSMENT TO A PUBLIC OR PRIVATE ENTITY WHICH IS NOT PART OF THE AGENCY BY DAILING 911 TO LOCAL LAW ENFORCEMENT. THIS INFORMATION IS ALSO AVAILABLE ON AGENCY WEBSITE. AGENCY SECURED AN MOU WITH PUEBLO PD PUEBLO RAPE CRISIS CENTER AND HAS SECURED MOU FROM BTS FOR PRIVATE REPORTING. INTERVIEW WITH PREA COORDINATOR INDICATES RESIDENTS CAN REPORT TO THE PUEBLO RAPE CRISIS CENTER & DOC TIPS LINE. RANDOM SAMPLE OF 12 RESIDENTS INDICATE THEY HAVE LIMITED KNOWLEDGE OF THE CONFIDENTIAL NUMBERS TO THE PUEBLO RAPE CRISIS CENTER & DOC TIPS LINE PROVIDED ON POSTERS IDENTIFIED THROUGHOUT THE FACILITY.
3. POLICY #160 MANDATES IMMEDIATE REPORTING OF ANY INCIDENT OF SEX ABUSE/HARASSMENT. METHOD OF RECEIPT OF REPORTS IS INCLUDED IN POLICY. NARRATIVE IS INCLUDED IN THE RULES OF CONDUCT BOOK PAGE #20 PROVIDED TO ALL RESIDENTS AT INTAKE, WHICH INCLUDES METHOD STAFF MAY RECEIVE REPORTS. INTERVIEW WITH 12 RANDOM SAMPLE OF STAFF VERIFIES TRAINING & KNOWLEDGE TO ACCEPT REPORTS VERBALLY, IN WRITING, ANNONYMOUSLY AND FROM 3RD PARTIES. THEY WILL DOCUMENT IMMEDIATELY & INFORM SUPERVISORS. INTERVIEW WITH 12 RANDOM SAMPLE OF RESIDENTS INDICATE THE MAJORITY ARE AWARE OF THE DIFFERENT METHODS THEY CAN REPORT. THIS INFORMATION IS READILY AVAILABLE THROUGH THEIR RESIDENT HANDBOOKS AND POSTERS PLACED THROUGHOUT THE FACILITY & IN THEIR RESIDENTIAL ROOMS & DAYROOM. INTERVIEW WITH 12 RANDOM SAMPLE OF STAFF INDICATE THEY CAN PRIVATELY REPORT THROUGH GREELEY PD OR CALL DOC TIPS LINE.
4. POLICY #160 PROVIDES METHOD FOR STAFF TO PRIVATELY REPORT SEXUAL ABUSE/HARASSMENT OF RESIDENTS BY CONTACTING THE PROGRAM DIRECTOR OR PREA COORDINATOR IMMEDIATELY BY PHONE OR E-MAIL. INTERVIEW WITH 12 RANDOM SAMPLE OF STAFF INDICATE THEY CAN PRIVATELY REPORT THROUGH GREELEY PD OR CALL DOC TIPS LINE.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.251.

115.252	Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

1. POLICY #340 INCLUDES NARRATIVE TO MANDATE PROCEDURES FOR SEX ABUSE COMPLIANTS & GRIEVANCES. INTERVIEW WITH PREA COORDINATOR DURING ON-SITE AUDIT VERIFIES DEMONSTRATION OF POLICY AND STANDARD PROVISION 115.252(a). ANY GRIEVANCE, WHICH RELATES TO A PREA RELATED INCIDENT, GIVEN DIRECTLY TO ANY STAFF MEMBER WHO IS TO IMMEDIATELY NOTIFY THE PROGRAM DIRECTOR OR ON-CALL SUPERVISOR. STAFF WILL TAKE IMMEDIATE ACTION TO PROTECT THE RESIDENT. RESIDENT CAN ALSO PLACE THE GRIEVANCE IN A LOCKED DROP-BOX LOCATED NEAR SECURITY OFFICE IN BOTH BUILDINGS TO WHICH ONLY THE PROGRAM DIRECTOR, PREA COORDINATOR & SECURITY SUPERVISOR HAS ACCESS TO.
2. POLICY #340 MANDATES A TIME LIMIT WILL NOT BE IMPOSED WITH REGARDS TO THE FILING OF A GRIEVANCE REGARDING AN ALLEGATION OF SEXUAL ABUSE. GREIVANCES REGARDING SEX ABUSE ARE TO BE PROVIDED DIRECTLY TO ANY STAFF MEMBER WHO IS TO IMMEDIATELY NOTIFY THE PROGRAM DIRECTOR OR ON-CALL SUPERVISOR. STAFF WILL TAKE IMMEDIATE ACTION TO PROTECT THE RESIDENT. REVIEW OF RESIDENT HANDBOOK PROVIDES LANGUAGE COMPLIANT WITH STANDARD PROVISION 115.252 & PROHIBITS TIME LIMITS WHEN RESIDENT MAY SUBMIT A GRIEVAKCE ALLEGING ALLEGATION OF SEXUAL ABUSE. RESIDENT HAS THE OPPORTUNITY TO SUBMIT THE GRIEVANCE VIA LOCKED GRIEVANCE DROP-BOX TO WHICH ONLY THE PROGRAM DIRECTOR, PREA COORDINATOR & SECURITY SUPERVISOR HAS ACCESS TO.
3. POLICY #340 COMPLIES WITH STANDARD PROVISION 115.252(c) AS IT MANDATES THAT RESIDENT IS NOT REQUIRED TO SUBMIT A NORMAL GRIEVANCE TO STAFF MEMBER WHO IS SUBJECT OF THE GRIEVANCE OR HAVE IT REFERRED TO THAT STAFF MEMBER. THIS STATEMENT IS INCLUDED IN THE GRIEVANCE SECTION OF THE RULES OF CONDUCT HOUSE POLICY FOR FILING A GRIEVANCE REGARDING AN ALLEGATION OF SEXUAL ABUSE. RESIDENT HAS THE OPPORTUNITY TO SUBMIT THE GRIEVANCE VIA LOCKED GRIEVANCE DROP-BOX LOCATED ON BOTH FLOORS OF THE FACILITY TO WHICH ONLY THE PROGRAM DIRECTOR OR ON CALL SUPERVISOR HAS ACCESS TO.
4. POLICY #340 NOT COMPLIANT WITH STANDARD PROVISION 115.252(d). THE POLICY 340 B 2 REQUIRES THAT THE ALLEGED VICTIM MUST AGREE TO HAVE A 3RD PARTY FILE THE GRIEVANCE ON THEIR BEHALF, VICTIM MUST ALSO AGREE TO PERSONALLY PURSUE ANY SUBSEQUENT STEPS IN THE ADMINISTRATIVE REMEDY PROCESS. NO GRIEVANCES FILED OVER PAST 12 MONTHS WHICH ALLEGES SEXUAL HARASSMENT.
5. POLICY #340 PERMITS 3RD PARTIES TO ASSIST RESIDENTS IN FILING REQUESTS FOR ADMINISTRATIVE REMEDIES RELATING TO ALLEGATIONS OF SEXUAL ABUSE OR MAY FILE ON BEHALF OR A RESIDENT. IF THE ALLEGED VICTIM DECLINES 3RD PARTY ASSISTANCE IT WILL BE DOCUMENTED IN THEIR CHRONOLOGICAL NOTES. THE POLICY REQUIRES THAT THE ALLEGED VICTIM MUST AGREE TO HAVE A 3RD PARTY FILE THE GRIEVANCE ON THEIR BEHALF, VICTIM MUST ALSO AGREE TO PERSONALLY PURSUE

ANY SUBSEQUENT STEPS IN THE ADMINISTRATIVE REMEDY PROCESS. NO RECORD OF 3RD PARTY DECLINATIONS OVER THE PAST 12 MONTHS

6. POLICY #340 ESTABLISHES PROCEDURE FOR FILING AN EMERGENCY GRIEVANCE ALLEGAING THAT A RESIDENT IS SUBJECT TO A SUBSTANTIAL RISK OF IMMINENT SEXUAL ABUSE AND COMPLIES WITH STANDARD PROVISION 115.252(f). NO EMERGENCY GRIEVANCES FILED IN THE PAST 12 MONTHS.
7. POLICY #340 LIMITS ITS ABILITY TO DISCIPLINE RESIDENT FOR FILING A GRIEVANCE ALLEGING SEXUAL ABUSE TO OCCASIONS WHERE AGENCY DEMONSTRATES RESIDENT FILED THE GRIEVANCE IN BAD FAITH. THERE HAVE BEEN NO RESIDENT GRIEVANCES IN THE PAST 12 MONTHS THAT RESULTED IN DISCIPLINARY ACTION AGAINST THE RESIDENT FOR FILING THE REPORT IN BAD FAITH. AGENCY IS IN COMPLIANCE WITH STANDARD PROVISION 115.252(g).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.252.

115.253	**Resident access to outside confidential support services**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

1. POLICY #165 PROVIDES RESIDENTS WITH ACCESS TO OUTSIDE VICTIM ADVOCATES (PUEBLO RAPE CRISIS CENTER) FOR EMOTIONAL SUPPORT. CONTACT INFORMATION IS PROVIDED IN RESIDENT BROCHURE IN ENGLISH & SPANISH PROVIDED AT INTAKE. POSTERS THROUGHOUT THE FACILITY AND ON PREA DOOR POSTER PROVIDED ON ENTRY DOOR TO RESIDENT ROOMS AND NEXT TO PHONES. INTERVIEW WITH 12 RANDOM SAMPLE OF RESIDENTS INDICATED MAJORITY WERE AWARE OF PREA ADVOCACY INFORMATION FACTS YOU KNOW BROCHURE WRITTEN IN BOTH ENGLISH & SPANISH. THERE IS NO LANGUAGE IN THE PREA HANDBOOK WHICH SPEAKS TO VICTIM ADVOCACY. SOME RESIDENTS INTERVIEWED WERE UNFAMILIAR WITH THE INFORMATION PROVIDED ON THE PREA POSTERS THROUGHOUT THE FACILITY WHICH PROVIDES THEM WITH TELEPHONE ACCESS NUMBER TO VICTIM ADVOCATES THROUGH THE PUEBLO RAPE CRISIS CENTER.
2. POLICY #160 MANDATES MEDICAL AND MENTAL HEALTH PRACTITIONERS INFORM RESIDENTS OF DUTY TO REPORT & LIMITS OF CONFIDENTIALITY. HOUSING DOOR POSTERS ARE COMPLIANT WITH STANDARD PROVISION 115.253(b). POLICY 160 MANDATES PRACTITIONERS PROVIDE LIMITS OF CONFIDENTIALITY TO RESIDENTS PRIOR TO PROVIDING SERVICES. POLICY #165 PROVIDES THE EXTENT TO WHICH OUTSIDE SUPPORT SERVICES COMMUNICATIONS WILL BE MONITORED & LIMITS OF CONFIDENTIALITY. RULES OF CONDUCT & HOUSE POLICIES PROVIDES CONTACT INFORMATION FOR OUTSIDE REPORTING SERVICES BUT NO MENTION OF ACCESS TO

ADVOCACY, AGENCY MONITORING CONTACT WITH THE ADVOCATE SERVICES OR LIMITS OF CONFIDENTIALITY. THE FACTS YOU NEED TO KNOW BROCURE PROVIDES THE LOCAL CONTACT NUMBER FOR THE PUEBLO RAPE CRISIS CENTER & INDICATES IT IS A CONFIDENTIAL SERVICE, CALLS NOT MONITORED BY AGENCY & PROVIDES THE LIMITS OF CONFIDENTIALITY. POSTERS PROVIDED IN ALL DAY-ROOMS AND INSIDE THE DOOR OF EACH RESIDENT ROOM PROVIDES LOCAL CONTACT NUMBER FOR THE PUEBLO RAPE CRISIS CENTER AND DOC TIPS & INDICATES IT IS A CONFIDENTIAL SERVICE, CALLS NOT MONITORED BY AGENCY & PROVIDES THE LIMITS OF CONFIDENTIALITY. POSTERS PROVIDED BETWEEN RESIDENCE PHONES THROUGHOUT THE FACILITY INDICATES PHONE CONTACT WITH PUEBLO RAPE CRISIS CENTER & DOC TIPS WILL NOT BE MONITORED BY AGENCY. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATES THEIR KNOWLEDGE OF BEING PROVIDED LIMITS OF CONFIDENTIALITY PRIOR TO CONFIDENTIAL AGENCY PROVIDING THEM SERVICES. ONCE THEY SAW THE PREA REPORTING & ADVOCACY POSTER THEY WERE ABLE TO REPEAT WHAT LIMITS OF CONFIDENTIALITY MEANS.

3. SIGNED PUEBLO RAPE CRISIS CENTER MOU PROVIDED TO AUDITOR BY AGENCY. PUEBLO RAPE CRISIS CENTER MOU WOULD PROVIDE ADVOCACY FOR EMOTIONAL SUPPORT FOR RESIDENTS AT THE PUEBLO FACILITY. INTERVIEW WITH PUEBLO RAPE CRISIS CENTER STAFF VERIFIES PRESENCE OF MOU BETWEEN THE PUEBLO RAPE CRISIS CENTER & ICCS AND THE SERVICES THEY PROVIDE VIA THE MOU.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.253.

115.254	**Third-party reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard
AGENCY PUBLICLY PROVIDES METHODS BY WHICH 3RD PARTY REPORTS CAN BE RECEIVED WHICH IS POSTED VIA AGENCY WEBSITE. AUDITOR VERIFIED AGENCY STATEMENT.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.254.

115.261	Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

1. POLICY #160 MANDATES ALL STAFF TO IMMEDIATELY REPORT ANY SEXUAL MISCONDUCT, KNOWLEDGE OR SUSPICION OF SEXUAL MISCONDUCT. INTERVIEW WITH 12 RANDOM SAMPLE OF STAFF INDICATES THEIR KNOWLEDGE & UNDERSTANDING OR THEIR REPORTING REQUIREMENTS SHOULD THEY HAVE ANY KNOWLEDGE, SUSPICION OR INFORMATION REGARDING AN INCIDENT OF SEXUAL ABUSE/HARASSMENT.
2. POLICY #165 STATES ICCS WILL ONLY SHARE INFORMATION AS REQUIRED BY LAW IN ORDER TO PROTECT THE CONFIDENTIALITY OF ITS CLIENTS. INTERVIEW WITH 12 RANDOM SAMPLE OF STAFF MEMBERS INDICATE THEIR EDUCATION & KNOWLEDGE WITH REGARDS TO REPORT OR REVEAL INFORMATION RELATED TO A SEXUAL ABUSE REPORT TO ONLY THOSE WHO HAVE A NEED TO KNOW.
3. POLICY #160 PROVIDES NARRATIVE THAT IDENTIFIES LIMITS OF CONFIDENTIALITYAND PROVIDES NARRATIVE STATING PRACTIONER WILL INFORM RESIDENTS AT THE INITIATION OF SERVICES WITH REGARDS TO THEIR DUTY TO REPORT. INTERVIEW WITH MENTAL HEALTH PRACTITIONERS INDICATED EDUCATION & KNOWLEDGE REGARDING THEIR RESPONSIBILITY TO REPORT SEXUAL ABUSE & INFORMING RESIDENTS OF THE PRACTITIONERS DUTY TO REPORT & LIMITS OF CONFIDENTIALITY AT THE INITIATION OF SERVICES. INTERVIEWEE INDICATED THE PRACTITIONER MUST COMPLETE A FORM INDICATING TO RESIDENT THE LIMITS OF CONFIDENTIALITY AT INITIATION OF SERVICES. AUDITOR WAS NOT PROVIDED A COPY OF THIS FORM. TO VERIFY IT'S EXISTENCE OR TO VERIFY THIS INFORMATION WAS PROVIDED TO RESIDENT WHO ALLEGED SEXUAL HARASSMENT TO A THERAPIST WHICH RESULTED IN AN INVESTIGATION AND CONTINUED BTS MONITORING.
4. POLICY #261 MANDATES ALLEGED VICTIMS WHO ARE VULNERABLE ADULTS, ICCS WILL REPORT THE CASE TO THE DESIGNATED LOCAL SERVICES AGENCY FOR INVESTIGATION. ICCS DOES NOT HOUSE RESIDENTS UNDER THE AGE OF 18. INTERVIEW WITH DIRECTOR & PREA COORDINATOR INDICATE ALLEGATIONS OF SEXUAL ABUSE FOR VICTIM UNDER THE AGE OF 18 YEARS AND VULNERABLE ADULTS ARE REPORTED BOTH TO LOCAL LAW ENFORCEMENT FOR INVESTIGATION & THE DEPARTMENT OF HUMAN SERVICES FOR ELDER ABUSE.
5. POLICY #165 COMPLIES WITH STANDARD PROVISION 115.261(e) IN THAT ALL ALLEGATIONS, SUSPECTED, THREATENED OR REPORTED ACTS OF SEXUAL MISCONDUCT WILL BE REPORTED TO LOCAL LAW ENFORCEMENT. NARRATIVE TO INCLUDE 3RD PARTY AND ANNONYMOUS REPORTS IS PROVIDED IN THE POLICY. INTERVIEW WITH DIRECTOR DESIGNEE INDICATES POLICY MANDATES ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT INCLUDING 3RD PARTY & ANONYMOUS REPORTS ARE FORWARDED TO THE FACILITIES DESIGNATED INVESTIGATORS FOR DISPOSITION. REVIEW OF ALL 3 PREA ALLEGATIONS WHICH OCCURRED WITHIN THE PAST 12 MONTHS WERE

INVESTIGATED ADMINISTATIVELY, IN HOUSE, BY FACILITY STAFF. NONE OF THE IN-HOUSE STAFF IS TRAINED IN THE INVESTIGATION OF SEXUAL ABUSE IN A CONFINEMENT SETTING. THE SECURITY SUPERVISOR WHO HAS NOT BEEN TRAINED TO INVESTIGATE ALLEGATIONS OF SEXUAL ABUSE IN A CONFINEMENT SETTING, INVESTIGATED ALL 3 ALLEGATIONS OF SEXUAL ABUSE. ONE STAFF MEMBER OBTAINED SPECIAL INVESTIGATOR TRAINING & PROVIDED VERIFICATION VIA NIC CERTIFICATE PRIOR TO SUBMISSION OF INTERIM REPORT. AT LEAST 2 OTHER STAFF MEMBERS ARE PENDING CERTIFICATION.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.261 AS PROVISION 115.261(e) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.261(e): 1) PROVIDE SPECIAL INVESTIGATOR CERTIFICATION FOR STAFF PENDING TRAINING.

2) SHOULD AN ALLEGATION OF SEXUAL ABUSE OCCUR PRIOR TO THE CORRECTIVE ACTION DEADLINE, ENSURE THE INVESTIGATION IS CONDUCTED BY SPECIALLY TRAINED STAFF WHO CONDUCT SEX ABUSE INVESTIGATION IN A CONFINEMENT SETTING AND PROVIDE VERIFICATION DOCUMENTATION TO AUDITOR.

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: <u>OCTOBER 6, 2016</u>

CORRECTIVE ACTION COMPLETION 11/3/16:

AGENCY PROVIDED TRAINING CERTIFICATION VERIFICATION FOR ALL 3 SPECIAL INVESTIGATORS ASSIGNED TO THE PUEBLO RESIDENTIAL FACILITY TO INCLUDE SECURITY SUPERVISOR AND NEWLY ASSIGNED PROGRAM DIRECTOR. NO ALLEGATIONS OF SEXUAL ABUSE HAS OCCURRED SINCE THE ON-SITE AUDIT. AGENCY COMPLIES WITH STANDARD PROVISION 115.261(e).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.261.

115.262	Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #340 MANDATES IMMEDIATE ACTION TO BE TAKEN BY STAFF REGARDING EMERGENCY SEX ABUSE COMPLAINTS OR GRIEVANCES, IN COMPLIANCE WITH STANDARD PROVISION 115.262(a). IN THE PAST 12 MONTHS FACILITY INDICATED NO RESIDENTS IDENTIFIED AS SUBJECT TO SUBSTANTIAL RISK OF IMMINENT SEXUAL ABUSE. INTERVIEW WITH AGENCY HEAD DESIGNEE & DIRECTOR INDICATE IMMEDIATE ACTION IS TAKEN TO PROTECT A RESIDENT WHO IS SUBJECT TO A SUBSTANTIAL RISK OF IMMINENT SEXUAL ABUSE. ACTION TAKEN WILL INCLUDE SEPARATING RESIDENT & KEEP HIM/HER IN A SAFE PLACE. CONSIDER RE-HOUSING RESIDENT & MONITOR FOR SAFETY. INTERVIEW WITH 12 RANDOM SAMPLE OF STAFF INDICATE SAME. THEY WOULD SEPARATE RESIDENT & KEEP HIM/HER IN A SAFE PLACE, CONTACT SUPERVISOR, DOCUMENT & REHOUSE RESIDENT EITHER ON ANOTHER ROOM, FLOOR OR FACILITY.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.262.

115.263	Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

WHILE CONFINED AT OTHER FACILITY OVER PAST 12 MONTHS. AGENCY POLICY COMPLIANT WITH STANDARD PROVISION 115.263(b).

c) POLICY #160 MANDATES SUCH NOTIFICATION BE PROVIDED BY PROGRAM DIRECTOR TO HEAD OF FACILITY WHERE ALLEGED SEX ABUSE IS ALLEGED TO HAVE OCCURRED WITHIN 72 HOURS OF NOTIFICATION AND DOCUMENT THE CONTACT WITH HEAD OF THE FACILITY. NO SUCH ALLEGATIONS HAVE BEEN RECEIVED. AGENCY HAS NOT RECEIVED ALLEGATION THAT RESIDENT WAS ABUSED WHILE CONFINED AT OTHER FACILITY OVER PAST 12 MONTHS. AGENCY POLICY COMPLIANT WITH STANDARD PROVISION 115.263(c).
d) POLICY #165 MANDATES ALL RECEIVED ALLEGATIONS, SUSPICION OF, SEXUAL ASSAULT, SEXUAL VIOLENCE, THREATENED OR REPORTED ACTS OF SEXUAL MISCONDUCT OR SEXUAL CONTACT THAT OCCURS IN COMMUNITY CORRECTIONS OR ANY OTHER LOCATION WHERE CLIENTS ARE HOUSED, WORK, OR PROVIDED SERVICES WILL BE INVESTIGATED IN ACCORDANCE WITH ESTABLISHED LOCAL LAW ENFORCEMENT AGENCIES INVESTIGATIVE STANDARDS AND PROTOCOLS. OVER PAST 12 MONTHS, FACILITY HAS NOT RECEIVED ANY ALLEGATION OF SEXUAL ABUSE FROM ANOTHER AGENCY. INTERVIEW WITH AGENCY HEAD DESIGNEE & DIRECTOR INDICATE ONCE AN ALLEGATION HAS BEEN RECEIVED FROM ANOTHER AGENCY CASE IS INVESTIGATED IMMEDIATELY LIKE ANY OTHER CASE.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.263.

115.264	**Staff first responder duties**

■ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 HAS PROTOCOL ELEMENTS AS DICTATED IN STANDARD PROVISION 115.264(a). OVER PAST 12 MONTHS, NO ALLEGATIONS OF RESIDENT SEX ABUSE HAS OCCURRED WHICH ALLOWED FOR COLLECTION OF EVIDENCE OR UTILIZE PROTOCOL AS IDENTIFIED IN STANDARD PROVISION 115.264(z).. INTERVIEW WITH SECURITY STAFF INDICATE THEIR KNOWLEDGE & TRAINING ON HOW TO RESPOND WHEN RECEIVING AN ALLEGATION OF SEXUAL ABUSE. ALL SECURITY & NON-SECURITY 1ST RESPONDERS CAME TO INTERVIEW WITH A SEXUAL ABUSE RESPONSE PROTOCOL CARD PROVIDED BY AGENCY. ALL STAFF POSSESS 1ST RESPONDER PROTOCOL CARDS TO ASSIST WITH RESPONDING TO ALLEGATIONS OF SEXUAL ABUSE. THE EXTRA STEP AGENCY HAS TAKEN TO EDUCATE STAFF ON RESPONSE POLICY AND PROTOCOL EXCEED STANDARDS & PROVIDES PROMPT, CONSISTENT RESPONSE TO PROVIDE SAFETY FOR THEIR RESIDENTS AND EXCEEDS STANDARD PROVISION 115.264(a).

b) POLICY #165 HAS PROTOCOL ELEMENTS AS DICTATED IN STANDARD PROVISION 115.264(a). OVER PAST 12 MONTHS, THERE HAS NOT BEEN ANY ALLEGATION OF RESIDENT SEX ABUSE INVOLVING A NON-SECURITY STAFF MEMBER WHO REPONDED TO AN ALLEGATION OF SEXUAL ABUSE. INTERVIEWS WITH NON-SECURITY STAFF INDICATED THEY WOULD SEPARATE THE VICTIM, TAKE THEM TO A SAFE PLACE, REMAIN WITH THEM TO ENSURE NO DESTRUCTION OF PHYSICAL EVIDENCE, INFORM SUPERVISOR & DOCUMENT.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.264.

115.265	**Coordinated response**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) THERE IS NO COORDINATED RESPONSE TO INCIDENTS OF SEXUAL ABUSE SPECIFIC TO PUEBLO FACILITY THAT PROVIDES FOR ACTIONS TAKEN IN RESPONSE TO AN INCIDENT OF SEXUAL ABUSE AMONG STAFF 1ST RESPONDERS, MEDICAL AND MENTAL HEALTH PRACTITIONERS, INVESTIGATORS AND LEADERSHIP REVIEWED BY AUDITOR. INTERVIEW WITH DIRECTOR INDICATES THERE IS A WRITTEN PLAN WHICH COORDINATES ACTIONS TAKEN IN RESPONSE TO AN INCIDENT OF SEXUAL ABUSE AMONG STAFF 1ST RESPONDERS, MENTAL HEALTH PRACTITIONERS, INVESTIGATORS & FACILITY LEADERSHIP. THE PLAN ALSO PROVIDES FOR CONTACTING ADVOCATES FOR EMOTIONAL SUPPORT & FORENSIC EXAMINERS AT THE HOSPITAL. AUDITOR VERIFIED NO SUCH COORDINATED RESPONSE PLAN TO AN INCIDENT OF SEXUAL ABUSE SPECIFIC TO THE PUEBLO FACILITY EXISTS.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.261 AS PROVISION 115.265(a) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.265(a): AGENCY TO PROVIDE AUDITOR WITH COORDINATED RESPONSE PLAN (PROTOCOL) **SPECIFIC TO THE PUEBLO FACILITY**. ENSURE RESPONSE PLAN MEETS CRITERIA PROVIDED IN STANDARD PROVISION 115.265(a) AND UPLOAD TO DROPBOX.

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION

PERIOD DEADLINE: <u>OCTOBER 6, 2016</u>

<u>CORRECTIVE ACTION COMPLETION 9/23/16</u>:
AGENCY PROVIDED AUDITOR WITH ICCS COORDINATED RESPONSE PLAN SPECIFIC TO THE PUEBLO FACILITY.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.265

115.266	Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) INTERVIEW WITH AGENCY HEAD DESIGNEE DETERMINES AGENCY HAS NOT ENTERED INTO ANY COLLECTIVE BARGAINING AGREEMENTS SINCE AUGUST 20, 2012.
b) N/A – STANDARD PROVISION 115.66(b) DOES NOT APPLY TO THIS AGENCY/FACILITY PER DOJ

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.266.

115.267	Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 MANDATES THE PROGRAM DIRECTOR AND PREA COORDINATOR AS DESIGNATED STAFF MEMBERS TO MONITOR RETALIATION IN ACCORDANCE WITH STANDARD PROVISION 115.267(a).
b) POLICY #165 INCLUDES NARRATIVE COMPLIANT WITH STANDARD PROVISION #115.267 WHICH OUTLINES THE MULTIPLE PROTECTION MEASURES TO PROTECT RESIDENTS FROM RETALIATION. INTERVIEWS WITH AGENCY HEAD DESIGNEE AND PROGRAM DIRECTOR (WHO MONITORS RETALIATION IN THE FACILITY), BOTH

INDICATE MULTIPLE MEASURES ARE IMPLEMENTED TO PROTECT THE RESIDENT VICTIMS OF ABUSERS SUCH AS REMOVING RESIDENT & STAFF ABUSERS FROM THE FACILITY, ROOM CHANGES, MOVING RESIDENT TO DIFFERENT FLOORS AND TRANSFERRING RESIDENT TO ANOTHER FACILTY. BTS STAFF PROVIDE EMOTIONAL SUPPORT AND MONITORING.

c) POLICY #165 MANDATES MONITORING OF RESIDENT WHO REPORTED SEXUAL ABUSE OR SUFFERED SEXUAL ABUSE OR POSSIBLE RETALIATION ON A REGULAR BASIS FOR AT LEAST 90 DAYS, OR LONGER SHOULD THERE BE EVIDENCE OF A CONTINUING NEED. INTERVIEW WITH PROGRAM DIRECTOR WHO MONITORS RETALIATION INDICATES MONITORING PERIOD IS AT LEAST 90 DAYS & CAN CONTINUE SHOULD THE NEED MANDATE CONTINUED MONITORING UNTIL THE RESIDENT IS NOT LONGER ASSIGNED TO THE AGENCY. RESIDENT WILL THEN BE PROVIDED REFERRALS TO OUTSIDE AGENCIES FOR CONTINUED EMOTIONAL SUPPORT.

d) POLICY #165 NARRATIVE MANDATES PERIODIC STATUS CHECKS DURING MONITORING PERIOD PER STANDARD PROVISION 115.267(d). INTERVIEW WITH PROGRAM DIRECTOR INDICATES HE CONTACTS WITH RESIDENT, MAKING PERIODIC STATUS CHECKS. RESIDENT WHO WAS BEING MONITORED FOR OVER 90 DAYS WAS DISCHARGED FROM THE FACILITY IN 2015. CASE MANAGERS SEE RESIDENTS WEEKLY ON AN ONGOING BASIS.

e) POLICY #165 MANDATES THAT ANY CLIENT OR STAFF THAT REPORTS OR IS A WITNESS TO ANY SEXUAL ABUSE OR SEXUAL HARASSMENT SHALL BE PROVIDED THE SAME PROTECTION AS ANY VICTIM. POLICY INCORPORATES NARRATIVE WHICH INCLUDES INDIVIDUAL WHO COOPERATES WITH AN INVESTIGATION EXPRESSING FEAR OF RETALIATION IS PROVIDED SAME PROTECTION AS ANY OTHER VICTIM. INTERVIEW WITH AGENCY HEAD & PROGRAM DIRECTOR INDICATE AN INDIVIDUAL WHO EXPRESSES FEAR OF RETALIATION (RESIDENT OR STAFF) AFTER COOPERATING WITH AN INVESTIGATION WILL BE PROVIDED THE SAME MEASURES OF PROTECTION & MONITORING.

f) N/A – STANDARD PROVISION 115.267(f) DOES NOT APPLY TO AGENCY PER DOJ.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.267.

115.271	**Criminal and administrative agency investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 PROVIDES INVESTIGATIVE DIRECTION WITH REGARDS TO BOTH ADMINISTRATIVE AND CRIMINAL AGENCY INVESTIGATIONS. AGENCY INVESTIGATES ONLY ADMINISTRATIVE INVESTIGATIONS. INTERVIEW WITH INVESTIGATIVE STAFF

VERIFY ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT ARE INVESTIGATED PROMPTLY AND THOROUGHLY. 3RD PARTY & ANNONYMOUS REPORTS ARE TREATED IN THE SAME OBJECTIVE PROFESSIONAL MANNER.

b) AGENCY INDICATES THERE ARE 2 SPECIAL INVESTIGATORS ASSIGNED WHO HAVE COMPLETED TRAINING FOR SEX ABUSE IN A CONFINEMENT SETTING THROUGH NIC. 1 SIGNED CERTIFICATES OF COMPLETION PROVIDED PRIOR TO ON-SITE AUDIT AND THE OTHER SPECIAL INVESTIGATOR CERTIFICATION PROVIDED AFTER ON-SITE AUDIT. INTERVIEW WITH INVESTIGATIVE STAFF INDICATE SEX ABUSE INVESTIGATORS ARE MANDATED TO COMPLETE THE NIC SEX ABUSE INVESTIGATION IN A CORRECTIONAL SETTING COURSE BEFORE BEING ALLOWED TO INVESTIGATE SEX ABUSE/HARASSMENT CASES. AGENCY HAS DESIGNATED 2 SEX ABUSE INVESTIGATORS, HOWEVER, AUDITOR HAS ONLY 1 VERIFICATION OF THE SPECIALIZED TRAINING. REVIEW OF THE 3 ALLEGATIONS OF SEXUAL ABUSE THAT WERE INVESTIGATED OVER THE PAST 12 MONTHS, AUDITOR DETERMINED ALL THREE WERE INVESTIGATED BY SECURITY SUPERVISOR, WHO IS NOT CERTIFIED AS SPECIAL INVESTIGATOR TO INVESTIGATE ALLEGATIONS OF SEXUAL ABUSE IN A CONFINEMENT SETTING.

c) POLICY #165 MANDATES AGENCY CONDUCT ONLY ADMINISTRATIVE INVESTIGATIONS & ASSISTS LOCAL LAW ENFORCEMENT WITH CRIMINAL INVESTIGATIONS. IN CASE OF CRIMINAL INVESTIGATIONS, AGENCY INVESTIGATORS WILL SECURE CRIME SCENE & COLLECT EVIDENCE THAT CANNOT BE PROTECTED OR SECURED WITHOUT COMPROMISING SAFETY & SECURITY OF THE FACILITY, MAINTAINING IN FINDER'S POSSESSION UNTIL TURNED OVER TO INVESTIGATORS. INTERVIEW WITH INVESTIGATIVE STAFF INDICATES COLLECTION AND PRESERVATION OF EVIDENCE TRAINING IS PROVIDED IN THE NIC SPECIAL INVESTIGATOR COURSE.

d) AGENCY CONDUCTS ONLY ADMINISTRATIVE INVESTIGATIONS & COMPELLED INTERVIEWS ARE ONLY CONDUCTED BY LOCAL LAW ENFORCEMENT. INTERVIEW WITH INVESTIGATIVE STAFF INDICATE THEY DO NOT CONDUCT COMPELLING INTERVIEWS AS THAT IS THE PERVUE OF LOCAL LAW ENFORCEMENT INVESTIGATORS.

e) POLICY #165 PROHIBTS POLYGRAPH EXAMINATION AS CONDITION OF PROCEEDING WITH INVESTIGATION OF ALLEGATION OF SEXUAL ABUSE. CREDIBILITY OF ALLEGED VICTIM, SUSPECT OR WITNESS SHALL BE ASSESSED ON INDIVIDUAL BASIS & NOT DETERMINED BY PERSONS STATUS AS RESIDENT OR STAFF. INTERVIEW WITH INVESTIGATIVE STAFF INDICATE CREDIBILITY OF AN ALLEGED VICTIM, SUSPECT OR WITNESS IS ASSESSED ON A CASE BY CASE BASIS. INVESTIGATORS RELY ON THE EVIDENCE, INTERVIEWS & CORROBORATION WHICH DETERMINES CREDIBILITY.

f) POLICY #165 MANDATES INVESTIGATION SHALL BE DOCUMENTED. NARRATIVE ALSO STATES THAT INVESTIGATION SHALL INCLUDE EFFORT TO DETERMINE WHETHER STAFF ACTIONS OR FAILURES TO ACT CONTRIBUTED TO THE ALLEGED ABUSE IN COMPLIANCE WITH STANDARD 115.271(f). INTERVIEW WITH INVESTIGATIVE STAFF INDICATE STAFF'S FAILURE TO ACT IS CONSIDERED WITH DETERMINING WHAT CONTRIBUTED TO THE ABUSE. ALL REPORTS SHALL BE DOCUMENTED IN WRITING AS EVIDENCED BY THE 3 DOCUMENTED ALLEGATIONS OF SEXUAL ABUSE WHICH OCCURRED DURING THE PAST 12 MONTHS.

g) CRS 18-3-401 THROUGH 18-3-417 WILL GOVERN DETERMINATION OF SPECIFIC VIOLATIONS OF COLORADO LAW PERTAINING TO UNLAWFUL SEX ACTS. CRIMINAL INVESTIGATIONS WILL BE INVESTIGATED IN ACCORDANCE WITH ESTABLISHED LOCAL LAW ENFORCEMENT AGENCY'S INVESTIGATIVE STANDARDS AND PROTOCOLS DICTATED

BY THE CRIMINAL INVESTIGATIONS DIVISION DUTY SUPERVISOR AND CASE INVESTIGATOR. INVESTIGATIVE STAFF INDICATE LAW ENFORCEMENT CONDUCT CRIMINAL INVESTIGATIONS & ALL INVESTIGATIONS ARE DOCUMENTED. THERE HAVE BEEN NO CRIMINAL SEXUAL ABUSE INVESTIGATIONS OVER THE PAST 12 MONTHS.

h) POLICY #165 COMPLIES WITH STANDARD PROVISION 115.271(h) LANGUAGE. NO SUBSTANTIATED ALLEGATIONS OF CONDUCT THAT APPEARED TO BE CRIMINAL REFERRED FOR PROSECUTION SINCE AUGUST 20, 2012. INTERVIEW WITH INVESTIGATIVE STAFF INDICATES SUBSTANTIATED ALLEGATIONS OF CONDUCT THAT APPEARS TO BE CRIMINAL SHALL BE REFERRED TO LOCAL LAW ENFORCEMENT FOR PROSECUTORIAL REFERRAL.
i) POLICY #165 MANDATES DEPARTURE OF ALLEGED ABUSER OR VICTIM FROM ICCS, WHETHER EMPLOYEE OR CLIENT, SHALL NOT PROVIDE BASIS FOR TERMINATING AN INVESTIGATION. POLICY IS COMPLIANT WTH STANDARD PROVISION 115.271(j).
j) INTERVIEW WITH INVESTIGATIVE STAFF INDICATES THAT SHOULD AN ALLEGED ABUSER OR VICTIM DEPART THE AGENCY/FACILITY, THE INVESTIGATION WILL CONTINUE UNTIL COMPLETED.
k) N/A – STANDARD PROVISION 115.271(k) IS NOT APPLICABLE TO AGENCY/FACILITY PER DOJ.
l) POLICY #165-C MANDATES WHEN OUTSIDE AGENCIES INVESTIGATE SEXUAL ABUSE, FACILITY WILL ASSIST WITH INVESTIGATION AND REQUEST INVESTIGATIVE AGENCY ADHERE TO ALL PREA STANDARDS WHILE INVESTIGATING ANY ALLEGATIONS. NO SPECIFIC NARRATIVE TO DIRECT AGENCY TO ENDEAVOR TO REMAIN INFORMED ABOUT THE PROGRESS OF THE INVESTIGATION. INTERVIEW WITH PROGRAM DIRECTOR, PREA COORDINATOR & INVESTIGATIVE STAFF VERIFY THE GOOD WORKING RELATIONSHIP THEY HAVE WITH PUEBLO PD & PROGRAM DIRECTOR WILL BE KEPT APRISED OF THE STATUS OF THE INVESTIGATION AS STATEDIN THE PUBELO PD MOU.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.271 AS PROVISION 115.271(b) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.271(b): 1) PROVIDE SPECIAL INVESTIGATOR CERTIFICATION FOR STAFF PENDING TRAINING IN DROP BOX.

2) SHOULD AN ALLEGATION OF SEXUAL ABUSE OCCUR PRIOR TO THE END OF THE CORRECTIVE ACTION PERIOD. ENSURE THE INVESTIGATION IS CONDUCTED BY SPECIALLY TRAINED STAFF WHO CONDUCT SEX ABUSE INVESTIGATION IN A CONFINEMENT SETTING.

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: <u>OCTOBER 6, 2016</u>

CORRECTIVE ACTION COMPLETION 11/3/16:

AGENCY PROVIDED TRAINING CERTIFICATION VERIFICATION FOR ALL 3 SPECIAL INVESTIGATORS ASSIGNED TO THE PUEBLO RESIDENTIAL FACILITY TO INCLUDE SECURITY SUPERVISOR AND NEWLY ASSIGNED PROGRAM DIRECTOR. NO ALLEGATIONS OF SEXUAL ABUSE HAS OCCURRED SINCE THE ON-SITE AUDIT. AGENCY COMPLIES WITH STANDARD PROVISION 115.261(e).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.271.

115.272	Evidentiary standards for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 MANDATES THAT AGENCY IMPOSES NO STANDARD HIGHER THAN PREPONDERANCE OF THE EVIDENCE IN COMPLIANCE WITH STANDARD PROVISION 115.272(a). INTERVIEW WITH INVESTIGATIVE STAFF INDICATES PREPONDERANCE OF THE EVIDENCE IS THE STANDARD IN DETERMINING WHETHER ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT ARE SUBSTANTIATED.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.272.

115.273	Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 IS COMPLIANT WITH STANDARD PROVISION 115.273(a) WITH REGARDS TO INFORMING RESIDENTS WHETHER ALLEGATIONS ARE DETERMINED TO BE SUBSTANTIATED, UNSUBSTANTIATED, OR UNFOUNDED. 3 –ALLEGATIONS OF SEXUAL ABUSE OVER THE PAST 12 MONTHS. 2 – RESIDENT ON RESIDENT ALLEGATIONS, BOTH WERE UNFOUNDED. THE 2 UNFOUNDED ALLEGATIONS WERE MADE BY STAFF, NOT

RESIDENTS. 1 UNSUBSTANTIATED STAFF ON RESIDENT CASE. INTERVIEW WITH PROGRAM DIRECTOR & INVESTIGATIVE STAFF INDICATE UPON CONCLUSION OF THE INVESTIGATION, RESIDENTS ARE INFORMED AS TO THE OUTCOME OF THE INVESTIGATION. THE 1 UNSUBSTANTIATED CASE RESULTED IN NOTICE OF INVESTIGATIVE FINDINGS TO THE VICTIM, WHICH WAS PROVIDED IN WRITING & VICTIM SIGNED THE NOTIFICATION. SINCE THE OTHER TWO UNFOUNDED CASES WERE ALLEGED BY STAFF OBSERVATIONS, NO NOTICE WAS PROVIDED.

b) IF LOCAL LAW ENFORCEMENT CONDUCTS THE CRIMINAL INVESTIGATION, FACILITY PROGRAM DIRECTOR WILL BE KEPT INFORMED OF THE STATUS OF THE INVESTIGATION. UPON COMPLETION OF THE INVESTIGATION, THE FACILITY WILL INFORM RESIDENT OF THE DISPOSITION OF THE INVESTIGATION. OVER THE PAST 12 MONTHS NO ALLEGATIONS OF SEXUAL ABUSE WERE INVESTIGATED BY OUTSIDE AGENCIES.
c) POLICY #165 COMPLIES WITH STANDARD PROVISION 115.273(c) TO NOTIFY RESIDENT OF STAFF'S PLACEMENT IN THE FACILITY AND LEGAL STATUS. ONE ALLEGATIONS OF SEXUAL ABUSE INVOLVING STAFF ON RESIDENT IN THE PAST 12 MONTHS WHICH WAS FOUND TO BE UNSUBSTANTIATED. THE STAFF MEMBER WAS TERMINATED DUE TO POLICY VIOLATIONS RELATED TO THE ALLEGATION. RESIDENT WAS PROVIDED INITIAL NOTICE AS TO THE INVESTIGATIVE FINDINGS. AGENCY HAS NOT PROVIDED NOTIFICATION MADE TO RESIDENT REGARDING STAFF'S EMPLOYMENT STATUS WITHIN THE FACILITY OR LEGAL STATUS.
d) POLICY #165 MEETS STANDARD PROVISION 115.273(d). NO ALLEGED ABUSER HAS BEEN INDICTED OR CONVICTED ON A CHARGE RELATED TO SEXUAL ABUSE WITHIN THE FACILITY.
e) POLICY #165 MANDATES ALL NOTIFICATIONS TO CLIENT-VICTIMS OR ATTEMPTS TO NOTIFY SHALL BE DOCUMENTED IN CLIENT-VICTIM'S CHRONOLOGICAL NOTES. OVER THE PAST 12 MONTHS 3 SEX ABUSE ALLEGATION INVESTIGATIONS WERE CONDUCTED. THE 1 UNSUBSTANTIATED CASE RESULTED IN NOTICE OF FINDINGS TO THE VICTIM, WHICH WAS PROVIDED IN WRITING & VICTIM SIGNED THE NOTIFICATION. SINCE THE OTHER TWO UNFOUNDED CASES WERE ALLEGED BY STAFF OBSERVATIONS, NO NOTICE WAS PROVIDED.
f) N/A – STANDARD PROVISION 115.273(f) DOES NOT APPLY TO AGENCY/FACILITY PER DOJ.

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.273 AS PROVISION 115.273(c) IS NON-COMPLIANT

CORRECTIVE ACTION:

115.273(c): AGENCY TO PROVIDE NOTIFICATION MADE TO RESIDENT REGARDING STAFF'S EMPLOYMENT STATUS WITHIN THE FACILITY OR LEGAL STATUS IN ACCORDANCE WITH STANDARD PROVISION 115.273(c). SEE ACCOMPANYING ISSUE PAPER FOR IDENTIFIER.

AGENCY TO PROVIDE 90 DAY STATUS REPORT BY JULY 2016 AND VERIFICATION

OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD DEADLINE: <u>OCTOBER 6, 2016</u>

CORRECTIVE ACTION COMPLETION 10/4/16:
AGENCY PROVIDED AUDITOR WITH NOTICE TO ALLEGED VICTIM. CASE WAS UNSUBSTANTIATED AND NO DISCIPLINE WAS PLACED ON STAFF DUE TO THE OUTCOME OF THE UNSUBSTANTIATED INVESTIGATION. AGENCY HAS COMPLIED WITH STANDARD PROVISION 115.273(c).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.273

115.276	**Disciplinary sanctions for staff**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #275 MANDATES STAFF IS SUBJECT TO DISCIPLINARY SANCTIONS UP TO & INCLUDING TERMINATION FOR VIOLATING SEX ABUSE/HARASSMENT POLICIES.
b) POLICY #275 MANDATES TERMINATION FOR STAFF WHO VIOLATE SEX ABUSE POLICY. OVER PAST 12 MONTHS 1 STAFF VIOLATED AGENCY SEX ABUSE/HARASSMENT POLICY WHICH RESULTED IN TERMINATION. AGENCY PROVIDED CRITICAL INCIDENT REPORTS FOR THIS CASE WHICH IDENTIFIED THE OFFICIAL DETERMINATIONS REACHED FOR TERMINATION.
c) IN THE PAST 12 MONTHS, NO STAFF WERE DISCIPLINED SHORT OF TERMINATION FOR VIOLATION OF AGENCY SEXUAL ABUSE/HARASSMENT POLICIES.
d) POLICY #275 MANDATES ANY ALLEGATION AGAINST AN ICCS EMPLOYEE THAT IS SUBSTANTIATED OR UNSUBSTANTIATED WILL SUBJECT THE EMPOYEE TO DISCIPLINARY SANTIONS UP TO, AND INCLUDING TERMINATION. 1 STAFF REPORTED TO LAW ENFORCEMENT FOR VIOLATION OF AGENCY SEX ABUSE/HARRASSEMENT POLICY OVER PAST 12 MONTHS. PUEBLO PD TOOK THE REFERRAL BUT DECIDED IT COULD NOT BE SUBSTANTIATED OR REFERRED TO THE DA DUE TO LACK OF EVIDENCE.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.276.

115.277	Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.277 TO REPORT CONTRACTOR OR VOLUNTEER WHO ENGAGES IN SEX ABUSE REPORTED TO LAW ENFORCEMENT IF ACTION WAS CRIMINAL IN NATURE IN ACCORDANCE WITH STANDARD PROVISION 115.277(a). THERE HAVE BEEN NO CONTRACTORS OR VOLUNTEERS REPORTED TO LAW ENFORCEMENT FOR SEX ABUSE VIOLATIONS IN PAST 12 MONTHS.
b) INTERVIEW WITH PROGRAM DIRECTOR INDICATES IN THE CASE OF CONTRACTOR OR VOLUNTEER ALLEGED TO HAVE VIOLATED AGENCY SEXUAL ABUSE/HARASSMENT POLICIES, SAID CONTRACTOR OR VOLUNTEER WILL BE PROHIBITED FROM COMING ONTO FACILITY GROUNDS UNTIL CLEARED VIA INVESTIGATION.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.277.

115.278	Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #275 MANDATES DISCIPLINARY SANCTIONS AGAINST RESIDENTS WHO VIOLATE SEX ABUSE/HARASSMENT POLICIES IN THE CASE OF RESIDENT ON RESIDENT SEXUAL ABUSE EVEN IF ACT WAS CONSENSUAL, NOT COERCED OR FORCED, IN COMPLAINCE WITH STANDARD PROVISION 115.278. NO REPORTED ADMINISTRATIVE FINDING OF RESIDENT ON RESIDENT SEXUAL ABUSE OVER PAST 12 MONTHS. PER RESIDENT HAND BOOK, RESIDENT ON RESIDENT SEXUAL ABUSE IS BOTH AN ADMINISTRATIVE & CRIMINAL VIOLATION.
b) POLICY #275 IS COMPLIANT WITH STANDARD PROVISION 115.278(b) AS IT MANDATES SANCTIONS SHALL BE COMMENSURATE WITH THE NATURE AND CIRCUMSTANCES OF THE ABUSE COMMITTED. INTERVIEW WITH PROGRAMS DIRECTOR INDICATES SANCTIONS SHALL BE COMMENSURATE WITH THE NATURE & CIRCUMSTANCES OF THE ABUSE COMMITTED BASED UPON RESIDENTS DISCIPLINARY HISTORY & SANCTIONS

IMPOSED FOR COMPARABLE OFFENSES BY OTHER RESIDENTS WITH SIMILAR HISTORIES.

c) POLICY #275 MEETS STANDARD PROVISION 115.278(b) AS MANDATES CONSIDERATION IF RESIDENTS MENTAL DISABILITIES OR MENTAL ILLNESS CONTRINUTED TO HIS OR HER BEHAVIOR WHEN DETERMINING SANCTIONS TO BE IMPOSED. INTERVIEW WITH PROGRAMS DIRECTOR INDICATES A RESIDENTS MENTAL DISABILITY WILL BE CONSIDERED DURING THE DISCIPLINARY PROCESS TO DETERMINE IF MENTAL ILLNESS CONTRIBUTED TO THE BEHAVIOR WHEN DETERMINING STANCTION.
d) POLICY #275 STATES IF THERE IS THERAPY & COUNSELING AVAILABLE TO ADDRESS AND CORRECT THE UNDERLYING REASONS FOR MOTIVATIONS FOR ABUSE ICCS WILL CONSIDER MANDATING OFFENDING RESIDENT TO PARTICIPATE. INTERVIEW WITH MENTAL HEALTH STAFF INDICATES FACILTY OFFERS THERAPY & COUNSELING FOR ABUSERS AND CAN REFER CASES TO OUTSIDE AGENCIES AT NO CHARGE TO THE RESIDENT. RESIDENT'S PARTICIPATION OR LACK THEROF IS NOT A CONDITION OF ACCESS TO PROGRAMMING OR OTHER BENEFITS.
e) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.278(e) AS IT CONTAINS SAME NARRATIVE AS INDICATED IN STANDARD PROVISION 115.278(e).
f) POLICY #275 PROVIDES FOR SEX ABUSE ALLEGATION MADE IN GOOD FAITH BASED UPON REASONABLE BELIEF ALLEGED CONDUCT OCCURRED, THIS SHALL NOT CONSITUTE FALSE REPORTING PER STANDARD PROVISION 115.278(f).
g) POLICY #275 CONSISTENT WITH STANDARD PROVISION 115.278(g) AND IS COMPLIANT. RESIDENT HANDBOOK PROHIBITS SEXUAL ACTIVITY BETWEEN RESIDENTS & IS COMPLIANT WITH STANDARD PROVISION 115.278(g).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.278.

115.282	**Access to emergency medical and mental health services**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 MANDATES RESIDENT VICTIMS OF SEXUAL ABUSE RECEIVE IMMEDIATE MEDICAL TREATMENT AND ADVOCACY SERVICES. POLICY NARRATIVE MANDATES NATURE AND SCOPE OF SERVICES TO BE DETERMINED BY MEDICAL AND MENTAL HEALTH PRACTIONERS ACCORDING TO THEIR PROFESSIONAL JUDGEMENT AS REQUIRED BY STANDARD PROVISION 115.282(a). INTERVIEW WITH SANE NURSE & MENTAL HEALTH STAFF INDICATE RESIDENT VICTIMS OF SEXUAL ABUSE ARE PROVIDED EMERGENCY MEDICAL TREATMENT & CRISIS INTERVENTION THROUGH PUEBLO RAPE CRISIS CENTER, BTS & PARKVIEW MEDICAL CENTER. SERVICES ARE

PROVIDED ACCORDING TO THE PROFESSIONAL JUDGEMENT OF MENTAL HEALTH & MEDICAL PRACTITIONERS.

b) INTERVIEW WITH SECURITY/CUSTODY STAFF INDICATE THEIR KNOWLEDGE & TRAINING ON TAKING PRELIMINARY STEPS TO PROTECT VICTIM & NOTIFYING APPROPRIATE STAFF TO ASSIST. STAFF CARRIES RESPONSE PROTOCOL CARDS ON THEIR PERSON DURING THEIR SHIFT.
c) POLICY #165-D MANDATES RESIDENT VICTIMS RECEIVE TIMELY INFORMATION ABOUT AND TIMELY ACCESS TO EMERGENCY CONTRACEPTION & STDs AND PROPHYLAXIS PER PROFESSIONALLY ACCESPTED STANDARDS OF CARE. INTERVIEW WITH MENTAL HEALTH & SANE NURSE INDICATES RESIDENT VICTIMS ARE PROVIDED TIMELY INFORMATION & ACCESS TO EMERGENCY CONTRACEPTION & STD PROPHYLAXIS AT THE PUEBLO MEDICAL CENTER.
d) POLICY #165 MANDATES TREATMENT SERVICES PROVIDED TO EVERY VICTIM WITHOUT FINANCIAL COST IN ACCORDANCE WITH STANDARD PROVISION 115.282(d).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.282.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 MANDATES MEDICAL/MENTAL HEALTH TREATMENT TO ALL RESIDENT VICITMS OF SEX ABUSE. INTERVIEW WITH MENTAL HEALTH PRACTITIONER VERIFIES MENTAL HEALTH EVALUATIONS ARE OFFERED TO ALL RESIDENTS WHO HAVE A HISTORY OF VICTIMIZATION.
b) POLICY #165-D MANDATES EMERGENCY & ONGOING MEDICAL AND MENTAL HEALTH TREATMENT TO VICTIMS OF SEXUAL ABUSE IN COMPLIANCE WITH STANDARD PROVISION 115.283(b). MENTAL HEALTH PRACTITIONERS PROVIDE TREATMENT PLANS & ONGOING MONITORING TO LOOK FOR BEHAVIORAL ISSUES. IN ADDITION, CASE MANAGERS MEET WITH RESIDENTS MONTHLY FOR SAME EVALUATION GOALS.
c) MEDICAL HEALTH SERVICES TO VICTIMS IS CONDUCTED AT PARKVIEW MEDICAL CENTER. MENTAL HEALTH SERVICES ARE CONTRACTED THROUGH BTS, WHO IS MANDATED TO PROVIDE MENTAL HEALTH SERVICES PER PREA PROVISIONS. ALL MENTAL HEALTH STAFF ARE CERTIFIED SOCIAL WORKERS OR THERAPISTS. ANY MEDICAL NEEDS ARE PROVIDED THROUGH THE PARKVIEW MEDICAL CENTER.
d) POLICY #165 MANDATES PROVISION OF PREGNANCY TESTS FOR FEMALE VICTIMS OF SEXUAL ASSAULTS. INTERVIEW WITH SANE NURSE AT PARKVIEW MEDICAL CENTER INDICATES PREGANCY TESTS ARE OFFERED AT THE HOSPITAL FOR FEMALE VICTIMS OF

SEXUALLY ABUSIVE VAGINAL PENETRATION. NO RECORD OF FEMALE VICTIMS OF SEXUAL ABUSE OVER THE PAST 12 MONTHS.

e) POLICY #165 MANDATES COMPREHENSIVE INFORMATION & TIMELY ACCESS TO ALL PREGNANCY-RELATED MEDICAL SERVICES IF PREGNANCY RESULTS FROM SEXUAL ABUSE. INTERVIEW WITH SANE NURSE AT PARKVIEW MEDICAL CENTER INDICATES INFORMATION & ACCESS TO ALL LAWFUL PREGANCY-RELATED MEDICAL SERVICES ARE PROVIDED AT THE HOSPITAL FOR FEMALE VICTIMS OF SEXUALLY ABUSIVE VAGINAL PENETRATION. NO RECORD OF FEMALE VICTIMS OF SEXUAL ABUSE OVER THE PAST 12 MONTHS.
f) POLICY #165 MANDATES RESIDENTS WHO ARE VICTIMS OF SEX ABUSE BE PROVIDED INFORMATION & TREATMENT FOR STD's & PROHYLAXIS IN ACCORDANCE WITH STANDARD PROVISION 115.283(f). INTERVIEW WITH MENTAL HEALTH & SANE NURSE INDICATES RESIDENT VICTIMS ARE PROVIDED TIMELY INFORMATION & ACCESS TO EMERGENCY CONTRACEPTION & STD PROPHYLAXIS AT THE PARKVIEW MEDICAL CENTER.
g) POLICY #165 MANDATES TREATMENT SERVICES PROVIDED TO RESIDENT VICTIM OF SEXUAL ABUSE WITHOUT FINANCIAL COST PER STANDARD PROVISION 115.283(g).
h) POLICY #165 INCLUDES NARRATIVE COMPLIANT WITH STANDARD PROVISION #115.283(h) MANDATING AGENCY CONDUCT MENTAL HEALTH EVALUATION OF ALL KNOWN RESIDENT ON RESIDENT ABUSERS WITHIN 60 DAYS F LEARNING SUCH ABUSE HISTORY AND OFFER TREATMENT WHEN DEEMED APPROPRIATE BY MENTAL HEALTH PROFESSIONALS. INTERVIEW WITH MENTAL HEALTH PRACTITIONER INDICATES MENTAL HEALTH STAFF OFFER EVALUATION FOR RESIDENT ON RESIDENT ABUSERS IMMEDIATELY UPON LEARNING OF THE ABUSE HISTORY TO OFFER TREATMENT EITHER ON SITE OR AT A OFF SITE MENTAL HEALTH FACILITY.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.283.

115.286	**Sexual abuse incident reviews**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 MANDATES SEXUAL ABUSE INCIDENT REVIEW & PROVIDES EVALUATION CRITERIA FOR EACH CASE, COMPLIANT WITH STANDARD PROVISION 115.286(a). IN THE PAST 12 MONTHS (1) ONE UNSUBSTANTIATED ALLEGATION OF SEXUAL ABUSE OCCCURRED. INCIDENT REVIEW WAS CONDUCTED ON THIS CASE 1 DAY FOLLOWING COMPLETION OF THE INVESTIGATION.
b) IN THE PAST 12 MONTHS (1) ONE UNSUBSTANTIATED ALLEGATION OF SEXUAL ABUSE OCCCURRED. INCIDENT REVIEW WAS CONDUCTED ON THIS CASE 1 DAY FOLLOWING COMPLETION OF THE INVESTIGATION.

c) POLICY #165 MANDATES NON-INVESTIGATING SUPERVISOR, PROGRAM DIRECTOR, WITH INPUT FROM INVESTIGATING SUPERVISOR AND APPLICABLE STAFF WILL MAKE UP THE INCIDENT REVIEW TEAM. AUDITOR VERIFIED PRACTICE OF CASE REVIEW TEAM INCLUSION BASED UPON DOCUMENT REVIEW OF STAFF ON CLIENT INCIDENT INVESTIGATION AND CASE REVIEW WHICH OCCURRED DURING PAST 12 MONTHS. INTERVIEW WITH PROGRAM DIRECTOR INDICATES THE INCIDENT REVIEW TEAM INCLUDES UPPER LEVEL STAFF.

d) POLICY #165 INCLUDES CRITERIA SPECIFIC TO STANDARD PROVISION 115.286(d). FINDINGS OF SEX ABUSE INCIDENT REVIEW IS FORWARDED TO QUALITY ASSURANCE DIRECTOR TO ENSURE ALL RECOMMENDED IMPROVEMENTS AND CHANGES ARE IMPLEMENTED. FACILITY HEAD AND PREA COORDINATOR IS INCLUDED IN THE DISTRIBUTION OF THE RECOMMENDATIONS IN ACCORDANCE WITH STANDARD 115.286(d). ANY FAILURE TO IMPLEMENT RECOMMENDATIONS WILL BE DOCUMENTED. STAFF ON CLIENT INCIDENT REVIEW VERIFIES AGENCY'S COMMITMENT TO SEXUAL SAFETY BY CONSIDERATION OF CRITERIA OUTLINED IN THIS STANDARD PROVISION, IDENTIFYING PROBLEM AREAS & BLIND SPOTS, THEM IMPLEMENTING REVIEW TEAM RECOMMENDATIONS. INTERVIEWS WITH PROGRAM DIRECTOR, PREA COORDINATOR & INCIDENT REVIEW TEAM MEMBER INDICATE THE REVIEW TEAM SHALL CONSIDER ALL 6 CRITERIA AS OUTLINED IN STANDARD PROVISION 115.286(d). AUDITOR REVIEWED A COPY OF THE INCIDENT TEAM REVIEW ON THE UNSUBSTANTIATED CASE THAT OCCURRED OVER THE PAST 12 MONTHS. THE REVIEW TEAM CONSIDERED TRAINING AND POLICY AREA THAT MAY NEED TO BE ADJUSTED, PHYSICAL PLANT REVIEW, GENDER OF CLIENTS, VIDEO MONITORING AND STAFFING AVAILABILITY

e) POLICY #165 INCLUDES CRITERIA SPECIFIC TO STANDARD PROVISION 115.286(d). FINDINGS OF SEX ABUSE INCIDENT REVIEW IS FORWARDED TO QUALITY ASSURANCE DIRECTOR TO ENSURE ALL RECOMMENDED IMPROVEMENTS AND CHANGES ARE IMPLEMENTED. ANY FAILURE TO IMPLEMENT RECOMMENDATIONS WILL BE DOCUMENTED. STAFF ON CLIENT INCIDENT REVIEW VERIFIES AGENCY'S COMMITMENT TO SEXUAL SAFETY BY CONSIDERATION OF CRITERIA OUTLINED IN THIS STANDARD PROVISION, IDENTIFYING PROBLEM AREAS & BLIND SPOTS, THEM IMPLEMENTING REVIEW TEAM RECOMMENDATIONS. AUDITOR OBSERVED IMPLEMENTATION OF THE INCIDENT REVIEW TEAM'S RECOMMENDATIONS DURING THE ON-SITE REVIEW.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.286.

115.287	**Data collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #160 & #165 PROVIDES SET OF DEFINITIONS & STANDARDIZED INSTRUMENT USED IN DATA COLLECTION FOR EACH PREA RELATED INVESTIGATION. AGENCY PROVIDED PREA INVESTIGATION REPORT DATA COLLECTION INSTRUMENT, WHICH PROVIDES DEFINITIONS. REQUESTED DATA MEETS REQUIREMENTS TO ANSWER ALL QUESTIONS FROM MOST RECENT SURVEY OF SEXUAL VIOLENCE CONDUCTED BY THE DOJ. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.287(a)/(c).
b) POLICIES #160 & 165 MANDATE AGGREGATED INCIDENT-BASED DATA BE COLLECTED ANNUALLY.
c) SAMPLE OF AGGREGATED DATA PROVIDED FROM ALL FACILITIES FOR 2015 ON AGENCY'S WEBSITE.
d) POLICY #165 MANDATES AGENCY MAINTAIN & COLLECT DATA FROM ADMINISTRATIVE REVIEWS, DOCUMENTATION OF ALL NON-IMPLEMENTED RECOMMENDATIONS, INVESTIGATION REPORTS, VIDEO SURVEILLANCE ETC, KEEPING DATA INDEFINATELY FOR RECORD KEEPING.
e) N/A - STANDARD IS NOT APPLICABLE TO THIS FACILITY AS AGENCY DOES NOT CONTRACT FROM OTHER FACILITIES FOR THE CONFINEMENT OF ITS RESIDENCE.
f) N/A - DOJ HAS NOT REQUESTED AGGREGATED DATA FROM PREVIOUS CALENDAR YEAR.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.287.

115.288	**Data review for corrective action**

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) AGENCY PROVIDED ANNUAL REPORT FROM 2015 LOCATED ON AGENCY WEBSITE. CORRECTIVE ACTION PLANS FOR A NUMBER OF FACILITIES INDICATING ENHANCED VIDEO MONITORING HAS BEEN CONDUCTED OR IS PLANNED FOR 2016. INTERVIEW WITH AGENCY HEAD & PREA COORDINATOR INDICATES AGENCY USES AGGREGATED DATA FROM ALL FACILITIES TO MAKE DECISIONS ON TRAINING, SECURITY & POLICIES.
b) BOTH 2014 & 2015 ANNUAL REPORTS ARE AVAILABLE ON AGENCY WEBSITE. 2015 ANNUAL REPORT PROVIDES COMPARISON OF CURRENT YEAR AND PREVIOUS YEAR DATA.
c) 2015 ANNUAL REPORT AVAILABLE ON AGENCY WEBSITE. INTERVIEW WITH AGENCY HEAD DESIGNEE INDICATES AGENCY HEAD APPROVES THE ANNUAL REPORT.
d) POLICY #165 MANDATES PERSONAL IDENTIFIERS REMOVED & REDACTING SPECIFIC MATERIAL WHICH MAY PRESENT A CLEAR AND SPECIFIC THREAT TO THE SAFETY & SECURITY OF THE FACILITY PRIOR TO MAKING PUBLICATION PUBLIC. NATURE OF THE MATERIAL REDACTED MUST BE INDICATED PER STANDARD PROVISION 115.288(d). INTERVIEW WITH PREA COORDINATOR INDICATES THE TYPES OF MATERIAL TYPICALLY

REDACTED FROM THE ANNUAL REPORTS ARE IDENTIFYING MARKERS. THE 2014 ANNUAL REPORT DID NOT INDICATE THE NATURE OF THE MATERIAL REDACTED.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.288.

115.289	Data storage, publication and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a) POLICY #165 MANDATES ALL COLLECTED DATA IS MAINTAINED BY PREA COORDINATOR, COMPLIANT WITH STANDARD 115.289(a). INTERVIEW WITH PREA COORDINATOR INDICATES ALL COLLECTED DATA RELATED TO ANNUAL REPORT IS MAINTAINED IN HIS LOCKED OFFICE.
b) POLICY #165 MANDATES COLLECTION OF DATA FROM AGENCY FACILITIES & MAKE IT AVAILABLE THROUGH THE AGENCY WEBSITE. AGGREGATED DATA FROM 2014 AND 2015 ANNUAL REPORTS ARE AVAILABLE ON AGENCY WEBSITE. AGENCY DOES NOT CONTRACT WITH OUTSIDED ENTITY FOR CONFINEMENT OF RESIDENTS.
c) POLICY #165 MANDATES ALL PERSONAL IDENTIFIERS SHALL BE REMOVED BEFORE MAKING DATA PUBLICLY AVAILABLE. INTERVIEW WITH PREA COORDINATOR INDICATES THE TYPES OF MATERIAL TYPICALLY REDACTED FROM THE ANNUAL REPORTS ARE IDENTIFYING MARKERS. AUDITOR REVIEW OF 2014 AND 2015 ANNUAL REPORTS VERIFIES COMPLIANCE WITH STANDARD PROVISION 115.289(c) AS THERE ARE NO PERSONAL IDENTIFIERS IN EITHER REPORT.
d) POLICY #165 MANDATES AGENCY RETAIN SEX ABUSE DATA FOR A MINIMUM OF 10 YEARS

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.289.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

ERIC WOODFORD

Digitally signed by ERIC WOODFORD
DN: cn=ERIC WOODFORD, o=CORRECTIONAL CONSULTING SERVICES LLC, ou, email=eiw@comcast.net, c=US
Date: 2016.11.05 20:46:38 -07'00'

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Auditor Signature