PREAAUDITREPORTxINTERIM☐FINAL

JUVENILE FACILITIES

Date of report: August 10, 2017

Auditor Information			
Auditor name: Nate Parker			
Address:7555 4th Ave Lino Lakes, MN 55014			
Email:nate.parker@co.anoka.mn.us			
Telephonenumber:763-688-5104			
Date of facilityvisit: January 3-6, 2017			
Facility Information			
Facility name: 180 Degrees Group Homes; St Cloud Group Home and Vonwald Group Home			
Facilityphysical address: 1101 Washington Memorial Drive, St Cloud, MN 56301; 4435 Bamber Valley Rd SW, Rochester, MN 55902			
Facility mailingaddress: *(ifdifferentfromabove)* Click here to enter text.			
Facility telephonenumber:320-259-6764; 507-280-0110			
The facility is:	☐ Federal	☐ State	☐County
	☐ Military	☐ Municipal	☐ Private for profit
	xPrivate not for profit		
Facilitytype:	x Correctional	x Detention	x Other
Name of facility's Chief Executive Officer: Rick Sundberg			
Number of staff assigned to the facility in the last 12 months: 31			
Designed facility capacity: 12 at each location			
Current population of facility: 7 at St Cloud Group Home; 12 at Vonwald Group Home			
Facility security levels/inmate custody levels: non-secure			
Age range of the population: 10-21			
Nameof PREAComplianceManager: Carrie Neid; Laura Johnson		**Title:**Program Manager	
Emailaddress:carrie@180degrees.org laura.johnson@180degrees.org		**Telephonenumber:**320-259-6764 507-280-0110	
AgencyInformation			
Nameof agency:180 Degrees, Inc.			
Governingauthority orparentagency: *(ifapplicable)* Click here to enter text.			
Physicaladdress:236 Clifton Ave S. Minneapolis, MN 55403			
Mailingaddress: *(ifdifferentfromabove)* Click here to enter text.			
Telephonenumber:612-813-5000			
AgencyChief Executive Officer			
Name: Dan Pfarr		**Title:**CEO	
Emailaddress:dan.pfarr@180degrees.org		**Telephonenumber:**612-813-5010	
Agency-WidePREACoordinator			
Name: Nuwoe Cooper		**Title:**Senior Program Manager	
Emailaddress:nuwoe.cooper@180degrees.org		**Telephonenumber:**612-813-5014	

AUDITFINDINGS

NARRATIVE

On January 3, 2017, I arrived at the Vonwald Group Home located in Rochester, MN. I was met by the PREA Coordinator, Nuwoe Cooper; Laura Johnson, Program Manager; and Rick Sundberg, Senior Program. This facility is licensed by the Minnesota Department of Corrections for male and female residents. The audit was started by reviewing the pre-audit questionnaire and establishing a schedule for the two day onsite portion of the audit. The audit interviews began with identifying the current resident population which numbered twelve. The maximum capacity of the facility is twelve. All twelve residents were interviewed and all showed a clear and thorough understanding of the agency's zero tolerance to sexual abuse and sexual harassment and were well versed on the reporting methods in place if an incident needed to be reported. A thorough facility tour took place in the early afternoon, led by the Program Manager. Areas toured included the day room/bed room area, kitchen/dining area, classroom, resident bathrooms, storage rooms, and staff area. Cameras were observed in all resident areas. Camera placement was noted as a future improvement area so more coverage could be included with the existing technology. PREA posters and an anonymous drop box was noted in a common area for PREA complaints if needed. Auditor contact information was also visibly displayed. The remainder of the day was spent interviewing staff and the Agency PREA Coordinator.

On January 4, 2017, I returned to complete the onsite audit at the Vonwald Group Home. The morning started with an extensive interview with the Program Manager, who also serves as the PREA Compliance Manager. At the conclusion of that interview, the remainder of the available staff were interviewed. The rest of the day was spent reviewing staff files, resident files, and agency policy.

In summary, five direct care staff, two staff responsible for risk screening and one school staff were interviewed. In addition, the Program Manager/PREA Compliance Manager and PREA Coordinator were interviewed. All twelve residents placed at the facility were interviewed as part of the onsite audit.

On January 5, 2017, I arrived at the St Cloud Group Home located in St Cloud, MN. This facility is licensed by the Minnesota Department of Corrections for male and female residents. I was met by the PREA Coordinator and Carrie Neid, Program Manager. A brief meeting occurred and a schedule was established for the day. The audit interviews started with two staff interviews to include a youth lead worker who is also responsible for completing risk screening on all new residents placed at the facility. At the time of the audit, seven residents were placed with a maximum capacity of twelve. The remainder of the morning was spent interviewing residents who all displayed a thorough knowledge of the agency's efforts to prevent and detect sexual abuse and sexual harassment. The afternoon began with an extensive tour of the facility. The school, resident rooms, staff area, bathrooms, kitchen/dining area and resident laundry were included in the tour. PREA education posters were noted throughout the facility as well as an anonymous drop box in a common area for filing PREA complaints. PREA Auditor contact information was also displayed clearly throughout the facility. Camera placement was noted on the tour. Camera's were thoughtfully placed to provide even and consistent coverage throughout the facility. The remainder of the day was spent conducting staff interviews.

On January 6, 2017, I arrived at the St Cloud Group Home for the final day of the onsite audit. The day started with extensive interviews of the Program Manager/PREA Compliance Manager and Senior Program Manager/Agency Head Designee. Following the interviews, staff files, resident files, and agency policy was reviewed. The remainder of the day was spent completing an exit interview and reviewing any follow up items for the corrective active period.

In summary, three direct care staff, one staff responsible for risk screening and one youth lead worker were interviewed. In addition, the Program Manager/PREA Compliance Manager and Senior Program Manger/Agency Head Designee were interviewed at this location. At the time of the audit, seven youth were placed at the facility. All seven were interviewed as part of the audit.

I would like to thank the staff from the Vonwald Group Home and St Cloud Group Home for their cooperation and professionalism throughout the audit process. In addition, Mr. Cooper, Mr. Sundberg, Mrs. Johnson and Mrs. Neid for the open access to their respective programs.

DESCRIPTIONOF FACILITYCHARACTERISTICS

The Vonwald Group Home, located in Olmsted County, Rochester, MN is situated in a rural setting. Upon entry into the front door, you will find the office of the Program Manager. A visitor sign in area is located just off of this office space where PREA notices and visitor expectations are hung for review prior to signing into the facility. A staff office area is located further down the hallway where work space and camera viewing is available. Off of the staff area is the day room and resident bed room area. This was a well lit space and provides residents an area to do group programming as well as leisure activities. The kitchen/dining area was located directly off of the day room and had the remainder of the resident bedrooms. The facility has a total eight bedrooms, four that are double bunked and four for single occupancy only. All resident bedrooms are equipped with an alarm system for safety purposes. At the rear of the facility is the school classroom which also is used for resident recreation, programming, and visitation. The facility has two single use bathrooms which are door alarmed and always locked from the outside. Cameras were placed throughout the facility with uneven coverage. Blind spots were noted and a plan is in place to provide better coverage in the future. The facility is on one level with open viewing and overall good site lines for staff observation.

The St Cloud Group Home, located in Stearns County, St Cloud MN is situated in a residential area. Entrance was gained on the back side of the building facing the parking lot through a locked door. A staff office area was located immediately to the right upon entry into the facility. To the left is a living room/day room space with comfortable furniture. Resident bedrooms and bathrooms are located down a long hallway. Each bedroom has an alarm system on it and the bathrooms are single use and always locked from the outside. At the far end of the hallway is the school classroom and sun porch. Off of the initial day space is a second day room space and large open work area where meals are served. Program Manager office and remaining bedrooms are located at the far end of the building. A kitchen/dining room space is at the back end of the building with large windows and much natural light. A laundry room is located in the basement off of the kitchen area for resident use. Only one resident is allowed in this space at any one time. The facility has a total of eight bedrooms, four that are double occupancy, and four for single occupancy only. Cameras were placed throughout the facility and overall provided adequate coverage. Blind spots were minimal and high traffic areas had excellent coverage. Facility layout does not provide for advantageous site lines, however, staff placed themselves in good viewing areas to provide direct supervision of residents.

SUMMARY OF AUDITFINDINGS

On January 3-6, 2017, an onsite inspection was completed at Vonwald Group, in Olmsted County, MN and St Cloud Group Home, in Stearns County, MN. The results of the audit are noted below:

Numberof standardsexceeded:2

Numberof standardsmet:33

Numberof standards notmet:0

Number of standards not applicable:6

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

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

☒ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

As part of the pre-audit phase, the agency provided policy #67 which identifies the agency Zero Tolerance of all forms of sexual abuse and sexual harassment. The policy outlines how the agency will implement prevention, detection, and response to sexual abuse and sexual harassment. The policy also outlines definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

The agency has a designated PREA Coordinator who indicated through his interview that he has sufficient time and authority to oversee agency efforts to comply with PREA standards.

The agency has identified two PREA Compliance Managers who oversee efforts in each of the two group locations to ensure compliance with PREA standards. Each Compliance Manager indicated during their interview that they have sufficient time to complete their PREA related duties.

Standard115.312Contracting with other entities for the confinement of residents

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

☐ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

This standard does not apply.

Standard 115.313Supervision and monitoring

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

Does NotMeetStandard(requirescorrectiveaction)

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 correctiveaction recommendations where the facilitydoesnotmeetstandard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

The agency provided a staffing plan for each group home it operates. The staffing plan takes into account each item designated in sub section (a) of this standard. Staffing plan was reviewed with Senior Program Manager and each PREA Compliance Manager. The agency had no instances of deviating from the established staffing plan in the past 12 months. This was confirmed with the Senior Program Manager.

At the time of the audit, the facility has not had the opportunity to formally review their staffing plan as outlined in sub section (d) based on PREA implementation. The PREA Coordinator has identified a timeline when such review will take place.

At the time of the audit, agency policy requires the Program Manager or Lead Youth Worker to conduct unannounced rounds but has not established a system for documenting those rounds. During the corrective action period, the agency will have the staff who completed the unannounced rounds send an email verification to the agency wide PREA Coordinator confirming that rounds were completed. The PREA Coordinator will establish a tracking form to document rounds in each of the group homes to include date and time of the rounds completed.

During the corrective action period, the agency has established a documentation protocol for Program Manager's and Lead Youth Workers. The PREA Coordinator provided documentation of unannounced rounds for each group home location that included all three shifts of operation.

Standard 115.315Limits to cross-gender viewing and searches

☒ ExceedsStandard(substantiallyexceedsrequirementof standard)

☐ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Agency policy does not require any type of pat or strip search for any resident while in their care. Residents are required at the time of entering the facility to empty their pockets and take off their shoes for a visual check. All residents and staff interviewed confirmed this policy and practice in each of the group homes.

During the tour of each group home location, all bathrooms available to youth are single use which affords all residents the privacy needed to shower, use the bathroom and change clothes in a private setting. Agency policy requires all staff to announce their presence when entering a resident's room or bathroom, where residents are likely to be showering, performing bodily functions or changing clothing. This practice was confirmed in interviews with staff and all residents.

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

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

☒ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency has established procedures to provide disabled residents or those with limited English proficiency access to agency efforts to prevent, detect, and respond to sexual harassment. At the time of the audit, there were no residents with disabilities or limited English proficiency placed at either group home.
The Agency does not rely on the use of resident interpreters for any reason. Procedures are in place to access interpreter services through placing case manager or community based provider.

Standard 115.317Hiring and promotion decisions

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

Does NotMeetStandard(requirescorrectiveaction)

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Agency policy requires that the appropriate background check be completed on all selected candidates. Minnesota Licensing Rule 2960 requires a BCA back ground check, drivers license check, and DHS abuse registry check be completed on every staff, volunteer, and contractor. All prior incidents of sexual harassment will be considered when determining to hire or promote anyone or to enlist services of any contractor who may have contact with residents.

At the time of the audit, the auditor reviewed staff files. At the time of the audit, all files reviewed had an up to date background check completed. At the time of the audit, there were no contractors providing service to clients.

As part of the hiring process, all applicants are asked about any previous misconduct that make impact eligibility to work. Any material omissions regarding such misconduct is grounds for immediate termination.

Agency policy also requires that information be provided on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

At the time of the audit, agency policy does not require a background check every five years. As part of the corrective action period, the agency will revise the policy and provide the new policy with the revision to the auditor for review.

During the corrective action period, the agency has added additional language into their hiring and promotion policy addressing the requirement for all employees to have a background investigation at least every five years. As part of the corrective action period, that revised policy was provided to the auditor for review and meets the standard.

Standard 115.318Upgrades to facilities and technologies

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

☐ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

This standard does not apply. The agency has not installed or updated its electronic surveillance system since 8/20/12. The Agency has also not acquired a new facility or made a substantial expansion since 8/20/12.

Standard 115.321Evidence protocol and forensic medical examinations

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

Does NotMeetStandard(requirescorrectiveaction)

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

At the time of the audit, agency policy does not provide access to SANE/SAFE services at no cost to the resident victim. As part of the corrective action period, the Agency will revise its policy to include access for these services at no cost to the victim. The agency has also not entered into an agreement with the local emergency medical services center to provide SAFE/SANE services in the event of a sexual abuse incident. As part of the corrective action period, the Agency will attempt to enter into an agreement and provide documentation of those attempts.

At the time of the audit, the agency does not have documentation of attempted agreements with a rape crisis center for services. As part of the corrective action period, the Agency will attempt to enter into an agreement for these services or provide proof of all attempts.

At the time of the audit, the agency has not entered into an agreement with the agency responsible for conducting a sexual abuse investigation. As part of the corrective action period, the Agency will attempt to enter into an agreement for these services or provide proof of all attempts.

During the corrective action period, the agency updated their policy to ensure SANE/SAFE services are provided at no cost to the resident victim. The agency provided the policy to the auditor for review. Agency policy meets the standard.

The agency was also required to obtain memorandum of understanding with community service providers to ensure SAFE/SANE services are made available to resident victims, advocates are made available to resident victims, and that agencies responsible for conducting investigations follow the appropriate evidence protocols. During the corrective action period, the agency provided all of the necessary memorandum's of understanding to satisfy this standard.

Standard 115.322Policies to ensure referrals of allegations for investigations

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency provided policy #67 as part of the pre-audit phase. This policy requires an investigation of all allegations of sexual abuse and sexual harassment. At the time of the audit, the agency has had no allegations of either sexual abuse or sexual harassment in the past 12

months. Agency policy and incident data was reviewed with the Senior Program Manager as part of the onsite audit.

Agency policy also requires that all allegations be referred for investigation to the appropriate agency. Responsibilities of both the agency and the investigative authority were also noted. This information was confirmed in the pre-audit phase on the agency website.

Standard 115.331Employee training

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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The agency provided documentation and training curricula for all staff as detailed in subsection .331 (a). All staff interviewed were able to articulate the training received and the means of delivery. The training offered to staff was tailored based on the specific needs of the residents placed at the facility. The agency provides gender specific training to better meet the needs of its female residents. The agency provided signed documentation for each staff verifying the training received and thorough understanding.

Standard 115.332Volunteer and contractor training

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Agency practice requires all volunteers and contractors who have contact with residents to receive training on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

The agency provided training materials at the time of the onsite audit for auditor review. At the time of the audit, neither group home location had any volunteers or contractors assigned.

Standard 115.333Resident education

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency provided policy #67 as part of the pre-audit phase. Agency policy requires all residents to receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This process was verified at the time of the onsite audit with all residents placed at both group home locations. Residents were able to explain what information they received at intake and the time line in which it occurred. Staff responsible for completing intakes were also interviewed in both locations. These staff were able to explain the process of information delivery and the timeline for delivery. Agency process calls for the resident to receive comprehensive education at the time of the intake to ensure all residents receive thorough and timely education.

Agency provided education materials to the auditor for review. Resident files were reviewed for written verification. All files reviewed had resident signature detailing education had been received and an understanding of the material. At the time of the audit, all residents currently housed at both group home locations had received education sessions.

The agency ensures that residents have continuous and ready access to education materials through posters and resident handbook. At the time of the audit, posters were placed throughout each location and handbooks were available to all residents.

Standard 115.334Specialized training: Investigations

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

☐ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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This standard does not apply.

Standard 115.335Specialized training: Medical and mental health care

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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The agency provided training records for nursing staff that are contracted to provide services at both group home locations. Training documentation included all areas as described in .335 (a). The agency also provided training as mandated in the employee section of the standards. This training was documented and provided to the auditor at the time of the onsite audit.

Standard 115.341Screening for risk of victimization and abusiveness

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency provided policy #67 as part of the pre-audit phase. This policy was reviewed by the auditor prior to the onsite audit. Agency policy requires that each resident be screened at the time of intake for risk of sexual victimization or sexual abusiveness. Per agency practice, offender risk is reassessed weekly during team meetings. During the onsite inspection, residents were interviewed at both group home locations. Residents were able to articulate the screening information that had been reviewed with them at the time of their intake. Staff responsible for completing the screening were also interviewed at the time of the onsite inspection. Process was reviewed during this interview. All staff were well versed on policy and practice and were able to detail what measures would be taken if a resident was determined to be high risk for sexual victimization or sexual perpetration.

The agency has deployed an objective screening instrument that calculates a residents risk score based on collateral data, criminal history, resident and family interview and static risk factors. The screening tool provided to the auditor was reviewed in its entirety. The risk tool collects data in all areas as detailed in .341 (c). Risk screening information is kept in the resident file to ensure limited access to that information. The Agency PREA Coordinator and each PREA Compliance Manager were interviewed as to the process for limiting access to sensitive data. At the time of the audit, the agency does not have an electronic information management system. All relevant resident information is secured in a paper resident file which is kept in a staff only area of the facility.

Standard 115.342Use of screening information

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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During the onsite audit, staff who complete resident risk screening were interviewed as part of the audit process. Staff were able to explain the process used when placing youth in housing, bed, program, education, and work assignments. All relevant information to include information regarding risk of sexual victimization or sexual perpetration is used in making programming decisions. This process was reviewed with each PREA Compliance Manager and both group home locations are using a consistent thorough process.

At the time of the audit, the agency does not use isolation for any reason.

The agency provided policy #67 which prohibits the placement of lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments, based solely on the basis of such identification or status. This policy and practice was reviewed with each PREA Compliance Manager and the Agency PREA Coordinator.

The agency reviews placement and programming of each resident weekly in team meetings. This process was confirmed with each PREA Compliance Manager at the time of the onsite audit.

Standard 115.351Resident reporting

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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The agency provided policy #67 as part of the pre-audit process. This policy was reviewed prior to the onsite audit. The agency has provided multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency takes verbal reports, written reports, has an anonymous drop box available to residents and provides phone numbers and mailing addresses to local county agencies that are responsible for investigating claims of sexual abuse or sexual harassment.

Agency policy requires staff to accept all forms of reports and to document promptly any reports received verbally. Policy and procedure were reviewed with residents and staff during the onsite audit. All staff interviewed were well versed on procedure and all residents interviewed knew they were able to make reports verbally to staff if needed.

The facility provides all the tools necessary for residents to make a report. Complaint forms and pencils were available to all residents. This was observed during the onsite audit and confirmed in interviews with each PREA Compliance Manager.

The agency provides staff with multiple methods to privately report sexual abuse and sexual of residents. Staff can report to their PREA Compliance Manager, Senior Program Manager, PREA Coordinator, file a report in the anonymous drop box or call county level agencies responsible for investigating such claims. All staff interviewed were able to describe reporting mechanisms available.

Standard 115.352Exhaustion of administrative remedies

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

☐ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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This standard does not apply.

Standard 115.353Resident access to outside confidential support services

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

Does NotMeetStandard(requirescorrectiveaction)

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

Each group home location provides residents with access to outside victim advocates for emotional support services. Phone numbers and mailing addresses are made available to residents in handbooks and posters. The agency provided a copy of the resident handbook as part of the audit process. Contact information for support services was also available on educational posters located throughout the facility. Residents interviewed were able to explain what services were available and how to access those services.

Per Agency policy, the facility will inform the resident prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The knowledge of this provision was reviewed with residents and all interviewed knew of this requirement.

During interviews with residents and confirmed in interviews with the Senior Program manager, PREA Compliance Managers and PREA Coordinator, all residents are given reasonable and confidential access to their legal representation and daily access to parents and legal guardians.

At the time of the audit, the Agency has not secured or attempted to secure a memo of understanding with their community service provider. During the corrective action period, the agency will attempt to secure this agreement or document such attempts.

During the corrective action period, the agency was able to enter into a memorandum of understanding with community based providers who will provide confidential support services. The agency provided the auditor with copies of both documents to support this standard.

Standard 115.354Third-party reporting

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency has established a method to receive third party reports. Information is available at both group home locations to allow for third party reporting. Information is also available on the agency website providing means for making a report if needed.

Standard 115.361Staff and agency reporting duties

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The Agency provided policy #67 as part of the pre-audit phase. This policy was reviewed by the auditor. Agency policy requires all staff to immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in either group home location. Agency policy also requires staff to report any retaliation against residents or staff who reported such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. This policy and practice was confirmed during interviews with staff in both group home locations.

All staff are trained as mandated reporters and are bound by applicable state laws regarding mandated reporting. All staff interviewed were well versed on State of Minnesota Mandated Reporting law.

Agency policy prohibits staff members from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. This policy and procedure was affirmed during staff interviews.

Agency policy requires the Program Manager to promptly report any allegation of sexual abuse to the Senior Program Manager and PREA Coordinator. Parents or legal guardians of the alleged victim will also be notified per agency policy. This reporting process was confirmed during interviews with both Program Managers, Senior Program Manager and PREA Coordinator.

Per agency policy, all allegations of sexual abuse and sexual harassment will be reported to the Program Manager for initial investigation. At the time of the audit, neither group home location had an allegation reported in the past 12 months. Data and procedure was reviewed with the Senior Program Manager.

Standard 115.362Agency protection duties

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Agency policy #67 was reviewed as part of the pre-audit phase. Agency policy requires staff to take immediate action if they learn a resident is in imminent risk of sexual abuse. All staff interviewed were well versed on agency policy and the requirement to take immediate action. Multiple staff were given scenarios where they had to define the steps taken to ensure resident safety. All did so in a thorough and thoughtful manner. The policy and procedure was reviewed with the Senior Program Manager as well.

Standard 115.363Reporting to other confinement facilities

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency provided a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Program Manager must notify the facility head or appropriate office of the agency where the sexual abuse is alleged to have occurred. In the past 12 months, neither group home has received any such reports.

Agency policy such notification be made within 72 hours of receiving the allegation. All notifications made will be documented per policy. At the time of the audit, the Agency has received no such notifications of alleged sexual abuse that occurred at one of its group home that was reported by another agency. Policy and procedure was reviewed with the Senior Program Manager.

Standard 115.364Staff first responder duties

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The Agency provided policy #67 as part of the pre-audit phase. The auditor reviewed this policy. The first responder policy requires staff to follow all provisions in .364 (a). In the past 12 months, the facility has had no allegations of sexual abuse or sexual harassment. All staff interviewed were able to describe in detail their role as a staff first responder. Non- security staff interviewed were also able to describe their role as a staff first responder as it relates to resident safety and evidence preservation.

Standard 115.365Coordinated response

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Each group home location provided a written institutional plan to coordinate actions taken in response to an incident of sexual abuse amongst staff first responders, medical and mental health staff, investigators and facility leadership. This written plan was reviewed with each PREA Compliance Manager.

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

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

☐ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

This standard does not apply. The agency does not have employees in a collective bargaining agreement.

Standard 115.367Agency protection against retaliation

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

Does NotMeetStandard(requirescorrectiveaction)

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

At the time of audit, the Agency has not developed a policy in regards to agency protection against retaliation. During the corrective action period, the Agency will develop a policy and train staff based on the provisions of the standard.

As part of the corrective action period, the agency updated policy to include providing for protection against retaliation. Staff were trained as to the revisions of the policy. The agency provided a copy of the revised policy and training documentation.

Standard 115.368Post-allegation protective custody

x ExceedsStandard(substantiallyexceedsrequirementof standard)

☐ MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Based on Agency policy and practice, neither group home facility uses isolation for any reason.

Standard 115.371Criminal and administrative agency investigations

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The Agency provided policy #67 as part of the pre-audit phase. The auditor reviewed this policy. Agency policy requires Program managers to conduct administrative investigations or information gathering. At the time of the audit, neither group home has had an allegation of sexual abuse or sexual harassment. If sexual abuse is alleged, those cases are referred to local law enforcement for investigation. Law enforcement policies and procedures will be used in terms of investigative protocol.

Per agency policy, an investigation cannot be terminated solely because the source of the allegation recants the allegation. The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and not determined by the person's status as resident or staff. Administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse and shall be documented in written reports that include a description of the evidence.

Per agency policy, all substantiated allegations of conduct that appears to be criminal shall be referred to law enforcement.

Agency policy requires that all written reports be retained for as long as the alleged abuser is a resident or employed by the agency plus five years. Agency policy requires the facility to cooperate with outside investigators and remain informed about the progress of the investigation. This policy and practice was reviewed with both PREA Compliance Managers, PREA Coordinator and Senior Program Manager.

Standard 115.372Evidentiary standard for administrative investigations

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

Does NotMeetStandard(requirescorrectiveaction)

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

During the onsite portion of the audit, the Agency could not provide an evidentiary standard in its investigation policy. As part of the corrective action period, the agency will add a provision to its investigation policy requiring a standard of a preponderance of the evidence when determining whether allegations of sexual abuse or sexual harassment are substantiated.

During the corrective action period, the agency updated its investigation policy to include an evidentiary standard no higher than a preponderance of the evidence. As part of the corrective action period, the agency provided a copy of this policy for auditor review. The policy meets the standard.

Standard 115.373Reporting to residents

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

Does NotMeetStandard(requirescorrectiveaction)

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

As part of the pre-audit phase, the facility was unable to provide a policy in regards to reporting to residents. As part of the corrective action period, the agency will develop a policy outlining its responsibilities to keep resident victims informed. The agency will also train staff who are responsible to perform such notifications. Policy and staff training will be provided to the auditor as part of the corrective action period.

As part of the corrective action period, the agency updated their investigation policy to include reporting requirements to resident victims. As part of the corrective action period, the auditor reviewed the updated policy. The updated version meets the standard. All Program Managers have been trained on this policy revision.

Standard 115.376Disciplinary sanctions for staff

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency provided policy #67 as part of the pre-audit phase. This policy was reviewed by the auditor. Per agency policy, all staff members are subject to disciplinary sanctions up to and including termination of employment for violating sexual abuse and sexual harassment policies. Termination is presumptive for staff who have engaged in sexual abuse. In the past 12 months, there have been no staff violations of sexual abuse or sexual harassment policies. All staff terminations for violation of sexual abuse or sexual harassment will be referred to law enforcement unless the activity was clearly not criminal and to any relevant licensing bodies.

Standard 115.377Corrective action for contractors and volunteers

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Agency policy provided requires any contractor or volunteer who engages in sexual abuse with a resident of the facility be reported to law enforcement for investigation. All contact with residents will be prohibited as part of the investigation. The contractor or volunteer will also be reported to any relevant licensing body. Agency policy was reviewed with the Senior Program Manager. There are no documented reports of sexual abuse of residents by contractors or volunteers.

Standard 115.378Disciplinary sanctions for residents

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Per Agency policy, a resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in inappropriate behavior. At the time of the audit, neither group home facility uses isolation.

All consequences used for problematic behavior take into account a resident's mental disabilities or mental health illness. The facility uses psycho-educational opportunities as a means of intervention to correct underlying reasons or motivations for abusive or harassing behavior.

Agency policy reviewed prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred.

Agency policy also profits any sexual activity between residents. The resident discipline policy and philosophy was reviewed with both Program Managers at the time of the audit.

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

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

At the time of intake, all resident's complete a medical screening to include a risk screening for sexual victimization and sexual perpetration. At the time of this screening, all youth who have experienced sexual abuse or who have past sexual perpetration are offered a follow up meeting with medical staff within seven days of their intake. The facility provided a copy of the screening form for auditor review. The form allows for nursing staff to recommend any follow up action needed so appropriate community resources can be accessed for the resident. This practice was put in place just prior to the audit. No residents at the time of audit requested follow up services. All information as it relates to past sexual victimization or sexual perpetration is limited to informing treatment plans and security and management decisions, including housing, bed, work, education, and program assignments.

All medical and mental health practitioners who provide service to clients are bound by State of Minnesota Mandated Reporting Laws.

Policy and procedure was reviewed with each group home Program Manager.

Standard 115.382Access to emergency medical and mental health services

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Agency policy requires all resident victims of sexual abuse to receive timely, unimpeded access to emergency medical treatment and crisis intervention services. All resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted disease prophylaxis where medically appropriate. Treatment services are provided at no cost to the resident victim regardless of whether the victim names the abuser or cooperates with any investigation.

Policy and practice was reviewed with the PREA Compliance Manager at each group home location.

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

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

As part of the pre-audit process, the agency provided information regarding ongoing access to medical and mental health care for sexual abuse victims and abusers. Each group home offers medical and mental health evaluation through the assigned case worker to all residents who have been victimized by sexual abuse in a confinement setting. The evaluation and treatment includes follow-up services, treatment plan and referrals for continued care if necessary.

Any resident victim of sexually abusive vaginal penetration while incarcerated is offered a pregnancy test. If pregnancy results from aforementioned conduct, such victims will receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. Resident victims will also be offered tests for sexually transmitted infections as medically appropriate. All treatment services will be offered at no cost to the resident victim regardless of whether the victim names the abuser or cooperates with any investigation.

Each group home location attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer programming when deemed appropriate.

Policy and procedure was reviewed with each group home Program Manager.

Standard 115.386Sexual abuse incident reviews

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor

therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The Agency provided the auditor with policy #67. This policy was reviewed by the auditor. Agency policy requires each group home location to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation. At the time of the audit, the agency has had no allegations of sexual abuse in the past 12 months.

Agency policy requires the review to be completed within 30 days. The review team includes investigative staff, PREA Compliance Managers, PREA Coordinator, Senior Program Manager and Lead Youth Workers.

As part of the audit process, the Senior Program Manager and PREA Compliance Managers were able to review what factors were considered in a sexual abuse incident review. All factors identified in .386 (d) were included by each staff interviewed.

Agency policy requires that recommendations made by the review team be implemented for improvement or reasons for not doing so be documented.

Standard 115.387Data collection

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency has developed a process for collecting accurate, uniform data for every allegation of sexual abuse at its group home facilities. The data collected meets the requirements of the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

The agency will aggregate its incident based data at a minimum annually. At the time of the audit, the agency does not contract with other facilities for the confinement of residents. At the time of the audit, the facility has not completed its first year of aggregating data based on the implementation date of PREA standards.

Standard 115.388Data review for corrective action

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

The agency plan is to review collected data in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. This includes identifying problem areas, taking corrective action on an ongoing basis and preparing an annual report of its findings and corrective actions for each group home facility. At the time of the audit, the agency has not yet completed its first annual report due to implementation schedule.

The agency report will be approve by the CEO of the agency and made available to the public on its public website. Any published report may contain redacted material to safeguard the safety and security of the facility.

Standard 115.389Data storage, publication, and destruction

☐ ExceedsStandard(substantiallyexceedsrequirementof standard)

x MeetsStandard(substantial compliance;compliesinallmaterialwayswith thestandardfor therelevantreviewperiod)

☐ Does NotMeetStandard(requirescorrectiveaction)

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

Agency policy ensures that all data collected is securely retained. Agency policy also mandates that all aggregated sexual abuse data be readily available to the public at least annually through its website. Before making aggregate data available, all personal identifiers will be removed. The agency will maintain sexual abuse data for at least ten years after its initial collection. This policy and procedure was reviewed with the PREA Coordinator. At the time of the audit, the Agency has not completed its first year of data collection.

AUDITORCERTIFICATION

I certifythat:

x Thecontents of thisreportareaccuratetothebestofmy knowledge.

x Noconflictof interestexistswith respecttomyabilitytoconductan auditof theagencyunderreview, and

x 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.

Nate Parker 8/10/17

AuditorSignature Date