PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: November 22, 2016

Auditor Information			
Auditor name: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: October 17-18, 2016			
Facility Information			
Facility name: Woodland Hills (Juvenile Justice Residential Program)			
Facility physical address: 4321 Allendale Avenue, Duluth, MN 55803			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 218-728-7500			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Mary Steiner, Director of Residential Services			
Number of staff assigned to the facility in the last 12 months: 181			
Designed facility capacity: 96			
Current population of facility: 71			
Facility security levels/inmate custody levels: Open Campus/Probation			
Age range of the population: 12-20			
Name of PREA Compliance Manager: NA		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of agency: Woodland Hills			
Governing authority or parent agency: *(if applicable)*			
Physical address: 4321 Allendale Avenue, Duluth, MN 55803			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 218-728-7500			
Agency Chief Executive Officer			
Name: Jeff Bradt		**Title:** Chief Executive Officer	
Email address: jbradt@woodlandhills.com		**Telephone number:** 218-623-6421	
Agency-Wide PREA Coordinator			
Name: Mary Steiner		**Title:** Director of Residential Services	
Email address: msteiner@woodlandhills.org		**Telephone number:** 218-623-6423	

AUDIT FINDINGS

NARRATIVE

The Woodland Hills agency provides juvenile justice, mental health and community-based services to male and female adolescents. It is located in Duluth, Minnesota and serves males and females with programs and services that promote behavioral, mental and chemical health, and physical well-being. Day treatment and community programs are available to youth in the local area and residential services may be provided to youth from throughout Minnesota. Referrals from other states for residential services are also considered. The Prison Rape Elimination Act (PREA) audit was conducted for the juvenile justice residential program component of the agency. The residents in the juvenile justice component of the program are involved with the juvenile courts. Woodland Hills is licensed by the Minnesota Department of Corrections and the Minnesota Department of Human Services. The licenses provide the campus with a correctional certificate and a Severe Emotional Disturbance (SED) certificate. The SED certificate is applicable to the residential mental health units. Woodland Hills is also accredited by the Council on Accreditation (COA) which is an international, independent, nonprofit human service accrediting organization. The population served ranges from 12 to 20 years of age and the average length of stay is 193 days.

The programs and services provided to the residents include but are not limited to: special and regular education; trauma focused cognitive behacioral therapy; cultural/spiritual awareness; crisis counseling; social and interpersonal skills groups; medical and dental care; recreation; behavioral group therapy; chemical dependency education and services; and religious services. Individualized treatment plans are developed for residents within 10 days of admission and incorporates information from the screening assessments, including the vulnerability assessment. Input to the treatment plan is also provided by the resident, family and referring workers. The individualized treatment plan is designed to meet the emotional, cognitive, behavioral and developmental needs of the resident. Team meetings are held each week to review cases and discuss treatment issues. Families are encouraged to visit the facility through a flexible visitation schedule and to participate in the treatment planning of the resident. A community transition program exists that assists identified residents in their return to the community. The services in the transition program focuses on education, employment and life skills by emphasizing productivity, independence, self-reliance and personal development.

There is a Registered Nurse who serves as the manager of the medical clinic and also coordinates residents' health care needs with community clinics and health care providers. A clinical medical assistant provides support services to the Nurse and the medical clinic. Additional medical services are provided through a contract with Essentia Health. A contract physician visits the facility twice a month. Forensic medical examinations are not conducted at the facility and will be conducted at an Essential Health facility by a Sexual Assault Nurse Examiner. Mental health staff include the Director of Clinical Services; clinical therapists; and mental health practitioners. Psychiatric services are provided through a contract with the Human Development Center. A contract psychiatrist visits the facility weekly and a contract psychiatric nurse practitioner visits the facility three times a month. A Chemical Dependency Counselor is obtained through a contract with the Center for Alcohol and Drug Treatment. Education services are provided through a contract with the Duluth School District #709. Direct care staff and supervisors are responsible for the general management and supervision of the residents. Case Managers provide oversight to assigned cases; work closely with residents and their families; ensure the coordination of services for residents; and assist in creating and maintaining a positive culture among the residents. The comprehensive tour of the campus revealed that staff members were providing direct supervision; and positive interactions among the staff and residents and between the residents were observed .

Recreation services are provided that include both outdoor and indoor activities. The facility has a comprehensive outdoor adventure program that includes hiking; canoeing; outdoor cooking; camping; fishing; and a low ropes course which was inactive during the PREA audit. Outdoor activities also include gardening; a hobby farm; walking trail; disc golf; and basketball. There is an animal husbandry program, located on campus, that is educational and also involves caring contact with the animals by the residents. In the husbandry program, residents are responsible for the care and feeding of rabbits; chickens; goats; sheep; llamas; and various water fowl. In collaboration with the South St. Louis County 4-H, the residents participate in a variety of 4-H competitions, including county and state fairs. Identified residents give tours of the barn and garden areas.

A behavior management system exists, consisting of four levels. The orientation phase, level one, is where the resident learns the basic program expectations and rules. The expectations increase with the advancement of the level and levels two, three and four contain privileges that range from participation in activities off campus to community visits. Woodland Hills is the recipient of various awards, including the Minnesota Corrections Association President's Award; Duluth Superior Area Community Foundation Touchstone Award; Reclaiming Youth's Spotlight on Excellence Award; Minnesota Association of County Probation Officers' Excellence in Corrections Award; and Junior League of Duluth Community Award.

DESCRIPTION OF FACILITY CHARACTERISTICS

Woodland Hills is located on a 140-acre campus in a residential area of Duluth and a one foot creek runs the entire property. Residents are not allowed to move around the campus without staff supervision. The design capacity is 96 and the population during the time of the audit for the juvenile justice residential program was 65. The mission statement for the agency is, "Woodland Hills provides unwavering hope and opportunity for youth, families and communities." The mission statement is included in the Client (resident) Handbook. The residents have the opportunity to provide community services by participating in various activities and volunteering their time at community events. The facility provides gender responsive services for female and male residents.

The campus contains the main building, transition house, health and recreation center, and school building. The school building is located four blocks from the main campus and a school bus transports the residents to and from school. The main building is a large multi-level structure that accommodates offices; living units; storage rooms; primary entrance and reception area; fitness room; multi-purpose room; laundry room, primarily used for the females; kitchen and dining hall; group rooms; conference rooms; intake area; and lockers for visitors. The living units contain rooms that vary in housing from one to three residents and includes a dayroom area. Bathrooms are located on each living unit and the male units contain laundry rooms. Seclusion areas are located in the main building and contain rooms that are used when a resident has been identified as a serious threat to harm self or others. Seclusion may be used for a short period of time until a resident has calmed down and/or can safely be returned to the general population. Seclusion is not an option for protecting a resident from sexual assault or sexual harassment; other methods are used such as the reassignment of a resident's room or housing area.

Residents in the staff-supported transition house have completed the regular program and have been identified as being able to live more independently prior to their release. The community transition program focuses on the skills needed to live independently and offers services that address education, employment and life skills. A tour of the transition house demonstrated staff involvement and supervision and the residents' preparation for school which may be in the community, and for work in the community. The school building contains offices; classrooms; gymnasium; group rooms; library; breakroom; resident lockers; medical clinic; and storage rooms. A time-out room is located in the school and may be used for a brief period for a resident to gain self-control. An array of sports and other activities may be conducted in the health and recreation center which is located across from the main building.

All the bathrooms in the living units have doors to the toilets and shower curtains. The bathrooms in the school building are also equipped with doors to the toilets. Reidents are provided a reasonable amount of privacy while they change clothes, use the toilet and take showers. The described procedures by staff, observations, review of policy, and interviews with residents confirmed the practice of the provision of a reasonable amount of privacy for residents as they perform the aforementioned personal functions. The number of staff currently employed at the campus who may have contact with residents is 181 and the number of staff hired during the past 12 months who may have contact with residents is 76. The campus identifies 15 volunteers and contractors who are currently authorized to enter the facility and who may have contact with residents.

A camera system was installed earlier this year, during the summer, and mirrors have been posted in certain areas to assist in the supervision of residents. The installation of the camera system, posting of signs indicating restrictive areas for residents; and mirrors support direct supervision and increase visibility which assist in keeping residents and staff safe. Cameras may be monitored from the Case Managers' offices and the system stores information for 30 days. The facility continues to monitor and assess areas and program activities toward determining the need and use for an increase of mirrors, signage, staff deployment, and other measures that would continuously improve visibility and enhance direct supervision and visibility. Recommendations were made by the Auditor for the placement of additional signs and mirrors as staff continue in their assessment of various areas of the facility. The housing units contain reporting information and the campus has received printed information from the victim advocacy agency, Program for Aid to Victims of Sexual Assault.

The buildings and grounds of the Woodland Hills campus are clean and well maintained. The campus grounds contain a basketball court; pavilion; volley ball court; frisbee field; softball field that doubles as a football field; low ropes course; camping site; and a work area where wood is chopped and stacked for selling and donating. The work site safety rules are reviewed with the assigned residents and are prominently posted in the work area. The grounds also contain two barns; garden; hobby farm; and the housing and maintenance areas for the various aminals.

The interviews were conducted with staff in the main campus building in the privacy of a conference room. The interviews with the residents were conducted in the school in an office which provided privacy. The comprehensive tour of the campus, interviews with staff and residents, review of documentation, and observations support that the campus environment is aligned with the stated Guiding Principles of the program. The Guiding Principles are also included in the Client Handbook, along with commentary summarizing each one. The five Griding Principles are: Caring; Commitment; Courage; Integrity and Learning.

SUMMARY OF AUDIT FINDINGS

Prior to the site visit, an introductory telephone call was held with the Director of Residential Services/PREA Coordinator and the Program Office Supervisor to discuss the the audit process and data gathering. The sign announcing the audit site visit and the Auditor's contact information was sent to the PREA Coordinator. During the comprehensive facility tour, the printed notifications of the PREA site visit were observed to be posted in various areas of the facility, accessible to residents, staff and visistors. Pictures of the posted signs were sent to this Auditor prior to the site visit. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive which was mailed to this Auditor. After a review of the information provided, a conference call was held with the Director of Residential Services/PREA Coordinator and the Program Office Supervisor to discuss the information; clarify documents and processes; and to request additional information. There was communication with the PREA Coordinator and the Program Office Supervisor throughout the document review process. Documentation that was requested for the site visit was provided in folders onsite and additional supportive documentation was received by the Auditor after the site visit and prior to the completion of the audit report.

The site visit was conducted October 17-18, 2016 and began on the first day with a comprehensive tour of the main building and the house used for the community transition program. The tour concluded on the second day of the site visit to include the outside grounds, recreation building and school building which houses classrooms; offices; medical clinic; and a gymnasium. The complete comprehensive tour included housing units; gymnasium/recreation areas; fitness center; offices; storage areas; cafeteria; auditorium; and intake area; and multipurpose room. During the tours, staff members were observed directly supervising and interacting with residents while they were in the school building, cafeteria and transition house. Signs are posted indicating where residents are not allowed and areas where staff must be present with the residents.

Ten residents were interviewed that included all housing units for the juvenile justice program. Ten direct care staff members were interviewed that covered all three shifts. There were 14 specialized staff interviews conducted and included a contractor and a volunteer. The interviews with staff members and residents revealed that they are aware of the zero-tolerance policies of the agency and understand how to report allegations of sexual abuse and sexual harassment. Staff members were knowledgeable of their duties and responsibilities in preventing, detecting, and responding to all forms of sexual abuse and sexual harassment.

An exit meeting was held at the conclusion of the the site visit and a summary of the audit findings was provided. The facility staff present in the exit meeting were the agency head, Jeff Bradt, Chief Executive Officer; Mary Steiner, Director of Residential Services/PREA Coordinator; Kevin Szcyrbak, Assistant Director of Residential Services; and Samantha Carlson, Program Office Supervisor.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There are various PREA Policies that provide the guidelines for zero-tolerance of all forms of sexual abuse and sexual harassment and outlines the approach for preventing, detecting, and responding to such allegations. The collection of PREA Policies are parallel to the PREA Standards and each Policy is identified by the number(s) of the Standard it addresses. Many of the PREA policies are titled similarly to the related standard(s). There are additional facility policies that lend support to maintaining a safe environment for both residents and staff. The Zero Tolerance Towards Sexual Abuse and Harassment Policy and the other PREA Policies outline the strategies for addressing the components of the PREA Standards which are as follows: prevention and responsive planning; training and education; risk screening; reporting; official response following a resident report; investigations; discipline; medical and mental care; and data collection and review. The policies contain prohibited behaviors and sanctions for those who participate in such behaviors. The Zero Tolerance Towards Sexual Abuse and Harassment Policy and the other PREA policies contain related definitions.

The Director of Residential Services who provides oversight to the juvenile justice residential program also serves as the PREA Coordinator and reports to the Chief Executive Officer (CEO). The role of the PREA Coordinator was verified through interviews with the CEO, Director of Residential Services and other staff. The organization chart also identifies the position of the agency's PREA Coordinator and shows the direct supervision of the PREA Coordinator by the agency's CEO. The PREA Coordinator/Director of Residential Services stated that she has adequate time and the authority to manage and coordinate processes and services for compliance with the PREA Standards. Her interview also included information on how team work of the staff members guarantee the implementation of processes and systems that ensures the PREA Standards are met.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not contract with other facilities for the confinement of its residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Abuse Prevention Plan Policy and the Staffing Plan Policy address this standard. Both Policies provide for the staffing ratios and for same gender staff to be on duty at all times. The acceptable staffing ratio was observed during the tour of the school. The Program Abuse Prevention Plan Policy provides that in an emergency situation, relief staff may be called in to provide same gender coverage. A tracking form, Deviation from Staffing Plan, has been developed to document any deviation from the staffing ratios. During the interview, the Director of Residential Sercices/PREA Coordinator eplained that the staffing ratios for the licensing requirements are the same as the PREA requirements. The Assistant Director of Residential Services explained the staffing plan and how staff coverage is maintained.

The Staffing Plan Assessment completed by the Director of Residential Services/PREA Coordinator document a review of staffing and the 1:8 and 1:16 staff ratios for direct care staff, as well as staffing in other program units. The staffing plan considers the make-up of the population; any substantiated or unsubstantiated significant incidents; licensing requirements; general practices for juvenile correctional facilities; numbers and placement of supervisory staff; and program activities. Completion of the Staffing Plan Assessment form includes a review of the monitoring system by detailing the number of cameras and their locations and identifying the casual work pool and overtime provisions as the resources available and committed to ensure adherence to the staffing plan. The average daily number of residents since August 20, 2012 is 64 in the juvenile justice program and the average daily number of residents on which the staffing plan was predicated for this program since August 20, 2012 is 64.

The Program Abuse Prevention Plan Policy provides for unannounced rounds to be conducted by the Director of Residential Services/PREA Coordinator, Assistant Director of Residential Services, Clinical Director, or a designee. The unannounced rounds are conducted throughout the campus to identify and deter sexual abuse and sexual harassment. A review of documentation and interviews with the Director of Residential Services, Clinical Director, and Assistant Director of Residential Services confirmed that the unannounced rounds occur. The Policy, which is supported by practice, is that staff does not alert other staff when the rounds are occurring. According to the interview with the Clinical Director, radios are available and the staff conducting the interview would be able to hear if other staff are being alerted of unannounced rounds through radio transmission. She further stated that staff members are informed not to alert other staff. Forms were reviewed that document unannounced rounds and contains notes regarding the sections visited. The form and Policy requires that the staff conducting the rounds document contact with staff and residents and any concerns or recommendations that may arise during the rounds. The review of documentation also revealed that concerns noted during the unannounced rounds are followed up on and responded to as evident through the review of written communication between the Assistant Director of Residential Services and a Case Manager.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Control and Recovery of Contraband/Searches Policy provide guidance to staff regarding searches and defines the type of searches to be conducted. The practice is that cross-gender searches are not conducted at the facility and was confirmed through interviews with direct care staff and residents. Body cavity searches are not conducted at the facility; where one may be indicated the resident will be transported to the

hospital emergency room. According to the Policy, if a resident is suspected of hiding drugs or a weapon on his/her person, 911 emergency services will be called. The facility reports that no type of cross-gender searches have been conducted at the facility during this audit period. Searches are conducted and are documented by staff. It was determined through staff interviews and a review of the staff training roster that staff members have received training in conducting cross-gender pat-down searches and pat-down searches of transgender and intersex residents. The Classification of Clients Policy prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status and this information was verified by staff members through the interviews. The Policy and the staff interviews confirmed that where the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner in private.

The agency has policies, procedures and practices which ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by staff of the opposite gender. The staff and resident interviews, a review of the policies and procedures, and the staffs' discussion of the rules regarding using the bathroom and shower procedures confirmed the practices. The procedures and practices and the observed doors to toilets and shower curtains provide residents with the reasonable expectation of privacy. Staff members of the opposite gender are directed by policy to announce their presence when entering the housing units where residents may be showering, changing clothes or performing bodily functions. According to staff and resident interviews, the female staff generally announce their presence verbally when entering the living units of the opposite gender; this practice was also observed during the tour of the campus on the first day of the site visit.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Information to Clients Policy addresses this standard. The Policy requires that residents with disabilities and who are limited English proficient be provided equal opportunity to participate in or benefit from all aspects of the PREA education sessions with the goal of preventing, detecting, and responding to sexual abuse and sexual harassment. According to documentation reviewed and conversation with the PREA Coordinator, the facility has a contract with Clarity Interpreting Services LLC for the provision of services to the facility when requested. Assistance to deaf or hard of hearing residents will be provided through the Minnesota Department of Human Resources, Deaf and Hard of Hearing Services. The facility will coordinate with the Minnesota State Services for the Blind for support as needed. Qualified facility and contract staff may also provide identified support services to residents as required.

The Information to Clients Policy provide that the facility does not rely on resident interpreters, resident readers or any type of resident assistance, except in limited circumstances where an extended delay in obtaining an interpreter could compromise a client's safety; performance of first responder duties; or investigation of allegations of sexual abuse or sexual harassment. The facility reports that residents have not been used as interpreters, readers or in any way to provide interpretive services during this audit period. Interviews with direct care staff members revealed that the practice is that residents are not used as interpreters, readers or for any related assistance for other residents. The Client Handbook contains information regarding reporting allegations of sexual abuse and sexual harassment. Reporting information is also located in the Wellness Center/medical clinic and in the offices of the Case Managers.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Employee Selection and Promotion Policies provide details regarding the hiring process, completion of background checks, and the grounds for termination. The Policy is aligned with the standard and the interview with the Human Resources Management and Development Director. Background checks are conducted on potential employees and contractors who have direct contact with residents. The facility is in the process of completing the five-year background checks for the identified staff members meeting the requirement. A review of documentation and the interview with the Human Resources Management and Development Director provided a review of the types and sources of the various background checks and records reviewed by the Minnesota Department of Human Services (DHS) prior to providing approval for hiring or assigning staff. The DHS also reviews reports of all substantiated perpetrators of maltreatment reported to DHS from the Minnesota Department of Health and from counties within the State; and all substantiated perpetrators from investigations that resulted in negative licensing actions.

The hiring process includes completion of the Privacy Notice Form which contains information required in submitting a request for a background check. The Privacy Notice Form also contains the inquiry to the potential hire about whether he/she may have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; have convictions of engaging in or attempting to engage in sexual assault; or has been civilly or administratively adjudicated for sexual assault. The hiring practices are aligned with the Employee Selection Policy and the interview with the personnel officer, as evidenced through a review of a sample of personnel records. The Promotion Policy and confirmation through the interview confirmed that the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire an employee or contractor or whether to promote an employee.

The agency reports that in the past 12 months, there have been 76 new hires who may have contact with residents that had criminal background checks conducted. The agency also reports that there have been four contracts for sevices, during the past 12 months, where criminal background checks were conducted on all staff covered in the contract who might have contact with residents. The DHS provides documentation to the facility acknowledging the completion of the background check for each request and provides the hiring/assignment status for the potential employee or contractor and also provides notification to the facility when current employees are charged with an offense. The Employee Selection Policy provides that staff has a continuing duty to report related misconduct and that omissions of such conduct or providing false information will be grounds for termination, which was also supported by the interview with the Human Resources Management and Development Director.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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A camera system has been installed during this audit period and supplements the direct supervision provided to residents provided by staff. The camera system is equipped to store information for 30 days and monitoring may be conducted from the offices of identified program staff. Cameras have been installed in various areas, including the cafeteria; recreation areas; and hallways and are strategically placed in other aeas. Additional areas of the facility have been identified where additional mirrors will be installed. The facility is continually monitoring to identify and address areas in efforts to increase the monitoring of residents. There have been no expansions made to the facility during this audit period.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The Response Planning and the Zero Tolerance Towards Sexual Abuse and Harassment Policies address this standard. The Director of Residential Services and the Assistant Director of Residential Services primarily conduct administrative investigations. The Duluth Police Department is responsible for conducting investigations that may appear to be criminal in nature. A review of documentation shows that the identified facility investigators have received training on conducting PREA related investigations. Facility policy contains the guidelines outlining the requirements for PREA related investigations. An interview with the Director of Residential Services and a documented statement indicate the communication between her and the representative of the Duluth Police Department regarding PREA investigations that may be criminal in nature.

A Letter of Understanding exists between the Program for Aid to Victims of Sexual Assault (PAVSA), a victim advocacy agency, and Woodland Hills. The Letter of Understanding outlines the services that would be provided to an alleged victim, including the forensic examination which would be conducted by a Sexual Assault Nurse Examiner (SANE). The Response Planning Policy indicates that forensic examinations and related treatment will be provided at no cost to the victim. Policies and staff interviews support that practices will be implemented that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Medical forensic examinations will be conducted at Essentia St. Mary's Hospital as stated in the Letter of Understanding with PAVSA. The interview with the Executive Director of PAVSA confirmed as stated in the Letter of Understanding that, in cooperation with the hospital, a SANE will be dispatched by PAVSA to the hospital to conduct the forensic examination and assist in emergency medical care. The SANE staff may be requested by the alleged victim, Woodland Hills staff member or law enforcement.

In addition to the forensic medical examination, the Letter of Understanding provides that PAVSA will provide services through a 24-hour crisis line; crisis intervention services; short and long-term individual counseling services; sexual assault therapeutic support groups; and advocacy to assist with the medical, legal and personal ramifications of sexual violence. The Letter of Understanding further states that PAVSA will provide services to residents that have experienced sexual violence in the community or in the facility. Information such as a large poster and leaflets regarding the victim advocacy services offered and contact information has been provided to the facility by PAVSA. There have been no criminal investigations or forensic examinations conducted during this audit period.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Response Planning Policy and staff interviews provide that allegations of sexual abuse be referred to the Duluth Police Department through calling 911 and to other State investigative entities as governed by the facility and the other State agency's policies. Administrative

investigations are conducted by trained facility investigators. During the past 12 months there were four allegations of sexual harassment received and investigated by investigators at Woodland Hills. There have been no allegations of sexual abuse or criminal investigations conducted at the facility. Woodland Hills' policies direct staff to report all allegations of sexual harassment or sexual abuse and to document the referrals made for investigations. The review of the completed investigations and interviews with the Assistant Director of Residential Services and the Director of Residential Services/PREA Coordinator, who serve as facility investigators, document that the allegations of sexual harassment were reported and completed. The agency's website contains the steps to take and contact information for reporting allegations of sexual abuse and reporting information is posted on the campus. The random staff interviews confirmed the agency's requirement of the documentation of verbal allegations of sexual abuse or sexual harassment.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a training packet of PREA related policies and a combination of electronic and manual training rosters documenting the name of the attendee and date. One training roster indicates the final score regarding compentency-based training. A review of the sample training materials including rosters, policies, and outlines and staff interviews confirmed that the required training occurs. Initial training is provided to staff and refresher training is also provided for staff as needed as determined through the interviews and documentation. All random staff interviewed reported receiving the PREA training.

Interviews with staff and a review of sample documentation verify that the PREA training includes the following:
The agency zero-tolerance policies;
Staff responsibilities regarding allegations or incidents of sexual abuse or sexual harassment;
Resident's right to be free from sexual abuse and sexual harassment;
The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation;
The dynamics of sexual abuse and sexual harassment in juvenile facilities;
Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment;
How to avoid inappropriate relationships with residents;
The common reactions of sexual abuse and sexual harassment juvenile victims;
How to communicate effectively and professionally with residents, including gay, bisexual, transgender, intersex, or gender non-comforming residents;
Mandatory reporting; and
Relevant laws regarding the applicable age of consent.

The Employee Training (PREA) Policy addresses this standard. The facility house both males and females with varied needs and situations and the training is tailored to the unique needs and attributes and gender of the population served. The interviews conducted with direct care staff revealed the occurrence of initial PREA training and refresher training.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

A review of samples of Volunteer Agreements, Contractor Compliance Attestation Form, and memos from the Volunteer Program Manager and the Director of Residential Services/PREA Coordinator document that volunteers and contractors understand the facility's zero-tolerance of sexual abuse and sexual harassment. The documents also indicate the volunteers and contractor's receipt and understanding of PREA related policies and their role in reporting allegations of sexual abuse and sexual harassment. The contractors and volunteers are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation.

The facility reports that the number of volunteers and contractors who have contact with residents and who have received the PREA training is 15. The policies contain definitions of sexual assault and sexual harassment and describes reporting responsibilities. Interviews with an animal husbandry program volunteer and a contractor, the Chemical Dependency Counselor, confirmed that the training occurs. They also revealed that volunteers and contract staff understand the zero-tolerance policy and other PREA related policies regarding sexual abuse and sexual harassment of residents and how to report such allegations or incidents.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Information to Clients Policy provides that all residents admitted to Woodland Hills (juvenile justice residential program) receive information about the facility. PREA education is also included and involves information about how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. The Policy provides that residents receive PREA education within 24 hours of admission to the facility. The Client Handbook also provides information to residents on how to report allegations of sexual harassment and sexual abuse. Residents and staff initial the Orientation Checklist form used to document the provision of the PREA information by staff and receipt of the information by the resident. Interviews with Case Managers and the residents indicated that the PREA education sessions had occurred. The PREA related information is provided to staff in the Information to Clients Policy and through training and staff meetings.

The facility has the capability of providing the PREA education in formats accessible to all residents including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. The facility has the rights of the residents (Client Rights) and related information posted in the living units and it is contained in the Client Handbook. A contract for interpretive and translation services exist and staff interviews confirmed that residents are not used as translators or readers for other residents. Facility staff also provide support services to residents as needed and to ensure access to services that will provide disabled residents the opportunity to participate in PREA education sessions.

The facility reports that 152 residents, admitted in the last 12 months, received comprehensive age-appropriate PREA education including the right to be free from sexual abuse and sexual harassment; the right to be free from retaliation for reporting such incidents; and agency policies and procedures for responding to such incidents. According to the Information to Client Policy and a Case Manager interview, residents must receive the PREA education within 24 hours of admission; however, the residents interviewed stated that they receive the information during the first day of the admission process. The Case Manager described the use of the Orientation Checklist, signed by the resident and staff, to assist in tracking the provision of PREA education to each resident. Periodic refresher education sessions are conducted with residents as indicated.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Zero Tolerance Towards Sexual Abuse and Harassment Policy addresses the required training for staff identified to conduct administrative investigations. A review of documentation and interviews with the Director of Residential Services/PREA Coordinator and the Assistant Director of Residential Services confirmed completion of the online training course, Investigating Sexual Abuse in a Confinement Setting, with the National Institute of Corrections.

The interview with the Assistant Director of Residential Services and a review of documentation support that the training topics included techniques for interviewing juvenile sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria and evidence required to substantiate a case for administrative or prosecution referral. Investigations that are criminal in nature are investigated by the Duluth Police Department and there has been communication between the Director of Residential Services and the Police Department regarding conducting PREA investigations.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Employee Training (PREA) Policy addresses this standard and provides that medical and mental health staff receive the initial PREA training and specialized training. In addition to the general training and PREA updates, medical and mental health staff complete an online training course through the National Institute of Corrections (NIC). Training certificates were reviewed that document completion of the courses obtained through the NIC. The training certificates show completion of the modules in PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting and Behavior Healthcare for Sexual Assault Victims in a Confinement Setting.

The nurse also has a Certificate of Attendance which documents training titled, Adolescent/Adult Sexual Assault Nurse Examiner (SANE) Training Program, provided through Essentia Health. The interviews with staff and the review of the training certificates revealed participation in the online training course and the nurse's training through Essentia Health. Forensic medical examinations are not conducted at the facility; they will be conducted at an Essentia Health hospital.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Program Abuse Prevention Plan Policy requires that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents be conducted by the Case Manager on each resident admitted to the facility within 72 hours of the resident's arrival. Where vulnerability is identified, a Safety Plan is documented. The screening instrument, Vulnerability Assessment and Sexually Abusive Behavior Screening, was one of the instruments used in assessing risk of sexual victimization and abusiveness. Prior to the onsite visit, the facility staff developed a consolidated instrument to be used that contains some of the same information and adaptations from other instruments to produce an objective screening instrument that meets the requiremnents of the standard and facility-specific requirements.

A Case Manager was interviewed and documentation was reviewed that support the completion of the vulnerability screening process to assess and obtain information that will assist staff in reducing the risk of sexual abuse by or upon a resident. Reassessments are conducted when the resident is assigned to another group or when additional information is received. Reassessments may be conducted informally on a quarterly basis during the review of treatment goals, according to the Case Manager interviewed. The recently revised screening instrument is designed to accommodate the documentation of a safety plan and a vulnerability plan for the resident.

The risk screening instrument obtains personal and other information that includes but is not limited to the following:
Prior sexual victimization or abusiveness;
Resident's identification as gay, lesbian, bisexual, transgender, or intersex;
Intellectual impairment;
Mental health issues;
Social skills;
Observations for features of youth's presentation and behaviors;
Previous placement in institutions;
Physical disability or disfigurement;
History of sexual activity in a correctional facility;
Resident's concern for his/her own safety;
Age; and,
Physical appearance.

According to the interview with a Case Manager, the required information to complete the risk screening instrument is obtained by the Case Manager through a review of the related court paperwork packet; interview that may be conducted with the court worker; and an interview with the youth prior to his/her arrival to Woodland Hills. The interviews with the Case Manager and the residents and a review of documentation verified that the assessments are being conducted. The facility reports that the number of youth admitted to the facility within the past 12 months who were screened for risk of sexual victimization and the risk of sexually abusing other residents within 72 hours of admission is 150.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Classification of Clients Policy provide guidance to staff on how the information obtained from the risk screening instrument is used. The Policy criteria is aligned with the screening instrument, including age; developmental level; and level of risks related to keeping all residents safe and free from sexual abuse and sexual harassment. The information from the screening instrument assists staff in determining housing and program assignments, as determined by a review of the Policy and the interview with a Case Manager. The recently revised screening instrument is designed to accommodate the documentation of a safety plan and/or a vulnerability plan for a resident as determined by the information obtained.

Isolation is not used to house residents who may be at risk for sexual abuse or sexual harassment. Other methods will be implemented such as room or housing unit reassignment, close staff supervision, or removal of the alleged perpetrator or the alleged threatening resident from the facility. During the tour of the campus for each day, all seclusion rooms were empty and staff explained their use for disciplinary reasons, when a resident needs to calm down, or if a resident is a threat to others; and the infrequency and brief period of seclusion. During this audit period, there were no residents placed in isolation because they had been determined to be at risk of sexual victimization.

The Classification of Clients Policy prohibits placing gay, bisexual, transgender, or intersex residents in separate housing based solely on such identification or status which was verified through observations and interviews with residents and staff. Observations during the comprehensive tours and the interview with the Director of Residential Services/PREA Coordinator support that assigning transgender or intersex youth to the facility, including program and housing assignments, is made on a case-by-case basis. Staff interviews and observations support the Policy which prohibits considering gay, bisexual, transgender or intersex identification or status as an indicator of the likelihood of them being sexually abusive. A review of risk screening instruments, description of the intake process, and interviews with residents confirmed that staff consider all residents' concern for their own safety while they are in the facility. Policy provides that a transgender or intersex resident be reassessed at least twice a year and must be given the opportunity to shower separately; staff inteviews confirmed there awareness of the policy.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting of Sexual Abuse and Sexual Harassment Policy provides internal methods for a resident to report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation that may lead to abuse. According to the Policy and resident and staff interviews, residents may submit a grievance form directly to the Director of Residential Services/PREA Coordinator or place it in one of the locked grievance boxes which are accessible to all residents; and may tell a staff member that they trust. Residents may also write a note to a Case Manager, Director of Residential Services, Assistant Director of Residential Services, or Clinical Director. The agency provides a hotline number within the facility for residents to report allegations of sexual abuse or sexual harassment. The call on the hotline goes to the office and email of the Director of Quality and Strategic Planning. A 24-hour crisis line for reporting allegations of sexual abuse and sexual harassment is also accessible to the residents by the victim advocacy agency, Program for Aid to Victims of Sexual Assault (PAVSA).

The information about reporting allegations is printed in the Client Handbook and reviewed with residents during the intake process. The PAVSA poster is in the wellness center/medical clinic and PAVSA leaflets are maintained in the Case Managers' offices. The leaflets and the poster which contain reporting information and services offered to alleged victims are accessible to all residents. The PAVSA agency is in the process of printing additional posters and the facility will be included in the distribution of the additional posters, which will be placed in the housing units. Staff members are required to promptly document verbal reports of allegations of sexual abuse and sexual harassment and no later than 24 hours. The Policy states that staff will accept reports from third-parties, which was confirmed through staff and resident interviews. The residents interviewed stated that they had someone who does not work at the facility that they can report to about sexual abuse or sexual harassment.

A review of documentation, in addition to the resident and staff interviews, demonstrated that the grievance process may be used to report allegations of sexual abuse or sexual harassment. Residents have access to writing utensils, paper, and the grievance forms for submitting written allegations of sexual abuse and sexual harassment. The grievance forms are accessible to residents in their housing units. The grievance form is designed to accommodate complaints by residents, third-parties and staff. Grievance forms are maintained at the front desk in the main entrance lobby area of the primary building and on the agency's website, accessible to the public and staff. There were no grievances submitted alleging sexual abuse or alleging substantial risk of imminent sexual abuse during the past 12 months. One grievance was submitted during the past 12 months alleging sexual harassment and it was investigated by a facility investigator. Resident interviews revealed that they are aware of the different ways they can report and are aware that reports may be received by facility staff members from anonymous or third-party sources.

Staff interviews revealed that they are aware of the resident reporting methods and are aware that staff may make anonymous and private reports of allegations of sexual abuse and sexual harassment. Staff further stated that they were aware of the requirement to promptly document verbal reports. The methods that staff shared for them to privately or anonomously report allegations include the agency hotline; completion of a grievance form; talk to supervisor or management staff; complete an incident report; or contact the state corrections investigative agency. Staff members are informed of resident reporting methods through policy, training and printed leaflets and poster. The facility reports that youth are not detained on campus for civil immigration purposes.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting Sexual Abuse and Sexual Harassment Policy provides that an administrative process is used in dealing with grievances which is supported by staff interviews and paperwork. Details are contained in the Policy that outlines the residents' grievance process; any third-party assistance to the resident; and appealing the initial decision in response to the grievance. The Policy provides that there is no time limit for filing the grievance. Residents are not required to use an informal process or give the grievance to any staff member regarding the allegations. The residents have access to grievance forms, writing materials, and locked grievance boxes for depositing the competed grievance form. Residents have the option of giving the grievance directly to the Director of Residential Services/PREA Coordinator if they choose to; however, they are not required to. The grievance forms are located on each living unit and the locked grievance boxes are located in the common areas where residents pass regularly on a daily basis. The Reporting Sexual Abuse and Sexual Harassment Policy also provides that a resident may be disciplined for filing a grievance related to alleged sexual abuse only when it has been demonstrated that the resident filed the grievance in bad faith.

The Reporting Sexual Abuse and Sexual Harassment Policy contains the timelines regarding the grievance procedure including that an initial response to an emergency grievance is provided within 48 hours of receipt of the grievance and that a final decision is provided within five days of receipt of the grievance. A grievance alleging or related to sexual abuse or sexual harassment is considered an emergency grievance. There were no grievances submitted alleging sexual abuse or alleging substantial risk of imminent sexual abuse during the past 12 months. The grievance process is provided for the resident in the Client Handbook and is reviewed with the residents by staff. Interviews with residents and staff confirmed that they are aware that they are not required to use an informal grievance process or otherwise attempt to resolve a PREA related issue with staff. A grievance form is also included in the Client Handbook.

All of the residents interviewed are familiar with how to submit an emergency grievance to report allegations of sexual abuse or sexual harassment. Residence also reported that they could write a note to treatment and management staff members to report allegations and they were aware that a third-party could make a complaint. Staff members stated that they may also use the grievance form to privately report allegations of sexual abuse or sexual harassment. The grievance process serves as a resource for residents, staff members and others to report allegations of sexual abuse or sexual harassment. A review of documents and the interviews demonstrated that residents are afforded the right to submit a grievance and it is responded to by staff within the parameters of the policy.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Response Planning Policy addresses this standard. The facility provides residents with a 24-hour, seven days a week access to outside victim advocacy services through the Program for Aid to Victims of Sexual Assault (PAVSA). The contact information is provided to the residents during PREA education sessions, PAVSA leaflets, Client Handbook, and posted information. A Letter of Understanding exists between PAVSA and Woodland Hills. The Letter of Understanding outlines the services that would be provided to an alleged victim, including the forensic examination which would be conducted by a Sexual Assault Nurse Examiner (SANE). The leaflet provided to the residents supports the information that is contained in the Letter of Understanding and information gleaned from the resident interviews. The leaflet shows that the advocacy services are free and confidential, as provided in the Response Planning Policy.

The interviews with the Executive Director of PAVSA and the Director of Residential Services/PREA Coordinator, review of the Letter of Understanding, and the disseminated materials; confirmed that the victim advocacy services include the following: forensic medical examination by a SANE; 24-hour crisis line; crisis intervention services; short and long-term individual counseling services; sexual assault therapeutic support groups; and advocacy to assist with the medical, legal and personal ramifications of sexual violence. The leaflet provided to the residents contains the definition of the term, sexual violence, and describes what it can look like. The residents knew enough about the victim advocacy services that would be available to them if they ever needed them to support that the PREA education occurs. The Client Handbook contains information to residents regarding access to the telephone for contacting PAVSA. The Director of Residential Services serves as a Board Member for the First Witness Child Advocacy Center which is located in Duluth. The First Witness Child Advocacy Center offers advocacy and counseling services for victims of sexual and physical abuse and provides related services to families.

All resident interviews and the interview with the Director of Residential Services and observations during the comprehensive campus tour document that residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents/legal guardian. The Client Rights are posted in each living unit and in the Client Handbook regarding access to attorneys and the courts and the receipt of visitors and access to reasonable communication. All residents could identify visitation and phone call days and confirmed their access to an attorney or legal representative, including a court worker/Probation Officer. Residents also confirmed that they had someone on the outside to report allegations of sexual abuse if they needed to.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting Sexual Abuse and Sexual Harassment Policy provides that third-party reporting of sexual abuse and sexual harassment will

be received by facility staff and reported as required. Third-party reporting information is posted on the agency's website and staff interviews revealed that staff members are aware of their obligation to receive and submit reported allegations from others. Third-parties may also use the grievance form, by its design, to report allegations of sexual abuse or sexual harassment. Additionally, third-party reports may be made directly to the Director of Residential Services/PREA Coordinator whose phone number is posted on the website and the Woodland Hills hotline number is also posted on the website. Resident interviews confirmed their knowledge of the meaning of third-party reporting and staff members are aware of the policy requirement to document all verbal reports. The residents interviewed could identify someone that did not work at the facility that they could report to about sexual abuse or sexual harassment.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting of Maltreatment of Minors Policy and Minnesota statute provide that staff members are mandated reporters and must immediately report all allegations of sexual abuse and no later than 24 hours; a written report must follow within 72 hours. In addition to notifying facility supervisors and management staff members, staff may call 911; St. Louis County Social Services-Initial Intervention Unit; and the Department of Corrections-Licensing Division. All direct care staff members interviewed were aligned with the policy reporting requirements and 70% of that staff added that the practice is that the expectation is that reports are documented immediately and no later than the end of the shift. The facility staff members are also required by policy to report allegations that were made anonymously or by a third-party.

Agency policy provides direction to staff regarding reporting duties and prohibits staff from revealing any information related to a sexual abuse report to anyone, other than those persons required to make treatment, investigation, security or administrative decisions. Based on interviews with the mental health and medical personnel, residents are informed of the staffs' duty to report and they added that they are mandated reporters. Administrative investigations are investigated by the identified facility staff members and allegations that are criminal in nature are investigated by the Duluth Police Department and the St. Louis County Social Services-Initial Intervention Unit may also investigate allegations of sexual abuse. The policies and staff interviews reveal that notifications will be made immediately, including to the courts; appropriate child welfare agency; and parents/legal guardians.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency Protection Duties Policy and interviews with the Director of Residential Services/PREA Coordinator and the Chief Executive

Officer provide that immediate action is to be taken to protect the resident where it is indicated that the resident is at risk for imminent harm. Immediate actions that may be taken to protect an alleged victim include secluding the alleged perpetrator with constant staff supervision; assigning a staff member to provide one-on-one supervision the alleged victim; and/or removing the alleged perpetrator from the facility. Staff interviews revealed that immediate measures to protect a resident would be taken and include but are not limited to close monitoring; moving resident to another room/unit; single room placement; and contact a supervisor and/or management staff for assistsance. The facility reports that during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting to Other Facilities Policy provides that upon the facility receiving an allegation that a resident was sexually abused while confined in another facility, the Director of Residential Services/PREA Coordinator or the Clinical Director will notify the appointing authority or designee of the facility where the alleged abuse occurred and will also notify the appropriate investigative agency. The Policy provides that the notification is made as soon as possible but no later than 72 hours of receipt of the allegation. During the past 12 months, there were no allegations received of a resident being sexually abused while confined in another facility.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Staff First Responder Duties Policy requires that any staff acting as a first responder must separate the alleged victim from the alleged abuser; call for help; and preserve and protect the scene until appropriate steps can be taken to collect any evidence. The Policy directs the first responder to request that the alleged victim does not wash; brush their teeth; change clothes; urinate; defecate; drink; or eat. Interviews with staff members who would serve as first responders and a non-security staff revealed that they are aware of their duties. The non-security staff, Program Office Supervisor, who may act as a first responder indicated in the interview that she knew and understood to request that physical evidence be preserved and to contact direct care staff for assistance. During this audit period there has not been a sexual abuse incident or allegation.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The written Sexual Abuse Incident Coordinated Response Plan provides guidance to staff regarding the actions to take when there is an alleged incident of sexual abuse. The Plan outlines, in a charted format, steps to be taken in response to an incident of sexual abuse. The Plan identifies the staff positions required for an effective facility response, such as the direct care staff; Supervisor; Director of Residential Services/PREA Coordinator; medical; and mental health; and the PREA Response Team which consist of treatment, management and leadership staffs. According to the staff interviews, they are aware of their duties in response to an incident of sexual abuse.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not maintain collective bargaining agreements.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

According to the Agency Protection Against Retaliation Policy, no resident or employee who reports an allegation in good faith and/or cooperate with an investigation will suffer retaliation from other residents or other employees. The Administrative Team is identified as the unit responsible for monitoring retaliation. This team includes but is not limited to the Director of Residential Services/PREA Coordinator; Human Resources Management and Development Director; Clinical Director; and the Chief Executive Officer. The Policy states that the protection measures may include removal of staff from contact with the alleged victim and emotional support services for residents and/or

staff. Additionally, the Human Resources Management and Development Director stated that the resident may be moved to another housing unit; staff may be placed on leave; or staff may be assigned to a different team.

The Agency Protection Against Retaliation Policy supported by the interview with the Human Resources Management and Development Director, identifies the items that would be monitored to assess retaliation and includes: resident disciplinary reports; staff write-ups; reassignments of staff; program changes; and negative performance reviews. There have been no allegations of sexual abuse during this audit period; however, a retaliation monitoring form has been developed to track retaliation activities according to the standard and to document the monitoring activities. The Agency Protection Against Retaliation Policy provides that the retaliation monitoring will occur for at least 90 days, longer if needed, following a report of sexual abuse. The Human Resources Management and Development Director added during the interview that retaliation monitoring would last beyond the 90 days for as long as necessary.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. Segregation is not used in this facility to protect a resident who alleged to have suffered sexual abuse.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Response Planning Policy and the Reporting of Sexual Abuse and Sexual Harassment Policy provide that administrative investigations are conducted by the Woodland Hills staff members who have been identified as an investigator and who have received the required training for conducting investigations in a confinement setting. Allegations that are criminal in nature are conducted by the Duluth Police Department and the Initial Intervention Unit. The Director of Residential Services/PREA Coordinator has had communication with the Duluth Police Department regarding the PREA related investigations that are criminal in nature. There have been no sustained allegations of conduct that appear to be criminal that were referred for prosecution since the time period identified by the standard of August 20, 2012; substantiated allegations of criminal investigations will be referred for prosecution.

The facility investigators have received training on conducting investigations through the National Institute of Corrections as confirmed from a review of the paperwork and interviews with the Director of Residential Services and Assistant Director of Residential Services. The administrative investigations are documented through written reports completed by the trained investigators. According to the Assistant

Director of Residential Services, the training topics included: techniques for interviewing juvenile sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria and evidence required to substantiate a case for administrative or prosecution referral. A review of reports demonstrates that the facility does not terminate an investigation solely because the source of the allegation recants the allegation; once an investigation is initiated, it is completed.

The Assistant Director of Residential Services described the administrative investigation process and discussed the type of information that is included in the completed reports. He reported that the facility remains informed of the progression of investigations through prompt reports after an investigation is conducted by the Initial Intervention Unit and that the facility has a primary contact with the Duluth Police Department where contact will be maintained regarding investigations of allegations of sexual abuse that are criminal in nature.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Response Planning Policy provides directions to staff regarding the administrative and criminal investigations. The Director of Administrative Services and the Assistant Director of Administrative Services conduct the administrative investigations and allegations that are criminal in nature are referred to the Duluth Police Department. According to the review of documentation and the interview with the Assistant Director of Residential Services, the standard of evidence required to substantiate allegations of sexual harassment or sexual abuse is a preponderance of the evidence.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting to Residents Policy provides that the resident be informed when the investigation has been concluded and the outcome of whether it was determined to be substantiated, unsubstantiated or unfounded. The notification must be done in writing as confirmed by the Reporting to Residents Policy and interviews with the Director of Residential Services/PREA Coordinator and Assistant Director of Residential Services. The alleged victim would receive a letter from the Director of Residential Services stating the outcome of the investigation.

The Reporting to Residents Policy provides that following an allegation of sexual abuse committed by staff, the resident will be informed when the staff member is no longer posted in the unit or employed in the facility and of the staff member's indictment or conviction. Following an allegation of sexual abuse committed by another resident, the alleged victim will be informed if the alleged abuser has been

indicted, charged, or convicted. According to the Director of Residential Services, if there should be a criminal investigation conducted by the Duluth Police Department or another investigative entity, she would remain abreast of the investigation through a primary contact person within the investigative agency. There were no investigations conducted during this auditing period regarding allegations of sexual abuse.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

According to the Disciplinary Sanctions for Staff Policy, staff members are subject to disciplinary santions up to and including termination for violations of sexual abuse or sexual harassment policies. According to the Policy, terminations for violations of sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, will be reported as required to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies.

The disciplinary sanctions for violations relating to sexual abuse or sexual harassment, other than engaging in sexual abuse, will be commensurate with the act committed; the staff member's disciplinary history; and the similar history of other staff. During this audit period, documentation and staff interview reflect that one staff member was terminated due to substantiated findings of an administrative investigation regarding an allegation of sexual harassment. The staff member's position did not require notification to a licensing body.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Corrective Action for Contractors and Volunteers Policy address this standard. The Policy requires that when a contractor or volunteer engages in sexual abuse with a resident, contact with the resident will be prohibited and law enforcement will be notified, unless the activity was clearly not criminal, and contact will be made to relevant licensing bodies. According to the Corrective Action for Contractors and Volunteers Policy, appropriate remedial measures will be taken and consideration will be given as to whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies. Contractors and volunteers sign an acknowledgement statement regarding their responsibilities and receipt of the PREA information and policies. During the past 12 months, there have been no contractors or volunteers who have been reported for a violation of PREA policies. The interview with the Director of Residential Services/PREA Coordinator reflected her awareness of the Corrective Action for Contractors and Volunteers Policy.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Interventions and Disciplinary Sanctions for Clients Policy address this standard and provide that residents may be subject to disciplinary sanctions only after formal proceedings regarding resident-on-resident sexual abuse. The Policy states that residents found in violation of facility rules are subject to sanctions pursuant to the administrative process or following a criminal finding of guilt. The Policy contains the requirements of the standard, such as treatment services, in the event that a resident remains at the facility following an incident of resident-on-resident sexual abuse. However, management staff report that the expectation is and the practice would be that such allegation would result in the alleged perpetrator being removed from the facility and legal charges may occur.

Unacceptable behaviors are identified in the Client Handbook and are catagorized as minor rule violations and major rule violations and the consequences for the violations are described. The disciplinary sanctions have been developed to be commensurate with the nature and circumstances of the violation; resident's disciplinary history; similar histories of other residents; and consideration of mental disabilities or mental illness contributing to the behavior. The disciplinary process and disciplinary actions are contained in the Client Handbook. It also informs the resident about removal from the program and that some rule violations may result in legal consequences. A review of policies, observations and interviews with the mental health and medical staffs revealed that a resident's participation in treatment services are not required for him/her to access programming or education.

According to the Interventions and Disciplinary Sanctions for Clients Policy, the facility may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. A resident who reports an allegation of sexual abuse will not be disciplined or considered to have made a false report if the allegation was made in good faith. The agency prohibits all sexual activity between residents. The Interventions and Disciplinary Sanctions for Clients Policy states, and a review of documentation and discussions with staff members, demonstrate that the facility considers that sexual activity consititutes sexual abuse only if it is determined that the activity was coerced. There was not an incident, during the past 12 months, of administrative findings or findings of guilt regarding resident-on-resident sexual abuse.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Medical and Mental Health Care Policy requires that when a resident discloses prior victimization or abusiveness during the intake screening process, a follow-up meeting would be provided with a mental health or medical practitioner within 14 days of the intake screening and the policy is supported by the interviews with staff. The facility reports that during the past year the facility reports that there were no disclosures during the intake process of a resident being a previous victim of sexual abuse or having previously perpetrated sexual abuse. The facility receives a packet on the youth prior to admission and social, legal and other information is contained in the packet; routinely, prior such information is already known to the facility. If prior victimization or abusiveness is learned through the admission packet prior to the resident's arrival, a follow-up meeting is scheculed and referrals are requested as indicated through reviewed forms and interviews with staff.

The facility has a Referrals form that documents when formal and specific referrals are indicated during the resident's stay at the facility. The Referrals form document the request for services that include but are not limited to: psychological evaluation; psychosexual evaluation; medication assessment; individual therapy; and diagnostic assessment. All residents are screened during the intake process to measure their level of vulnerability. Facility practice indicate that the Referrals form would be used to document the date and request for the follow-up meeting with a medical or mental health practitioner for a resident who discloses prior victimization or previously perpetrated sexual abuse during a screening.

The Medical and Mental Health Care Policy states that any information related to sexual victimization or abusiveness occurring in an institutional setting is limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by law. Clinical records are maintained by mental health and medical staffs that document the services provided to the residents. All facility staff, including medical and mental health practitioners, are mandated reporters as required by Minnesota law. Interviews with mental health staff revealed that when a resident may disclose prior victimization or previously perpetrating sexual abuse they will be seen during the intake process by medical and mental health staff members.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Medical and Mental Health Care Policy ensures timely and unimpeded emergency medical and mental health services related to sexual abuse and the services will be provided at no cost to the victim and whether or not the victim names the accuser or cooperates with the investigtion. The interviews with the Nurse and the Clinical Therapist confirmed that a victim of sexual abuse would receive immediate and unimpeded access to emergency medical treatment and crisis intervention services. Both the Nurse and the Clinical Therapist reported during their interview that the nature and scope of these services would be determined according to their professional judgment in either medical or mental health services.

The observations of the interactions and delivery of services by medical and mental health practitioners indicate that unimpeded services would be available to a victim of sexual abuse. The staff interviews confirmed and the Medical and Mental Health Care Policy states that timely information would be provided to a victim regarding sexually transmitted infection prophylaxis. It was determined through the interviews with medical and mental health staff members; interviews with other staff and residents; review of the coordinated written response plan; and observations that immediate medical treatment and crisis intervention services will be provided to an alleged victim of sexual abuse.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Medical and Mental Health Care Policy provides for ongoing medical and mental health evaluations and treatment, where appropriate, for sexual abuse victims and abusers. According to the Policy and staff interviews, the ongoing medical and mental health care may include follow-up services; mental health and medical treatmemt plans; and when necessary, referrals for continued care following a resident's transfer to or placement in another facility or the resident's release from custody. The Medical and Mental Health Care Policy, in agreement with the Nurse and the Clinical Therapist who were interviewed, provide that the services that will be provided regarding an incident of sexual abuse are consistent with the community level of care.

The Policy and staff interviews document that resident victims will be offered tests for sexually transmitted infections as medically appropriate; provided timely information about and timely access to emergency contraception; and pregnancy tests where indicated. All treatment services will be provided at no cost to the victim. The Clinical Therapist confirmed that a mental health evaluation of all known resident-on-resident abusers will be conducted within 60 days of learning of such abuse history and treatment will be provided as deemed appropriate by mental health practitioners. The Medical and Mental Health Care Policy also provides for the mental health evaluation within 60 days of all known resident-on-resident abusers.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Sexual Abuse Incident Review Policy provides details regarding the role of the incident review team and identifies the team members responsible for conducting the review of the incident where the allegation was determined to be substantiated or unsubstantiated. According to the Sexual Abuse Incident Review Policy, the incident reviews will occur within 30 days of the conclusion of the investigation. The incident review team members have been identified as the Administrative Team which consists of the Chief Executive Officer; Director of Quality and Strategic Planning; Director of Residential Services/PREA Coordinator; Human Resources Management and Development Director; Controller; Director of Community Services; and Clinical Director. There will also be input from the line supervisors; investigator; medical practitioner; and/or mental health practitioner, per the Policy.

The Sexual Abuse Incident Review Policy also requires documentation of the considerations assessed by the team during the incident review process such as the need to change policy or practice; motivation factors that may have contributed to the incident; physical barriers; adequacy of staffing levels; and adequacy of monitoring technology. The Policy requires that the recommendations of the incident review team be implemented and that when they are not, the reasons are documented. The interview with the Clinical Director, an incident review team member, was aligned with the Sexual Abuse Incident Review Policy and the standard. The Clinical Director was familiar with items that must be considered during the incident review process. During the past 12 months, there have been no criminal or administrative investigations of alleged sexual abuse completed at the facility.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Data Collection Policy addresses this standard and provides that the facility will maintain data for every allegation of sexual abuse, including data gathering necessary to answer all questions from the most recent version of the Survey of Sexuial Violence conducted by the Department of Justice. A review of documents and reports and interviews with administrative staff indicate the review of collected data of significant incidents.

The agency has the capacity to collect data for allegations of sexual abuse and sexual harassment through current data gathering efforts and aggregate incident-based data at least annually. The identified data has been collected and reviewed and an annual PREA-specific report has been developed. The agency will provide the related data from the previous calendar year to the United States Department of Justice as requested, as stated in the Data Collection Policy. A review of the documentation and interviews with the Director of Residential Services/PREA Coordinator, Chief Executive Officer and the Program Office Supervisor support the data collection activities.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Internal data review occurs and corrective actions are implemented as indicated. An Annual Risk Report is currently completed and a report specific to PREA has been developed for the past year. The facility has conducted and current practices demonstrate data review specific to PREA related issues and the implementation of corrective measures to improve the effectiveness of the applications of the PREA standards. The addition of the staff position, Director of Quality and Strategic Planning, can be significant in assisting in identifying the opportunities for improvement related to sexual abuse prevention, detection, response policies, and training. An annual report is documented and is accessible to the public. The report does not contain identifying information.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Data Storage, Publication, and Destruction Policy addresses this standard. The Policy and practice provides that the incident-based and

aggregate data and other related documents are securely retained. The Data Storage, Publication, and Destruction Policy also provides for the required data to be maintained for at least 10 years after the date of its initial collection unless a state, federal or local law requires otherwise. A review of documentation shows that all personal identifiers are removed from the annual report and the report is available to and accessible by the public.

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 inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Shirley L. Turner November 22, 2016

Auditor Signature Date