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

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: Click or tap here to enter text. ☐ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: October 30, 2021

Auditor Information

Name: Kayleen Murray	**Email:** kmurray.prea@yahoo.com
Company Name: Click or tap here to enter text.	
Mailing Address: P.O. Box 2400	**City, State, Zip:** Wintersville, Ohio 43953
Telephone: 740-317-6630	**Date of Facility Visit:** October 4-5, 2021

Agency Information

Name of Agency: Oriana House, Inc			
Governing Authority or Parent Agency *(If Applicable)*: Click or tap here to enter text.			
Physical Address: 885 East Butchel Avenue		**City, State, Zip:** Akron, Ohio 44309	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: Click or tap here to enter text.			

Agency Chief Executive Officer

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

Agency-Wide PREA Coordinator

Name: Lori McGrady	
Email: LoriMcGrady@orianahouse.org	**Telephone:** 330-535-8116 x 2030
PREA Coordinator Reports to: Mary Jones, Vice President of Administration and Legal Counsel	**Number of Compliance Managers who report to the PREA Coordinator:** 12

Mary Jones, VP of Administration and Legal Counsel	

Facility Information

Name of Facility: CROSSWAEH Community Based Correctional Facility			
Physical Address: 13055 S. St. Rt. 100		**City, State, Zip:** Tiffin, Ohio 44883	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal

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

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

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

☒ ACA

☐ NCCHC

☐ CALEA

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

☐ N/A

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

Facility Director

Name:	Dawn Root		
Email:	DawnRoot@orianahouse.org	**Telephone:**	419-447-1444

Facility PREA Compliance Manager

Name:	Dawn Root		
Email:	DawnRoot@orianahouse.org	**Telephone:**	419-447-1444

Facility Health Service Administrator ☒ N/A

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

Facility Characteristics

Designated Facility Capacity:	50 males/36females

Current Population of Facility:	48males/18females
Average daily population for the past 12 months:	38males/22females
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	18 and older
Average length of stay or time under supervision	179 days
Facility security levels/resident custody levels	minimum

Number of residents admitted to facility during the past 12 months	161males/86females
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	160males/84females
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	147males/81females
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☒ Yes ☐ No

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

Number of staff currently employed by the facility who may have contact with residents:	28
Number of staff hired by the facility during the past 12 months who may have contact with residents:	9
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	2
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	4 (2 in each building)
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	7/5
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☐ Yes ☒ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations

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

Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☐ Facility investigators ☒ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

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

The PREA onsite visit for CROSSWAEH Community Based Corrections Facility (CBCF), 3055 South State Route 100, Tiffin, Ohio, was conducted on October 4-5, 2021. The facility is a part of Oriana House, Inc. operated community confinement programs. The goal of the audit is to ensure operational compliance with the Prison Rape Elimination Act standards for community confinement facilities. The auditor interviewed staff and residents in accordance with the PREA Compliance Audit Instrument Interview Guide and the PREA Auditor Handbook's Effective Strategies for Interviewing Staff and Resident Guide. The goal of the audit is to ensure operational compliance with the Prison Rape Elimination Act (PREA) standards for community confinement facilities.

The facility elected to use Power DMS to upload documentation relevant to showing compliance with each standard. The auditor received notification that the information was available approximately four weeks prior to the onsite visit. The information included the pre-audit questionnaire, policy and procedures, MOUs, facility staffing plan, table of organization, job descriptions, and post orders. The auditor received photos showing proof of audit notices posted in resident and staff areas six weeks prior to the onsite visit. The auditor has conducted the audits for this agency in the past, including the last audit in 2018. The auditor reviewed the prior final audit report and previous documentation for comparison to the current audit.

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

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

The tour included observations of the housing units, dorm rooms, bathrooms, closets/storage rooms, administration area, and outdoor recreation area. During the walkthrough, the auditor was able to have informal conversations with both staff and residents. The auditor made notes of cameras, security mirrors, blind spot areas, and staff/resident interaction.

The auditor interviewed sixteen (16) residents based on the population of sixty-six (66) residents during the onsite visit (48 males/18 females). The residents selected were based on the requirements of the PREA Resource Center's Auditor Handbook guidelines. The residents were selected based on their housing unit, targeted interview status, risk assessment screening, intake dates, demographics, and commitment status. The auditor conducted the following interviews:

- Random = 16
- Targeted = 4

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

- Residents that identify as lesbian, gay, or bisexual = 2
- Residents that have a physical disability impairment = 4
- Residents that have a cognitive disability = 1
- Residents that have a mental disability = 3

*Some targeted residents fit into more than one targeted category. In categories where there was more than one resident, only one was counted as a targeted resident. All residents in the targeted category were interviewed on all specialized (that applied) and random interview protocols.

The auditor conducted the interviews in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook Guide for Effective Strategies for Interviewing Staff and Residents. The auditor explained the interview process to each resident and that they were under no obligation to answer questions. The auditor asked questions concerning the resident's experience with PREA education, allegation reporting requirements, retaliation, staff communication, grievance reporting, knock and announcements, searches (pat, enhanced pat, strip, body cavity, and cross-gender), housing unit concerns, limits to confidentiality, outside supportive services, disciplinary sanctions, and other PREA related concerns.

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

- PREA Coordinator
- VP of Administration and Legal Counsel
- VP of Correctional Programs, North Central Region
- Human Resource Director
- Administrative Investigators
- Program Administrator
- Program Coordinator
- Crisis Counselor
- Risk of Victimization/Abusiveness screener
- Retaliation monitor
- SART team members
- First Responders (security and non-security)
- PREA education facilitators

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

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

The auditor reached out to the facility's community resources by email to confirm the MOUs and scope of services. These community partners include representatives from SANE director, Megan Holman and the Director of Cocoon, Jodie Broadwell. The auditor was able confirm the services they would provide to residents free of charge.

Facility Characteristics

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

CROSSWAEH is a community based correction facility in Tiffin, Ohio that serves both male and female offenders. There is a separate male and female facility that are located across the parking lot from each other. The facility has limited the number of outside contractors, volunteers, and vendors allowed in the facility.

Staff and visitors enter through the main entrance by ringing a buzzer that will alert staff at the control office. Once inside the main lobby, visitors and staff must sign into the facility and sign acknowledgement of Oriana House's zero tolerance policy. There is a separate entrance for offenders. The offender entrance leads clients to the intake area. In this area, the resident will receive a pat down that is visible by video surveillance or residents may receive an enhanced pat down (residents receiving an enhanced pat down will strip down to their underclothes) which is supervised by two staff of the same gender. Posted in this location is the agency's policy on searches and urine drug screenings.

Male Facility: The male facility is a single level brick building. The visitor/staff entrance lobby has a male and female visitor bathroom and access to administrative offices and a sally port entrance to the housing unit. After entering through the sally port, one would be in the male day room. The dayroom has exercise and recreation equipment, television, payphones, bulletin board with PREA related information (hotline numbers, ways to report, phone number and addresses for state and local rape crisis agencies, rules and regulations, and client rights), and dorm rooms, dining hall/multipurpose room, laundry room, rec yard entrance, and entrance to the second housing unit around the perimeter. Clients have access to staff at the main post from the dayroom.

All rooms around the perimeter of the dayroom have windows in the door for clear line of site views into the rooms. Rooms with corners or difficult viewing angles, have security mirrors inside to allow for views from the doorway.

The facility has a treatment wing that clients must have a staff member unlock the door or escort for access to this area. The treatment wing has staff offices and group rooms. These offices and group rooms have windows in the doors and some also have security mirrors.

The auditor entered all dorm rooms. There are six dorm rooms in the main housing unit area. The dorm rooms are set up with bunk beds and wardrobes around the perimeter of the room. The set up makes for good line of site views into the room from the doorway. The auditor noted the dorm room assigned to clients who may need increased monitoring from Resident Security staff. Staff are aware of any client that may need more monitoring for any reason by the number of required "whereabout" checks list on the daily count sheet.

There are two bathrooms for clients in the main housing unit. There is no door at the entrance of either bathroom and each is set up to provide clients an appropriate level of privacy (see standard 115.215 for detailed bathroom descriptions). Staff members are required to increase the number of circulation checks in the bathrooms due to it being designated a blind spot area.

The second housing unit is designated for high-risk offenders and can be accessed through the dayroom. This housing unit is significantly smaller, but contains its own dayroom area, laundry room, bathroom, and outdoor recreation yard. Clients that are assigned to this area can also access the amenities in the main housing unit, however; the clients assigned the main housing unit cannot enter into the one designated for high-risk offenders.

The outdoor recreation yard for the main housing unit is surrounded by a 16 foot curved fence. The area has outdoor rec equipment and smoking area. The clients have free access to the rec yard.

The dining hall/multipurpose room has a wall of glass that separates the room from the dayroom. Clients have access to the dayroom at all times except when vendors are filling the vending machine. Off of the dining hall is a serving room. Staff and residents pick up the meals from the Aramark vendor. Clients serve the meals under staff supervision. There is a clean tray area in the serving room where clients clean trays after meals.

The facility has seventeen cameras and four of those cameras also have the ability to record audio. The cameras can record and playback up to thirty days. Some of the perimeter cameras also cover the female building. The facility has also installed callbox cameras at entrance points to various areas of the facility. Staff/clients can press a button to alert staff to the door where staff can permit access through a camera system at the main post. Security staff have access to these cameras at the main post. Administrative staff can access the cameras from their desktop computers. Supervisors review live and recorded footage at least one time per week.

Female Facility: The female facility is a single level brick building. The visitor/staff entrance lobby has a male and female visitor bathroom and access to administrative offices. After entering through the sally port, one would be in the dayroom. The dayroom has exercise and recreation equipment, television, payphones, bulletin board with PREA related information (hotline numbers, ways to report, phone number and addresses for state and local rape crisis agencies, rules and regulations, and client rights), and dorm rooms, dining hall, conference room, laundry room, group rooms, rec yard entrance, and entrance to the second housing unit around the perimeter. Clients have access to staff at the main post from the dayroom.

All rooms around the perimeter of the dayroom have windows in the door for clear line of site views into the rooms. Rooms with corners or difficult viewing angles, have security mirrors inside to allow for views from the doorway.

The auditor entered all dorm rooms. There are five dorm rooms in the main housing unit area. The dorm rooms are set up with bunk beds and wardrobes around the perimeter of the room. The set up makes for good line of site views into the room from the doorway. The auditor noted the dorm room assigned to clients who may need increased monitoring from Resident Security staff. Staff are aware of any client that may need more monitoring for any reason by the number of required "whereabout" checks list on the daily count sheet.

There are two bathrooms for clients in the main housing unit. There is no door at the entrance of either bathroom and each is set up to provide clients an appropriate level of privacy (see standard 115.215 for detailed bathroom descriptions). Staff members are required to increase the number of circulation checks in the bathrooms due to it being designated a blind spot area.

The second housing unit is designated for high risk offenders and can be accessed through the dayroom. This housing unit is significantly smaller, but contains its own dayroom area, laundry room, bathroom, and outdoor recreation yard. Clients that are assigned to this area can also access the amenities in the main housing unit, however; the clients assigned the main housing unit cannot enter into the one designated for high risk offenders.

The outdoor recreation yard for the main housing unit is surrounded by a 16 foot curved fence. The area has outdoor rec equipment and smoking area. The clients have free access to the rec yard.

The dining hall/multipurpose room has a wall of glass that separates the room from the dayroom. Clients have access to the dining hall at all times except when vendors are filling the vending machine. Off of the dining hall is a serving room. This room is used for the setup of all meals. Staff and clients pick up the meals from the male facility and return the trays to the male facility at the end of the day. Clients serve the meals under staff supervision.

The facility has twenty-two cameras and six of those cameras also have the ability to record audio. The cameras can record and playback up to thirty days. Some of the perimeter cameras also cover the male building. Security staff have access to these cameras at the main post. Administrative staff can access the cameras from their desktop computers. The main post also has access to door cameras. The facility is equipped with video camera coverage over all strike doors that require staff to provide access. Supervisors review live and recorded footage at least one time per week.

Staff can be assigned to work in either building and receive cross training in gender specific sexual abuse and sexual harassment issues.

Resident supervisor staff also are required to conduct "where abouts" 3x per shift and 6x per shift for residents who have been classified as highly abusive or highly susceptible until a review can be done by a supervisor team to remove the resident from the increased "where abouts". During a "where about" staff must document physically seeing each resident. Along with "where abouts", Resident Supervisor staff circulate throughout the whole facility once every 30 minutes. Identified blind spot areas have increased circulation. The facility has placed surveillance mirrors in strategic areas in order to capture areas that are not immediately visible when looking through the window, and in the hallways to cover corners and other hidden areas.

The facility's goals are to alleviate jail and prison overcrowding; improving the community integration process for residents; addressing chemical dependency, employment, education, and other issues prior to release; and reducing recidivism by addressing certain behaviors, attitudes, and thought processes. The facility accomplishes these goals by using programming that has demonstrated the ability to reduce crime.

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 7

List of Standards Exceeded: 115.215, 115.231, 115.232, 115.233, 115.264, 115.265, 115.276

Standards Met

Number of Standards Met: 35

Standards Not Met

Number of Standards Not Met: 0

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

PREVENTION PLANNING

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

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

115.211 (a)

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

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

According to the agency's table of organization, the agency wide PREA Coordinator is the agency's PREA and Wellness Coordinator, and reports directly to the agency's Vice President of Administration and Legal Counsel. During the onsite interview, she states she assist with implementing PREA strategies at each facility. She also develops the training curriculum for required monthly PREA training at each facility and provides facilities guidance and assistance in complying with the standards. She is a Department of Justice Certified PREA Auditor and had extensive experience in interpreting the scope and intent of each standard. She indicated that she has enough time and authority to develop, implement, and oversee the agency's efforts to comply. The PREA Coordinator supervises each facility's PREA Compliance Manager. She states that 90% of her job duties are PREA related. The PREA Coordinator reports that COVID has not impacted how she accomplishes her duties related to complying with the PREA standards.

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

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

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

The auditor interviewed the VP of Administration and Legal Counsel during a zoom video interview. She states that she has full confidence in the PREA Coordinator and provides her the support and assistance when needed to ensure each facility is in compliance with the standards. She states that she is still involved in determining the outcome of administrative investigations and is a part of the SART review. She states that 20% of her responsibilities include PREA compliance.

The auditor was also able to interview the VP of Correctional Programs, North Central Region. He states that is job is to assist the facility in ensuring clients' rights are protected, policies and procedures are being followed, and services are being offered/provided according to policy. He is a member of the SART and assist in making recommendations to facilities after a substantiated or unsubstantiated allegation of sexual abuse.

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

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

The auditor interviewed the Program Administrator during the onsite visit. The Program Administrator states that she is responsible for ensuring all staff and clients have received proper PREA education and understand their rights and responsibilities under the PREA standards. She coaches staff on how to create a culture where clients and staff feel comfortable reporting information, suspicion, or knowledge of sexual abuse and sexual harassment.

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

Review:
Policy 1080
Program Administrator job description
PREA and Wellness Coordinator job description
Agency table of organization
Interview with PREA Coordinator
Interview with VP of Administration and Legal Counsel
Interview with PREA Managers
Interview with VP of Correctional Programs, North Central Region

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

Standard 115.213: Supervision and monitoring

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

115.213 (a)

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

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

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

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

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The facility provided the auditor with their most recent staffing plan. The staffing plan reviewed the availability of video surveillance (fifteen cameras in the male facility and twenty-two cameras in the female facility strategically placed throughout the interior and exterior of each building), security mirrors, and identified blind spot areas. The staffing levels noted on the plan includes availability of security staff twenty-four hours a day, seven days a week, three hundred sixty-five days per year. The facility will have one male and one female staff member on each shift. The plan also identified the minimum number of staff for each shift:

Shift	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6am-2pm	5	5	5	5	5	5	5
2pm-10pm	5	5	5	5	5	5	5
10pm-6am	4	4	4	4	4	4	4

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

- **Female Facility**
  - 1st Shift (6am-2pm): 2 full time security staff
  - 2nd Shift (2pm-10pm) 2 full time security staff
  - 3rd Shift (10pm-6am) 2 full time security staff

- **Male Facility**
  - 1st Shift (6am-2pm): 3 full time security staff
  - 2nd Shift (2pm-10pm) 3 full time security staff
  - 3rd Shift (10pm-6am) 2 full time security staff

The Program Administrator reports that the facility had not deviated from the staffing plan. The facility has two staff undergoing *new employee orientation* in the security department. She states that staff will be offered overtime hours to fill positions until new staff can be hired and trained. Supervisors, Administration, and Program staff can also assist security staff when necessary.

The facility has traditional security cameras and door cameras throughout both facilities. The system has audio capabilities in the cameras above the main post. The facility has cameras located in rooms where staff conduct enhanced pat searches. These cameras

record to a different DVR and only the administrative investigators have access. The facility has increased the amount of time video can be stored from 14 days to 30 days since the last audit in 2018. Supervisory staff are required to review camera footage during their shift and document in the ORION database system.

There is an intercom system in the female housing unit. The intercom allows for two-way communication to the main post desk twenty-four hours a day.

Security checks are conducted by resident supervisor staff and shift supervisors. The staffing plan requires three whereabout checks per shift. Whereabout checks require the staff member to visually identify a resident and document on form that the resident was seen. Residents that have been identified as being vulnerable, abusive, or have mental health issues are required to have six whereabout checks per shift. Along with whereabout checks, security staff will also conduct circulations at minimum three times per hour. Circulations are complete facility walk-throughs. Staff will conduct more frequent circulations in designated blind spot areas.

All residents are required to be on increased whereabout checks during their first 48-hours in the facility. This allows the staff to ensure the residents are adjusting to the facility appropriately.

During the past twelve months the facility has had one unfounded client-to-client allegation and one unsubstantiated staff-to-client allegation.

The plan did not identify any changes that needed to be made in response to the facility staffing levels, resident composition, or prevalence of substantiated or unsubstantiated sexual abuse allegations.

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

Review:
Policy and procedure
Staffing plan 2020
Floor plan
Camera monitors
Building tour
Interview with agency investigators
Interview with PREA Coordinator

Interview with Program Administrator
Interview with VP of Correctional Programs
Interview with Lead Resident Supervisor

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

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

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

115.215 (c)

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

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

115.215 (d)

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

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency's search procedures are outlined in agency policy 8089. The policy states that strip searches and body cavity searches for residents will only be conducted with the prior approval of the President/Chief Executive Officer or designee. The searches are limited to the staff member conducting the search and the resident being searched. Should a search be authorized, the following conditions will apply:

- A body cavity search must only be conducted under sanitary conditions by medical personnel. A strip search must only be conducted by same gender staff and with two staff members present. A resident who is under the jurisdiction of the FBOP can only have a strip or body cavity search by medical personnel or law enforcement.
- The strip search and/or body cavity search must be conducted in a manner and in a location that permits only the person or person who are physically conducting the search and the person who is being searched to observe the search.
- A strip search and/or body cavity search must be conducted in a professional manner that preserves the dignity of the person searched to the highest degree possible.
- At the completion of a strip search and/or body cavity search, the staff member who conducted the search must document in the resident log the date and time of the approval, the authorized person who granted the approval, the time and time of the search and all the findings.

The policy states the facility has the right to conduct reasonable searches of persons, packages, and property. A pat search will be conducted on all residents entering the facility and whenever a resident is suspected of possessing contraband in the facility. A pat search will only be conducted by a members of the same gender in a professional and respectful manner. Searches will be conducted in the line of the security camera, if searches in front of a camera are not possible, a witness must be present and documentation is ORION is required. When conducted a pat search, staff must,

- Allow only one resident in the designated pat search area at a time
- Verbally describe the pat down search steps to the resident using a firm, fair, and empathetic tone of voice
- Instruct the resident to remove all outer clothing to be searched so that the resident is wearing one layer of street clothes
- Instruct the resident to empty all pockets in clothing and place the contents in a designated area
- Instruct the resident to untuck his/her shirt
- Conduct an inspection of the resident's mouth, looking above and below the tongue and in the cheeks. Instruct the resident to open wide and move their tongue around to ensure that no contraband is located within their mouth
- Complete a metal detection search on the resident. Have the resident stand with legs open and arms up. With the metal detector, swipe the back of the neck area, across both arms, down the back, under both arms, down both sides, down the

outside of each leg and inside of each leg. Step to either side of the resident and follow the same procedure for the front of the body. Continue the search and pat down until the resident is able to be screened with a metal detector without an alert

- Instruct the resident to place his/her hands on the wall, and to spread feet on the floor more than shoulder-width apart. Instruct the resident to take a step backwards while keeping their hand on the wall. The resident's feet should be far enough back from the wall to make them off balance if they did not use the wall for support
- Position yourself in a protective stance with your dominant foot positioned inside the resident's foot and reposition your body throughout the pat down process to ensure you are always in a protective stance
- Start at the wrist, using both hands with thumbs touching, run your hands down the arm, over the resident's shoulder, around the collar, underneath the arm and down the side of the torso. Repeat the process on the other side
- Run your hands thoroughly and carefully over the resident's back
- Run your hand over the chest, abdomen, and stomach area
- Move your hands using your thumbs in between underwear and other layer around the resident's waistband
- Using the back of your hands, swipe horizontally across the resident's lower waistline
- Using both hands in a blade-like manner, vertically run your inside hand up the inside of the resident's leg up to the groin area. Using both hands, run your hands down the pant legs searching the entire the leg down to the ankle
- Ask the resident to sit down in a chair and remove their shoes and socks. Ask the resident to turn socks inside out and hand both shoes and socks to staff. Search both shoes and socks

During an enhanced pat search, policy states that residents are to remove all clothing except one layer of undergarments and will only be conducted by members of the same gender in a professional and respectful manner and on a random, scheduled, and/or for cause basis. When performing an enhanced pat down search, the staff member must follow these steps:

- Conducted by two staff members of the same gender as the resident
- Searches are conducted in a designed area that maintains the appropriate level of privacy
- Verbally describe the enhanced search steps to the resident using a firm, fair, and empathetic tone of voice

- Direct the resident to remove their clothing, one article at a time, via staff verbal cues in the following order- shoes, socks, shirts, pants, skirts, dresses (all clothing down to one layer of undergarments) and have the resident hand it to the staff member
- Direct the resident NOT to remove their undergarments
- Do not physically touch the resident when they are in their undergarments or their underwear
- Direct a resident to utilize their thumbs and go around the inside of the waistband and then show the inside of the waistband by flipping it outward without exposing their genitals
- Direct the resident to conduct a self-pat down of the genital and breast area. Observe and listen to this process for purposes of detecting hidden contraband
- Direct the resident to jump up and down several times and/or shake out each leg of the undergarment
- Direct the resident to show the bottoms of their feet and in between their toes

In the pat search area are posted notices of the expected steps for a pat search, enhanced pat search, and urine drug screens. Residents also sign a Search of Person Acknowledgement. The acknowledgment form list what is to be expected for pat and enhanced pat searches, when searches may be conducted, and refusal of searches can be cause for termination.

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

As part of supportive documentation sent prior to the onsite visit, the auditor received and reviewed the training curriculum provided to staff members who are responsible for conducting pat searches. The training included instructions on appropriate pat search techniques for cross-gender and transgender searches, respectful communication with LGBTI residents. These training also include instructions on how to conduct a pat search in a professional and respectful manner and in the least intrusive manner possible,

consistent with security needs. The auditor also reviewed staff training completions sheets for searches.

The training, power point and hands on, also demonstrates to staff how to conduct cross-gender searches (only allowed in exigent circumstances) and transgender/intersex searches.

The auditor was able to view a same gender pat search in both the male and female buildings. The searches were conducted as outlined in policy and procedure. The auditor also reviewed camera views for the rooms where urinalysis and enhanced pat searches are conducted. The view from the male facility is completely blacked out from the monitor on the male side and was blocked with the use of paper to obstruct the view from the monitor on the female side.

The auditor interviewed RS staff from all shifts. All staff reported to the auditor that they were comfortable with the training provided, and felt they could conduct searches in a respectful and professional manner based on their training. Staff was also questioned by the auditor on their cross-gender search training. All male staff interviewed stated that at no time are they allowed to conduct a female search of any kind. The facility ensures that female staff work each shift; therefor female clients are never refused programing outside the facility. The lead resident supervisor discussed with the auditor her practice of reviewing pat searches either in person or reviewing video footage in order to ensure pat searches are completed according to policy and make correction if necessary.

The agency has implemented a policy addressing the proper housing, search, and showering of any transgender or intersex resident. A transgender or intersex resident would be offered private shower times. Facility leadership would consult with a transgender resident before identifying what gender staff would conduct searches and UDS. The policy does not allow staff to physically examine a transgender or intersex resident for the sole purpose of determining genital status.

The facility has not housed a transgender resident since the last PREA audit in 2018. Staff that were employed during that time were able to discuss their experience and felt that the training was sufficient enough to conduct a respectful professional search that still met security needs.

The facility allows residents to shower, perform bodily functions, and dress in areas not viewable to staff. The facility has a restroom in each of the housing units for residents to be able to shower and use the toilets. Policy 1080 requires all staff to announce their

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

The facility has two housing units in both the male and female building. The male building has three client restrooms including one that is contained in a separate housing unit. The bathroom in the housing unit for clients that have been assessed as low risk offenders contains three sinks with mirrors above directly across from open entrance, one urinal that is incased in a stall with no door, and one toilet stall that has a half door. The shower/changing area is blocked from view by a shower curtain. Inside the shower/changing area are two single use showers each covered by a shower curtain. The other two bathrooms are located in the main housing unit. One bathroom contains three sinks with mirrors above directly across from open entrance. The two toilet stalls are across from the sings and have half doors for privacy. The one urinal is not covered by a stall but cannot be seen from the open entrance. The three individual use showers are covered by shower curtains. The second bathroom in the main housing unit contains four sinks with mirrors above, two toilet stalls with half doors, and one urinal. The four individual shower stalls with curtains are located on the others side of the divided bathroom. All shower curtains, including the one at the entrance to the shower/changing area in all three bathrooms allow for staff to view the lower half of clients without viewing the breast, buttocks, or genital areas. The male facility also has a single use bathroom with a door at the entrance in the client intake area. If requested, transgender/intersex clients would have use of this private bathroom.

The female building also has two housing units. The bathroom in the self-contained housing unit reserved for clients with a high risk score does not have a door at the entrance, but does have an opaque shower curtain at the entrance in order to offer more privacy. The bathroom contains two sinks with mirrors above, two toilet stalls with half doors across from the sink area, and two individual shower stalls with shower curtains. The two bathrooms in the main housing unit both contain two sinks with mirrors, two toilet stalls with half doors, and two individual shower stalls with curtains. There is a private single use bathroom in the client intake area. If requested, transgender/intersex clients would have use of this private bathroom.

The auditor interviewed sixteen (16) residents during the onsite visit. The residents were questioned on searches as well as cross-gender knock and announcements. All residents reported that staff announce themselves whenever entering into the bathroom or dorm

rooms. The female residents report that male RS staff rarely work in the facility and if they do it is usually at night with a female staff member. The residents report pat searches, enhanced pat searches, and urinalysis are all completed as the posted notices indicate and no resident reported feeling uncomfortable during searches.

The facility had one client who did not alleged a PREA allegation but did have some questions as to the proper procedure for male staff searching the bathroom. He stated that a staff member entered the bathroom while he was using the toilet and "peeked" at him. The resident states that the staff member did not watch him use the toilet but he did not think staff was allowed to do that. The toilet stalls in all the bathrooms have custom ½ doors that allow staff to easily view for incidents (medical, contraband, PREA) but offers the resident privacy. The auditor questioned the resident as to any concerns he has about his safety or staff watching him while undressed. The resident reports feeling safe and has no concerns about staff watching him. He also has no issues or problems with the staff member in question. The auditor explained to the resident the definition of voyeurism and that there will some incidental viewing at times when staff is conducting official business; however, if at any time staff behaviors changes to voyeurism or something more overt, to report the behavior through the available reporting options.

The auditor interviewed the staff member involved in the situation. He states that while conducting a circulation into the bathroom, he detected the smell of smoke. The residents are not allowed to smoke in the facility so he was searching for the source of the smoke. The staff member that he will only look into the staff when there is cause and only for the amount of time needed to assess the situation.

The agency has begun to post "What to Expect During a Security Check" postings in resident areas. The posters include:

- Staff are Instructed to view over the half doors and behind shower curtains, when necessary, to ensure the safety of each client and the security of the facility
- Staff can request that clients remove any towels or personal items on bunks that obstruct viewing
- Staff may have incidents of incidental viewing of genitalia, breast, or buttocks during security checks. Prolonged peering or requiring exposure of genitalia, breast, or buttocks, that is unrelated to official duties may be considered sexual abuse and should be reported
- Clients are not allowed to obstruct viewing into restroom stalls with towels or any other personal item

- Clients are not allowed to move or remove shower curtains from the shower stalls
- Clients are not allowed to move security mirrors located throughout the facility
- Clients are not allowed to change clothes in dorms. All clients must change clothing in the bathroom
- Clients who violate these policies are subject to disciplinary action
- Definition of a "good faith" report
- Definition of a "bad faith" report

The auditor was able to witness the agency's knock and announce practice during the onsite visit. All staff announced themselves according to agency policy during each day of the visit.

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

The Program Administrator states training is completed during new staff orientation and a refresher training is given annually on the proper way to supervise residents. This includes how to conduct searches and cross gender announcements. The Lead Resident Supervisor is required to periodically review pat downs, live or reviewing surveillance video, and provide training/guidance to staff if necessary.

The facility does not currently have an identified transgender/intersex resident.

Review:
Policy 1080
Policy 8089
Facility tour
Interview of random residents
Interview of staff
Interview of PREA Coordinator
Interview of Program Administrator
Interview of Lead Resident Supervisor
Training Curriculum

Posters of pat search, enhanced search, and UDS expectations

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

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

115.216 (a)

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

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

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

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

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

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

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

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

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

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

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

115.216 (b)

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

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

115.216 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The policy also states:

- Telecommunications device for the deaf (TDD), shall be provided as needed with no cost to residents, family members, and/or significant others. Mobile units are stationed at the Administrative Office and the Detox facility. The Admissions Manager, or designee, will coordinate with the Communications Specialist to install the unit at the requested facility
- If an interpreter is needed for continuing case management services, the Program Director or designee should utilize the contact list for these services
- When a translator (i.e., Spanish, Vietnamese, etc.) is needed for prospective residents, the Admissions Manager or designee will make arrangements through The International Institute
- Once a resident is placed in a program, a Program Director or designee should arrange for ongoing services
- The Program Director/designee in the facility where the resident is placed can utilize the contact list during standard business hours and off-hours
- There are no fees to residents, family members, and/or significant others with regard to language barrier/literacy services. The Agency has signed agreements and/or billing guidelines set up with the contacts listed

- Should an employee offer/be directed to provide in-house services, his/her supervisor must authorize him/her to leave his/her regular duties during the time in which he/she is interpreting
- Any request by a resident to have a family member or friend interpret, following the Agency's offer to provide an interpreter, must be documented in the resident's file. The resident's request will be honored unless the Admissions Manager and/or facility's Program Director feels the person the resident is requesting is not sufficiently qualified and, in such cases, must provide the resident an interpreter from the contact list. Documentation must include a written statement signed by the resident

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

The facility has identified Heidelberg College, International Institute for language interpreter Services, and Deaf Resource Center for hearing impairment services as community partners that would provide services for residents needing assistance or auxiliary aids.

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

The auditor spoke to RS staff who provide residents with PREA resident information at intake including a resident handbook and grievance instructions. The staff report that they are to ensure that clients can read and understand the material during the intake process. If there is a cognitive, physical, or mental disability, or the client is limited English proficient, the staff member is to document the deficiency and provide assistance that would ensure the client understands their rights under the PREA standards. The RS staff report having to read most of the intake packet to each client during intake regardless of their reading/comprehension abilities. They state that are various points during the intake process, they will ask questions to ensure the residents understand the material. If the client needs additional assistance or auxiliary aids, the staff will contact the Program Administrator. The staff report that they have not had any issues with clients not speaking/understanding English, nor have they needed the assistance of community partners.

The Program Administrator provided orientation education with both male and female clients. During orientation group, the Program Administrator will show clients a PREA education video produced by *Just Detention.* She states that she will review facility specific information with the clients and will work one-on-one with any client that has a condition that would impair their ability to understand the material or benefit from the policies and procedure established by the agency. The Program Administrator reports that the facility has not housed a client that did not speak and understand English.

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

Review:
Policy 8004
PREA Plan to Assist Residents with Disabilities
Resident intake materials
Interviewed target residents
Interviewed Program Administrator
Interviewed PREA Coordinator
Interviewed RS staff

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

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

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

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described in the above section.

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

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

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

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

The auditor conducted a lengthy interview with the Director of Human Resources, through zoom video conference, who took the auditor systematically through the hiring and promotion process. The Director states that during the hiring process, applicants are questioned about criminal or administrative sexual misconduct allegations on the

application, during the telephone interview, and during the in person interview. Once hired, all new employees are provided the agency's zero tolerance policy 1080 and continued affirmation policy 3009 to disclose misconduct. Employees document their acknowledgment of this annually. The Director reports that to be eligible for a promotion, all interested employees must submit a letter of interest to the Human Resource Department. The department will review the employees file including disciplinary actions. Employees with disciplinary action that includes sexual misconduct are not eligible for promotion.

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

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

The facility provided the auditor with documentation for each step of the hiring process to ensure that the facility is complying with each provision of the standard. This includes interview questions with the confirmation of no administrative, civil, or criminal allegations of sexual abuse or sexual harassment, continued affirmation, background checks, disciplinary action, promotions, and reference checks.

Review:
Policy 1080
Policy 3006
Policy 3009
Employee files
Continued affirmation
Prior institutional referral
Applicant interview questions
Background checks
Promotion documentation
Interview with Human Resources Director

Standard 115.218: Upgrades to facilities and technologies

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

115.218 (a)

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

115.218 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The VP of Correctional Programs, North Central Region reports that the facility has not acquired any new facility nor is it planning any substantial expansion or modification to the current facility.

The facility has increased the number of cameras in the facility and has upgraded the camera server. The upgrades have allowed the facility to reduce the number of blind spot areas and increase the amount of time cameras can be reviewed from 14 days to 30 days. The upgrade to the electronic monitoring system assist the facility in detecting and responding to incidents of sexual abuse and sexual harassment.

Facility management will continue to monitor and address technology monitoring issues as needed.

Review:
Interview with VP of Correctional Programs North Central Region
Interview with Program Administrator

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

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

115.221 (a)

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

115.221 (b)

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

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

115.221 (c)

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

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

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

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

115.221 (d)

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

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

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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The agency has a policy that requires all allegations of sexual abuse and sexual harassment, regardless of how it was reported, to be administratively and/or criminally investigated. All administrative investigations will be investigated by a specialized trained investigator. All allegations that appear to be criminal will be referred to the Seneca County Sheriff's Office, who have the legal authority to conduct such investigations. The facility has an MOU with this office. The MOU states that the Seneca County Sheriff's Office agrees to:

- Investigate all criminal allegations of PREA with a uniform evidence protocol adapted from the Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examination, Adults/Adolescents," or similarly comprehensive and authoritative protocol developed after 2011.
- Investigators will have specialized training in conducting investigations in confinement settings
- Investigators will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interview victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse involving suspected perpetrators
- Investigations will be documented in a written report that contains a thorough description of physical testimonial and documentary evidence with attached copies of all documentary evidence where feasible
- Substantiated allegations of conduct that appears to be criminal will be referred for criminal prosecution

Administrative investigations will be conducted by trained agency investigators. The agency has provided the auditor with training certificates for the administrative investigators.

Clients that are in need of a forensic medical examination will be taken to Mercy Medical in Tiffin, Ohio. The auditor spoke with the SANE Supervisor who stated that hospital would provide Sexual Assault Nurse Examiners to any client from the Oriana House when necessary free of charge. The hospital employs five SANE nurses including the supervisor. The Supervisor reports that SANEs are on duty for most shifts; however, should one not be available, the hospital would make the on-call nurse available. The hospital works in conjunction with local advocate agencies and would offer the services of a victim advocate should the client request one. The supervisor states that the hospital has never provided SANE services to any client at CROSSWAEH.

The facility has a MOU with Cocoon Incorporated. The MOU states that the center will agree to:

- Accompanying and supporting the victim through the forensic examination process
- Accompanying and supporting the victim through the investigatory interview
- Provide emotional and crisis support
- Provide information on community resources
- Provide psycho-educational support groups as needed
- Provide follow-up (legal advocacy and face-to-face crisis intervention services)
- Provide flyers and brochures with organization contact information

The facility provided the auditor with documentation of a MOU with Cocoon for rape crisis, victim advocacy, and emotional support services. Services in the MOU include a toll-free hotline number, emergency room advocates, emotional support, crisis intervention, community resource referrals, and assistance during law enforcement interviews and/or court proceedings. The auditor spoke with the Director of Cocoon who has confirmed the services offered to the clients at CROSSWAEH and these services are free of charge to the clients. The Director also states that no one from the facility has requested any of these services.

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

The auditor conducted an interview with the Crisis Counselor. She sates that she can provide immediate assistance to any resident experiencing trauma related to sexual

harassment or sexual abuse. She states that she will also make referrals to Cocoon for victim advocacy or mental health counseling if the resident feels uncomfortable working with them directly.

Review:
Policy and Procedure
MOU with Seneca County Sheriff's Office
MOU with Cocoon (SAAFE Center)
Interview with Administrative Investigators
Interview with PREA Coordinator
Interview with Crisis Counselor
Phone interview with SANE services director
Mercy Medical Hospital website
Phone interview with Cocoon (SAAFE Center)

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

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

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

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

115.222 (c)

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

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The facility has had two allegations reported during the past audit cycle. The auditor reviewed the investigation with the administrative investigators during a zoom video conference call.

Investigation #1: The facility received a third party client-to-client report. The reporter stated that a client who was openly gay was making inappropriate sexual comments to another client and that the statements made everyone uncomfortable. The administrative investigator interviewed the possible victim and reviewed camera footage. The investigator did not find any evidence of sexual harassment and the alleged victim denied any sexual harassment was directed toward him. The allegation was determined to be unfounded.

Investigation #2: The facility received a staff report of staff sexual misconduct with a client. The allegation started at an Oriana House facility in Sandusky, Ohio but was transferred to CROSSWAEH once the facility closed down and the alleged abuser was transferred to CROSSWAEH. The staff reported stated that a staff member was currently living with a former client and she believed the relationship started while the former client was a resident. The administrative investigator interviewed the staff member and other clients that were housed at the facility where the incident was to have taken place. The investigator was only able to establish that there were rumors about the relationship but no proof that anything took place. The allegation was determined to be unsubstantiated. The staff member no longer works for the agency.

Review:
Policy 1080
Agency website
Investigation reports
Interview with administrative investigators

TRAINING AND EDUCATION

Standard 115.231: Employee training

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

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

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

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

115.231 (c)

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

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

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

115.231 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The facility provided the auditor with the power point used for training new staff. The training sufficiently covers section a.1-10 of standard 115.231. After completing training, the staff member documents their training by signing a sign-in sheet.

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

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

The agency completes refresher training during monthly staff meetings. Every month, each facility conducts a training on a PREA subject directed by the agency.

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

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

The auditor interviewed programming and security staff. All staff report having onboarding and annual training that included PREA. The staff report that they receive PREA training monthly through monthly meetings and more recently the agency's new online training site- Oriana University. The staff was able to discuss specific training topics and relate the training to their specific job duties. A few staff members identified the PREA Staff Guide Book as a means of refreshing themselves on agency PREA policies or a resource they could use in the event of an allegation.

The PREA Coordinator and the HR Director described the new training program to the auditor. The new training site will allow the PREA Coordinator to upload the monthly training to the site and issue a posttest to all staff ensuring they understand the material. She states that the system will not allow a person to skip through the slides or video. It will also provide real time reports on staff completion of required training.

The staff have available a PREA Staff Guide Book that is located at all post desk. The auditor reviewed the contents of the book. It includes:

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

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

The auditor was provided training sign-in sheets to verify training.

Review:
Policy 1080
PREA training power point
Training records
Interview with PREA Coordinator
Interview with HR Director
Interview with staff

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

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

During the onsite visit, the auditor reviewed the agency's visitor zero tolerance noticed and signed acknowledgement of the zero tolerance policy each day.

The facility is currently not allowing volunteers into the facility due to COVID-19 protocols. Aramark staff does not enter into the facilities and residents are removed from any area where a vendor may be performing a service. The auditor was able to verify this practice during the onsite visit.

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

Standard 115.233: Resident education

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

115.233 (a)

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

115.233 (b)

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

115.233 (c)

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

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

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

115.233 (d)

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

115.233 (e)

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

Auditor Overall Compliance Determination

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

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

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

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

The auditor received a copy of the intake packet that all residents including transfer residents receive. The packet includes information on the program rules which includes possible sanctions for violating the facility's zero tolerance policy. The form is signed

and dated by the resident. The intake packet also includes a Guide for Sexual Abuse and Sexual Harassment Prevention. This form includes information on how to report, phone numbers and address for facility, local, and stated reporting agencies, limitations of confidentiality, and how to keep oneself safe. This form is signed and dated by the resident. The resident is also provided a form explaining the facility's search policy and the types of searched that the facility conducts. The resident also signs and dates this form.

The auditor reviewed documentation that the residents received this information at intake.

During the onsite visit, the auditor noted various posters in English and Spanish throughout the facility. The posters provided information to residents, visitors, and staff on how to report allegations and phone numbers and address to reporting agencies. The facility also posts information on pat searches. The posters give a step by step explanation of the search process. The posters are in locations where residents are searched. The auditor used the payphone in the dayroom to call the outside reporting agency. The phone number listed connected the auditor with a PREA hotline recorded message that requested certain information in order to investigation the allegation. The recording reminded the caller that they could report anonymously and that all allegations would be investigated. The PREA administrative investigator returned the auditor's call within 20 minutes.

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

The auditor spoke to the RS staff who provide residents with PREA resident information at intake including a resident handbook and grievance instructions. The staff members state that they explain all areas of the handbook; will ensure each resident can read and write; and inform staff of the resident's need for additional services if necessary. See standard 115.216 for how the facility ensures residents with physical, mental, or cognitive disabilities or residents who are limited English proficient receive PREA education.

The auditor interviewed sixteen (16) residents. The residents were questioned on the information they received concerning PREA during intake. The residents reported receiving information on reporting, free medical services, confidentiality, sanctions, and searches. Most of the residents stated that they already knew about PREA before arriving at the facility and that there are posters all over the facility should they need to report an

allegation. The residents report having an orientation class with the Program Director where she shows the *Just Detention* resident PREA education video. The residents are able to ask the Director any questions during orientation concerning the agency's zero tolerance policies.

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

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

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

115.234 (b)

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

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

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

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form

of administrative or criminal sexual abuse investigations. See 115.221(a).)
☒ Yes ☐ No ☐ NA

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Agency policy 1080 requires all administrative investigators to receive specialized training. The agency has two investigators as well as the PREA Coordinator who received in-person training from the Moss Group. The training provided includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garity warnings, evidence collection in a confinement setting, and required evidence to substantiate a case for administrative action or criminal referral. The agency retains completion of training certificates as proof of training. The investigators receive refresher training on specialized investigator training through the PREA Resource Center's website or in-person facilitated training when available.

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

The administrative investigators were able to discuss the training they received on trauma informed care, evidence collection as it relates to administrative investigations in a confinement setting, proper documentation, and how to determine an appropriate finding to an investigation. One investigator is a former police officer and has extensive experience in investigating crimes. The agency has new administrative investigator. The investigator had been the Program Director at several Oriana House sites and has an excellent understanding of the PREA standards and ensuring compliance. The investigators understand Garity; however, this is a private non-profit organization and Garity warnings do not apply.

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

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

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

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

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

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

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

115.235 (b)

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

115.235 (c)

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

115.235 (d)

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

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

Auditor Overall Compliance Determination

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Instructions for Overall Compliance Determination Narrative

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Policy 1080 requires specialized training for medical and mental health care employees who work regularly in individual facilities are trained in specific areas related to their job duties specific to resident sexual abuse and sexual harassment. Depending upon their status with the agency, medical and mental health practitioners will also receive the same training that is mandated for employees or the same training that is mandated for independent contractors, vendors, inters, and volunteers. The agency will maintain documentation that the designated staff has received the specialized training.

The facility has counselors and contract medical staff. The auditor interviewed the crisis counselor. She confirmed that the counselors received the facilities annual PREA training (monthly during staff meetings) as well as receiving specialized training for medical and mental health professionals. The auditor was also able take with a nurse who states that she has completed the PREA Medical and Mental Health training.

The specialized training, *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting,* was developed by the National Institute of Corrections.

All resident medical care is taken care of in the community including sexual assault examinations. Medical staff in the facility manage client care until the clients are allowed community access.

The agency provided the auditor with training certificates for the medical and mental health practitioners.

Review:
Policy and procedure
Training certification
Interview with Crisis Counselor

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

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

115.241 (a)

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

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

115.241 (b)

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

115.241 (c)

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

115.241 (d)

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

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

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

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

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

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

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

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

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

115.241 (e)

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

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

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

115.241 (f)

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

115.241 (g)

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

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

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

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

115.241 (h)

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

115.241 (i)

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

Auditor Overall Compliance Determination

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

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

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

a. Whether the resident has a mental, physical, or developmental disability
b. The age of the resident
c. The physical build of the resident
d. Whether the resident has a prior conviction for sex offenses against an adult or child
e. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, gender non-conforming, or intersex
f. Whether resident has previously experienced sexual victimization
g. The residents own perception of vulnerability
h. Prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse

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

The auditor was given a copy of the risk assessment instrument. The assessment not only documents the residents answers to the required questions, but also identifies sources of additional information, areas of concern or other considerations, and reasons for a

professional override to the score. After the screening is complete, the screener will score the instrument based on the resident's answers. The resident can receive a classification of susceptible, highly susceptible, abusive, highly abusive, or no risk.

The auditor was given a copy of the training curriculum provided to staff that are charge with conducting the initial, 30-day, or cause risk screening. The training includes:

- When to conduct the assessment
- What information is collected using the tool
- Where and how the screening tool should be used
- Why the tool is used
- Classification results
- What to do with the results
- Protecting the information collected

The auditor interviewed Resident Supervisor staff responsible for conducting the initial risk screening. The staff reports that they have received training on how to complete the assessment and score the instrument. Before completing the assessment, they are to explain the assessment took and its purpose. The staff reviewed the interview process with the auditor. They state that they are to verbally read the questions to each residents. If the resident does not understand a term or the question, the RS will break down the question and use terms the resident understands (may give an example). The staff also report asking follow-up questions depending upon resident answers. The staff, when questioned, state that residents are not disciplined when refusing to give answers to questions.

The RS staff report trying to build a rapport with the client and being conscious of their own body language during the screening process. The staff report explaining how the information is used and that it will only be shared with staff necessary to make safety assessments and decisions.

Should the resident report information that indicates that he may be more vulnerable to victimization or to abuse another resident, staff will report that information to the Lead Resident Supervisor and assign the resident to a designated PREA bed. The RS staff state that residents of opposite classifications will not be housed in the same dorm room.

The case managers are responsible for conducting thirty-day reassessments. The case managers report they will review the initial assessment and ensure that the information is in line with the information already received from the referring agency. The case

managers report being trained on how to conduct an assessment and the Program Coordinator will complete a quality assurance check on both the initial and reassessment.

The auditor interviewed the Program Director. She states that the Program Coordinator tracks both initial and reassessments. She reports that she will conduct a quality assurance check on the risk assessments. The review ensures accuracy of information and that assessments are completed timely. The Program Director reports that residents will receive a reassessment if the facility should receive any additional relevant information or if the resident is involved in a sexual abuse incident.

Residents interviewed stated they remember having an assessment performed during intake. They state that the RS staff explained the assessment, and most stated that they are familiar with the process due to being incarcerated at other facilities. Not all residents could remember if they had the assessment conducted once or twice, but all state staff remind them that at any time they can report any safety concerns and it will be addressed.

During the onsite visit the auditor was able to review assessments in the online database system. The auditor was also given a report that identifies each resident, their risk classification, intake date, assessment date, and reassessment date. All assessments and reassessments were completed within the required time period.

The assessments are kept in the agency's ORION database system and access to this information is limited to clinical staff.

Review:
Policy and procedure
Risk assessments (initial and reassessments)
Resident files
Interview with RS staff
Interview with Case managers
Interview with Program Director
Interview with residents

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 1080 states that the screening information will be made available to appropriate staff to ensure that all housing, programming, and community assignments are given in a way to minimize the risk of the resident being sexually victimized. The facility has

specifically assigned dorms and beds for residents that have been identified as being highly susceptible or highly abusive. These specific beds are located in areas that are easily visible from the doorway of each room. Programming staff will make every effort when scheduling groups not to place residents with opposing PREA statuses in the same group. The policy states when that is not possible, that the staff will monitor appearance and behavior and report any significant changes.

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

During the onsite visit, the auditor was shown the whereabout check sheet and verification of increased checks for those with PREA statuses. The auditor was also able to view the designated PREA rooms/beds. The Lead Resident Supervisor reports to the auditor that all residents entering the facility are on increased whereabout watch during their first 48-hours in the facility. This allows the facility to monitor residents' acclimation to the facility adjust accommodation methods if necessary.

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

During interviews with the case managers, the auditor inquired about how the facility uses the information collected for the risk assessments. The staff report that the information is used to develop a resident's individual program plan. The residents are able to attend group programming to address issues and/or individual counseling sessions. The group or individual counseling will be completed in the community.

The agency has developed a plan to ensure the safety of transgender/intersex residents while in Oriana House facilities. The plan includes a review of the perspective resident by the PREA Coordinator, PREA manager, admissions personnel, and crisis counselor that will address issues that come with the placement of a transgender resident. Once an appropriate facility has been identified, the intake department will notify supervisory staff

at the proposed facility. In order to ensure placement decisions are on an individualized case-by-case basis, the facility will collect information into consideration the transgender resident's concerns in terms of safety- housing placement and programming, name, pronoun, shower, preference, and searches. The resident will be asked:

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

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

The facility does not current have a transgender or intersex resident. However, the facility has housed a transgender resident in the previous audit cycle. The Program Director reports that the team will screen the resident prior to placement. They address the resident's concerns at intake and developed a plan for appropriate accommodations. The Crisis Counselor reports that she will make contact with the client and make recommendations/referrals as necessary.

During Resident Supervisor interviews, they state that they were instructed on proper transgender pat searches as well as the gender of staff allowed to complete pat searches

on this specific resident. The RS staff also discussed their instructions on preferred pronouns and shower accommodations. They state that during the last transgender resident's stay, there were no issues of bullying or harassment.

The auditor interviewed any resident that identified as gay or bisexual. All residents interviewed stated that they have not experienced any discrimination and did not feel as if they were placed in a housing unit or dorm based on their status. All residents interviewed were asked about dorm placement and all stated that the rooms were based on ORAS risk assessment.

The facility does not have a dedicated unit for residents that identify as LGBTI. Residents that identify as LGBTI will be housed in a safe, appropriate dorm/bed where staff have clear line of site views to the resident's bed. All residents that have been identified as being at higher risk, including LGBTI residents, will have increased whereabout checks.

Review:
Policy and procedure
Facility tour
Risk screening
Individual case plan
Staffing plan
Interview with Case Managers
Interview with Resident Supervisors
Interview with PREA Coordinator
Interview with Crisis Counselor
Interview with residents

REPORTING

Standard 115.251: Resident reporting

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

115.251 (a)

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

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

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

115.251 (b)

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

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

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

115.251 (c)

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

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

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 requires Oriana House to provide residents with the opportunity to report sexual abuse and sexual harassment, retaliation by other residents or employees for

reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse. The policy allows for residents to report anonymously and lists the following as ways a resident can report:

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

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

The auditor has tested the outside hotline number managed by the Community Sanctions PREA Liaison, the internal hotline number, and the internal email reporting link, to ensure the methods are operable. The Liaison, Cynthia Ali, returned the auditor's phone call. The auditor also tested the inside hotline number from the payphones in the dayroom. The administrative investigator returned my call within 20 minutes.

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

The auditor interviewed a total of sixteen (16) residents. The residents were asked questions on ways a resident can report, private and anonymous reporting, and how residents received this information. The residents were able to list several ways they could report. The residents were able to identify as least one staff member they felt comfortable with addressing any PREA related issue. The residents felt like staff would respond appropriately to any and all allegations.

The facility has received two allegations during this audit period. All allegations reported to staff by residents were referred to the administrative investigators for an investigation.

All staff interviewed were questioned on reporting obligations and who/how they could report allegations or suspicions of sexual abuse or sexual harassment. The staff report that during onboarding training, they are given written instructions on staff reporting duties. The form was provided to the auditor. It instructs staff on their reporting obligations, and the ability to report confidentially. The staff report that the Program Director has created an environment where both staff and clients feel comfortable reporting allegations.

Review:
Policy 1080
Client Sexual Abuse and Sexual Harassment Reporting Form
Reporting posters
Resident handbook
Agency website
Reporting hotline numbers
Staff how to report client sexual abuse form
Interview with Administrative investigators
Interview with staff
Interview with residents

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

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

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

Standard 115.253: Resident access to outside confidential support services

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

115.253 (a)

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

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

115.253 (b)

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

115.253 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 requires each facility to provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers of local, state, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, in as confidential manner as possible. Policy requires staff to notify residents, prior to giving them access, of the extent to which the communication will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

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

CROSSWAEH has an MOU with Cocoon Rape Crisis Center in Bowling Green, Ohio. The MOU states that facility has the agency's permission to provide clients at CROSSWAEH Cocoon's toll-free hotline number and address, and that agency agrees to provide the clients emotional supportive and rape crisis services. The auditor was given a copy of the MOU to review.

After the onsite visit, the auditor contacted the director of Cocoon, Julie Broadwell. Ms. Broadwell was able to confirm that the agency would provide rape crisis and emotional supportive services to any client at CROASSWAEH who has experienced sexual abuse. The director confirmed the hotline number and the address provided to the clients would in fact contact a client with an agency advocate. Ms. Broadwell states that she has not received a phone call or mail from a client requesting services.

The residents are informed that they have the right to privacy while making a report of sexual abuse to outside agencies; however, due to state and federal mandatory reporting laws, the agency may be required to report allegation. The residents can also find this information inside the resident handbook.

Case managers are required to have role clarification meeting where residents are given information on the limits to confidentiality. The residents are informed that all information would be immediately reported to proper authorities. The case managers interviewed confirmed the meeting and the information provided to the residents.

During the interview with the Crisis Counselor, she confirmed that she informs all residents prior to the beginning of services of the limits of confidentiality and the agency's mandatory reporting requirement for all incidents, reports, or suspicions of sexual abuse and sexual harassment.

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

Review:
Policy 1080
PREA Postings
MOU with EVE Incorporated
Resident Handbook
Email with Rape Crisis Center director
Interview with Crisis Counselor
Staff interviews
Resident interviews

Standard 115.254: Third-party reporting

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

115.254 (a)

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

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The facility has received one third-party report of sexual harassment during the past audit cycle. The third party reporter was identified as another resident. The allegation was referred to the administrative investigators.

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

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

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

115.261 (b)

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

115.261 (c)

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

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

115.261 (d)

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

115.261 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

- Immediately email the Resident Sexual Abuse Response Team
- Documenting the allegation, including verbal reports to management staff

- Limit the number of people who have knowledge of the allegation to designated officials who are responsible for making treatment, investigation, and other security decisions
- Perform any first responder duties as needed

A review of the PREA Staff Guide Book provides instructions to staff on how to report resident sexual abuse or harassment. The guide speaks to the agency's responsibility of creating a culture where residents feel safe to report sexual abuse or sexual harassment without the fear of retaliation. The book provides a phone number, email address, and required reporting form.

Each staff file contains a signed acknowledgment of receiving the following information:

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

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

All staff interviewed reported that they are mandated reporters of any information, knowledge, or suspicions of sexual abuse and sexual harassment. The staff state they feel comfortable approaching the Program Director to address any suspicion or knowledge they have about sexual abuse and sexual harassment. The facility had one allegation that was reported to the facility by a staff member.

The facility Crisis Counselor was also interviewed during the onsite visit. She states that at the beginning of services she informs clients to the limits of confidentiality. This information is also given to the clients at intake and is listed in the client handbook. The auditor verified this by sitting in on a new client intake, reviewing the client handbook, and inspecting ten client files for a signed acknowledgement of receiving this information.

Review:

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

Standard 115.262: Agency protection duties

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

115.262 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The facility had two allegations during the past twelve months. One allegation was determined to be unfounded and no protection protocols were necessary. The other allegation was determined to be unsubstantiated; however, the client was no longer

housed at the facility when the allegation was reported and the alleged staff member no longer works at the facility.

The Program Director reports that she would be responsible for ensuring client safety and would use all available means to protect clients from sexual abuse and sexual harassment. She states that during investigations, the practice is to place a staff member on administrative leave if they are the subject of an allegation, and to use separation as a means of keeping away alleged abusers from victims. The Program Director also states that clients involved in PREA allegations will be placed on increase whereabout checks.

The facility did not have a report from a resident that they were in fear of imminent sexual abuse.

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

Standard 115.263: Reporting to other confinement facilities

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

115.263 (a)

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

115.263 (b)

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

115.263 (c)

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

115.263 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The Program Director reports that the facility has not received an allegation from another confinement facility on behalf of a former resident. The facility did not make a report to another confinement facility of alleged abuse or harassment.

Any allegation reported to the facility from another confinement facility or if a resident makes a report for another confinement facility is required to be reported to the PREA Coordinator.

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

Policy 1080
Interview with Administrative Investigators
Interview with Program Director
Investigation reports

Standard 115.264: Staff first responder duties

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

115.264 (a)

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

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

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

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

115.264 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

- Staff shall immediately notify, by telephone, Management staff following the internal chain of command and shall notify by telephone the Clinical Director.
- Management staff will contact appropriate law enforcement and notify the Resident Sexual Abuse Response Team appropriate to the designated region via email.
- If the Clinical staff is on the premise, they will assess the resident to determine services and support needed
- If a sexual abuse incident occurs outside of normal business hours, the Clinical Director and if not available, the Clinical Administrator will assess

the client via telephone to determine services and support needed. Clients who request to talk with a counselor immediately will be referred to emergency mental health services. Clients who request to see a mental health counselor but state their need is not immediate will be seen by the facility crisis counselor the following business day and referred for appropriate services.

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

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

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

The facility staff interviewed were all able to discuss the first responder duties and list the specific steps. The staff state that some of the additional coordinated response responsibilities they do not know by heart, but know the location of the PREA book with the plan. The staff state that they all take resident safety seriously and feel their training was adequate enough to prepare them to respond to sexual harassment and sexual abuse allegations appropriately.

The facility has not had an incident where first responder duties were implemented.

Review
Policy and procedure
Staff First Responder Duties
Interview with staff

PREA book

Standard 115.265: Coordinated response

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

115.265 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Policy 1080 list the coordinated response plan as the following:

- First Responder Duties (see standard 115.264)
- Management staff, consisting of the Lead Resident Supervisor, Program Coordinator, Program Administrator, or the Program Director, will contact law enforcement to investigate the incident and collect evidence.
- The First Responder will notify in-house medical and mental health staff if available. If not available, call 911 to arrange for immediate access to emergency medical services and/or mental health
- Offer to contact **Coccoon rape crisis at 419-352-1545** to request a victim advocate to accompany and support the victim through the forensic medical exam process and investigatory interview
- Comply with law enforcement directives

- Notify facility management staff, appropriate Vice President, and Clinical Director and if not available, the Clinical Administrator. At least one facility management staff will report to the facility within 30 minutes of notification of the incident to assist with coordination
- Staff will document the incident as a violation report
- Email appropriate geographical "Client Sexual Abuse Reporting" group to report the incident
- If Clinical staff is on the premise they will assess the client to determine services and support needed
- If a sexual abuse incident occurs outside of normal business hours, the Clinical Director or designee will assess the client via telephone to determine services and support needed

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

The Coordinated Response to an Incident of Client Sexual Abuse Plan as stated in the PREA Staff Guide Book:

- Enact first-responder duties
- Management staff shall contact law enforcement
- First responders will notify in-house mental health staff if available and call 9-1-1 to arrange for immediate access to emergency medical and/or mental health services
- Offer to contact rape crisis services, at 419-352-1545, for victim advocate services
- Document incident as a violation report
- Follow all directives of law enforcement

The auditor was given a copy of the coordinated response plan and viewed the posted plan during the onsite visit.

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

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Review:
Interview with Human Resource Director

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The report will include periodic status checks, and a review of the resident's disciplinary records, housing, program changes, or negative performance reviews and reassignments of staff. The report will be sent to the appropriate facility and administrative team members. Residents that are on 90-day retaliation monitoring will also be placed on the facility "whereabout" checklist at an increased rate. The auditor was shown the process and the facility whereabout checklist and identified high risk residents with increased whereabout checks.

The Program Director or Crisis Counselor will responsible for conducting retaliation monitoring. They will meet with the resident or staff member in private and inquire about any concerns of retaliation. They report they will address any concerns issued by the resident or staff member.

The Crisis Counselor reports to the auditor that she will conduct status checks during one on one sessions weekly. She would assess any changes and any concerns that the resident had concerning their safety and/or retaliation.

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

The facility had two allegations of during the past twelve months. One allegation was determined to be unfounded; therefore, no retaliation monitoring protocols where necessary. The other allegation was reported after the alleged victim was no longer housed at the facility and the alleged abuser resigned not long after the allegation was reported.

Review:
Policy 1080
Whereabout checklist
Interview with Program Director
Interview with Crisis Counselor

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

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

115.271 (a)

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

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

115.271 (b)

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

115.271 (c)

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

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

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

115.271 (d)

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

115.271 (e)

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

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

115.271 (f)

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

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

115.271 (g)

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

115.271 (h)

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

115.271 (i)

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

115.271 (j)

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

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 requires an administrative investigation on any allegation on sexual harassment and sexual abuse. This includes allegations received through third-parties or anonymous reports. If the allegation is of sexual abuse/assault or appears to be criminal in nature, the Sexual Abuse Response Team will promptly refer the allegation to the Seneca County Sheriff Department. In instances of sexual abuse or sexual harassment that are not criminal in nature, the facility shall gather and preserve direct and circumstantial evidence, including any physical and electronic data; interview alleged victims, suspected perpetrators, and witnesses; and review prior complains, and reports of sexual abuse/sexual harassment involving the suspected perpetrator.

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

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

- Parent agency notification
- Interpreter services
- Video evidence available
- Physical barriers
- Investigation determination
- Disciplinary action

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

The process of investigation, referral, and outcome determination was described to the auditor. The PREA Coordinator states that the agency prohibits administrative investigators from requiring a polygraph examination or other truth telling devise during an investigation. She states that all investigators are also prohibited from conducting any type of criminal investigation. All criminal investigations are conducted by the local legal authority and the administrative investigators will remain in contact with the criminal investigators in order to remain informed about the progress of the investigation.

The PREA Coordinator and policy state that the departure of the allege abuser or victim from employment or control of the facility or Agency shall not provide a basis for terminating an investigation.

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

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

The administrative investigators reviewed the two allegations reported at the facility during the past twelve months (see standard 115.222).

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

The facility did not have an allegation that required referral for a criminal investigation.

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

Standard 115.272: Evidentiary standard for administrative investigations

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

115.272 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

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

resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

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

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

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

115.273 (d)

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

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

115.273 (e)

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

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

The facility had two allegations during this audit cycle. One resident was notified of the "unfounded" determination, while the other alleged victim was no longer at the faciltiy.

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

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

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

115.276 (a)

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

115.276 (b)

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

115.276 (c)

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

115.276 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy 1080 states that employees shall be subject to disciplinary action up to and including termination for violating the Resident Sexual Abuse and Sexual Harassment

Prevention policy. Policy 3037 specifically outlines employee discipline. This policy states disciplinary action may take the following steps:

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

Policy 3037 also states that disciplinary action may not always be progressive. The agency reserves the right to take whatever disciplinary action it deems appropriate for employee misconduct, including termination of employment for a first offense.

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

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

All files contained acknowledgements of receiving the employee handbook and the agency's zero tolerance policy. Employees who have been disciplined by the agency had a Notice of Employee Disciplinary Action. The documentation listed the disciplinary charge, appeal, information, and sanction.

Staff interviewed during the onsite visit state that during orientation, they are given an employee handbook and HR staff review the agency's zero tolerance policy. The staff all understand the consequences of engaging in sexually harassing or abusive behavior.

The facility had one allegations of staff sexual misconduct during this audit cycle. The allegations were investigated was determined to be unsubstantiated. An allegation summary can be found in standard 115.222.

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

Standard 115.277: Corrective action for contractors and volunteers

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

115.277 (a)

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

115.277 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

The facility is not currently allowing contractors in the facility due to COVID-19 protocols.

Review:
Policy 1080
Investigation reports
Interview with Human Resource Director

Standard 115.278: Interventions and disciplinary sanctions for residents

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

115.278 (a)

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

115.278 (b)

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

115.278 (c)

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

115.278 (d)

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Oriana House policy 1080 requires all residents to face disciplinary action up to and including termination from the program following a substantiated allegation of resident to resident sexual abuse and sexual harassment or a criminal finding of guilt for resident to resident sexual abuse. The policy requires the agency to consider whether a resident's mental disabilities or mental illness contributed to his/her behavior, the resident's disciplinary history and sanctions imposed for comparable offenses by other residents with similar histories, when determining what type of sanction, if any, should be imposed.

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

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

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

The PREA Coordinator states that any resident found to have sexually abused another resident will be terminated from the facility. All other substantiated allegations of sexual harassment will be disciplined according to the agency's progressive discipline policy. She states that if sexual harassment incidents are egregious or repetitive, the agency will terminate the resident. The agency does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse.

Residents interviewed stated that they received a handbook at intake and were informed of the potential sanctions related to sexual abuse and sexual harassment, including termination for substantiated sexual abuse allegations. The residents were able to discuss the education they received at orientation group from the Program Director that included program rules and disciplinary procedures.

The auditor reviewed resident files which included a review of residents signed and dated acknowledgements of receiving a handbook and PREA education.

The facility has had one allegation of resident-to-resident sexual harassment during the past twelve months. The allegation was determined to be unfounded.

The facility did not have an incident of non-consensual resident-to-staff sexual harassment or abuse.

Review:
Policy 1080
Resident handbook
PREA information sheet
Interview with PREA Coordinator
Investigation reports

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

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

115.282 (a)

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

115.282 (b)

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

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

115.282 (c)

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

115.282 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The PREA Coordinator reports that residents who experience sexual victimization would be offered services provided by the agency's crisis counselor. The counselor would be available for immediate crisis intervention or to complete weekly status checks. The agency would refer sexual abuse victims to community rape crisis counseling or other appropriate community resources.

The auditor interviewed the Crisis Counselor who confirmed the services she would provide to residents that experience sexual victimization. She states that she would perform status checks and counseling. Should the resident wish, services from rape crisis advocates, she will ensure the referral is made.

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

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

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

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

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

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

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

115.283 (e)

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

115.283 (f)

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

115.283 (g)

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

115.283 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility offers community medical and mental health counseling services for residents who have been sexually abused in jail, lockup, or juvenile facility. Policy 1080 states that all treatment including testing for sexually transmitted disease and treatment within sixty-days to all known resident on resident abusers be offered free of charge. While the facility does have part-time medical staff, clients will use community medical providers after 30-days of confinement.

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

The policy also states that should a pregnancy result from sexually abusive penetration while incarcerated, timely and comprehensive information about and timely access to all lawful pregnancy related medical services will be offered. The facility has not had an incident of sexual abuse that involve sexually abusive penetration.

The auditor spoke to the Clinical Coordinator who acts as the facility's emotional support person and counselor. She states she will provide services for any resident that has experienced past sexual violence. She also states that residents have access to community counselors and treatment groups.

The facility has not made a medical and/or mental health referral based on a resident who has been sexually abused in a jail, lockup, or juvenile facility.

The Program Director reports to the auditor that the facility has not housed a resident that is a known resident-to-resident abuser. Should the facility become aware that a resident has previously abused another resident, the Crisis Counselor would meet with the resident to assess how to address any underlying issues. The facility does not provide treatment for known abusers. Any available services would be provided by community agencies.

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

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

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

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Oriana House policy 1080 states that the PREA Coordinator will activate a Client Sexual Abuse Review of all substantiated or unsubstantiated allegations of sexual abuse within thirty days of the conclusion of the investigation. The review team shall include an upper management designee, compliance/accreditation manager, admissions manager, and input from a designated resident supervisor and/or caseworker, administrative investigator, and mental and/or medical practitioner.

According to agency policy and as well as the PREA Coordinator, the team shall consider the following when reviewing the allegation and investigation:

- Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse
- Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility
- Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse
- Assess the adequacy to staffing levels
- Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff

The team is then tasked with preparing a report of its findings and any recommendations for improvement and submit the final report to the Vice President of Administration and Legal Counsel who will be responsible to distribute the final report to the Executive Team. The Executive Team will review and determine (with the input of the PREA Coordinator) which recommendations will be implemented or will document the reasons for not doing so. The regional Vice President of Corrections will be responsible for distribution the report to facility management and overseeing the implementation of the approved recommendations.

The auditor was able to interview several members of the SART team (VP of Correctional Programs, PREA Coordinator, and Program Director). The team report that they will review any dynamics that might have contributed to the allegation, and address any physical barriers that may have led to the incident. The Program Director will collect information needed to complete the SART form and be reviewed by the team. The Program Director would be responsible for implementing any recommendations that were made by the team and report progress to the PREA Coordinator.

The auditor interviewed the Vice President of Correctional Program North Central Region to discuss his role on the incident review team and his responsibility in ensuring any and all recommendations that stem from the review are implemented at the facility. The VP states that he would report on the facility dynamics that might have contributed to the report, conduct a review of the physical plan to see if there are physical barriers that may have led to the incident, and collect reports from facility staff that may assist in discerning whether the facility could have prevented the incident. As far as implementation of recommendations, he would ensure facility staff had the resources to comply with the recommendations and report to the PREA Coordinator after implementation.

The facility provided the auditor with the Resident Sexual Abuse Review form. The form list a summary of the allegation and findings, the considerations of the committee as listed above, collateral information, and committee recommendations. The second section of the form is completed by the Executive Team. This section lists the approved recommendations, reasons for not approving recommendations, and the implementation plan.

The facility did not have a substantiated or unsubstantiated allegation of sexual abuse that the SART needed to review.

Review:
Policy 1080
Client Sexual Abuse/Harassment Review
Interview with PREA Coordinator
Interview with VP of Correctional Programs
Interview with Program Director
Interview with Lead Resident Supervisor

Standard 115.287: Data collection

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

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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Agency policy 1080 requires the tracking of accurate, uniform data for every allegation of sexual abuse in all Oriana House facilities and that information will be aggregated at least annually. The PREA Coordinator reports that the information is collected, reviewed, and retained from all PREA related reports. The agency is using Ohio Department of Rehabilitation and Corrections PREA reporting form as their collection instrument, as well as completing the Department of Justice's SSV Form.

The facility provided the auditor with the ODRC data collection instrument. The information on the form is enough to complete the Survey of Sexual Violence conducted by the Department of Justice. The tool includes data on:

- Resident-to-Resident sexual abuse
- Resident-to-Resident sexual harassment
- Staff-to-Resident sexual abuse
- Staff-to-Resident sexual harassment
- Administrative investigations
- Criminal investigations
- Retaliation
- Staff training
- Resident education
- Initial and 30-day risk screening

The auditor reviewed the forms used to collect the data and confirmed that the information collected is appropriate enough to complete the Survey of Sexual Victimization for all Oriana House facilities.

The information on the form is aggregated and listed in the agency's annual PREA report. The report is posted on the agency's website, http://www.orianahouse.org/accreditations/prea/prea.php. The auditor accessed the agency's website and reviewed the 2020 annual report. The report contains the aggregated sexual abuse and sexual harassment allegation data from all Oriana House, Inc. operated facilities.

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

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

Standard 115.288: Data review for corrective action

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

115.288 (a)

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

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

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

115.288 (b)

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

115.288 (c)

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

115.288 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

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

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

- Agency wide number of reported incidents
- Ensuring all new staff have appropriate PREA training. Providing monthly training versus annual to keep information fresh
- Memos sent to Program Managers to clarify policy, procedure, or practice questions that arise from employee training
- PREA policies and procedures are reviewed by a multi-disciplinary committee
- Preventative measures
    - Placement of a camera in a maintenance closet

- Re-evaluated camera angles and made adjustments
- Increased required training for all contractors
- Continued to provide a high level of ethics training

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

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

Review:
Policy 1080
PREA annual report (2020)
Oriana House website

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Agency policy 1080 requires the agency collect data requested in standard 115.287 and that this information will be aggregated, and made available to the public through the agency's website. The information posted to the agency's website is required to have all personal identifying information removed. The PREA Coordinator is mandated by policy to securely retain the information collected and to retain the data collected for at least ten years.

The auditor accessed the agency's website, www.orianahouse.org/accreditations/prea/prea.php, to ensure that the agency has posted its annual report. The annual reports are completed based on a calendar year and the agency has posted the 2020, 2019, 2018, 2017, 2016, 2015, and 2014 annual reports. The information in the report is collected by each facility's PREA Manager and is then submitted to the agency's PREA Coordinator. The agency PREA Coordinator aggregates the information and prepares the information for the annual report. The report is then submitted to the President/CEO for approval.

The PREA Coordinator reports that all information is only accessible to approved staff members and that she retains control of all information. The information is kept for ten-years as per policy 1080.

The information collected in standard 115.287 is made available to the public through the agency website.

The auditor did not view any information in the report that could jeopardize the safety and security of the facility, nor was there any personal identifying information contained in the report.

Review:
Policy 1080
Oriana House website
PREA annual reports 2014-2020

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency post all final PREA reports for each of its facilities on the agency website. The auditor reviewed the agency website to ensure that during the previous audit cycle all Oriana House facilities have been audited and reports posted. The facility has a total of ten (the agency has had to close facilities due to COVID-19) facilities and will have 1/3 of facilities audited each year of the three-year cycle.

The auditor interviewed staff and residents in accordance with the PREA Compliance Audit Instrument Interview Guide and the PREA Auditor Handbook's Effective Strategies for Interviewing Staff and Resident Guide. Residents and facility staff were interviewed during the onsite visit and agency staff were audited via video teleconferencing.

The auditor was given full access to the facility during the onsite visit. Agency administration and facility management escorted the auditor around the facility and opened every door for the auditor. The tour of the facility included all interior and

perimeter areas. The auditor was able to observe the housing units, dorms, bathrooms, group rooms, dining room, staff offices, storage closets, and administration area. The auditor was able to have informal interaction with both staff and residents during the walk through and saw how staff interacted with residents.

The auditor received documentation on the agency and facility prior to the onsite visit through Power DMS web based audit system. The auditor was also provided requested documentation during the onsite visit

The auditor reviewed electronic documentation during the onsite visit. This includes camera views and ORION resident database system.

Appropriate audit notices were posted in conspicuous areas throughout the facility. These places included areas resident, staff, and visitors would frequent. The notices included the auditors mailing and email addresses. The PREA Coordinator emailed the auditor photos of audit notice postings on September 2, 2021. The auditor did not receive any correspondence with a staff or resident prior to or after the onsite visit. During the onsite visit no resident or staff member requested to speak to the auditor.

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has published on its agency website, www.orianahouse.org/accreditations/prea/prea.php, the final PREA reports for all Oriana House operated facilities. The final PREA report for CROSSWAEH from the previous audit is currently posted. The auditor reviewed the agency website and verified that all the facilities that were audited during the previous audit cycle had their final audit report posted. The PREA Coordinator states that she understands the requirement of having all final reports posted.

In the state of Ohio, all final audit reports are also posted on the Ohio Department of Rehabilitation and Corrections website, https://www.drc.ohio.gov/prea.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

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

Kayleen Murray 10/28/2021

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.