

PREA AUDIT: AUDITOR'S SUMMARY REPORT

COMMUNITY CONFINEMENT FACILITIES



FINAL REPORT

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| Name of facility: ICCS - KENDALL | | | |
| Physical address: 1651 Kendall Street, Lakewood, CO 80214 | | | |
| Date report submitted: August 21, 2015 | | | |
| Auditor Information | | | |
| Address: PO Box 732 Benicia, CA 94510-0732 | | | |
| Email: eiw@comcast.net | | | |
| Telephone number: (707) 333-8303 | | | |
| Date of facility visit: July 20 th thru July 22 nd , 2015 | | | |
| Facility Information | | | |
| Facility mailing address: <i>(if different from above)</i> | | | |
| Telephone number: (303) 232-4002 | | | |
| The facility is: | <input type="checkbox"/> Military | <input type="checkbox"/> County | Federal |
| | <input type="checkbox"/> Private for profit | <input type="checkbox"/> Municipal | State |
| | <input checked="" type="checkbox"/> Private not for profit | | |
| Facility Type: | <input type="checkbox"/> Community treatment center | <input checked="" type="checkbox"/> Community based confinement facility | Other: |
| | <input type="checkbox"/> Halfway house | | |
| | <input type="checkbox"/> Alcohol or drug rehabilitation center | <input type="checkbox"/> Mental health facility | |
| | | | |
| Name of Facility Head: James McRae | Title: Director | (720) | |
| Email address: jmcrae@int-iccs.org | Telephone number: | 544-5529 | |
| Name of PREA Compliance Manager (if applicable): N/A | Title: | | |
| Email address: | Telephone number: | | |
| Agency Information | | | |
| Name of agency: Intervention Community Corrections Services (ICCS) | | | |
| Governing authority or parent agency: <i>(if applicable)</i> N/A | | | |
| Physical address: 1651 Kendall Street, Lakewood, CO 80214 | | | |
| Mailing address: <i>(if different from above)</i> | | | |
| Telephone number: (303) 232-4002 | | | |
| Agency Chief Executive Officer | | | |
| Name: Gregg Kildow | Title: | Executive Director | |

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| Email address: gkildow@int-iccs.org | Telephone number: | (720) 544-5559 |
| 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 Kendall Facility was conducted from July 20, 2015 to July 22, 2015 by a certified PREA Auditor. The following is a summary of the observations noted during the facility tour and a description of the audit process:

Staff accompanying Auditor during tour:

Joe Clark – PREA Coordinator

James McRae – Program Director

Brian Hulse – Quality Assurance Director

Gregg Kildow – Executive Director

Living Unit: C-1 Wing

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Opposite Sex Viewing?: NO
- Camera Placement?: MULTIPLE CAMERA PLACEMENTS ALONG HALLWAY
- General Discussion with Staff (Not Interviews): NO STAFF AVAILABLE
- General Discussion with Inmates (Not Interviews): INMATE KNOWS OF PREA & AWARE OF AUDITOR ARRIVAL FOR AUDIT. CAN RECITE INFORMATION OBTAINED DURING INTAKE. RESIDENT INDICATES HE FEELS SAFE IN FACILITY.
- Phones: PHONES ALONG HALLWAY
- Grievance Process: OUTSIDE SECURITY OFFICE – 1 BOX ONLY FOR FACILITY
- Showers and Bathrooms: SEPARATE SHOWERS AND TOILET STALLS
- Recreation Areas/TV/Multi-Purpose: DAY ROOM MIDDLE OF WING HALLWAY

Living Unit: C-2

- 2 – 4 MAN ROOMS ALONG HALLWAY. MEDICAL ISOLATION ROOM LOCATED ON THIS FLOOR.
- PREA Information Posted?:_NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Opposite Sex Viewing?:_RESIDENTS INSTRUCTED TO CHANGE CLOTHES IN BATHROOM.
- Camera Placement?: CAMERAS ALONG HALLWAY – NO BLIND SPOTS
- Phones: LOCATED ALONG HALLWAY
- Grievance Process: FACILITY GRIEVANCE BOX LOCATED ACROSS HALL FROM SECURITY
- Showers and Bathrooms: SHOWER & BATHROOM STALLS PROVIDE PRIVACY FOR RESIDENTS
- Recreation Areas/TV/Multi-Purpose: OPEN DAY ROOM IN MIDDLE OF HOUSING WING, CAMERA COVERAGE. MULTIPLE OUTSIDE RECREATION AREAS COVERED BY CAMERAS

Living Unit: A-1 WING (PRIVILEGE WING)

- PREA Information Posted?:_DOC TIP LINE SIGNAGE & ZERO-TOLERANCE SIGNAGE
- Opposite Sex Viewing: NONE
- Camera Placement?: STAIRWELL SEALED – NO ACCESS. HALLWAY CAMERAS – NO BLIND SPOTS
- Phones: LOCATED IN RESIDENCE HALLWAY
- Showers and Bathrooms: LOCATED IN MIDDLE OF HALLWAY ACROSS FROM DAYROOM, COVERED BY HALLWAY CAMERAS. BLIND SPOT LOCATED UNDER HALLWAY CAMERA LEADING TO SHOWER ROOM. CAMERA NEEDS TO BE RETASKED AND VERIFIED TO COVER BLIND SPOT. CAMERA RETASK VERIFIED 3/8/16 VIA AGENCY PHOTO PROVIDED
- Recreation Areas/TV/Multi-Purpose: OPEN DAY ROOM IN MIDDLE OF HOUSING WING, CAMERA COVERAGE. MULTIPLE OUTSIDE RECREATION AREAS COVERED BY CAMERA

Living Unit: A-2 WING

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Opposite Sex Viewing?:_NONE
- Camera Placement?: ALL ALONG HALLWAYS – NO BLIND SPOT
- Phones: LOCATED ALONG HALLWAYS
- Grievance Process: OUTSIDE SECURITY OFFICE
- Showers and Bathrooms: PROVIDE PRIVACY FOR RESIDENTS – PREA COMPLIANT. LOCATED IN MIDDLE OF WING HALLWAY ACROSS FROM DAYROOM, COVERED BY HALLWAY CAMERAS.
- Recreation Areas/TV/Multi-Purpose: OPEN DAY ROOM IN MIDDLE OF HOUSING WING, CAMERA COVERAGE. MULTIPLE OUTSIDE RECREATION AREAS COVERED BY CAMERAS.

Living Unit: B-2 WING

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Opposite Sex Viewing?:_NONE
- Camera Placement?: ALL ALONG HALLWAY. MIRRORS ALSO PROVIDED. CAMERAS FOR STAIRWELL LEADING TO AND FROM THE HALLWAY
- Phones: LOCATED ALONG HALLWAY
- Grievance Process: ONLY LOCATED ACROSS FROM SECURITY
- Showers and Bathrooms: LOCATED IN MIDDLE OF HALLWAY ACROSS FROM DAYROOM, COVERED BY HALLWAY CAMERAS. MEETS PREA STANDARDS
- Recreation Areas/TV/Multi-Purpose: OPEN DAY ROOM IN MIDDLE OF HOUSING WING, CAMERA COVERAGE. MULTIPLE OUTSIDE RECREATION AREAS COVERED BY CAMERAS

Living Unit: D-1 WING

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Opposite Sex Viewing?: NONE
- Camera Placement?: CAMERAS ALONG HALLWAY AND IN ALL CLASSROOMS AND 2 CAMERAS LOCATED ALONG STAIRWELL LANDING
- Phones: ALONG HALLWAYS
- Showers and Bathrooms: PREA COMPLIANT. PROVIDES PRIVACY FOR RESIDENTS. LOCATED IN MIDDLE OF HALLWAY ACROSS FROM DAYROOM, COVERED BY HALLWAY CAMERAS.
- Recreation Areas/TV/Multi-Purpose: OPEN DAY ROOM IN MIDDLE OF HOUSING WING, CAMERA COVERAGE. MULTIPLE OUTSIDE RECREATION AREAS COVERED BY CAMERAS

Living Unit: E-1 WING

- PREA Information Posted?: PREA SIGNAGE AVAILABLE & ZERO TOLERANCE POSTER AVAILABLE OUTSIDE SECURITY OFFICE
- Opposite Sex Viewing?: NONE
- Camera Placement?: INTAKE AREA – 2 CAMERAS. CAMERAS ALONG HALLWAY. SECURITY OFFICE IS CAMERA VIEWING OFFICE FOR THE WHOLE COMPLEX.
- General Discussion with Staff (Not Interviews): INTAKE STAFF AND SECURITY STAFF
- General Discussion with Inmates (Not Interviews): SPOKE WITH RESIDENTS GOING THROUGH INTAKE_
- INTERVIEW WITH SECURITY STAFF. OBSERVED PREA VIDEO AND RESIDENT EDUCATION DOCUMENTATION
- Phones: LOCATED ALONG HALLWAY
- Showers & Bathrooms: PREA COMPLIANT. PROVIDES PRIVACY FOR RESIDENTS. LOCATED IN MIDDLE OF HALLWAY ACROSS FROM DAYROOM, COVERED BY HALLWAY CAMERAS.
- Grievance Process: GRIEVANCE BOX LOCATED OUTSIDE SECURITY OFFICE. THIS IS THE ONLY GRIEVANCE BOX FOR ENTIRE FACILITY.
- Recreation Areas/TV/Multi-Purpose: OPEN DAY ROOM IN MIDDLE OF HOUSING WING, CAMERA COVERAGE. MULTIPLE OUTSIDE RECREATION AREAS COVERED BY CAMERAS

Living Unit: E-2 WING

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Opposite Sex Viewing?: NONE
- Camera Placement?: ALONG HALLWAY & IN DAYROOM – NO BLIND SPOTS
- Phones: LOCATED ALONG HALLWAYS
- Grievance Process: ONLY LOCATED ACROSS FROM SECURITY OFFICE
- Showers and Bathrooms: PREA COMPLIANT. PROVIDES PRIVACY FOR RESIDENTS. LOCATED IN MIDDLE OF HALLWAY ACROSS FROM DAYROOM, COVERED BY HALLWAY CAMERAS.
- Recreation Areas/TV/Multi-Purpose: OPEN DAY ROOM IN MIDDLE OF HOUSING WING, CAMERA COVERAGE. MULTIPLE OUTSIDE RECREATION AREAS COVERED BY CAMERAS

Laundry

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Hidden areas?: NONE – ALL LAUNDRY AREAS LOCATED ON EACH FLOOR HALLWAY.
- Camera Placement: 1 – 2 CAMERAS INSIDE LAUNDRY BASED ON SIZE OF ROOM AND ARCHITECTURE OF LAUNDRY ROOM
- Supervision: N/A

Warehouse/Storage

- Hidden areas: LARGE BLIND SPOT IN BASEMENT STORAGE. SECURITY PROTOCOLS TO BE ENHANCED TO INCREASE SEXUAL SAFETY WHEN STAFF TAKE RESIDENTS TO BASEMENT TO REMOVE OR PLACE STORAGE. NO CAMERAS INSIDE BASEMENT - RESTRICTED ACCESS. NO RESIDENTS ALLOWED WITHOUT STAFF SUPERVISION. SECURITY PROTOCOLS INCREASED TO PROVIDE ADDITIONAL SEXUAL SAFETY FOR RESIDENTS AND SAFETY FOR STAFF. AGENCY INSTITUTED DRAW KEY WITH SIGN-IN LOG. KEY IS LOCATED IN SECURITY OFFICE WHICH IS COVERED BY VIDEO MONITORING. INSTRUCTIONS ON DRAW-KEY LOG MANDATES THAT 2 STAFF ACCOMPANIES ANY RESIDENTS WHO ARE TASKED TO ENTER BASEMENT AREA WITH STAFF.
- Camera Placement: NO CAMERAS IN BASEMENT – ONLY ALONG STAIRWELL LEADING TO BASEMENT
- Supervision: DIRECT STAFF SUPERVISION OF RESIDENTS ASSISTING MOVEMENT OF PROPERTY

Receiving and Discharge (Intake)

- Strip Areas (Private): N/A
- Interview Areas (Confidential): SECURITY OFFICE FOR INTAKE & CASE MANAGERS OFFICES FOR ASSESSMENTS

- Information Posted: ZERO TOLERANCE & PREA ADVOCACY POSTER IDENTIFIED OUTSIDE SECURITY OFFICE
- Cameras: CAMERAS LOCATED INSIDE SECURITY OFFICE AND ALONG HALLWAYS SECURITY OFFICE IS LOCATED. NO BLIND SPOTS.
- Phones??: PHONES LOCATED ALONG HALLWAY
- Ask for Information Provided to Offenders: PREA BROCHURES AND HANDBOOK PROVIDED

Front Entrance (Reception Area)

PREA Information Provided: ONE PREA SIGNAGE POSTER ACROSS FROM INTAKE.

Education (ACADEMIC)

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Classrooms: ALONG 1ST FLOOR HALLWAY
- Camera Placement: MULTIPLE CAMERAS ALONG HALLWAY AND INSIDE CLASSROOMS
- Supervision: SECURITY ROAMS FACILITY & CHECKS ALL DOORS AT LEAST EVERY 2 HOURS
- Storage Areas: MOP CLOSETS ALONG 1ST FLOOR HALLWAY TOO SMALL TO COMPROMISE SEXUAL SAFETY

Food Service

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Dining Rooms: 1 DINING ROOM FOR ENTIRE FACILITY
- Officer Dining Area: N/A
- Kitchen: 1 ARAMARK STAFF PER SHIFT – 1 TO 3 RESIDENT WORKER PER SHIFT. 1 SECURITY STAFF ADDED DURING DINNER AND BREAKFAST FEEDINGS
- Coolers: MULTIPLE REEFERS IN DINING AREA.
- Freezers: SAME AS ABOVE
- Dry Goods Storage: STORAGE LOCATED IN KITCHEN AREA
- Garbage Area: OUTSIDE KITCHEN UNDER SURVEILLANCE CAMERA
- Dishroom: INSIDE KITCHEN AREA UNDER SURVEILLANCE CAMERA
- Tool Room: INSIDE KITCHEN AREA, COVERED BY SURVEILLANCE CAMERA
- Camera Placement: TWO ANALOG CAMERAS IN DINING AREA & ONE DIGITAL CAMERA IN KITCHEN.
- Supervision: 1 ARAMARK STAFF PER SHIFT, 1 – 2 SECURITY STAFF AVAILABLE DURING FEEDING.

Recreation Yard

- PREA Information Posted?: NONE AVAILABLE – SEE STANDARD 115.33 CORRECTIVE ACTION RESPONSE.
- Bathrooms: NO OUTSIDE BATHROOMS
- Camera Placement: DIGITAL CAMERAS COVER ALL RECREATION AREAS. CAMERAS CAN ZOOM AND PIVOT
- Hidden Areas?: ALL AREAS COVERED BY CAMERAS

Industries Area

- PREA INFORMATION POSTED:? NOT APPLICABLE
- Bathrooms: NO RESIDENTS ALLOWED IN MAINTENANCE BASEMENT
- Tool Rooms: MAINTENANCE – NO RESIDENTS ALLOWED
- Camera Placement: STAIRWELL TO BASEMENT
- Production Areas: N/A

- Quality Control Areas: N/A

Warehouse or Warehouse Area BASEMENT:

- CAMERA LOCATED ON STAIRWELL LEADING TO BASEMENT ENTRY DOORS. NO CAMERAS INSIDE BASEMENT - RESTRICTED ACCESS. NO RESIDENTS ALLOWED WITHOUT STAFF SUPERVISION. SECURITY PROTOCOLS INCREASED TO PROVIDE ADDITIONAL SEXUAL SAFETY FOR RESIDENTS AND SAFETY FOR STAFF. AGENCY INSTITUTED DRAW KEY WITH SIGN-IN LOG. KEY IS LOCATED IN SECURITY OFFICE WHICH IS COVERED BY VIDEO MONITORING. INSTRUCTIONS ON DRAW-KEY LOG MANDATES THAT 2 STAFF ACCOMPANIES ANY RESIDENTS WHO ARE TASKED TO ENTER BASEMENT AREA WITH STAFF.
- PREA Information Posted?: NOT APPLICABLE

Review of Documentation:

THE AUDITOR CONDUCTED A REVIEW OF 11 RANDOM SAMPLING OF RESIDENTS SCREENING FILES , 11 RANDOM SAMPLING OF STAFF 11 PERSONNEL FILES AND 4 RANDOM SAMPLING OF CONTRACTOR FILES TO DETERMINE COMPLIANCE WITH THE PREA STANDARDS. AUDITOR CONDUCTED INTERVIEWS WITH 14 SPECIALIZED STAFF, 11 RANDOM SAMPLING OF STAFF AND 12 RANDOM SAMPLING OF RESIDENTS TO DETERMINE AGENCY & FACILITY COMPLIANCE WITH THE PREA STANDARDS.

DESCRIPTION OF FACILITY CHARACTERISTICS:

ICCS-Kendall is a male only residential community corrections facility located at 1651 Kendall Street Lakewood, CO 80214. The facility is central to employment and service opportunities for Residents. ICCS provides in-house substance abuse treatment, cognitive skills groups as well as 12-step type support programs with a full compliment of educational programming. Specific mental health services are also provided through BTS and independent mental health services business. The building is a 1922 vintage 2-story hospital building with residential rooms on the first and second floors along with handicap accessibility to the entryway, toilets and showers. Adequate ingress and egress is available for handicapped individuals. The facility is in compliance with the Colorado Community Corrections Standards.

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 - Diversio residents are placed in the program as a condition of their probation or as a direct sentence. Diversio 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 - Diversio 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.

Residential Dual Diagnosis Treatment (RDDT) - This program provides treatment services designed to measurably reduce recidivism, incarceration and re-incarceration for the mentally ill and substance using offender population. The RDDT program is designed to effect a complete change in lifestyle, which includes control of compulsive behaviors, elimination of criminal behavior, and the acquisition of positive attitudes, values and behaviors which reflect honesty, responsibility, non-violence, and a balanced reliance on self and others. ICCS' goal is to retain or return those offenders to the community with the ability to succeed in society as productive individuals while preserving community safety.

John Eachon Re-Entry Program (JERP) - ICCS provides services to transition and diversion clients who have been diagnosed with serious and persistent mental illness and substance abuse problems. The provision of services to JERP clients is unique as it integrates services from ICCS and the Jefferson Center for Mental Health (JCMH). Upon approval referrals may be accepted with a singular mental health diagnosis. Most JERP clients are not fully employable. The multidisciplinary approach allows the JERP clients to receive appropriate treatment, evaluation, medication, and other support services, not otherwise attainable in the community setting.

Community Return to Custody Facility (CRCF) - CRCF allows non-violent class four, five and six felony parole clients, who have been revoked from parole for technical violations, the opportunity to serve their revocation term of up to 180 days in a community based facility instead of being returned to the DOC. ICCS staff and the Community Parole Officer assigned to the facility require the clients to address specific issues that led to their regression from parole

START - The Short Term Alternative Residential Treatment program (up to 90 days) is a collaborative program for Jefferson County 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.

Getting it Right (GIT) - Getting it Right is a grant funded program that targets medium to high risk offenders who have committed class 2, 3, 4 or 5 felonies. The program provides a comprehensive reentry process with wraparound services to clients starting at sentencing, continuing through community corrections, and transitioning to community and supported by Faith and Community Based organizations.

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.

Sex Offender (SXO) - Following Sex Offender Management Board (SOMB) standards, ICCS provides residential case management, accountability oversight and "Bridge Treatment" (provided by SOMB approved providers) to offenders who are or will become involved in Sex Offense Specific Treatment. ICCS staff is part of the containment team who meet regularly to insure compliance on the part of the offender. Per SOMB ICCS staff is a part of the Containment Team.

Sex Offender Lifetime Program - Along with RSA and parole, ICCS staff travels to prisons that facilitate the Sex Offender Treatment Monitoring Program and interview potential candidates face to face. ONLY those who are thoroughly vetted by the group are allowed to progress in the screening process. The program allows a step down program for offenders that need the support to become established with a residence, treatment and employment, which enhances community

safety.

Federal Probation Clinical Services - Through Behavioral Treatment Services (BTS), clinicians provide assessments for mental health and substance abuse issues for federal parole clients. This includes Cognitive Behavioral Therapy and other treatment on an individual or group basis. This modality allows for federal probationers to maintain their community placement.

SUMMARY OF AUDIT FINDINGS:

ON JULY 20, 2015 THROUGH JULY 22, 2015, A PREA AUDIT TOUR WAS CONDUCTED AT THE ICCS KENDALL COMMUNITY CORRECTIONS RESIDENTIAL FACILITY, LOCATED IN LAKEWOOD COLORADO. SUMMARY OF INTERIM AUDIT FINDINGS ARE AS FOLLOWS:

Number of standards exceeded: **1**

Number of standards met: **36**

Number of standards not met: **1**

Number of standards not applicable: **1**

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| 115.211 | Zero tolerance of sexual abuse and sexual harassment; PREA coordinator. |
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- 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 IN ACCORDANCE WITH STANDARD PROVISION 115.211(a).
- 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 INDICATES HE HAS SUFFICIENT TIME AND AUTHORITY TO DEVELOP, IMPLEMENT AND OVERSEE AGENCY EFFORTS TO COMPLY WITH THE PREA STANDARDS FOR ALL OF THE AGENCY COMMUNITY CONFINEMENT FACILITIES. PREA COORDINATOR'S PRIMARY DUTY AND FUNCTION IS TO ENSURE AGENCY FACILITIES MEET PREA COMPLIANCE.

AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.211.

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| 115.212 | Contracting with other entities for the confinement of residents |
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- 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

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 IS MET.

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) REVIEW OF STAFFING PLAN PROVIDED BY AGENCY IS SPECIFIC TO ICCS KENDALL. PLAN IDENTIFIES LAYOUT OF THE FACILITY, VIDEO MONITORING PLACEMENT AND DEFICIENCIES WHICH COMPROMISE RESIDENT SAFETY WITH RECOMMENDATIONS. COMPOSITION OF THE RESIDENT POPULATION, PREVELANCE OF SUBSTANTIATED AND UNSUBSTANTIATED INCIDENTS OF SEX ABUSE AND OTHER RELEVANT FACTORS WERE INCLUDED IN THE STAFFING PLAN. INTERVIEW WITH DIRECTOR DESIGNEE AND PREA COORDINATOR VERIFIES STAFFING PLAN DEVELOPMENT CONSIDERS ALL 4 CRITERIA AS OUTLINED IN STANDARD PROVISION 115.213(a). ADMINISTRATION HAS MADE CHANGES FOR SEXUAL SAFETY OF RESIDENTS BASED UPON THE FACTORS IDENTIFIED IN THE STAFFING PLAN.
- b) THERE HAVE BEEN NO DEVIATIONS FROM STAFFING PLAN FOR PAST 12 MONTHS PER PAQ. POLICY #400-B MANDATES ALL DEVIATIONS FROM THE STAFFING PLAN WILL BE DOCUMENTED. STAFFING PLAN INDICATES THERE HAVE BEEN NO DEVIATIONS FROM THE STAFFING PLAN IN PAST 12 MONTHS. INTERVIEW WITH DIRECTOR DESIGNEE VERIFY NO DEVIATIONS FROM THE STAFFING PLAN SINCE AUGUST 2012. SECURITY SCHEDULE CALLS FOR EXTRA STAFF AT TIMES SO STAFF COVERAGE IS MAINTAINED. ICCS STAFFING IS OVER THE MINIMAL STAFFING REQUIREMENTS TO ENSURE COMPLIANCE WITH STANDARD PROVISION 115.213(B)
- c) THIS IS AGENCY'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 CORROBORATES PAQ. THIS IS AGENCY'S 1ST PREA AUDIT, THEREFORE, THERE HAVE BEEN NO PREVIOUS STAFFING PLAN REVIEWS. CURRENT STAFFING PLAN CONSIDERS CRITERIA IDENTIFIED IN STANDARD 115.213(c).

AUDITOR HAS DETERMINED AGENCY HAS MET ALL PROVISIONS OF THIS STANDARD AND IS IN COMPLIANCE WITH 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 IDENTIFIED. NO LOGS OF CROSS GENDER STRIP OR CROSS GENDER BODY CAVITY SEARCHES CONDUCTED IN PAST 12 MONTHS. NO DOCUMENTATION OF INSTANCES WHERE MEDICAL STAFF CONDUCTED SUCH SEARCHES AS NONE WERE CONDUCTED NOR REQUIRED, IN ACCORDANCE WITH STANDARD 115.215(a).
- 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 AN INITIAL PREA AUDIT CONDUCTED IN JULY 2015. POLICY #450 STATES THAT ONLY STAFF OF SAME SEX IS ALLOWED TO CONDUCT PAT-DOWN SEARCHES. THIS IS AN ALL MALE FACILITY. THIS IS AN INITIAL PREA AUDIT CONDUCTED IN JULY 2015. STANDARD PROVISION 115.215(b) DOES NOT APPLY TO THIS FACILITY.
- c) POLICY #450 MANDATES CROSS-GENDER STRIP SEARCHES ARE CONDUCTED ONLY UNDER EXIGENT CIRCUMSTANCES AND ARE DOCUMENTED. VISUAL BODY CAVITY SEARCHES ARE PROHIBITED. THIS IS A MALE FACILITY WITH BOTH MALE AND FEMALE STAFF. NO CROSS GENDER STRIP OR CROSS GENDER VISUAL BODY CAVITY SEARCHES CONDUCTED AT THIS FACILTY NOR HAS THERE BEEN ANY CROSS GENDER PAT DOWN SEARCHES. CROSS GENDER SEARCHES ARE CONDUCTED WITH ELECTRONIC WAND. NO PHYSICAL CONTACT BETWEEN MALE RESIDENTS AND FEMALE STAFF. NO DOCUMENTATION OF IDENTIFIED SEARCHES AS NONE OCCURRED. FACILITY IS IN COMPLIANCE WITH STANDARD 115.215(c).
- d) POLICY #160 AND HOUSE POLICY PAGE #9 SPECIFICALLY MANDATES RESIDENTS CHANGE CLOTHING ONLY IN BATHROOM AREAS TO PROVIDE PRIVACY. POLICY #410 INDICATE STAFF OF OPPOSITE GENDER ARE REQUIRED TO ANNOUNCE THEIR PRESENCE WITH ENTERING AN AREA WHERE RESIDENTS ARE LIKELY TO BE SHOWERING, PERFORMING BODILY FUNCTIONS OR CHANGING CLOTHING. INTERVIEW WITH RANDOM RESIDENTS VERIFY STAFF OF OPPOSITE GENDER ANNOUNCE THEIR PRESENCE WHEN THERE IS A NEED TO CONDUCT COUNT OR ENTER THE BATHROOM SETTING. POLICY MANDATES FEMALE STAFF CANNOT ENTER THE BATHROOM, ONLY KNOCK, ANNOUNCE AND STAND IN THE DOORWAY OF THE BATHROOM. THIS ALLOWS RESIDENTS PRIVACY IN THE TOILET AND CHANGING AREA STALLS. INTERVIEW WITH RANDOM STAFF VERIFIES CORROBORATES RESIDENTS CLAIM AND VERIFIES DEMONSTRATED POLICY MANDATE IN ACCORDANCE WITH STANDARD 115.215(d).
- 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. INTERVIEW WITH RANDOM SAMPLE OF STAFF VERIFIES EDUCATION AND PRACTICE REGARDING THE PROHIBITION OF STAFF PHYSICALLY EXAMINING A TRANSGENDER OR INTERSEX RESIDENT FOR THE SOLE PURPOSE OF DETERMINING THE RESIDENT’S GENITAL STATUS. INTERVIEW WITH TRANSGENDER RESIDENTS CORROBORATE STAFF’S CLAIM THIS DOES NOT OCCUR IN KENDALL FACILITY IN ACCORDANCE WITH POLICY AND STANDARD PROVISION 115.215(e)
- f) SECURITY TRAINING CURRICULUM SECTION #4-A 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. DURING ON-SITE AUDIT TOUR, AUDITOR REVIEWED RANDOM SAMPLING OF 12 STAFF TRAINING RECORDS AND TRAINING ACKNOWLEDGEMENT FORMS. RANDOM SAMPLING OF RECORDS INDICATE SECURITY STAFF HAVE BEEN TRAINED IN CROSS GENDER PAT-DOWN SEARCHES. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATE ONLY ½ OF THOSE INTERVIEWED RECALLED THE CROSS GENDER PAT DOWN SEARCH AND SEARCH OF TRANSGENDER AND INTERSEX RESIDENTS IN A PROFESSIONAL AND RESPECTFUL MANNER. RECOMMEND AGENCY CONDUCT A REFRESHER TRAINING FOR ALL SECURITY STAFF TO INCREASE THEIR KNOWLEDGE FACTOR REGARDING REQUIREMENT OF STANDARD PROVISION 115.215(f).

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.215.

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| 115.216 | Residents with disabilities and residents who are limited English proficient |
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- 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 SPANISH, VOIANCE CONTRACT FOR INTERPRETERS. TRAINING CURRICULUM PROVIDED ENTAILS EXPLAINING THE SCOPE OF PREA 2003, WATCH STAFF & CLIENT ORIENTATION VIDEO, REVIEW REPORTING EXPECTATION & REQUIREMENT & READ POLICIES #160 & 165 AND SIGN PREA ACKNOWLEDGEMENT FORM. STAFF CURRICULUM FULL TRAINING PPT PROVIDED. RESIDENCE WATCH CDOC VIDEO, PROVIDED THE PREA BROCHURE IN BOTH ENGLISH & SPANISH & RULE BOOK WHICH IS AVAILABLE ONLY IN ENGLISH AT THIS TIME, BUT BEING TRANSLATED FOR SPANISH FOR FUTURE PUBLICATION. BILINGUAL STAFF ARE AVAILABLE TO PROVIDE EFFECTIVE COMMUNICATION FOR SPANISH SPEAKING RESIDENTS FOR PHYSICAL TRANSLATION OF PREA EDUCATIONAL MATERIALS. INTERVIEW WITH AGENCY HEAD DESIGNEE INDICATES AGENCY PROVIDES PREA LITERATURE IN ENGLISH & SPANISH AND ALSO PROVIDES FOR VOIANCE INTERPRETER SERVICES WITH WHICH THEY HAVE SECURED AN MOU TO PROVIDE EFFECTIVE COMMUNICATION FOR RESIDENTS. THERE ARE ALSO A NUMBER OF STAFF WHO SPEAK SPANISH AND CAN INTERPRET ALSO. THERE ARE NO RESIDENTS WHO ARE LIMITED ENGLISH PROFICIENT AT THE TIME OF THE ON-SITE TOUR. PREA BROCHURES IN BOTH ENGLISH AND SPANISH ARE PROVIDED DURING INTAKE ALONG WITH THE RULE BOOK. AUDITOR OBSERVED BROCHURES IN BOTH ENGLISH AND SPANISH PROVIDED IN THE HALLWAY OUTSIDE THE SECURITY OFFICE ACCESSIBLE TO RESIDENTS. AGENCY HAS TAKEN APPROPRIATE STEPS TO PROVIDE EFFECTIVE COMMUNICATION FOR RESIDENTS WITH DISABILITIES AND LIMITED ENGLISH PROFICIENT RESIDENTS PER STANDARD PROVISION 115.216(a).

- 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 SPANISH, VOIANCE CONTRACT FOR INTERPRETERS. CURRICULUM PROVIDED IS A CHECKLIST OF TOPICS WITH INSTRUCTIONS FOR STAFF/CLIENTS TO INITIAL AND SIGN. REFRESHER TRAINING PPT FOR STAFF INCLUDES TRAINING ON EFFECTIVE COMMUNICATION FOR RESIDENTS WITH LIIMITED ENGLISH PROFICIENCY & HOW TO TAKE STEPS TO ENSURE RESIDENTS HAVE THE OPPORTUNITY TO BENEFIT FROM ALL ASPECTS OF AGENCY’S EFFORT TO RESPOND TO SEXUAL ABUSE/HARASSMENT, IN COMPLIANCE WITH STANDARD 115.216(b). NO LIMITED ENGLISH PROFICIENT RESIDENTS HOUSED IN FACILITY WHEN ON-SITE TOUR WAS CONDUCTED. AGENCY HAS MET STANDARD PROVISION 115.216(b).
- 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 INDICATES THAT TRAINING HAS BEEN PROVIDED TO PROHIBIT USE OF RESIDENT INTERPRETERS EXCEPT IN EXIGENT CIRCUMSTANCES DURING INVESTIGATIONS OF A RESIDENT’S ALLEGATION OF SEXUAL ABUSE IN ACCORDANCE WITH STANDARD PROVISION 115.216(c).

AUDITOR HAS DETERMINED THAT AGENCY HAS COMPLIED WITH STANDARD 115.216.

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| 115.217 | Hiring and promotion decisions |
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- 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) REVIEW OF RANDOM SAMPLE OF PERSONNEL FILES INDICATED 100% OF STAFF HAVE CLEARED CCIC & NCIC BACKGROUND CHECK. PERSONNEL POLICY PROVIDES FOR PROMOTION CHECKS TO MEET STANDARD 115.217(a) CRITERIA. AGENCY POLICY IS IN COMPLIANCE WITH STANDARD PROVISION 115.217(a). REVIEW OF 3 BTS & 2 CEO CONTRACTOR BACKGROUND DOCUMENTS ASSIGNED TO KENDAL INDICATES ALL 5 CLEARED CCIC BUT ONLY 3 CLEARED NCIC BACKGROUND. 2 CEO CONTRACTOR RECORDS HAD NO DETERMINATION ON THE BACKGROUND CLEARANCE PROVISION FOR CBI/FBI CHECK. QUESTIONS REGARDING PAST CONDUCT IS ASKED DURING PROMOTION AND HIRING INTERVIEWS. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.217(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 THE HUMAN RESOURCES ADMINISTRATOR VERIFIES DEMONSTRATION OF AGENCY POLICY REGARDING HIRING AND PROMOTION IN ACCORDANCE WITH STANDARD PROVISION 115.217(b).
- c) POLICY #220 INCORPORATES THE NARRATIVE IDENTIFIED IN THIS STANDARD PROVISION AND IS COMPLIANT. 4 RECENTLY HIRED EMPLOYEE PERSONNEL FILES WERE REVIEWED BY AUDITOR WHO DETERMINIED THE AGENCY HAD CONDUCTED BACKGROUND CHECKS IN ACCORDANCE WITH STANDARD PROVISION 115.217(c). BACKGROUND CHECKS WERE INITIALLY RUN THROUGH THE STATE CCIC CHECK,

AND FINGERPRINT CARDS FORWARDED TO CBI/FBI FOR ADDITIONAL CLEARANCE CHECKS. TWO WERE DETERMINED TO HAVE MISDEMEANOR CASES, HOWEVER, NONE OF CASES WERE RELATED TO SEX ABUSE OR SEXUAL HARASSMENT.

- d) POLICY #220 MANDATES CRIMINAL BACKGROUND CHECK ON ALL APPLICANTS TO INCLUDE CONTRACTORS IN THE NARRATIVE. REVIEW OF 3 BTS & 3 CEO CONTRACTOR BACKGROUND DOCUMENTS ASSIGNED TO KENDAL INDICATES ALL 6 CLEARED CCIC BUT ONLY 5 CLEARED NCIC BACKGROUND. 2 CEO CONTRACTOR RECORDS HAD NO DETERMINATION ON THE BACKGROUND CLEARANCE PROVISION FROM CBI/FBI CHECK. INTERVIEW WITH HUMAN RESOURCED ADMINISTRATOR INDICATED THEY WERE UNABLE TO LOCATE THE CBI/FBI CLEARANCE SHEET ON THIS ONE OUTSTANDING CASE AS THIS EMPLOYEE WAS A CEO CONTRACTOR. IT HAS BEEN THE PRACTICE THAT CEO CONTRACTORS ARE PROVIDED A CCIC (STATE OF COLORADO) BACKGROUND CHECK BUT NOT THE CBI/FBI NATIONAL CLEARANCE NON-COMPLIANT WITH STANDARD PROVISION 115.217(d).
- e) POLICY #220 SPECIFICALLY MANDATES CRIMINAL BACKGROUND RECORDS CHECKS ON ALL EMPLOYEES AND CONTRACTORS. INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR INDICATES BACKGROUND RE-CHECKS ARE CONDUCTED EVERY 5 YEARS ON CURRENT EMPLOYEES. REVIEW OF SAMPLE NUMBER OF FILES CORROBORATES ADMINISTRATOR STATEMENT AND COMPLIANCE WITH BOTH POLICY AND STANDARD PROVISION 115.217(e).
- f) POLICY #220 MANDATES THE CRIMINAL HISTORY BACKGROUND CHECK FORM ASKS ALL APPLICANTS DIRECTLY ABOUT 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). INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR INDICATES APPLICANTS AND EMPLOYEES PENDING PROMOTION ARE ASKED DURING THE INTERVIEW PROCESS ABOUT PREVIOUS MISCONDUCT REGARDING SEX ABUSE OR SEXUAL HARASSMENT INCIDENTS IN ACCORDANCE WITH STANDARD PROVISION 115.217(f).
- g) POLICY #220 MANDATES MATERIAL OMISSIONS REGARDING SUCH MISCONDUCT OR THE PROVISION OF MATERIALLY FALSE INFORMATION ARE GROUNDS FOR TERMINATION. AGENCY POLICY IS IN COMPLIANCE WITH STANDARD PROVISION 115.217(g).
- h) 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. INTERVIEW WITH HUMAN RESOURCES ADMINISTRATOR INDICATES AGENCY WILL PROVIDE INFORMATION ON SUBSTANTIATED ALLEGATIONS OF SEX ABUSE/HARASSMENT INVOLVING A FORMER EMPLOYEE UPON RECEIVING A REQUEST FROM AN INSTITUTIONAL EMPLOYER FOR WHOM SUCH EMPLOYEE HAS APPLIED TO WORK, ACCOMPANIED WITH A RELEASE OF INFORMATION SIGNED BY SAID EMPLOYEE. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.217(h).

AUDITOR HAS DETERMINED AGENCY DOES NOT MEET STANDARD 115.217 AS PROVISION 115.217(d) IS OUT OF COMPLIANCE

CORRECTIVE ACTION:

1. AGENCY TO CONDUCT BACKGROUND CHECKS ON ALL CONTRACTORS ASSIGNED TO THE KENDALL FACILITY THROUGH THE CBI/FBI SYSTEM TO ENSURE ALL CONTRACTORS WHO HAVE CONTACT WITH RESIDENTS POSSESS A CLEAR RECORD PRIOR TO CONDUCTING BUSINESS WITH AGENCY.
2. PRACTICE OR PROCEDURE TO BE PROVIDED AUDITOR TO INCLUDE DOCUMENTATION TO VERIFY AGENCY HAS DEMONSTRATED COMPLIANCE WITH STANDARD PROVISION 115.217(a) & 115.217(d).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/15/16 :

POLICY #220 MANDATES CRIMINAL BACKGROUND CHECK ON ALL APPLICANTS TO INCLUDE CONTRACTORS . AGENCY HAS PROVIDED BACKGROUND CHECK VERIFICATION FOR ONE CEO CONTRACTOR WHICH IS COMPLIANT AS THE CCIC/NCIC/FBI CLEARANCE FORM INDICATES RECORD CLEAR. THE SECOND EMPLOYEE IDENTIFIED IN PAQ AS A CEO CONTRACTOR WAS FOUND TO BE A CEO VOLUNTEER. NO REQUIREMENT IN STANDARD 217 TO REQUIRE CRIMINAL BACKGROUND CHECKS FOR VOLUNTEERS. AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 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. THIS IS AGENCY'S 1ST PREA AUDIT. STANDARD DOES NOT APPLY TO AGENCY. INTERVIEW OF AGENCY HEAD DESIGNEE AND DIRECTOR INDICATES THERE HAVE BEEN NO ACQUISITION OR SUBSTANTIAL EXPANSION OR MODIFICATION OF EXISTING FACILITIES SINCE AUGUST 2012. STANDARD PROVISION 115.218(a) DOES NOT APPLY TO THIS AGENCY/FACILITY.
- b) PAQ INDICATES AGENCY/FACILITY HAS INSTALLED OR UPDATED VIDEO MONITORING SYSTEM SINCE AUGUST 20, 2012. AT KENDALL FACILITY WHERE DVR SYSTEM WAS CHANGED AND CAMERAS ADDED TO THAT FACILITY. AGENCY CONSIDERED THE NEED FOR ADDITIONAL VIDEO MONITORING SYSTEMS TO PROVIDE SEXUAL SAFETY FOR RESIDENTS. AGENCY HEAD DESIGNEE AND DIRECTOR INDICATED 5 DVR'S WERE UPDATED FOR INCREASED DATA STORAGE & 2 CAMERAS WERE ADDED. 2 ADDITIONAL CAMERAS WERE UPDATED FROM ANALOG TO DIGITAL TO PROVIDE WIDER VIEWING CAPABILITIES. AGENCY IS IN COMPLIANCE WITH STANDARD 115.218(b).

AUDITOR HAS DETERMINED AGENCY/FACILITY 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 LAKEWOOD PD. POLICY 165 B PROVIDES EVIDENCE PROTOCOL TO BE FOLLOWED BY ALL STAFF, CONTRACTORS & VOLUNTEERS. BOTH KENDALL FACILITY COORDINATED RESPONSE PROTOCOL AND POLICY 165 B MEET STANDARD PROVISION 115.221(a). INTERVIEWS WITH RANDOM SAMPLE OF STAFF VERIFY THAT STAFF HAVE BEEN PROPERLY TRAINED TO RESPOND TO INCIDENTS OF SEXUAL ABUSE. AGENCY POLICY SECURES THE SCENE FOR LAW ENFORCEMENT TO GATHER EVIDENCE FOR INVESTIGATION. AGENCY INVESTIGATORS ASSIST LOCAL LAW ENFORCEMENT IN THE INVESTIGATION IN WHATEVER CAPACITY IS REQUIRED. AGENCY ONLY INVESTIGATES ADMINISTRATIVE CASES, CRIMINAL CASES ARE INVESTIGATED BY LOCAL LAW ENFORCEMENT.
- 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. REVIEW OF EVIDENCE PROTOCOL FOR KENDALL FACILITY VERIFIES COMPLIANCE WITH STANDARD PROVISION 115.221(b). ICCS DOES NOT HOUSE ANYONE UNDER THE AGE OF 18 YEARS OF AGE, HOWEVER, THE PROTOCOL PROVIDES FOR CASES INVOLVING YOUTH AND VULNERABLE ADULTS TO BE REFERRED TO LOCAL LAW ENFORCEMENT FOR INVESTIGATION.
- c) POLICY 165 MANDATES FORENSIC MEDICAL EXAMINATIONS BE OFFERED TO VICTIMS OF SEX ABUSE WITHOUT FINANCIAL COST PER STANDARD PROVISION 115.221(c). FORENSIC EXAMINATIONS ARE CONDUCTED AT AN OUTSIDE HOSPITAL – MOU PROVIDED WITH PAQ. INTERVIEW WITH SAFE/SANE NURSE AT ST ANTHONY’S HOSPITAL INDICATE THEIR FACILITY IS RESPONSIBLE FOR CONDUCTING ALL FORENSIC MEDICAL EXAMINATIONS FOR ICCS FACILITIES PER THEIR MOU WITH ICCS. ALL SANE/SAFE NURSES ARE ON CALL 24/7 TO PROVIDE SERVICES FOR RESIDENTS. NO SEXUAL ASSAULTS REQUIRING FORENSIC EXAMINATIONS HAVE OCCURRED OVER THE PAST 12 MONTHS AT KENDALL FACILITY.
- d) POLICY 165 D-2 PROVIDES CONTACT WITH OUTSIDE RAPE CRISIS CENTER FOR VICTIM ADVOCACY. AGENCY PROVIDED AUDITOR WITH THE BLUE BENCH RAPE CRISIS CENTER MOU, WHICH PROVIDES ADVOCACY FOR VICTIMS OF SEXUAL ABUSE BOTH PRIOR TO AND DURING FORENSIC EXAMINATIONS AND CRIMINAL PROCEEDINGS IN ACCORDANCE WITH STANDARD PROVISION 115.221(d). INTERVIEW WITH PREA COORDINATOR VERIFIES AGENCY’S COMPLIANCE WITH STANDARD 115.221(d). THERE WERE NO RESIDENTS WHO REPORTED A SEXUAL ABUSE AT KENDALL FACILITY TO INTERVIEW.
- e) BLUE BENCH RAPE CRISIS CENTER MOU PROVIDED & VERIFIED SCOPE OF SERVICES COMPLIANT WITH STANDARD PROVISIONS IN THAT ADVOCATES ACCOMPANY VICTIM THROUGH THE FORENSIC EXAMINATION PROCESS. INTERVIEW WITH PREA COORDINATOR INFORMED AUDITOR AGENCY DOES NOT

POSSESS A QUALIFIED VICTIM ADVOCATE IN THE EVENT RESIDENT VICTIM OF SEXUAL ABUSE REQUESTS EMOTIONAL SUPPORT. AGENCY HAS MOU WITH BLUE BENCH RAPE CRISIS CENTER WHICH PROVIDES FOR CERTIFIED VICTIM ADVOCATE TO BE AVAILABLE TO RESIDENCE DURING ALL PORTIONS OF SEX ABUSE FORENSICS, INVESTIGATIONS AND NEED FOR VICTIM EMOTIONAL SUPPORT.

- f) UNSIGNED LAKEWOOD PD MOU COMPLIANT WITH STANDARD PROVISION REGARDING THE AGENCY FOLLOWING INVESTIGATIVE PROTOCOLS PER STANDARD PROVISION 115.221(f). CHIEF OF POLICE REVIEWING MOU PER E-MAIL CORRESPONDENCE. AGENCY PROVIDED UNSIGNED LAKEWOOD PD MOU AND E-MAIL CORRESPONDENCES REGARDING MOU RATIFICATION. CHIEF OF POLICE HAS REFERRED MOU TO THE CITY ATTORNEY FOR FINAL REVIEW AND APPROVAL.

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.221

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| 115.222 | Policies to ensure referrals of allegations for investigations |
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- 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 4 ALLEGATIONS OF SEX ABUSE/HARASSMENT RECEIVED IN LAST 12 MONTHS. NO ALLEGATION RESULTED IN ADMINISTRATIVE INVESTIGATION & 4 WERE REFERRED FOR CRIMINAL INVESTIGATION. ALL INVESTIGATIVE RESULTS WERE PROVIDED WITH PAQ. INTERVIEW WITH AGENCY DESIGNEE VERIFIES APPLICATION OF POLICY WHICH MANDATES ADMINISTRATIVE AND CRIMINAL INVESTIGATION OF ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT SHALL BE COMPLETED IN ACCORDANCE WITH STANDARD PROVISION 115.222(a). AUDITOR REVIEWED DOCUMENTATION OF THE 4 SEXUAL ABUSE ALLEGATIONS WHICH OCCURRED OVER THE PAST 12 MONTHS. 2 WERE ADMINISTRATIVE INVESTIGATIONS AND 2 WERE CRIMINAL INVESTIGATIONS. ALL INVESTIGATIONS HAVE BEEN COMPLETED.
- b) POLICY 165 INCORPORATES NARRATIVE CONSISTENT WITH STANDARD PROVISION 115.222(B). INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES COMPLIANCE WITH STANDARD PROVISION 115.222(b) IN THAT ALL ALLEGATIONS OF SEX ABUSE/HARASMENT ARE REFERRED FOR INVESTIGATION TO PROPER AGENCY ASSIGNED TO CONDUCT SAID INVESTIGATIONS. AUDITOR VERIFIED POLICY LANGUAGE IS PUBLISHED ON AGENCY WEBSITE. AUDITOR VERIFIED THAT ALL REFERRALS TO LOCAL LAW ENFORCEMENT HAD BEEN DOCUMENTED VIA INCIDENT REPORT.
- c) INVESTIGATIVE PROTOCOL IS PROVIDED ON POLICY #165 AND ON UNSIGNED LAKEWOOD PD MOU. 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).

AUDITOR HAS DETERMINED THAT AGENCY/FACILITY IS IN COMPLIANCE WITH STANDARD 115.222.

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 #255 MANDATES 40 HOURS OF TRAINING OF ALL STAFF WITHIN 90 DAYS OF EMPLOYMENT. SECURITY TRAINING CURRICULUM PROVIDES CHECKLIST OF TRAINING TOPICS WHICH INCLUDE TRAINER COMPLETE OVERVIEW OF PREA, PROVIDE ORIENTATION VIDEO FOR CLIENTS AND STAFF VIDEO, READ POLICIES #160 & #165, SIGN PREA ACKNOWLEDGEMENT FORM. BOTH EMPLOYEE FULL LENGTH AND REFRESHER TRAINING PPT PROVIDED WHICH MEETS CRITERIA MANDATED BY STANDARD 115.231(a). INTERVIEW RESPONSES FROM RANDOM SAMPLE OF STAFF INDICATE THEY HAVE RECEIVED TRAINING ON ALL 10 TRAINING ELEMENTS ESTABLISHED IN STANDARD 115.231(a). AUDITOR REVIEWED SAMPLE OF KENDALL STAFF TRAINING RECORDS AND DETERMINED ALL STAFF RECORDS REVIEWED CONTAINED SIGNED TRAINING ATTENDANCE AND PREA ACKNOWLEDGEMENT FOR EACH STAFF MEMBER.
- b) POLICY #255 MANDATES EMPLOYEES REASSIGNED FROM FACILITIES HOUSING THE OPPOSITE GENDER ARE GIVEN ADDITIONAL TRAINING SPECIFIC TO THAT GENDER. FULL LENGTH & REFRESHER PPT FOR STAFF TRAINING COMPLIES WITH STANDARD 115.231(b). INTERVIEWS WITH RANDOM SAMPLE OF STAFF INDICATE THEY RECEIVE REFRESHER TRAINING COMPONENTS 2X PER MONTH, EVERY OTHER FRIDAY.
- c) AGENCY CLAIMS 100% EMPLOYEE OR RETRAINING FOR STAFF IN PREA REQUIREMENTS. FULL LENGTH & REFRESHER PPT STAFF TRAINING PROVIDED WHICH MEETS MANDATE OF STANDARD 115.231(c). AUDITOR REVIEWED SAMPLE OF 11 STAFF TRAINING RECORDS & VERIFIED PAQ CLAIMS THAT 10 STAFF HAVE BEEN TRAINED IN PREA & SIGNED LETTERS OF ACKNOWLEDGEMENT INDICATING THEY UNDERSTAND THE TRAINING PROVIDED. ONE STAFF SIGNED PREA TRAINING ATTENDANCE BUT FACILITY COULD NOT LOCATE THE TRAINING ACKNOWLEDGEMENT FORM FOR THE PREA TRAINING.
- d) POLICY #265 #F MANDATES ALL STAFF RECEIVING TRAINING WILL SIGN A TRAINING FORM ACKNOWLEDGING THE TRAINING THEY HAVE RECEIVED. AUDITOR REVIEWED SAMPLE OF 11 STAFF TRAINING RECORDS & VERIFIED PAQ CLAIMS THAT 10 STAFF HAVE BEEN TRAINED IN PREA & SIGNED LETTERS OF ACKNOWLEDGEMENT INDICATING THEY UNDERSTAND THE TRAINING PROVIDED. ONE STAFF SIGNED PREA TRAINING ATTENDANCE BUT FACILITY COULD NOT LOCATE THE TRAINING ACKNOWLEDGEMENT FORM FOR THE PREA TRAINING.

AUDITOR HAS DETERMINED AGENCY HAS COMPLIED WITH STANDARD 115.231(c).

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 #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. FULL LENGTH & REFRESHER PPT STAFF TRAINING PROVIDED. PAQ STATES ALL 46 VOLUNTEERS & CONTRACTORS HAVE RECEIVED THE REQUIRED PREA TRAINING. INTERVIEW WITH CONTRACTORS INDICATE THEY HAVE BEEN TRAINED IN PREA RESPONSIBILITIES. REVIEW OF SAMPLE NUMBER OF TRAINING RECORDS FOR 2 BTS CONTRACTORS FOR KENDALL FACILITY INDICATE ONLY 1 HAS RECEIVED PREA TRAINING AND THE OTHER HAS BEEN EMPLOYED FOR 3 MONTHS, HAS CONTACT WITH RESIDENTS BUT HAS NOT RECEIVED ANY PREA TRAINING. REVIEW OF 2 CEO CONTRACTORS FOR KENDALL FACILITY INDICATE BOTH HAVE RECEIVED THE REQUIRED PREA TRAINING. AGENCY/FACILITY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.232(a).
- b) 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. FULL LENGTH & REFRESHER PPT STAFF TRAINING PROVIDED. INTERVIEW WITH CONTRACTORS AND REVIEW OF SAMPLE TRAINING RECORDS OF CONTRACTORS DETERMINE THE REQUIRED TRAINING RECEIVED MEETS STANDARD PROVISION 115.222(b). THEY RECEIVE THE SAME PREA TRAINING AS ICCS STAFF.
- c) 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. REVIEW OF TRAINING RECORDS FOR VOLUNTEERS & CONTRACTORS DEMONSTRATES APPLICATION OF AGENCY POLICY TO HAVE TRAINEES SIGN AND ACKNOWLEDGE RECEIPT OF PREA TRAINING IN ACCORDANCE WITH STANDARD 115.232(c).

AUDITOR HAS DETERMINED AGENCY/FACILITY IS NOT IN COMPLIANCE WITH STANDARD 115.232

CORRECTIVE ACTION:

AGENCY TO PROVIDE COPIES OF PREA TRAINING ATTENDANCE AND TRAINING ACKNOWLEDGEMENT FORMS FOR ALL CONTRACTORS AND VOLUNTEERS WHO HAVE COMPLETED PREA TRAINING FOR 4 MONTHS SINCE JUNE 22, 2015 TO VERIFY DEMONSTRATION OF COMPLIANCE WITH STANDARD PROVISION 115.232(a).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/15/16 :

AGENCY PROVIDED PREA ACKNOWLEDGEMENT FORMS FOR BOTH CEO CONTRACTOR AND CEO VOLUNTEER IN COMPLIANCE WITH CORRECTIVE ACTION MANDATE. AUDITOR HAS DEEMED AGENCY IN COMPLIANCE WITH STANDARD PROVISION 115.232(a) AND MEETS COMPLIANCE REQUIREMENTS OF STANDARD 115.232.

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| 115.233 | Resident education |
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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. ONE RESIDENT REFUSED TO UNDERGO INTAKE. INTERVIEW WITH INTAKE STAFF REVEALS ALL RESIDENTS RECEIVE PREA BROCHURE, RESIDENT HANDBOOK AND REVIEWS PREA VIDEO BEFORE BEING HOUSED. BROCHURE PROVIDES CONTACT INFORMATION FOR REPORTING SEX ABUSE/HARASSMENT TO INTERNAL & EXTERNAL AGENCIES, MENTIONS ZERO TOLERANCE POLICIES & PROVIDES FOR LIMITS OF CONFIDENTIALITY AND MONITORING RESTRICTIONS WHEN RESIDENT WISHES TO CONTACT OUTSIDE AGENCIES TO REPORT A PREA INCIDENT. RESIDENT HANDBOOK HAS PREA SECTION AND COVERS ALL RELEVANT PREA INFORMATION. INTERVIEW OF RANDOM SAMPLE OF 12 RESIDENTS VERIFY STATEMENTS MADE BY INTAKE STAFF. ALL RESIDENTS VIVIDLY RECALL THE PREA VIDEO, HOWEVER, FEW READ THE PREA BROCHURE. ALL STATE THEY RECEIVED PREA TRAINING 1ST DAY OF INTAKE. REVIEW OF 11 RESIDENTS WHO HAVE ENTERED THE FACILITY IN LAST 12 MONTHS REVEALS ALL HAVE RECEIVED PREA EDUCATION. AGENCY PROVIDED PREA BROCHURE AND RESIDENT HANDBOOK TO AUDITOR. PREA BROCHURES WERE OBSERVED IN PAMPHLET HOLDERS OUTSIDE SECURITY OFFICE AVAILABLE TO RESIDENTS IN COMPLIANCE WITH STANDARD PROVISION 115.233(a).
- b) POLICY #160-D MANDATES WHENEVER RESIDENTS TRANSFERRED TO A DIFFERENT FACILITY SHALL BE PROVIDED REFRESHER TRAINING. INTERVIEW WITH INTAKE STAFF AND RANDOM SAMPLE OF RESIDENTS INDICATE NO INTRA AGENCY TRANSFERS OF RESIDENTS HAVE BEEN CONDUCTED. INTAKE STAFF INDICATE IF A RESIDENT WERE TO BE TRANSFERRED TO OR FROM A DIFFERENT FACILITY, THEY WOULD RECEIVE REFRESHER TRAINING PER POLICY IN ACCORDANCE WITH STANDARD PROVISION 115.233(b).

- 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, HOWEVER, THE RULES OF CONDUCT, WHICH IDENTIFIES PREA ON PAGE 19, WAS PROVIDED WITH PAQ IN THE ENGLISH ONLY VERSION. SPANISH VERSION IS COMING, AGENCY USES PREA BROCHURE “FACTS TO KNOW” UNTIL SPANISH VERSION IS AVAILABLE. AGENCY PROVIDED MOU WITH VOIANCE, WHICH PROVIDES FOR ALL INTERPRETIVE SERVICES. RESIDENT BROCHURE AND “FACTS YOU KNOW” ADDENDUM IS PUBLISHED IN BOTH ENGLISH & SPANISH. A NUMBER ON INTAKE STAFF MEMBERS CAN TRANSLATE INTO SPANISH & VOIANCE INTERPRETER SERVICES IS AVAILABLE PER CONTRACT SHOULD A DIFFERENT LANGUAGE BE NEEDED IN ACCORDANCE WITH STANDARD PROVISION 115.233(c).
- d) 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. NO SPANISH VERSION OF VIDEO. AGENCY USES PREA BROCHURE “FACTS TO KNOW” AS AN ALTERNATIVE. AUDITOR REVIEWED RESIDENT SCREENING DOCUMENTS. 11 RANDOM RECORDS WERE REVIEWED AND ALL CONTAINED DOCUMENTED PREA TRAINING EDUCATION CONDUCTED ON DAY OF INTAKE IN ACCORDANCE WITH STANDARD PROVISION 115.233(d).
- e) WRITTEN MATERIALS AVAILABLE VIA PREA BROCHURES IN BOTH ENGLISH & SPANISH. THE RULES OF CONDUCT, WHICH IDENTIFIES PREA ON PAGE 19, WAS PROVIDED WITH PAQ IN THE ENGLISH ONLY VERSION. SPANISH VERSION IS COMING, AGENCY USES PREA BROCHURE “FACTS TO KNOW”, PUBLISHED IN BOTH ENGLISH AND SPANISH, UNTIL SPANISH VERSION OF RULES OF CONDUCT IS AVAILABLE. AGENCY PROVIDED ZERO TOLERANCE POSTER, WHICH INCLUDES CONTACT INFO FOR RAPE CRISIS CENTER & ESL ACCESS. DURING AUDIT TOUR, AUDITOR OBSERVED PREA BROCHURES IN PAMPHLET HOLDERS OUTSIDE SECURITY OFFICE AVAILABLE TO RESIDENTS. POSTERS WERE SCARCE THROUGHOUT THE FACILITY. DURING INTERVIEW WITH RANDOM RESIDENTS, THEY COULD NOT RECALL THE CONTACT INFORMATION OR WHAT SERVICES ARE PROVIDED FOR REPORTING INCIDENTS OF SEX ABUSE OR SEX HARASSMENT. FACILITY IS NOT IN COMPLIANCE WITH STANDARD 115.233(e)

AUDITOR HAS DETERMINED FACILITY IS NOT IN COMPLIANCE WITH STANDARD 115.233

CORRECTIVE ACTION:

1. FACILITY TO IDENTIFY PREA POSTERS, WHICH PROVIDE CONTACT INFORMATION TO RESIDENTS IN EFFECTIVE COMMUNICATION FORMATS.
2. POSTERS ARE TO BE LOCATED IN COMMON AREAS THROUGHOUT THE FACILITY SUCH AS ALL HALLWAYS, DAY ROOMS, INTERVIEW ROOMS, EDUCATION ROOMS, LIBRARY AND COUNSELING ROOMS.
3. VERIFICATION OF COMPLIANCE PROVIDED TO AUDITOR WILL BE IN THE FORM OF DATED PHOTOS, EACH INDICATING THE AREA OF PLACEMENT THROUGHOUT THE FACILITY.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETED 12/4/15:

AGENCY INSTALLED 19 LARGE POSTERS (24X36) AT THE KENDALL FACILITY THROUGHOUT THE HALLWAYS WHICH PROVIDES CONTACT INFORMATION TO RESIDENTS.

FLORESCENT COLORED POSTERS (11X7.5) PLACED IN EACH STAFF OFFICE. BLACK & WHITE STANDARD PAPER SIZE POSTERS HAVE BEEN PLACED INSIDE EACH RESIDENTIAL ROOM AND NEXT TO EACH PHONE. AGENCY VERIFIED PLACEMENT OF POSTERS VIA DATED PHOTOS OF PLACEMENT WHICH INCLUDED THE LOCATION OF EACH POSTER IN THE PHOTO. AUDITOR HAS DETERMINED THAT AGENCY EXCEEDS THE REQUIREMENT OF STANDARD 115.233. AGENCY HAS TAKEN STEPS TO PROVIDE PREA EDUCATION POSTERS NOT ONLY IN GENERAL AREAS OF THE FACILITY, BUT ALSO IN COUNSELOR OFFICES, STAFF OFFICES AND EACH RESIDENTIAL ROOM. POSTERS PROVIDE LIMITS OF CONFIDENTIALITY TO INCLUDE INFORMATION TO INDICATE THAT CALLS TO THE CONFIDENTIAL SOURCES ARE NOT MONITORED. AUDITOR HAS DETERMINED AGENCY COMPLIES WITH ALL PROVISIONS OF STANDARD 115.233.

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| 115.234 | Specialized training: Investigations |
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- 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). KENDALL FACILITY HAS 5 INVESTIGATORS. VERIFICATION CERTIFICATES OF NIC INVESTIGATOR TRAINING COMPLETION PROVIDED. INTERVIEW WITH INVESTIGATION STAFF INDICATE ALL INVESTIGATORS HAVE RECEIVED TRAINING IN CONDUCTING INVESTIGATIONS IN A CONFINEMENT SETTING THROUG NIC INVESTIGATOR TRAINING. REVIEW OF ALL 5 TRAINING RECORDS FOR INVESTIGATORS REVEALED ALL 5 POSSESSED NIC INVESTIGATION TRAINING COMPLETION CERTIFICATES IN COMPLIANCE WITH STANDARD PROVISION 115.234(b).
- 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 THE NIC INVESTIGATION TRAINING INCLUDE MIRANDA & GARRITY WARNINGS, EVIDENCE COLLECTION, AND EVIDENCE & CRITERIA REQUIRED TO SUBSTANTIATE A CASE FOR ADMINISTRATIVE ACTION OR PROSECUTION REFERRAL IN ACCORDANCE WITH STANDARD PROVISION 115.234(b).
- c) ALL 5 NIC INVESTIGATOR TRAINING COMPLETION SIGNED DOCUMENTS PROVIDED TO AUDITOR WITH PAQ. AUDITOR REVIEW OF SEX ABUSE INVESTIGATOR TRAINING RECORDS VERIFIES AGENCY MAINTAINS DOCUMENTATION OF THE REQUIRED SEX ABUSE INVESTIGATION IN A CONFINEMENT SETTING TRAINING DOCUMENTS.

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.234.

- 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 HAS NOT PROVIDED OF BTS STAFF THAT HAS BEEN TRAINED. MH STAFF IS CONTRACTED THROUGH BTS TO PERFORM SERVICES AT ICCS & NO MEDICAL STAFF ARE ASSIGNED TO ICCS AS ALL MEDICAL ACTIVITIES ARE CONDUCTED AT ST ANTHONY'S HOSPITAL. INTERVIEW WITH MENTAL HEALTH STAFF INDICATES THEY ARE TRAINED BY ICCS STAFF. AGENCY HAS NOT PROVIDED COPIES OF TRAINING RECORDS FOR BTS STAFF WITH PAQ OR DURING ON-SITE TOUR. REVIEW OF SAMPLE TRAINING RECORDS REVEALED ONE BTS STAFF MEMBER WHO HAS BEEN EMPLOYED FOR 3 MONTHS AND HAS UNSUPERVISED CONTACT WITH RESIDENTS, HAS NOT RECEIVED PREA TRAINING. ICCS DOES NOT EMPLOY OR CONTRACT MEDICAL STAFF TO WORK INSIDE IT'S FACILITIES. AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.235(a).
- b) FORENSIC EXAMINATIONS ARE NOT CONDUCTED AT ANY ICCS FACILTIES. ALL SUCH EXAMINATIONS ARE PROVIDED THROUGH MOU CONTRACT WITH ST ANTHONY'S HOSPITAL. STANDARD PROVISION 115.235(b) IS NOT APPLICABLE TO THIS AGENCY/FACILITY.
- c) AGENCY MAINTIANS PREA TRAINING DOCUMENTATION FOR MENTAL HEALTH STAFF (BTS). AUDITOR REVIEWED TRAINING RECORDS FOR SAMPLE BTS CONTRACTORS DURING AUDIT TOUR.
- d) ALL STAFF, INCLUDING MENTAL HEALTH PRACTITIONERS, RECEIVE THE SAME PREA TRAINING PER POLICY#165 IN ACCORDANCE WITH STANDARD PROVISION 115.235 (d). NO MEDICAL STAFF EMPLOYED AT ICCS FACILITIES.

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.235.

CORRECTIVE ACTION:

AGENCY TO PROVIDE AUDITOR WITH PREA EDUCATION TRAINING RECORDS WHICH IDENTIFIES PREA EDUCATION ATTENDANCE AND EDUCATION ACKNOWLEDGEMENT FOR ALL BTS STAFF TO VERIFY ALL STAFF ASSIGNED TO THE KENDALL FACILITY HAVE BEEN TRAINED IN PREA PER BTS MOU CONTRACT AND POLICY #165.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/15/16 :

AGENCY TRAINED ALL BTS STAFF IN PREA. AGENCY PROVIDED TRAINING ACKNOWLEDGEMENT FORMS WHICH INDICATE STAFF UNDERSTANDS THE PREA TRAINING THAT WAS PROVIDED FOR ALL BTS STAFF. 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. INTERVIEW WITH CASE MANAGERS WHO CONDUCT RISK SCREENINGS, INDICATE THEY CONDUCT THE 72 HOUR RISK ASSESSMENT SCREENINGS AFTER INTAKE OF RESIDENTS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEY HAVE THE INITIAL SCREENING AND SEE THE CASE MANAGER AFTER THEIR INITIAL INTAKE IN COMPLIANCE WITH STANDARD PROVISION 115.241(a).
- b) 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 DID NOT TRACK THE NUMBER OF RESIDENTS ENTERING FACILITY OVER PAST 12 MONTHS THAT WAS SCREENED FOR RISK OF SEXUAL VICTIMIZATION WITHIN 72 HOURS OF ENTRY INTO THE FACILITY. AGENCY HAS RECENTLY ADDED A 72 HOUR AND A 30 DAY EVENT TO MARK OFF IN CLIENT'S "SPECIAL CONCERNS" SECTION REGARDLESS IF A CLIENT HAS ANY CONCERNS OR NOT. INTERVIEW WITH CASE MANAGERS WHO CONDUCT RISK SCREENINGS, INDICATE THEY CONDUCT THE 72 HOUR RISK ASSESSMENT SCREENINGS AFTER INTAKE OF RESIDENTS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEY HAVE THE INITIAL SCREENING AND SEE THE CASE MANAGER AFTER THEIR ARRIVAL AT FACILITY. REVIEW OF RANDOM SAMPLE OF 11 RESIDENT SCREENING RECORDS INDICATE THAT 3 RESIDENT SCREENINGS WERE BEYOND THE 72 HOUR LIMIT AND ONE RESIDENT RECORD HAD NO DOCUMENTATION TO PROVE THE 72 HOUR SCREENING EVER OCCURRED. INTERVIEW WITH PREA COORDINATOR INDICATES THE 72 HOUR SCREENING WAS NOT TRACKED VIA DATABASE OR REVIEW. AUDITOR REVIEWED SCREENING INSTRUMENT DURING ON SITE TOUR. SCREENINGS FOR THE RESIDENTS WHO DEPT. OF CORRECTIONS REFERRALS ARE CONDUCTED ON A DATABASE THAT DOES NOT ALLOW FOR CASE MANAGERS TO REVIEW DATA ONCE COMPLETED, THEREFORE THEY HAVE NO RECORD OF COMPLETED SCREENINGS ON THOSE RESIDENTS. FACILITY IS NOT COMPLIANT WITH STANDARD PROVISION 115.241(b).
- 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 115.241(d). INTERVIEW WITH SCREENING STAFF INDICATE THEY ASK QUESTIONS FROM ALL RESIDENTS TO MEET CRITERIA OUTLINED IN STANDARD 115.241(d).
- e) INSTRUMENT CONSIDERS CRITERIA AS IDENTIFIED IN STANDARD 115.241(e). INTERVIEW WITH SCREENING STAFF VERIFIES USE OF SCREENING INSTRUMENT AS OUTLINED IN STANDARD PROVISION 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. NUMBER OF

RESIDENTS REASSESSED WITHIN 30 DAYS OF INTAKE OR TRANSFER WAS NOT TRACKED & NO CALCULATIONS PROVIDED. AGENCY HAS RECENTLY ADDED A 72 HOUR AND A 30 DAY EVENT TO MARK OFF IN CLIENT'S "SPECIAL CONCERNS" SECTION REGARDLESS IF A CLIENT HAS ANY CONCERNS OR NOT. INTERVIEW WITH CASE MANAGERS WHO CONDUCT RISK SCREENINGS, INDICATE THEY CONDUCT THE 30 DAY RISK ASSESSMENT SCREENING REQUIREMENT BETWEEN 20 AND 30 DAYS AFTER INTAKE OF RESIDENTS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE FEW RECALL HAVING A 30 DAY RE-ASSESSMENT SCREENING. REVIEW OF RANDOM SAMPLE OF 11 RESIDENT SCREENING RECORDS INDICATE THAT 3 RESIDENT SCREENINGS MET THE 30 DAY RE-ASSESSMENT REQUIREMENT, LIMIT, ONE RESIDENT RECORD WAS BEYOND THE 30 DAY RE-ASSESSMENT REQUIREMENT LIMIT AND 7 RECORDS HAD NO DOCUMENTATION TO PROVE THE 30 DAY SCREENING RE-ASSESSMENT EVER OCCURRED. INTERVIEW WITH PREA COORDINATOR INDICATES THE 30 DAY RE-ASSESSMENT SCREENING WAS NOT TRACKED VIA DATABASE OR REVIEW. AUDITOR REVIEWED SCREENING INSTRUMENT DURING ON SITE TOUR. SCREENINGS FOR THE RESIDENTS WHO DEPT. OF CORRECTIONS REFERRALS ARE CONDUCTED ON A DATABASE THAT DOES NOT ALLOW FOR CASE MANAGERS TO REVIEW DATA ONCE COMPLETED, THEREFORE THEY HAVE NO RECORD OF COMPLETED SCREENINGS ON THOSE RESIDENTS. FACILITY IS NOT COMPLIANT WITH STANDARD PROVISION 115.241(f).

- 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 CASE MANAGERS INDICATE ALL RESIDENTS ARE RE-SCREENED WITHIN 30 DAYS OF INTAKE REGARDLESS AS TO WHETHER ADDITIONAL OR RELEVANT INFORMATION WAS RECEIVED AFTER THE INITIAL ASSESSMENT. THERE WERE NO RECORDS OF RESIDENTS WHO HAD BEEN VICTIMS OR PERPETRATORS OF SEXUAL ABUSE FOR CONFIRMATION OF REASSESSMENT. AGENCY IS COMPLIANT WITH STANDARD 115.241(g).
- 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 REASSESSMENT. INTERVIEW OF SCREENING STAFF VERIFIES DEMONSTRATION OF POLICY MANDATES AND COMPLIANCE WITH STANDARD PROVISION 115.241(h)
- 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 WITHIN 72 HOURS OF INTAKE. ACCESS TO SCREENING INFORMATION IS NEED TO KNOW FOR SAFETY PURPOSES. INTERVIEW WITH RISK SCREENING STAFF INDICATE SCREENING RECORDS ARE SECURED IN THE CASE MANAGER'S OFFICE. CASE MANAGERS, ADMINISTRATORS AND STAFF ON A NEED TO KNOW BASIS HAVE ACCESS TO THESE RECORDS. INTERVIEW WITH PREA COORDINATOR INDICATE DEPT. OF CORRECTION RESIDENT SCREENING RECORDS ARE MAINTAINED ELECTRONICALLY ON A DOC DATABASE & HAVE NO ACCESS TO THESE RECORDS AFTER UPDATING THE SCREENING INFORMATION. 72 HOUR AND 30 DAY ASSESSMENTS WERE NOT TRACKED PRIOR TO AUDIT. ALL UPDATES RELATED TO SCREENING WILL BE ENTERED ON THE E-TRACK DATABASE SYSTEM AND HARD COPY OF SCREENING INSTRUMENTS USED IN ASSESSMENTS WILL BE MAINTAINED ALSO IN THE RESIDENTS CASE FILE IN ORDER TO COMPLY WITH STANDARD PROVISION 115.241(i).

AUDITOR HAS DETERMINED THAT AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.241.

CORRECTIVE ACTION:

1. AGENCY TO AMEND POLICY #600 TO MANDATE INTAKE AND SCREENING STAFF CONDUCT E-TRAC ELECTRONIC UPDATES OF INTAKE DATES, 72 HOUR ASSESSMENTS AND 30 DAY ASSESSMENTS OF ALL RESIDENTS ENTERING THE FACILITY AND RESIDENTS WHO TRANSFER BETWEEN AGENCY FACILITIES. POLICY WILL MANDATE THAT THE UPDATES WILL BE CONDUCTED THE SAME DAY THE ASSESSMENTS OCCUR.
2. AGENCY WILL PROVIDE VERIFICATION OF COMPLIANCE THROUGH RANDOM SELECTION OF RESIDENTS BY AUDITOR TO VERIFY THAT AGENCY HAS DEMONSTRATED COMPLIANCE OF STANDARD PROVISIONS 115.241(b) and 115.241(f) THROUGH BOTH THE E-TRAC ELECTRONIC SYSTEM AND HARD COPY INTAKE, 72 HOUR ASSESSMENT AND 30 DAY REASSESSMENT RECORDS.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/18/16 :

AGENCY AMENDED POLICY #600 TO MANDATE REQUIREMENT FOR CASE MANAGER TO ENTER ALL INTAKE INFORMATION INTO THE E-TRAC SYSTEM WITHIN 3 WORKING DAYS OF CLIENT'S ARRIVAL. WITHIN 72 HOURS OF ADMISSION, CASE MANAGER IS MANDATED TO COMPLETE THE PREA RISK ASSESSMENT AND REASSESS EACH RESIDENT WITHIN 30 DAYS OF INTAKE BASED ON ANY RELEVANT OR ADDITIONAL INFORMATION RECEIVED AFTER RISK ASSESSMENT. ALL ASSESSMENT RESULTS WILL BE ENTERED INTO THE SPECIAL CONCERNS SECTION OF THE E-TRAC SYSTEM.

ON 3/15/16, AGENCY PROVIDED AUDITOR WITH E-TRAC ASSESSMENT RESULTS FOR BOTH THE 72 HOUR SCREENING AND 30 DAY REASSESSMENTS WHICH OCCURRED BETWEEN AUGUST 2015 AND MARCH 2016. UPON REVIEW OF 42 72-HOUR INITIAL SCREENINGS, AUDITOR IDENTIFIED 27 NON-COMPLIANT 72-HOUR SCREENINGS. WITH A 64% ERROR RATE, AUDITOR DETERMINED AGENCY TO BE 36% COMPLIANT FOR THE 72-HOUR INITIAL SCREENINGS.

UPON REVIEW OF 147 30-DAY SCREENING RE-ASSESSMENTS, AUDITOR IDENTIFIED 39 NON-COMPLIANT 30 DAY REASSESSMENT SCREENINGS. WITH A 25% ERROR RATE, AUDITOR DETERMINED AGENCY TO BE 75% COMPLIANT FOR THE 30 DAY REASSESSMENT SCREENINGS. BOTH INITIAL 72-HOUR AND 30 DAY REASSESSMENT SCREENINGS WERE FOUND TO HAVE BEEN CONDUCTED AFTER THE 72-HOUR INITIAL SCREENING AND 30-DAY REASSESSMENT DEADLINES. AGENCY IS NON-COMPLIANT WITH STANDARD PROVISIONS 115.241(b) and 115.241(f).

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.241

- 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 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. INTERVIEWS WITH PREA COORDINATOR & RISK SCREENING STAFF AND REVIEW OF CLASSIFICATION DOCUMENTS BY AUDITOR DURING ON-SITE TOUR, VERIFIES BOTH THE OBJECTIVE SCREENING TOOL AND CLASSIFICATION FOR HOUSING DOCUMENTATION IS USED FOR HOUSING AND PROGRAM ASSIGNMENTS FOR RESIDENTS TO PROVIDE SEXUAL SAFETY WHILE HOUSED AT THE FACILITY PER STANDARD PROVISION 115.242(a).
- b) INTERVIEWS WITH CASE MANAGERS RESPONSIBLE FOR RISK SCREENING INDICATE INDIVIDUAL DETERMINATION ARE MADE ON A CASE BY CASE BASIS TO ENSURE RESIDENT SAFETY. CASE MANAGERS COORDINATE WITH SECURITY INTAKE STAFF AND ADMINISTRATION IN ORDER TO MAINTAIN A SAFE ENVIRONMENT FOR RESIDENTS. IN ACCORDANCE WITH STANDARD PROVISION 115.242(b). INTERVIEWS WITH CASE MANAGERS RESPONSIBLE FOR RISK SCREENING INDICATE INDIVIDUAL DETERMINATION ARE MADE ON A CASE BY CASE BASIS TO ENSURE RESIDENT SAFETY. CASE MANAGERS COORDINATE WITH SECURITY INTAKE STAFF AND ADMINISTRATION IN ORDER TO MAINTAIN A SAFE ENVIRONMENT FOR RESIDENTS. AUDITOR INTERVIEWED 2 TRANSGENDER RESIDENTS WHO VERIFIED THAT AGENCY HOUSES RESIDENTS ON A CASE BY CASE BASIS TO ENSURE SEXUAL SAFETY IN ACCORDANCE WITH STANDARD PROVISION 115.242(c). BOTH RESIDENTS ARE HOUSED IN THEIR OWN ROOM AND PERIODICALLY, OTHER RESIDENTS ARE HOUSED WITH THEM TEMPORARILY BEFORE MOVING TO ANOTHER ROOM.
- c) POLICY #600 MANDATES AGENCY MAKE INDIVIDUAL DETERMINATIONS ON CASE BY CASE BASIS TO ENSURE SAFETY OF EACH RESIDENT. INTERVIEWS WITH CASE MANAGERS RESPONSIBLE FOR RISK SCREENING INDICATE INDIVIDUAL DETERMINATION ARE MADE ON A CASE BY CASE BASIS TO ENSURE RESIDENT SAFETY. CASE MANAGERS COORDINATE WITH SECURITY INTAKE STAFF AND ADMINISTRATION IN ORDER TO MAINTAIN A SAFE ENVIRONMENT FOR RESIDENTS. AUDITOR INTERVIEWED 2 TRANSGENDER RESIDENTS WHO VERIFIED THAT AGENCY HOUSES RESIDENTS ON A CASE BY CASE BASIS TO ENSURE SEXUAL SAFETY IN ACCORDANCE WITH STANDARD PROVISION 115.242(c). BOTH RESIDENTS ARE HOUSED IN THEIR OWN ROOM AND PERIODICALLY, OTHER RESIDENTS ARE HOUSED WITH THEM TEMPORARILY BEFORE MOVING TO ANOTHER ROOM.
- d) POLICY #160 PROVIDES FOR CONSIDERATION PROVIDED FOR TRANSGENDER OR INTERSEX RESIDENT'S OWN VIEWS WITH RESPECT TO HIS OR HER OWN SAFETY. INTERVIEWS WITH PREA COORDINATOR AND CASE MANAGERS RESPONSIBLE FOR RISK SCREENING INDICATE TRANSGENDER AND INTERSEX RESIDENTS ARE ASKED QUESTIONS REGARDING THEIR VIEWS WITH RESPECT TO THEIR OWN SAFETY & THEIR RESPONSE IS GIVEN CONSIDERATION WITH RESPECT TO HOUSING AND PROGRAMMING NEEDS, COMPLAINT WITH STANDARD PROVISION 115.242(d). INTERVIEW WITH TRANSGENDER RESIDENTS INDICATE ONE WAS ASKED ABOUT VIEWS OF SAFETY WITHIN THE FACILITY AT SCREENING AND ONE

INDICATED INTAKE AND CASE MANAGER FAILED TO ASK ABOUT THE RESIDENTS OWN VIEW WITH RESPECT TO THEIR SAFETY.

- e) POLICY #160 PROVIDES FOR TRANSGENDER AND INTERSEX RESIDENTS TO BE AFFORDED THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. INTERVIEWS WITH PREA COORDINATOR, CASE MANAGERS RESPONSIBLE FOR RISK SCREENING AND TRANSGENDER RESIDENTS VERIFY AGENCY PROVIDES TRANSGENDER & INTERSEX RESIDENT THE OPPORTUNITY TO SHOWER SEPARATELY FROM OTHER RESIDENTS. DURING ON-SITE TOUR, AUDITOR VIEWED ALL BATHROOMS AND SHOWERS. EACH BATHROOM PROVIDES SEPARATE SHOWER AND TOILETING STALLS WITH HARD DOORS ON THE TOILETS AND HARD WALLS WITH CURTAINS FOR EACH SHOWER FOR PRIVACY. SHOWERS AND BATHROOMS ARE PREA COMPLIANT IN ACCORDANCE WITH STANDARD PROVISION 115.242(e).
- f) POLICY #160 PROHIBITS AGENCY FROM PLACING RESIDENTS IN DEDICATED FACILITIES BASED UPON THEIR LGBTI STATUS. INTERVIEW WITH PREA COORDINATOR AND GAY RESIDENT VERIFIES AGENCY POSSESSES NO DEDICATED FACILITIES FOR MEMBERS OF THE LGBTI COMMUNITY IN COMPLIANCE WITH STANDARD PROVISION 115.242(f).

AUDITOR HAS DETERMINED THAT AGENCY/FACILITY MEETS STANDARD 115.242.

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| 115.251 | Resident reporting |
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- 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 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 NEGLIGENCE 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 WEST 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. RANDOM SAMPLE OF STAFF AND RANDOM SAMPLE OF RESIDENT INTERVIEWS DETERMINES THAT INTERNAL WAYS TO PRIVATELY REPORT SEX ABUSE/HARASSMENT IS THROUGH THE PROGRAM DIRECTOR IN COMPLIANCE WITH STANDARD PROVISION 115.251(a).
- b) 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 IS IN PROCESS OF SECURITY AN MOU WITH LAKEWOOD PD AND HAS SECURED MOU FROM BTS FOR PRIVATE REPORTING.

- c) E-MAIL CORRESPONDENCE PROVIDED TO VERIFY ONGOING COMMUNICATION TO SECURE SAID MOU FROM LAKEWOOD PD. INTERVIEW WITH PREA COORDINATOR INDICATES THE DOC TIPS LINE AND BLUE BENCH RAPE CRISIS CENTER ARE BOTH AVAILABLE FOR RESIDENTS AND STAFF TO PRIVATELY REPORT INCIDENTS OF SEX ABUSE/HARASSMENT OUTSIDE THE AGENCY. PREA EDUCATION LITERATURE PROVIDED TO RESIDENTS INCLUDES CONTACT INFORMATION, LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING INFORMATION. AGENCY COMPLIES WITH STANDARD PROVISION 115.251(b).
- d) 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 RANDOM SAMPLE OF STAFF INDICATES THEIR EDUCATION AND KNOWLEDGE THAT THEY SHALL ACCEPT REPORTS MADE VERBALLY, IN WRITING, ANNONYMOUSLY AND FROM 3RD PARTIES AND SHALL DOCUMENT VERBAL REPORT IMMEDIATELY. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEIR KNOWLEDGE OF THEIR PREA RIGHTS THAT THEY CAN MAKE REPORTS OF SEX ABUSE & SEX HARASSMENT TO STAFF IN THE SAME WAY IN ACCORDANCE WITH STANDARD PROVISION 115.251(c).
- e) 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 RANDOM SAMPLE OF STAFF INDICATE THEY MAY REPORT SEX ABUSE/HARASSMENT OF RESIDENTS BY CONTACTING THE PROGRAM DIRECTOR, PREA COORDINATOR OR THE DOC TIPS LINE FOR PRIVATELY REPORTING PURPOSES IN ACCORDANCE WITH STANDARD PROVISION 115.251(d).

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.251.

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| 115.252 | Exhaustion of administrative remedies |
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- 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 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 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.
- b) 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.

- c) REVIEW OF RESIDENT HANDBOOK HAS NO RELEVANT INFORMATION REGARDING PROHIBITING TIME LIMITS ON GRIEVANCES ALLEGING SEX ABUSE/HARASSMENT. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.252(b).
- d) 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. REVIEW OF RESIDENT HANDBOOK RULES OF CONDUCT AND HOUSE POLICIES GREIVANCE SECTION, PAGE 12, COMPLIES WITH STANDARD PROVISION 115.252(c) & INCLUDES NARRATIVE TO MEET STANDARD.
- e) POLICY #340 COMPLIANT WITH STANDARD PROVISION 115.252(d). 1 GRIEVANCE WAS FILED OVER PAST 12 MONTHS WHICH ALLEGES SEXUAL HARASSMENT. AGENCY PROVIDED AUDITOR WITH A GREIVANCE FILED WITHIN LAST 12 MONTHS THAT ALLEGED SEXUAL ABUSE/HARASSMENT. CASE WAS INVESTIGATED AND CLOSED WITHIN 30 DAYS. RESIDENT WAS INFORMED OF THE DISPOSITION OF THE INVESTIGATION VIA FACE TO FACE MEETING WITH PROGRAM DIRECTOR IN ACCORDANCE WITH STANDARD 115.252.(d).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 OF A RESIDENT. IF THE ALLEGED VICTIM DECLINES 3RD PARTY ASSISTANCE IT WILL BE DOCUMENTED IN THEIR CHRONOLOGICAL NOTES. 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. THERE HAS BEEN 1 GRIEVANCE IN PAST 12 MONTHS WHERE RESIDENT DECLINED 3RD PARTY ASSISTANCE – NO DOCUMENTATION OF THAT DECLINATION PROVIDED WITH PAQ. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.252(e).
- f) POLICY #340 COMPLIES WITH STANDARD PROVISION 115.252(f). NO EMERGENCY GRIEVANCES FILED IN THE PAST 12 MONTHS.
- g) 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/FACILITY DOES NOT MEET STANDARD 115.252.

CORRECTIVE ACTION:

1. AGENCY TO AMEND RESIDENT HANDBOOK GRIEVANCE SECTION, PG#12-D TO INCLUDE NARRATIVE PROHIBITING TIME LIMITS ON GRIEVANCES ALLEGING SEXUAL ABUSE AND SEXUAL HARASSMENT TO COMPLY WITH STANDARD PROVISION 115.252(b).
2. AGENCY TO PROVIDE AUDITOR DECLINATION DOCUMENTATION REGARDING RESIDENT WHO DECLINED 3RD PARTY ASSISTANCE WHEN ASKED IF HE WISHED ASSISTANCE IN FILING HIS GRIEVANCE IN A PREA RELATED INCIDENT TO COMPLY WITH STANDARD PROVISION 115.252(e).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 3/15/16 :

AGENCY AMENDED RESIDENT HANDBOOK GRIEVANCE SECTION WITH NARRATIVE WHICH PROHIBITS TIME LIMITS ON GRIEVANCES ALLEGING SEXUAL ABUSE AND SEXUAL HARASSMENT. AGENCY PROVIDED E-TRAC ELECTRONIC GRIEVANCE DECLINATION DOCUMENTATION FOR RESIDENT WHO WAS OFFERED 3RD PARTY ASSISTANCE WITH HIS GRIEVANCE SUBMISSION BUT DECLINED 3RD PARTY ASSISTANCE WHICH WAS OFFERED BY STAFF. AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.252.

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| 115.253 | Resident access to outside confidential support services |
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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 RESIDENTS WITH ACCESS TO OUTSIDE VICTIM ADVOCATES (BLUE BENCH RAPE CRISIS CENTER) FOR EMOTIONAL SUPPORT. CONTACT INFORMATION IS PROVIDED IN RESIDENT BROCHURE IN ENGLISH & SPANISH PROVIDED AT INTAKE AND ON PREA DOOR POSTER PROVIDED ON ENTRY DOOR TO HOUSING UNITS. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS AND RESIDENTS WHO REPORTED A SEXUAL ABUSE WERE NOT KNOWLEDGEABLE REGARDING ACCESS TO OUTSIDE VICTIM ADVOCATES FOR EMOTIONAL SUPPORT. LESS THAN HALF STATED A RAPE CRISIS CENTER OR POLICE DEPARTMENT. THE OTHER HALF MENTIONED THE PROGRAM DIRECTOR. AUDITOR RECOMMENDS INCREASED PREA SIGNAGE WHICH PROVIDES CONTACT INFORMATION FOR VICTIM ADVOCATES WHICH WOULD PROVIDE RESIDENTS WITH ONGOING EDUCATION AS TO THEIR RIGHTS TO ADVOCACY FOR EMOTIONAL SUPPORT OUTSIDE OF THE AGENCY. CURRENT EDUCATION PROVIDED RESIDENTS AT INTAKE MEETS STANDARD PROVISION 115.253(a).

- b) POLICY #160 MANDATES MEDICAL AND MENTAL HEALTH PRACTITIONERS INFORM RESIDENTS OF DUTY TO REPORT & LIMITS OF CONFIDENTIALITY. POLICY #165 AND HOUSING DOOR POSTERS ARE NOT COMPLIANT WITH STANDARD PROVISION 115.253(b). THERE IS NO NARRATIVE DOCUMENTATION WHICH PROVIDES THE EXTENT TO WHICH OUTSIDE SUPPORT SERVICES COMMUNICATIONS WILL BE MONITORED. RULES OF CONDUCT & HOUSE POLICIES PROVIDES CONTACT INFORMATION FOR OUTSIDE VICTIM ADVOCATE SERVICES BUT NO MENTION OF AGENCY MONITORING CONTACT WITH THE ADVOCATE SERVICES. INTERVIEW WITH RANDOM SAMPLE OF RESIDENTS INDICATE THEY ARE AWARE OF LIMITS TO CONFIDENTIALITY REGARDING ADVOCATE SERVICES BUT ARE UNSURE AS TO IF THESE CALLS ARE MONITORED IF CONTACTING THESE SERVICES VIA FACILITY PHONE. DUE TO AGENCY'S FAILURE TO INFORM RESIDENTS PRIOR TO PROVIDING THEM ACCESS TO OUTSIDE SUPPORT SERVICES OF THE MONITORING REQUIREMENT, AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.253(b).
- c) AGENCY MEETS STANDARD PROVISION 115.253(c) AS A SIGNED MOU WITH BLUE BENCH RAPE CRISIS CENTER HAS BEEN REACHED AND SIGNED. BLUE BENCH PROVIDES ADVOCACY FOR EMOTIONAL SUPPORT FOR RESIDENTS AT ICCS FACILITIES. AGENCY MEETS STANDARD PROVISION 115.253(c) AS A SIGNED MOU WITH BLUE BENCH RAPE CRISIS CENTER HAS BEEN REACHED AND SIGNED. BLUE BENCH PROVIDES ADVOCACY FOR EMOTIONAL SUPPORT FOR RESIDENTS AT ICCS FACILITIES WHICH MEETS STANDARD PROVISION 115.253(c).

AUDITOR HAS DETERMINED AGENCY/FACILITY IS NOT COMPLIANT WITH STANDARD 115.253

CORRECTIVE ACTION:

AGENCY TO AMEND PREA EDUCATION BROCHURES, RESIDENT HANDBOOK, PREA DOOR POSTERS AND POSTERS PROVIDED IN COMMON AREAS THROUGHOUT RESIDENCE, TO PROVIDE LIMITS OF CONFIDENTIALITY AND AGENCY MONITORING INFORMATION REGARDING COMMUNICATIONS WITH OUTSIDE VICTIM ADVOCATE SERVICE AGENCIES. AGENCY TO PROVIDE AUDITOR WITH VERIFICATION DOCUMENTATION IN ORDER TO BE COMPLIANT WITH STANDARD PROVISION 115.253(b).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 12/4/15 :

AGENCY INSTALLED 19 LARGE POSTERS (24X36) AT THE KENDALL FACILITY THROUGHOUT THE HALLWAYS WHICH PROVIDES CONTACT INFORMATION TO RESIDENTS. FLORESCENT COLORED POSTERS (11X7.5) PLACED IN EACH STAFF OFFICE. BLACK & WHITE STANDARD PAPER SIZE POSTERS HAVE BEEN PLACED INSIDE EACH RESIDENTIAL ROOM, AND NEAR EACH PHONE. AGENCY VERIFIED PLACEMENT OF POSTERS VIA DATED PHOTOS OF PLACEMENT WHICH INCLUDED THE LOCATION OF EACH POSTER IN THE PHOTO. AUDITOR HAS DETERMINED THAT AGENCY EXCEEDS THE REQUIREMENT OF STANDARD 115.233. POSTERS PROVIDE LIMITS OF CONFIDENTIALITY TO INCLUDE INFORMATION TO INDICATE THAT CALLS TO THE CONFIDENTIAL SOURCES ARE NOT MONITORED. POSTERS ALSO PROVIDE LIMITS OF CONFIDENTIALITY. RESIDENT RULEBOOK ALSO PROVIDES THE SAME INFORMATION. AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.253. AUDITOR HAS DETERMINED THAT 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 NARRATIVE WITH RESPECT OF RECEIVING 3RD PART REPORTS IS PUBLISHED PUBLICLY ON THE AGENCY WEBSITE.

AUDITOR HAS DETERMINED AGENCY IS IN COMPLIANCE WITH 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

- a) POLICY #160 MANDATES ALL STAFF TO IMMEDIATELY REPORT ANY SEXUAL MISCONDUCT, KNOWLEDGE OR SUSPICION OF SEXUAL MISCONDUCT. INTERVIEW WITH RANDOM SAMPLE OF STAFF VERIFIES THEIR TRAINING AND KNOWLEDGE REGARDING STAFF AND AGENCY REPORTING DUTIES ARE COMPLIANT WITH STANDARD PROVISION 115.261(a).
- b) POLICY #165 STATES ICCS WILL ONLY SHARE INFORMATION AS REQUIRED BY LAW IN ORDER TO PROTECT THE CONFIDENTIALITY OF ITS CLIENTS. INTERVIEW WITH RANDOM SAMPLE OF STAFF DETERMINES STAFF HAVE BEEN TRAINED TO PROVIDE INFORMATION REGARDING SEXUAL ABUSE TO ONLY SUPERVISORS AND OFFICIALS ON A NEED TO KNOW BASIS IN ACCORDANCE WITH STANDARD PROVISION 115.261(b).
- c) POLICY #160 PROVIDES NARRATIVE THAT IDENTIFIES LIMITS OF CONFIDENTIALITY AND PROVIDES NARRATIVE STATING PRACTITIONER WILL INFORM RESIDENTS AT THE INITIATION OF SERVICES WITH REGARDS TO THEIR DUTY TO REPORT. INTERVIEW WITH CONTRACTED MENTAL HEALTH STAFF VERIFIES THEY ALL ARE TRAINED AND ACKNOWLEDGE THEIR DUTY TO REPORT AND INFORM RESIDENTS OF THEIR DUTY TO REPORT AND THE LIMITATIONS OF CONFIDENTIALITY PRIOR TO PROVIDING SERVICES TO RESIDENTS PER POLICY AND STANDARD PROVISION 115.261(c). AGENCY DOES NOT EMPLOY MEDICAL PERSONNEL.
- d) 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 AND PREA COORDINATOR REVEALS ANY VICTIM CONSIDERED A VULNERABLE ADULT IS REFERRED IMMEDIATELY TO LOCAL LAW ENFORCEMENT AND HEALTH & HUMAN SERVICES FOR THE ELDERLY SHOULD THEY BE VICTIM OF SEXUAL ABUSE. AGENCY DOES

NOT HOUSE RESIDENTS UNDER THE AGE OF 18 YEARS, BUT VISITORS OF RESIDENCE MAY BE UNDER THE AGE OF 18 YEARS. SHOULD ANY VISITOR UNDER THE AGE OF 18 YEARS OF AGE REPORT AN ALLEGATION OF SEXUAL ABUSE, LOCAL LAW ENFORCEMENT IS CONTACTED IMMEDIATELY TO INVESTIGATE THE ALLEGATION. AGENCY PROTOCOLS ARE ENACTED TO PROTECT VICTIMS AND SECURE EVIDENCE RELATED TO SAID ALLEGATION(S) IN ACCORDANCE WITH STANDARD PROVISION 115.261(d).

- e) 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. ALL ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT HAS BEEN REPORTED AND INVESTIGATED BY AGENCY INVESTIGATORS AND/OR LOCAL LAW ENFORCEMENT IF SAID ALLEGATION IS CRIMINAL IN NATURE IN ACCORDANCE WITH STANDARD PROVISION 115.261(e). REVIEW OF ALLEGATIONS OF SEX ABUSE/HARASSMENT ALLEGATIONS WHICH OCCURRED OVER THE PAST 12 MONTHS DEMONSTRATES AGENCY'S COMPLIANCE WITH POLICY AND STANDARD PROVISION.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.261.

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| 115.262 | Agency protection duties |
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- 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

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). INTERVIEW WITH AGENCY HEAD DESIGNEE AND FACILITY DIRECTOR INDICATES STAFF HAVE BEEN TRAINED TO PROTECT RESIDENTS WHEN THEY LEARN THAT THE RESIDENT IS AT RISK OF IMMINENT SEXUAL ABUSE. INTERVIEW WITH RANDOM SAMPLE OF STAFF INDICATES STAFF MEMBERS IMMEDIATELY TAKE ACTION TO PROTECT THE RESIDENT WHO MAY BE SUBJECT TO SUBSTANTIAL RISK OF SEXUAL ABUSE, SEPARATE RESIDENT FROM ABUSER, CONTACT IMMEDIATE SUPERVISOR, ON-CALL SUPERVISOR OR PROGRAM DIRECTOR & TAKE STEPS UP TO AND INCLUDING RE-HOUSING RESIDENT UPON APPROVAL OF ADMINISTRATION, IN COMPLIANCE WITH STANDARD PROVISION 115.262(a).

AUDITOR HAS DETERMINED AGENCY/FACILITY 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 RECEIVED ONE ALLEGATION OF SEXUAL ABUSE FROM ANOTHER AGENCY. INTERVIEW WITH AGENCY HEAD DESIGNEE AND FACILITY DIRECTOR INDICATES FACILITY FOLLOWS POLICY #165 & THE DIRECTOR NOTIFIES HEAD OF OTHER AGENCY/FACILITY OF ANY ALLEGATION RECEIVED BY KENDALL FACILITY. KENDALL FACILITY RECEIVED ALLEGATION OF SEX ABUSE FROM ANOTHER AGENCY AND DETERMINED THAT CASE HAD BEEN PREVIOUSLY INVESTIGATED BY THE KENDALL FACILITY INVESTIGATORS. AUDITOR HAS BEEN PROVIDED SAID INVESTIGATION AND DETERMINE IT WAS HANDLED APPROPRIATELY. OUTSIDE AGENCY WAS INFORMED OF THE INVESTIGATION AND ISSUE WAS CLOSED.

AUDITOR HAS DETERMINED AGENCY IS IN COMPLIANCE WITH 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, THERE HAS BEEN ONE ALLEGATION OF RESIDENT SEX ABUSE. AT THAT TIME THE 1ST SECURITY STAFF MEMBER TO RESPOND TO THE REPORT SEPARATED THE ALLEGED VICTIM & ABUSE. THIS CASE DID NOT PROVIDE A TIME PERIOD THAT STILL ALLOWED FOR THE COLLECTION OF PHYSICAL EVIDENCE. INTERVIEW WITH SECURITY STAFF 1ST RESPONDER INDICATED HIS CONCERN FOR SAFETY OF VICTIM WAS 1ST AND FORMOST OF DUTIES TO BE PERFORMED. THE ALLEGATION DID NOT PROVIDE TIME PERIOD TO ALLOW FOR COLLECTION OF PHYSICAL EVIDENCE AS THERE WAS NO PHYSICAL SKIN TO SKIN CONTACT. REVIEW OF INVESTIGATION DOCUMENTATION VERIFIED STAFF CLAIM. STAFF ACTED IN A MANNER APPROPRIATE TO COMPLY WITH STANDARD PROVISION 115.264(a). AUDITOR WAS UNABLE TO INTERVIEW THE VICTIM AS HE COMPLETED HIS TERM AND WAS RELEASED FROM THE FACILITY IN 2014.
- 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.

AUDITOR HAS DETERMINED THAT AGENCY/FACILITY 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

COORDINATED RESPONSE TO INCIDENTS OF SEXUAL ABUSE 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 PROGRAM DIRECTOR VERIFIES THE DEVELOPMENT OF A WRITTEN INSTITUTIONAL PLAN SPECIFIC TO KENDALL FACILITY THAT COORDINATES ACTIONS TAKEN IN RESPONSE TO AN INCIDENT OF SECUAL ABUSE AMONG STAFF 1ST RESPONDERS, MEDICAL AND MENTAL HEALTH PRACTITIONERS, INVESTIGATORS, AND FACILITY LEADERSHIP.

AUDITOR HAS DETERMINED FACILITY 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

INTERVIEW WITH AGENCY HEAD DESIGNEE DETERMINES AGENCY HAS NOT ENTERED INTO ANY COLLECTIVE BARGAINING AGREEMENTS SINCE AUGUST 20, 2012.

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. INTERVIEW WITH AGENCY HEAD DESIGNEE & PROGRAM DIRECTOR INDICATES AGENCY EMPLOYS MULTIPLE MEASURES TO PROTECT BOTH RESIDENTS AND STAFF FROM RETALIATION AND FROM ABUSERS, USING MULTIPLE LAYERS OF PROTOCOLS WHICH INCLUDE MOVING VICTIMS TO OTHER ROOMS, HALLWAYS OR TRANSFERRING THEM TO OTHER FACILITIES FOR THEIR SAFETY. STAFF CAN BE TRANSFERRED TO OTHER FACILITIES OR BUILDINGS FOR THEIR SAFETY & ALL ARE PROVIDED MONITORING. INTERVIEW WITH PREA COORDINATOR INDICATES HE IS RESPONSIBLE FOR MONITORING RETALIATION AND CITED THE SAME INFORMATION PROVIDED THE AUDITOR FROM THE PROGRAM DIRECTOR AND AGENCY HEAD DESIGNEE IN ACCORDANCE WITH STANDARD PROVISION 115.267(b).
- 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 MORE SHOULD THERE BE EVIDENCE OF A CONTINUING NEED. INTERVIEW WITH PROGRAM DIRECTOR AND PREA COORDINATOR INDICATES RESIDENT VICTIMS WHO REPORT SEXUAL ABUSE/HARASSMENT & RETALIATION ARE MONITORED FOR SIGNS OF CONTINUED ABUSE FOR AT LEAST 90 DAYS UNLESS THERE IS A NEED FOR CONTINUED MONITORING FOR UNLIMITED TIMEFRAME UNTIL MONITORING IS NO LONGER REQUIRED IN ACCORDANCE WITH PROVISION 115.267(c). THERE HAS BEEN NO INCIDENT OF RETALIATION IN PAST 12 MONTHS.

- d) POLICY #165 NARRATIVE MANDATES PERIODIC STATUS CHECKS DURING MONITORING PERIOD PER STANDARD PROVISION 115.267(d). PREA COORDINATOR INDICATES HE CONDUCTS PERIODIC FACE-TO-FACE PERIODIC CHECKS TO MONITOR RESIDENTS WHO HAVE REPORTED SEX ABUSE INCIDENTS OR VICTIMS OF RETALIATION IN ACCORDANCE WITH STANDARD PROVISION 115.267(d).
- 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 DESIGNEE & PROGRAM DIRECTOR INDICATES AGENCY TAKES PROTECTIVE MEASURES AS OUTLINED IN POLICY #165 TO PROTECT ANY INDIVIDUAL WHO COOPERATES WITH AN INVESTIGATION OR IN FEAR OF RETALIATION IN ACCORANCE WITH STANDARD PROVISION 115.267(e).

AUDITOR HAS DETERMINED AGENCY/FACILITY MEETS STANDARD 115.267.

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| 115.271 | Criminal and administrative agency investigations |
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- 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. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES AGENCY POLICY TO CONDUCT INVESTIGATIONS PROMPTLY, THOROUGHLY AND OBJECTIVELY FOR ALL ALLEGATIONS OF SEX ABUSE TO INCLUDE 3RD PARTY & ANNONYMOUS REPORTS. REVIEW OF INVESTIGATIONS THAT HAVE OCCURRED OVER PAST 12 MONTHS INDICATES AGENCY'S COMPLIANCE WITH STANDARD PROVISION 115.271(a).
- b) PAQ INDICATES THERE ARE 5 SPECIAL INVESTIGATORS ASSIGNED WHO HAVE COMPLETED TRAINING FOR SEX ABUSE IN A CONFINEMENT SETTING THROUGH NIC. 5 SIGNED CERTIFICATES OF COMPLETION PROVIDED WITH PAQ. INTERVIEW WITH INVESTIGATIVE STAFF CONFIRMS THEIR COMPLETION OF THE SPECIAL INVESTIGATOR TRAINING.

- 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 DETERMINES THE EXTENT TO WHICH EVIDENCE IS SECURED. AGENCY ONLY INVESTIGATES ADMINISTRATIVE CASES, WHERE COLLECTION OF EVIDENCE MAY BE ONLY LIMITED TO VIDEO OF THE INCIDENT. WHEN IT IS DETERMINED THAT THE CASE MAY BE CRIMINAL IN NATURE, INVESTIGATORS SECURE THE CRIME SCENE, COLLECT EVIDENCE WHICH MAY BE DAMAGED OR TAMPERED WITH PRIOR TO THE ARRIVAL OF LOCAL LAW ENFORCEMENT INVESTIGATORS & MAINTAIN CHAIN OF CUSTODY. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.271(c).
- d) AGENCY CONDUCTS ONLY ADMINISTRATIVE INVESTIGATIONS & COMPELLED INTERVIEWS ARE ONLY CONDUCTED BY LOCAL LAW ENFORCEMENT. INTERVIEW WITH INVESTIGATIVE STAFF CONFIRMS THEY DO NOT CONDUCT COMPELLED INTERVIEWS WITHOUT THE EXPRESS APPROVAL OF LOCAL LAW ENFORCEMENT OR PROSECUTORS IN ACCORDANCE WITH STANDARD PROVISION 115.271(d).
- e) POLICY #165 PROHIBITS 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 VERIFIES AGENCY'S DEMONSTRATION OF POLICY TO PROHIBIT USE OF POLYGRAPH EXAMINATION TO DETERMINE THE CREDIBILITY OF AN ALLEGED VICTIM OF SEXUAL ABUSE. INVESTIGATORS TAKE ALL ALLEGATIONS OF SEX ABUSE SERIOUSLY AND INVESTIGATE EACH ONE COMPLETELY IN ACCORDANCE WITH 115.271(e).
- 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 AND INTERVIEW OF ADMINISTRATIVE INVESTIGATIVE REPORTS VERIFY AGENCY'S COMPLIANCE WITH STANDARD PROVISION 115.271(f).
- 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. INTERVIEW WITH INVESTIGATIVE STAFF INDICATES ALL CRIMINAL INVESTIGATIONS ARE DOCUMENTED IN WRITTEN FORMAT AND CONTAINS A THOROUGH DESCRIPTION OF THE INVESTIGATION TO INCLUDE FORENSIC FINDINGS, INTERVIEWS, DOCUMENTARY EVIDENCE ETS. IN ACCORDANCE WITH STANDARD PROVISION 115.271(g).
- h) POLICY #165 COMPLIES WITH STANDARD PROVISION 115.271(h) LANGUAGE. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES THAT ANY CASE THAT APPEARS CRIMINAL IN NATURE IS REFERRED TO LOCAL LAW ENFORCEMENT FOR INVESTIGATION AS AGENCY INVESTIGATORS ONLY CONDUCT INVESTIGATIONS ON ADMINISTRATIVE CASES IN ACCORDANCE WITH STANDARD PROVISION 115.271(h).
- i) POLICY #165 MANDATES INVESTIGATIVE REPORTS, ALL DATA, VIDEO SURVEILLANCE, ETC, WILL BE FORWARDED TO THE PREA COORDINATOR, OR DESIGNEE. THIS DATA WILL BE KEPT INDEFINATELY FOR RECORD-KEEPING. INVESTIGATIVE REPORTS ARE ARCHIVED IN RECORDS REPOSITORY ON SITE IN FACILITY IN ACCORDANCE WITH STANDARD PROVISION 115.271(i).

- j) 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 WITH STANDARD PROVISION 115.271(j). INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES DEMONSTRATION OF POLICY #165 IN THAT INVESTIGATION CONTINUES EVEN SHOULD THE ALLEGED ABUSER OR VICTIM FROM EMPLOYMENT OR CONTROL OF FACILITY OR AGENCY TERMINATES EMPLOYMENT OR CEASE TO RESIDE IN FACILITY IN ACCORDANCE WITH STANDARD PROVISION 115.271(j).
- 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.

STANDARD PROVISION 115.271(k) DOES NOT APPLY TO THIS AGENCY. AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.271.

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| 115.272 | Evidentiary standards for administrative investigations |
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- 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

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 & REVIEW OF INVESTIGATION CASES DETERMINE AGENCY IMPOSES NO STANDARD HIGHER THAT PREPONDERANCE OF THE EVIDENCE TO DETERMINE WHETHER ALLEGATIONS OF SEXUAL ABUSE/HARASSMENT ARE SUBSTANTIATED IN ACCORDANCE WITH STANDARD PROVISION 115.272(a).

AUDITOR HAS DETERMINED THAT AGENCY MEETS STANDARD 115.272(a).

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| 115.273 | Reporting to residents |
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- 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. BOTH SEX ABUSE ALLEGATIONS PROVIDE DOCUMENTATION OF RESIDENT BEING INFORMED VERBALLY OF THE OUTCOME OF THE INVESTIGATIONS. INTERVIEW WITH PROGRAM DIRECTOR INDICATES RESIDENTS ARE INFORMED WHETHER THE ALLEGATION HAS BEEN DETERMINED TO BE SUBSTANTIATED, UNSUBSTANTIATED OR UNFOUNDED. INTERVIEW WITH INVESTIGATIVE STAFF VERIFIES STATEMENT OF PROGRAM DIRECTOR & STATE THE INFORMATION IS PROVIDED FACE TO FACE TO RESIDENTS IN A VERBAL FORMAT. REVIEW OF INVESTIGATIVE FILES INDICATE STATEMENT WITHIN THE CONCLUSION NARRATIVE OF ONE OF THE TWO INVESTIGATIONS WHICH REVEALS RESIDENT WAS INFORMED OF THE OUTCOME OF THE INVESTIGATION IN ACCORDANCE WITH STANDARD PROVISION 115.273(a).
- b) AGENCY REPORTS & LAW ENFORCEMENT REPORTS WERE PROVIDED TO AUDITOR INDICATING REQUESTED RELEVANT INFORMATION WAS PROVIDED FROM THE INVESTIGATIVE LAW ENFORCEMENT AGENCY. POLICY #165 F MANDATES AGENCY STAFF INFORM CLIENT-VICTIM OF THE OUTCOME OF ANY SEXUAL ABUSE INVESTIGATION WHETHER IT WAS INVESTIGATED BY AGENCY OR LOCAL LAW ENFORCEMENT. THE CASE PROVIDED BY AGENCY INVOLVED STAFF ALERTING LAW ENFORCEMENT OF ALLEGED STAFF ON RESIDENT SEXUAL MISCONDUCT, WHICH WAS FOUND TO BE UNSUBSTANTIATED. STAFF MEMBER WAS TERMINATED DUE TO EMPLOYMENT VIOLATION, NOT PREA VIOLATION. DOCUMENTATION IN THE CONCLUSION OF THE INVESTIGATION VERIFIES NOTIFICATION WAS MADE VERBALLY TO EACH RESIDENT. ALL FUTURE NOTIFICATIONS WILL BE LOGGED IN CLIENT NOTES.
- c) POLICY #165 COMPLIES WITH STANDARD PROVISION 115.273(c). PROVIDED INVESTIGATION INVOLVED STAFF ON RESIDENT SEXUAL MISCONDUCT REPORTED BY 3RD PARTY. INVESTIGATION WAS UNSUBSTANTIATED. AGENCY INDICATED IN PAQ THAT NOTIFICATION OF THE OUTCOME OF INVESTIGATION WAS MADE VERBALLY, AS THE CASE WAS DETERMINED TO BE UNFOUNDED. REVIEW OF INVESTIGATION DOCUMENTATION INDICATE THERE WAS MEETING BETWEEN INVESTIGATORS AND RESIDENT IN WHICH THE RESIDENT WAS INFORMED OF THE OUTCOME OF THE INVESTIGATION AS IT WAS DETERMINED TO BE UNFOUNDED BASED UPON VIDEO EVIDENCE TO SUBSTANTIATE THE FINDINGS. IN ACCORDANCE WITH STANDARD PROVISION 115.273(c).
- d) AUDITOR UNABLE TO INTERVIEW RESIDENT WHO REPORTED SEX ABUSE AS THEY WERE RELEASED FROM THE FACILITY IN 2014. THE ONE INVESTIGATION WHICH INVOLVED RESIDENT ON RESIDENT SEXUAL ABUSE WAS REVIEWED BY AUDITOR. RESIDENT WAS INFORMED DURING THE INVESTIGATIVE INTERVIEW THAT LOCAL LAW ENFORCEMENT CANNOT SUBSTANTIATE A CRIMINAL CASE. THIS INFORMATION WAS DOCUMENTED IN THE INVESTIGATIVE NOTES. THIS BEING THE CASE, AGENCY MEETS STANDARD 115.273 PROVISION(d).
- e) POLICY #165 MANDATES ALL NOTIFICATIONS TO CLIENT-VICTIMS OR ATTEMPTS TO NOTIFY SHALL BE DOCUMENTED IN CLIENT-VICTIM'S CHRONOLOGICAL NOTES. PER PAQ, 1 NOTIFICATION TO RESIDENT WAS MADE, VERBALLY & VERBAL NOTIFICATION WAS DOCUMENTED IN THE INVESTIGATIVE NOTES. ALL FUTURE NOTIFICATIONS WILL BE LOGGED IN CLIENT NOTES.

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 THERE IS NOT DOCUMENTATION TO INDICATE STAFF VIOLATED AGENCY SEX ABUSE/HARASSMENT POLICY. THERE ARE NO STAFF TERMINATIONS IN THE PAST 12 MONTHS TO REVIEW.
- c) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.276(c). NO DISCIPLINE OF STAFF OVER PAST 12 MONTHS FOR VIOLATION OF SEX ABUSE/HARASSMENT POLICIES.
- d) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.276(d). NO STAFF REPORTED TO LAW ENFORCEMENT FOR VIOLATION OF AGENCY SEX ABUSE/HARRASSEMENT POLICY OVER PAST 12 MONTHS.

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) POLICY #275 MEETS STANDARD PROVISION 115.277(b) AS IT TAKES APPROPRIATE ACTIONS TO PROHIBIT FURTHER CONTACT WITH RESIDENTS IN THE CASE OF ANY VIOLATION OF AGENCY SEX ABUSE/HARASSMENT POLICIES BY CONTRACTOR OR VOLUNTEER IN ACCORDANCE WITH STANDARD PROVISION 115.277(b)..

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.277

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 COMPLIANCE WITH STANDARD PROVISION 115.278. ONE REPORTED ADMINISTRATIVE FINDING OF RESIDENT ON RESIDENT SEXUAL ABUSE OVER PAST 12 MONTHS, NO CRIMINAL FINDINGS. THE INVESTIGATION OF RESIDENT ON RESIDENT SEXUAL ABUSE DID NOT RESULT IN CRIMINAL FINDING AS LOCAL LAW ENFORCEMENT WAS UNABLE TO SUBSTANTIATE THAT FINDING. THE ABUSER WAS FOUND CULPABLE IN A RULES VIOLATION CHARGE AND WAS TERMINATED FROM THE FACILITY. AGENCY IS COMPLIANT WITH STANDARD PROVISION 115.278(a).
- 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 PROGRAM DIRECTOR INDICATE ANY SANCTIONS LEVELED AT RESIDENTS IS COMMENSURATE WITH THE NATURE AND CIRCUMSTANCES OF THE ABUSE COMMITTED. THERE ARE LEVELS OF VIOLATIONS OUTLINED IN THE RESIDENTS RULE HANDBOOK AND SACTIONS FOR THOSE VIOLATIONS ARE PROVIDED FOR THE RESIDENTS IN ACCORDANCE WITH STANDARD PROVISION 115.278(b).
- 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 PROGRAM DIRECTOR INDICATES A RESIDENTS MENTAL DISABILITIES OR MENTAL ILLNESS IS ALWAYS CONSIDERED WHEN DETERMINING THE TYPE OF SANCTION THAT SHOULD BE IMPOSED IN ACCORDANCE WITH STANDARD PROVISION 115.278(c).
- 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 PRACTITIONER VERIFIES AGENCY PROVIDING RESIDENTS IDENTIFIED AS PREDATORS, THERAPY/COUNSELING FROM AN OUTSIDE AGENCY, TO ADDRESS UNDERLYING REASONS OR MOTIVIATIONS FOR ABUSE IN ACCORDANCE WITH STANDARD PROVISION 115.278(d).
- e) POLICY #275 COMPLIANT WITH STANDARD PROVISION 115.278(e) AS IT CONTAINS SAME NARRATIVE AS INDICATED IN STANDARD PROVISION 115.278(e). THERE ARE NO DOCUMENTS WHICH REVEAL ANY DISCIPLINARY ACTIONS AGAINST RESIDENTS FOR SEXUAL CONDUCT WITH STAFF.
- 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 DETERMINES AGENCY COMPLIES WITH 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 PRACTITIONERS ACCORDING TO THEIR PROFESSIONAL JUDGEMENT AS REQUIRED BY STANDARD PROVISION 115.282(a).
- b) INTERVIEW WITH MENTAL HEALTH STAFF DETERMINES AGENCY FOLLOWS POLICY AND STANDARD PROVISION 115.282 AS RESIDENTS ARE PROVIDED TIMELY AND UNIMPEDED ACCESS TO EMERGENCY MEDICAL AND CRISIS INTERVENTION SERVICES.
- c) POLICY #165-B 1ST RESPONDERS PROTOCOL MEETS STANDARD PROVISION 115.282(b)
- d) INTERVIEW WITH SECURITY STAFF & 1ST RESPONDERS INDICATE PROTOCOL IN RESPONSE TO SEXUAL ABUSE CASE INDICATE ADMINISTRATION IS IMMEDIATELY NOTIFIED & THEY CONTACT THE APPROPRIATE MEDICAL & MENTAL HEALTH PRACTITIONERS WHILE THEY PROTECT THE VICTIM, PRESERVE THE CRIME SCENE & ENSURE NO PHYSICAL EVIDENCE IS DESTROYED BY VICTIM OR ABUSER.
- e) POLICY #165-D MANDATES RESIDENT VICTIMS RECEIVE TIMELY INFORMATION ABOUT AND TIMELY ACCESS TO EMERGENCY CONTRACEPTION & STDs AND PROPHYLAXIS PER PROFESSIONALLY ACCEPTED STANDARDS OF CARE. INTERVIEW WITH MENTAL HEALTH STAFF & SAFE/SANE NURSE VERIFY AGENCY'S COMMITMENT TO ENSURE VICTIMS OF SEXUAL ABUSE ARE PROVIDED TIMELY INFORMATION AND ACCESS TO EMERGENCY CONTRACEPTION & STD PROPHYLAXIS IN ACCORDANCE WITH STANDARD 115.282(c).
- f) POLICY #165 MANDATES TREATMENT SERVICES PROVIDED TO EVERY VICTIM WITHOUT FINANCIAL COST IN ACCORDANCE WITH STANDARD PROVISION 115.282(d).
- g)

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 VICTIMS OF SEX ABUSE. INTERVIEW WITH INTAKE STAFF & CASE MANAGERS INDICATE ALL RESIDENTS TO ALLEGE PRIOR SEX ABUSE VICTIMIZATION IS OFFERED MENTAL HEALTH TREATMENT. MEDICAL TREATMENT IS ALWAYS PROVIDED TO ALL RESIDENTS AT ANY TIME DURING THEIR RESIDENCY PER STANDARD PROVISION 115.283(a).
- 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). RESIDENTS TO CLAIM VICTIMIZATION PRIOR TO ENTERING THIS FACILITY REFUSED TO BE INTERVIEWED. POLICY PROVIDES TREATMENT TO ANY AND ALL VICTIMS OF SEXUAL ABUSE TO INCLUDE FOLLOW-UP SERVICES WHILE THEY ARE RESIDENTS AT KENDALL FACILITY & IS PROVIDED REFERRALS TO OUTSIDE TREATMENT FACILITIES UPON RELEASE PER STANDARD PROVISION 115.283(b).
- c) MEDICAL HEALTH SERVICES TO VICTIMS IS CONDUCTED AT ST ANTHONY'S HOSPITAL. MENTAL HEALTH SERVICES ARE CONTRACTED THROUGH BTS, WHO IS MANDATED TO PROVIDE MENTAL HEALTH SERVICES PER PREA PROVISIONS. INTERVIEW WITH MENTAL HEALTH PRACTITIONERS VERIFY RESIDENTS ARE PROVIDED MENTAL HEALTH SERVICES CONSISTENT WITH THE COMMUNITY LEVEL OF CARE PER STANDARD PROVISION 115.283(c). ST. ANTHONY'S PROVIDE MEDICAL SERVICES.
- d) POLICY #165 MANDATES LEVEL OF CARE REQUIRED BY STANDARD PROVISION 115.283(d). STANDARD 115.283(d) IS NOT APPLICABLE TO THIS FACILITY AS THIS IS AN ALL-MALE FACILITY.
- e) POLICY #165 PROVIDES FOR COMPLIANCE WITH STANDARD PROVISION 115.283(e) WITH NARRATIVE STATING "ONGOING MEDICAL AND MENTAL HEALTH CARE". STANDARD PROVISION 115.283(e) IS NOT APPLICABLE TO THIS FACILITY AS THIS IS AN ALL-MALE FACILITY.
- 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). NO MEDICAL RECORDS OR SECONDARY DOCUMENTATION TO DEMONSTRATE VICTIMS WERE OFFERED SDT TESTS AS CASES OF RESIDENTS TO REPORTED SEXUAL ABUSE DID NOT INVOLVE SEXUAL PENETRATION OR SKIN CONTACT.
- 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. THE CASE WHICH INVOLVED RESIDENT ON RESIDENT SEX ABUSE RESULTED IN THE ABUSE BEING TERMINATED FROM THE FACILITY FOR A RULES VIOLATION AND RETURNED TO PAROLE JURSDICTION UPON COMPLETION OF THE INVESTIGATION. CASE DID NOT RESULT IN A CRIMINAL PROSECUTION.

AUDITOR HAS DETERMINED AGENCY MEETS STANDARD 115.283

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| 115.286 | Sexual abuse incident reviews |
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- 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). 2 INVESTIGATIVE REPORTS WERE PROVIDED WITH PAQ, HOWEVER, NO INCIDENT REVIEW ACCOMPANIED THE REPORTS. POLICY HAS BEEN UPDATED TO MANDATE COMPLIANCE WITH THIS STANDARD PROVISION IN THE FUTURE. THIS IS AGENCY'S 1ST PREA AUDIT & INCIDENT REVIEWS WILL BE CONDUCTED FOR FUTURE INVESTIGATIONS. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.286(a).
- b) 2 INVESTIGATIVE REPORTS WERE PROVIDED WITH PAQ, HOWEVER, NO INCIDENT REVIEW ACCOMPANIED THE REPORTS. POLICY HAS BEEN UPDATED TO MANDATE STANDARD PROVISION COMPLIANCE GOING FORWARD. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.286(b).
- c) POLICY #165 MANDATES NON-INVESTIGATING SUPERVISOR, PROGRAM DIRECTOR, WITH INPUT FROM INVESTIGATING SUPERVISOR AND APPLICABLE STAFF WILL MAKE UP THE INCIDENT REVIEW TEAM. POLICY IS COMPLIANT WITH STANDARD PROVISION 115.288(c).
- 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. INTERVIEW WITH PROGRAM DIRECTOR, PREA COORDINATOR AND AN ADDITIONAL MEMBER OF THE INCIDENT REVIEW TEAM VERIFY CONSIDERATIONS OF INCIDENT REVIEW TEAM AS IDENTIFIED IN THE CRITERIA OUTLINED IN STANDARD PROVISION 115.286(d).
- 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. THIS IS THE FACILITY'S 1ST PREA AUDIT. NEWLY FORMED INCIDENT REVIEW TEAM HAS NOT YET REVIEWED ANY INVESTIGATIVE FINDINGS TO MAKE RECOMMENDATIONS, HOWEVER, REVIEW OF CASES FOR THE STAFFING PLAN HAS BEEN CONDUCTED, RECOMMENDATIONS FORWARDED AND IMPLEMENTED BY AGENCY TO INCREASE MONITORING FOR SEXUAL SAFETY OF RESIDENTS.

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.286.

CORRECTIVE ACTION:

1. AGENCY TO DEMONSTRATE COMPLIANCE WITH STANDARD PROVISION 115.286(a) BY CONDUCTING INCIDENT REVIEW ON CASE(S) GOING FORWARD. PROVIDE VERIFICATION OF COMPLIANCE TO AUDITOR.
2. AGENCY TO DEMONSTRATE COMPLIANCE WITH STANDARD PROVISION 115.286(b) BY CONDUCTING INCIDENT REVIEW ON CASES GOING FORWARD WITHIN 30 DAYS OF THE COMPLETION OF THE INVESTIGATION. PROVIDE VERIFICATION OF COMPLIANCE TO THE AUDITOR.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 12/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION DATE 3/15/16 :

AGENCY PROVIDED ADMINISTRATIVE INCIDENT REVIEW DOCUMENTATION FOR AN UNSUBSTANTIATED INVESTIGATION WHICH OCCURRED IN NOVEMBER 2017 WHICH VERIFIES DEMONSTRATION AND PRACTICE OF STANDARD 115.286 MANDATES. THE REVIEW PROVIDES CONSIDERATION OF THE FOLLOWING:

1. POLICY & PROCEDURE BEING FOLLOWED BY STAFF
2. CHANGES OR IMPROVEMENTS OF POLICY OR PROCEDURE
3. MOTIVATIONS FOR THE INCIDENT TO OCCUR
4. EXAMINATION OF THE AREA WHERE THE INCIDENT OCCURRED
5. STAFFING LEVELS, VIDEO TECHNOLOGY IN THE AREA WHERE THE INCIDENT OCCURRED
6. ANY OTHER RECOMMENDATIONS FOR IMPROVEMENT.

THE 2ND INVESTIGATION IDENTIFIED BY AGENCY WAS DETERMINED TO BE UNFOUNDED, THEREFORE, ADMINISTRATIVE INCIDENT REVIEW IS NOT REQUIRED. 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 AGGEGATED INCIDENT-BASED DATA BE COLLECTED ANNUALLY. SAMPLE OF AGGREGATED DATA AVAILABLE ON AGENCY WEBSITE PER STANDARD PROVISION 115.287(b).
- c) 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).
- 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. INTERVIEW WITH PROGRAM DIRECTOR AND FACILITY VIDEO EXPERT DETERMINE VIDEO SURVEILLANCE IS MAINTAINED FOR 30 DAYS AND THEN OVERWRITTEN, UNLESS ALLEGATION OF SEXUAL ABUSE HAS BEEN MADE. EVIDENCE IS THEN COPIED OFF THE DVR SERVER & MAINTAINED INDEFINATELY PER POLICY AND IN ACCORDANCE WITH STANDARD PROVISION 115.287(d).
- e) STANDARD IS NOT APPLICABLE TO THIS FACILITY AS AGENCY DOES NOT CONTRACT FROM OTHER FACILITIES FOR THE CONFINEMENT OF ITS RESIDENCE.
- f) DOJ HAS NOT REQUESTED AGGREGATED DATA FROM PREVIOUS CALENDAR YEAR.

AUDITOR HAS DETERMINED THAT 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) THIS IS AGENCY'S 1ST PREA AUDIT & HAS NO ANNUAL REPORTS FROM PREVIOUS YEARS. ADDITIONALLY, THIS IS THE FIRST YEAR AGENCY IS COLLECTING DATA TO PROVIDE ANNUAL REPORT FOR YEAR 2015. INTERVIEW WITH AGENCY HEAD DESIGNEE & PREA COORDINATOR INDICATE THEY HAVE REVIEWED,

COLLECTED AGGREGATED DATA FROM ALL AGENCY FACILITIES FOR YEAR 2014 AND USE CRITERIA IDENTIFIED IN STANDARD PROVISION 115.288(a). AUDITOR VERIFIED AGGREGATED DATA ON AGENCY WEBSITE. NO ANNUAL REPORT AVAILABLE UNTIL 2015. CORRECTIVE ACTION PLANS USING AGGREGATED DATA USED IN CREATING & IMPLEMENTING RECOMMENDATIONS FROM THE FACILITY STAFFING PLAN. AGENCY IS NOT IN COMPLIANCE WITH STANDARD PROVISION 115.288(a).

- b) 1ST PREA REPORT, NO DATA COLLECTION OR ANNUAL REPORT COMPARISON FROM PREVIOUS YEARS AVAILABLE. AGGREGATED DATA AVAILABLE FOR YEAR 2014. THIS IS AGENCY'S 1ST PREA AUDIT & WILL PROVIDE ANNUAL REPORT COMPARISON WITH YEAR 2015.
- c) ANNUAL REPORT AVAILABLE ON AGENCY WEBSITE, HOWEVER, IT IS AN EXCEL SPREADSHEET WHICH PROVIDES ONLY DATA FOR 2014 FROM ALL FACILITIES. INTERVIEW WITH AGENCY HEAD DESIGNEE INDICATES THE AGENCY HEAD REVIEWS AND APPROVES ALL AGGREGATED DATA REPORTS PRIOR TO PROVIDING PUBLIC ACCESS ON THE AGENCY WEBSITE. THIS IS AGENCY'S 1ST PREA AUDIT & WILL HAVE THE OPPORTUNITY TO PROVIDE DATA COMPARISON BETWEEN 2014 AND 2015 THIS YEAR.
- 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 VERIFIES ALL SPECIFIC MATERIAL WHICH MAY PRESENT A CLEAR & SPECIFIC THREAT TO THE SAFETY AND SECURITY OF A FACILITY WILL BE REDACTED. NATURE OF THE REDACTION WILL BE INDICATED.

AUDITOR HAS DETERMINED AGENCY IS NOT IN COMPLIANCE WITH STANDARD 115.288.

CORRECTIVE ACTION:

1. AGENCY TO PROVIDE ANNUAL REPORT TO INCLUDE ALL AGGREGATED DATA FROM AGENCY FACILITIES, IDENTIFYING PROBLEM AREAS, DEMONSTRATION OF TAKING CORRECTIVE ACTION ON AN ONGOING BASIS AND INCLUDE FINDINGS FROM DATA REVIEW AND INCLUDE CORRECTIVE ACTIONS FROM EACH FACILITY AND THE AGENCY AS A WHOLE.
2. ANNUAL REPORT SHALL BE PUBLISHED ON AGENCY WEBSITE OR OTHER MEANS TO MAKE THE DOCUMENT READILY AVAILABLE TO THE PUBLIC.

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETED 3/18/16:

AGENCY PROVIDED 2014/2015 ANNUAL REPORT AND PLACED SAID REPORT UPON AGENCY WEBSITE FOR PUBLIC ACCESS. THE ANNUAL REPORT INCLUDES AGGREGATED DATA SUMMARY FROM ALL 5 ICCS FACILITIES FOR SUBSTANTIATED, UNSUBSTANTIATED AND UNFOUNDED SEXUAL MISCONDUCT FROM BOTH RESIDENTS AND STAFF. ANNUAL REPORT PROVIDED COMPARISONS BETWEEN THE 2014 AND 2015 AGGREGATED DATA FROM ALL AGENCY FACILITIES. DATA PROVIDED INCLUDED IDENTIFICATION OF PROBLEM AREAS, CORRECTIVE ACTIONS RECOMMENDED AND CORRECTIVE ACTIONS TAKEN TO IMPROVED RESIDENT AND STAFF SEXUAL SAFETY WITHIN EACH FACILITY. AUDITOR HAS DETERMINED THAT 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 VERIFIES COLLECTED DATA IS SECURITY MAINTAINED BY HIM IN LOCKED OFFICE AND/OR SECURE RECORD STORAGE AREA PER STANDARD PROVISION 115.289(a).
- b) POLICY #165 MANDATES COLLECTION OF DATA FROM AGENCY FACILITIES & MAKE IT AVAILABLE THROUGH THE AGENCY WEBSITE. POLICY DOES NOT MAKE A DISTINCTION OF "AGGREGATED DATA" PER STANDARD PROVISION 115.289(b).
- c) POLICY #165 MANDATES ALL PERSONAL IDENTIFIERS SHALL BE REMOVED BEFORE MAKING DATA PUBLICLY AVAILABLE. POLICY #165 MANDATES ALL PERSONAL IDENTIFIERS SHALL BE REMOVED BEFORE MAKING DATA PUBLICLY AVAILABLE. REVIEW OF DATA ON AGENCY WEBSITE VERIFIES AGENCY COMPLIANCE WITH STANDARD PROVISION 115.289(c).
- d) POLICY #165 MANDATES AGENCY RETAIN SEX ABUSE DATA FOR A MINIMUM OF 10 YEARS.

AUDITOR HAD DETERMINED AGENCY DOES NOT MEET STANDARD 115.289.

CORRECTIVE ACTION:

- 1. AGENCY TO AMEND POLICY #165 H-3 TO INCLUDE A NARRATIVE WHICH DEFINES THE USE OF "AGGREGATED DATA" IN ACCORDANCE WITH STANDARD PROVISION 115.289(b).

AGENCY TO PROVIDE VERIFICATION OF COMPLIANCE ON 11/20/15 BUT NO LATER THAN THE END OF THE 180 DAY CORRECTIVE ACTION PERIOD FEBRUARY 18, 2016.

CORRECTIVE ACTION COMPLETION 12/4/15:

AGENCY AMENDED POLICY #165 H-3 TO INCLUDE NARRATIVE WHICH INVOLVES THE USE OF "AGGREGATED DATA" IN ACCORDANCE WITH STANDARD PROVISION 115.289(b). AUDITOR HAS DETERMINED THAT 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.

Auditor Signature