

**PREA AUDIT REPORT    INTERIM    FINAL**  
**JUVENILE FACILITIES**

**Date of report:** August 10, 2017

<b>Auditor Information</b>			
<b>Auditor name:</b> Shirley L. Turner			
<b>Address:</b> 3199 Kings Bay Circle, Decatur, GA 30034			
<b>Email:</b> shirleyturner3199@comcast.net			
<b>Telephone number:</b> 678-895-2829			
<b>Date of facility visit:</b> July 26, 2017			
<b>Facility Information</b>			
<b>Facility name:</b> Lighthouse Youth Center-Paint Creek			
<b>Facility physical address:</b> 1071 Tong Hollow, Bainbridge, OH 45612			
<b>Facility mailing address:</b> <i>(if different from above)</i> same as above			
<b>Facility telephone number:</b> 740-634-3094			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input checked="" type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Other
<b>Name of facility's Chief Executive Officer:</b> Renee Hagan			
<b>Number of staff assigned to the facility in the last 12 months:</b> 65 who may have contact with residents			
<b>Designed facility capacity:</b> 52-60			
<b>Current population of facility:</b> 53			
<b>Facility security levels/inmate custody levels:</b> Non-secure			
<b>Age range of the population:</b> 14-20			
<b>Name of PREA Compliance Manager:</b> Joe Boggs		<b>Title:</b> Compliance Manager	
<b>Email address:</b> jboggs@lys.org		<b>Telephone number:</b> 740-634-3094	
<b>Agency Information</b>			
<b>Name of agency:</b> Lighthouse Youth and Family Services			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i>			
<b>Physical address:</b> 401 E. McMillan Street, Cincinnati, OH 45206			
<b>Mailing address:</b> <i>(if different from above)</i>			
<b>Telephone number:</b> 513-221-3350			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> Paul Haffner		<b>Title:</b> President & CEO	
<b>Email address:</b> phaffner@lys.org		<b>Telephone number:</b> 513-487-7101	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> NA		<b>Title:</b>	
<b>Email address:</b>		<b>Telephone number:</b>	

## AUDIT FINDINGS

### NARRATIVE

The Lighthouse Youth Center-Paint Creek, located in Bainbridge, Ohio is a residential program for male juvenile offenders who have been adjudicated delinquent. The facility provides program services through a contract with the Ohio Department of Youth Services (ODYS) and accepts referrals directly from juvenile courts in Ohio. The facility provides services that include but are not limited to mental health; alcohol and drug; sex offender treatment; and education. The facility is licensed by the Ohio Department of Jobs and Family Services. The facility is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and is chartered as a non-public school by the Ohio Department of Education.

At least six weeks prior to the PREA audit site visit to the facility, the signs announcing the visit and this Auditor's contact information were posted and pictures were sent to this Auditor via email with the areas of the postings identified. During the comprehensive facility tour, the printed notifications of the PREA site visit were observed to be posted in the various areas of the facility, accessible to residents; staff; contractors; volunteers; and visitors.

The PREA Pre-Audit Questionnaire, policies, and supporting documentation were uploaded to a flash drive and mailed to this Auditor prior to the site visit. After a review of the information provided, a written review was sent to the ODYS PREA Administrator and forwarded to the facility to obtain clarification of information and to request additional documentation, where indicated. The additional documentation that was requested was provided prior to the site visit. The facility created folders, provided onsite, of all of the related documentation. The folders were neatly arranged and easy to follow.

The site visit was conducted July 26, 2017 and Mable Wheeler, certified PREA Auditor, assisted with the audit. The Auditors and the ODYS PREA Administrator arrived at the facility early enough to interview two direct care staff members before they left the facility at the end of their shift. A comprehensive tour of the facility was conducted after completion of the initial interviews and included all areas of the facility and the outside grounds. The staff was observed positively interacting with residents and providing direct supervision.

There were 53 residents in the facility on the day of the site visit. Ten residents were interviewed and 10 direct care staff members were interviewed that covered all three shifts. There were 12 specialized staff interviews conducted, including a volunteer and a contractor. The interviews with staff members and residents revealed that they are aware of the zero-tolerance policies of the facility and understand how to report allegations of sexual abuse and sexual harassment. Staff could articulate their responsibilities in preventing, detecting, and responding to sexual abuse and sexual harassment.

An exit conference was held at the conclusion of the the site visit and a summary of the audit findings was provided to the Director, Renee Hagan; Joe Boggs, Compliance Manager; Jodi Slagle, ODYS Bureau Chief of Community Facilities; and Marlean Ames, ODYS PREA Administrator.

## **DESCRIPTION OF FACILITY CHARACTERISTICS**

The Lighthouse Youth Center-Paint Creek is located on 33 acres of property in Western Ross County, Ohio and the campus contains 13 buildings. There are three living units, including an independent living unit, with dayrooms that can accommodate groups of residents. Cameras have been installed in areas inside and outside of the facility since the last PREA audit in 2014, with the exception of inside the living units. Some of the areas where cameras have been installed are at the door outside of the living units; inside the gymnasium; inside and outside of the building that houses the kitchen and dining room; and outside of the school building. Signage and mirrors are posted and supplement direct staff supervision and the electronic monitoring system.

The outside grounds contain a greenhouse, softball field, and space to conduct a variety of recreation and other activities. A recreation building is located on the grounds that provide residents with an area for leisure activities and the opportunity to play games and watch television. In addition to classrooms, the school building contains a conference room; library; two computer labs; and a barber shop. The main building includes a reception area upon entry, offices and two conference rooms. Showers/bathrooms are located in each unit and residents are provided a reasonable amount of privacy when they change clothes, shower and use the toilet.

Posters and signs were observed in various areas of the facility regarding reporting allegations of sexual abuse or sexual harassment and for contacting the victim advocacy agency. Grievance boxes and grievance forms are posted on each living unit. Each unit also has a dedicated phone accessible to the 24/7 hotline number for residents to report allegations of sexual abuse or sexual harassment and/or to request a victim advocate.

The Registered Nurse conducts nursing assessments and coordinates medical services. The Clinical Supervisor is responsible for conducting and coordinating mental health and counseling services. Case management services and religious activities are also provided at the facility. Direct care staff members are responsible for the direct supervision of the residents and monitor them in their daily activities. During the comprehensive tour of the facility, staff was observed engaging residents in activities and providing direct supervision. The facility identified 14 volunteers and contractors who are currently authorized to enter the facility that may have contact with residents.

## **SUMMARY OF AUDIT FINDINGS**

The Lighthouse Youth Center-Paint Creek was found to be in compliance with all of the PREA standards that were applicable to the facility.

Number of standards exceeded: 2

Number of standards met: 36

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.**

The Zero Tolerance policy and other supporting policies provide the directions to staff and outline the approach for preventing, detecting, and responding to allegations of sexual abuse or sexual harassment. The policy contains definitions and addresses sanctions to be used when there are violations. The strategies contained in the PREA related policies for addressing the standards include:

- \*prevention and responsive planning;
- \*training and education;
- \*risk screening;
- \*reporting;
- \*official response following a resident's report;
- \*investigations;
- \*discipline;
- \*medical and mental care; and,
- \*data collection and review.

The facility's Compliance Manager serves in the role of the PREA Compliance Manager. He confirmed his role through the interview and described the process of the facility's efforts to achieve compliance for each standard. A review of the facility's organizational chart and the written job description verified the role and shows that the Compliance Manager is directly under the supervision of the facility Director. The Compliance Manager indicated that he has the time and observations and interactions indicated that he has the authority required to fulfill the PREA related duties. Interviews conducted with random staff also confirmed their awareness of the role of the Compliance Manager regarding PREA.

### **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.**

The 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 Admission and Screening policy and the Staffing Plan for Scheduling, Supervision and Monitoring policy address this standard. The policies and a documented staffing plan provide guidance to staff in adhering to the staffing ratio of 1:8. The facility report that there have been no deviations from the PREA standards requirements of 1:8 during the waking hours and 1:16 during the sleeping hours. Observations during the comprehensive facility tour demonstrated the adherence to the facility's staffing ratios and the facility policy. A staffing plan chart, aligned with policies, was developed that shows the required staff assigned to each shift. The Director explained during the interview how the appropriate staffing levels are maintained including mandatory overtime if needed, based on security and programming needs and other factors.

A review of meeting minutes and interviews with the Director and the Compliance Manager confirmed that a staffing plan assessment meeting was held to review the staffing plan; prevailing staffing patterns; camera coverage; and other factors and/or adjustments that may be needed to ensure the safety of the residents. The annual staffing plan review demonstrates the collaboration among the Compliance Manager, Director and other staff. During the comprehensive tour of the facility, observations were made of the addition of cameras that address blind spots identified through assessments. The facility reports that the average daily number of residents during the past year is 53 and the average daily number of residents on which the current staffing plan was predicated is 56.

The review of documented unannounced rounds and the interviews with the Assistant Director and the Compliance Manager demonstrates that unannounced rounds are conducted by intermediate level and higher level staffs. Staff members do not alert other staff when the rounds are occurring. The form that document the rounds provides an area for the staff conducting the rounds to note whether staff alerted other staff that the unannounced rounds were occurring.

### **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 Resident Search and Personal Privacy policy addresses this standard. Guidance is given to staff regarding searches and address the type of searches to be conducted. Cross-gender strip searches, cross-gender pat-down searches, and cross-gender visual body cavity searches are prohibited at the facility. The interviews with direct care staff members, residents and the Director confirmed that cross-gender pat-down searches are not conducted. Training is provided to staff on conducted searches of all residents as evident through staff interviews and training documentation. No type of cross-gender search has been conducted at the facility during this audit period. Searches are conducted and are documented by staff in accordance with policy.

A review of the training materials, including training roster confirmed that staff members have received training in conducting searches of transgender and intersex residents. The policy and staff interviews confirmed that staff is prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. When the

genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner.

Use of the bathroom and shower procedures are provided in the Resident Search and Personal Privacy policy and outlines to staff guidelines that ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by staff. Random staff and resident interviews, observations during the comprehensive facility tour confirmed the practices for residents being provided reasonable privacy.

It was observed and the residents indicated that female staff announce themselves by ringing the bell before entering the living units and that they are not viewed by female staff when they may be showering, changing clothes or performing bodily functions. There is a prominent sign posted beside the bell informing females to ring the bell prior to entering the living unit.

### **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 facility provides written guidelines that ensure the provision of support services for all residents to have an equal opportunity to receive the PREA information on how to prevent, detect, and respond to sexual abuse and sexual harassment. Posters in other languages were observed and the PREA education information is printed in other languages. The materials provided to the residents are age-appropriate and there are staff available to assist residents with limited reading skills.

The facility has a document, Local Customer Service Agreement & Rates, that outlines the interpreter services and American Sign Language that will be provided by Affordable Language Services as requested. An invoice was also reviewed for a service that is provided. Resident interpreters or readers are not allowed unless there are special circumstances that may cause a delay in protecting the resident or interfere with the investigation. The facility reports and the interviews with random staff support that residents are not used as interpreters and that during the past 12 months there has not been a need for interpreters. All of the posters inform residents on how to report allegations of sexual abuse.

### **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 Screening for New Employees and/or Promotions and the Zero Tolerance policies address this standard. The policies and interviews with the Compliance Manager and the Director provided information regarding the hiring process, completion of background checks, and the grounds for termination. Documentation in a sample of personnel files reviewed revealed that background checks occur prior to employment and every five years thereafter.

The application form seeks information from applicants regarding previously related sexual misconduct and/or attempts. The personnel practices include prohibiting hiring or promoting anyone who may have contact with residents and prohibit enlisting the services of any contractor who may have contact with residents who has engaged in previous misconduct. It was 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 facility reports that in the past 12 months, there have been 15 new hires who may have contact with residents that had criminal background checks conducted. During the past 12 months there were no contracts for services where a criminal background record checks was conducted. Staff members have a continuing duty to report related misconduct and the omissions of such conduct or providing false information are grounds for termination.

### **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)

**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 camera system has been installed and cameras are strategically placed around the campus after the completion of a facility assessment and since the 2014 PREA audit. The camera system works in conjunction with direct staff supervision, mirrors, and posted signs that indicate where residents may not go or only go with staff supervision, in order to keep residents safe from sexual abuse. There has not been substantial expansion or modification to the facility since the last PREA audit.

### **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)

**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 Administrative Investigations and Reporting to Youth policy and the Zero Tolerance policy address this standard. The facility has a written Affiliation Agreement with the Child Protection Center of Ross County for the provision of advocacy services that include: accompaniment through the forensic examination; emotional support; crisis intervention; information; and referrals. There is documented correspondence that implies an agreement with the Ross County Sheriff’s Office for conducting allegations of



sexual abuse and the PREA information is shared. The Clinical Supervisor may also serve as a victim advocate if needed. Forensic examinations will be conducted at the local hospital by a qualified medical practitioner with no cost to the victim. Specific information regarding the roles of advocates and advocacy services is provided to the residents. There is a dedicated telephone for the use of residents reporting sexual abuse or sexual harassment or who may be requesting advocacy services.

The Compliance Manager and the Clinical Supervisor serve as facility investigators responsible for conducting administrative investigations. The staff members participated in training through the online course by the National Institute of Corrections (NIC). Facility policy contains the guidelines outlining the requirements for PREA related investigations. The Ohio Department of Youth Services (ODYS), Office of the Chief Inspector may also conduct administrative investigations. The point of contact for the Ross County Sheriff's Office is the Director regarding an investigation that may be criminal in nature. The policies and the staff interviews support that practices will be implemented that maximizes the potential for preserving usable physical evidence for administrative proceedings and criminal prosecutions.

There were two allegations reported during this audit period. Both allegations involved one staff member; one allegation was referred for investigation by the Ross County Sheriff's Office which is still pending. The facility staff conducted an administrative investigation of that same allegation to determine any violation of policy and there was an investigation conducted by the ODYS Office of the Inspector General. The other allegation by that same staff received an administrative investigation and was not referred to the Sheriff's Office. As a result of the administrative review of the allegation that was also referred to the Sheriff's Office, the allegation was substantiated as an inappropriate relationship with a youth by the ODYS Office of the Chief Inspector. The second allegation of sexual harassment involving the same staff member was unsubstantiated. The staff member involved in the allegations has been terminated. There were no allegations of sexual abuse that required a forensic examination.

#### **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 Zero Tolerance policy provides for an administrative or criminal investigation to be completed for all allegations of sexual abuse and sexual harassment. A review of documentation and staff interviews demonstrated that two administrative investigations were conducted and one of the allegations was also referred to the Ross County Sheriff's Office. The allegation that was referred to the Sheriff's Office has not been completed.

The policy and interviews with random staff, Compliance Manager, and Clinical Supervisor and a review of documentation confirmed that allegations of sexual abuse and sexual harassment are investigated and sexual abuse allegations will be referred to local law enforcement and will be investigated by that agency.

The policy directs staff to report all allegations of sexual harassment or sexual abuse and to document the reports as confirmed through staff interviews and a review of documentaton. The facility's website provides for the reporting allegations of sexual abuse and reporting information is also posted in various areas of the facility.

#### **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 Staff Development policy addresses PREA related training for staff. A review of the training materials and staff interviews document that the staff training occurs. The staffs interviewed were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff annually. The direct care, medical and mental health staffs and an administrative investigator interviewed reported receiving the PREA training as required. The facility houses males and the training considers the needs of the population served.

The interviews supported the documentation that the general topics listed below are included in the training:

- \*Facility zero-tolerance and PREA related 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;
- \*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;
- \*Common reactions of sexual abuse and sexual harassment juvenile victims;
- \*Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents;
- \*Mandatory reporting; and
- \*Relevant laws regarding the applicable age of consent.

#### **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.**

The Zero Tolerance and Volunteer policies provide information regarding volunteer and contractor training. The practice was confirmed through a review of the Volunteer/Contractor Training Log, training curriculum and signed training acknowledgement forms. The interview conducted with a volunteer revealed his knowledge of his responsibilities relative to the zero-tolerance of sexual abuse and sexual harassment of residents. The interview and the documentation confirmed that contractors and volunteers are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided.

#### **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 Zero Tolerance policy addresses this standard. Residents sign an acknowledgement statement indicating that they have received the training and that they received a safety tips sheet during the admission process. There is other discussion and a video shown to the residents within 10 days of admission. Staff and resident interviews, and a review of the Orientation Checklist; Resident Training Log; and signed acknowledgement statements; confirmed that the education sessions occur. The facility provides additional PREA information to residents through informative posters, brochures and other materials. The review of policy and other documentation and interviews with staff and residents reveal that residents receive comprehensive age-appropriate PREA education.

The facility reports that 44 residents were admitted to the facility who received the comprehensive age-appropriate PREA education. The interviews with the residents revealed that they are knowledgeable about PREA and how to report allegations of sexual abuse and sexual harassment and how to obtain victim advocacy services and the services available.

Support services are provided for residents as needed to ensure that all residents have the opportunity to participate in PREA education. Services will be provided on an as needed basis by the Affordable Language Services and the Speech and Hearing Center which are located in Cincinnati. The facility also has access to a Text Telephone.

The interview with staff responsible for resident PREA education also confirmed that PREA education is provided to the residents. Information on how to report sexual abuse or sexual harassment is provided to the residents and information is provided on reporting abuse through the DYS Tip Line. Information about victim advocacy support services is posted in the living units at the phones dedicated for residents to report sexual abuse or request advocacy services. All random staff interviewed and a review of the policy confirmed that residents are not used as translators or readers for other residents. PREA information is posted in various areas of the facility.

### **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 Administrative Investigations & Reporting to Youth policy provide guidance to staff regarding this standard. Two staff members, the Compliance Manager and the Clinical Supervisor serve as the facility investigators and have received the online training through the National Institute of Corrections. Training documentation and the interview with the Clinical Supervisor confirmed receipt of the training.

According to the interview with the Clinical Supervisor, the training completed included topics covering techniques for interviewing juvenile sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria required to substantiate a case, as confirmed by the investigator interviewed.

Criminal investigations are conducted by the Ross County Sheriff’s Office as determined from interviews with the Clinical Supervisor and direct care staffs; conversations with the Compliance Manager and the Director; and review of documentation.

### **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 Medical and Mental Health Care Specialized Training policy address this standard. The mental health and medical staffs received the general PREA training and also completed the online course by the National Institute of Corrections which was confirmed through the review of certificates; training acknowledgement statements; training materials; and interviews with mental health and medical staffs. The training includes how to detect and assess signs of sexual abuse; responding effectively to victims of sexual abuse and sexual harassment; and reporting sexual abuse and sexual harassment. Forensic medical examinations are not conducted at the facility.

### **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 Assessment policy requires that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents be conducted by mental health staff on each resident admitted to the facility within 24 hours of the resident's arrival. A primary screening instrument is used to assess risk of sexual victimization and abusiveness and other assessment instruments are used to ascertain information about the resident in order to meet his individual needs. The staff member that conducts the risk screening 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.

The information in determining the risk for victimization or abusiveness is obtained through a face-to-face interview with the resident, asking direct questions and probing as needed. The court records are reviewed prior to the youth's arrival to the facility. The clinical team and the administrators have access to the information which is managed in a confidential manner by staff. A review of documentation and the interview with staff and residents verified that vulnerability assessments are conducted.

### **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 Use of Screening Information and Zero Tolerance policies address this standard. These policies and the staff interview provide that the information obtained from the risk screening is used in considering housing and other program assignments in efforts to keep all residents safe. The facility does not have isolation rooms; however each housing unit has a recessed area within the housing unit where residents may be placed for a cooling off period, monitored by staff during the residents time spent in the recessed area/room. The room or area has no doors. No residents have been placed in this area to protect them from sexual abuse.

Random staff interviews indicated that protective measures would be taken immediately if it is learned that a resident is of imminent risk of sexual abuse and the responses included separating residents and reporting to supervisor and/or the Director. The staff is prohibited from placing lesbian, gay, bisexual, transgender, or intersex residents in separate housing based solely on such identification or status and the interviews with staff were aligned with policy. The interviews and policy support that program assignments regarding transgender or intersex residents, including program and housing assignments, would be made on a case-by-case basis.

It is prohibited to consider lesbian, gay, bisexual, transgender or intersex identification or status as an indicator of the likelihood of those residents being sexually abusive. A review of a sample of risk screening instruments; staff’s description of the intake process; and interviews with residents confirmed that staff consider each residents’ concern for their own safety while they are in the facility.

### **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 Zero Tolerance and Admission and Screening policies provide that internal methods are put in place for a resident to report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation that may have led to abuse. A written agreement exists with the Child Protection Center of Ross County for reporting allegations and requesting victim services. The residents are provided unimpeded access to the phone, located in each living unit, to report allegations of abuse or to request advocacy services. The advocacy information and reporting information, including phone numbers is posted in the living units and additional information is included in the Youth and Family Handbook. Residents are also provided a sheet entitled, Youth Safety Guide,” which is reviewed with residents during the admission process. All of the PREA related information provided and that is accessible to residents is in an age appropriate manner.

Internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violations that led to sexual abuse include filing a grievance; talking to staff; completing a sick call form; and third parties may report allegations through the facility or Ohio Department of Youth Services websites. A completed grievance form may be placed in a locked box and writing tools are available for residents to complete the grievances. During the comprehensive facility tour, the posted grievance forms and locked boxes were observed and the dedicated phone on a unit was tested and found to be in working order. The representative from the victim advocacy agency explained the process once a call may be received from the facility by a resident.

Staff members are required to immediately document verbal reports of allegations of sexual abuse and sexual harassment as supported by the interviews conducted with the direct care staff members. Staff also reported that they must accept reports that are made anonymously and reports made from third-parties; this information was also confirmed through resident interviews. The residents interviewed stated that they had access to someone who does not work at the facility that they can report to about sexual abuse or sexual harassment that happened to them or someone else. Staff collectively responded that they could privately report sexual abuse and sexual harassment of residents through the use of the hotline number or talk directly to supervisor, Compliance Manager or Director. Staff members are informed of the residents' methods of reporting through the PREA training, facility policies and staff meetings.

### **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 Grievance policy address this standard and 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 and identifies the timelines contained in the grievance process. The grievance process includes the filing of an emergency grievance which is provided to the Compliance Manager within 24 hours of receipt of the grievance. Residents are not required to use an informal process or give the grievance to a staff member regarding allegations of sexual abuse.

The residents have access to grievance forms; writing materials; and locked grievance boxes for depositing the completed grievance form; as determined through observations during the comprehensive tour; and resident and staff interviews. A resident may be disciplined for filing a grievance related to alleged sexual abuse only when it has been determined that the resident filed the grievance in bad faith. There were no grievances submitted alleging sexual abuse or alleging substantial risk of imminent sexual abuse during the past 12 months. Residents and staff members are aware that a third-party may make a complaint regarding sexual abuse or sexual harassment.

### **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 Zero Tolerance Policy and the existence of the Affiliation Agreement with the Child Protection Center of Ross County address this standard and outlines the advocacy services to be provided. The residents are provided the contact information for the advocacy agency and a dedicated phone is on each living unit where the resident may directly make contact with the

Center. The limitations of confidentiality of the outside support service is provided on the posting of the information that informs the resident of what an advocate can and cannot do. The residents may have confidential access to attorneys or legal representatives and reasonable access to their parents/legal guardian.

The Affiliation Agreement with the Child Protection Center of Ross County provide that the services that will be provided by the agency include access to crisis hotline services; emotional support; crisis intervention; information; referrals for resources; and accompaniment during the forensic medical examination. A qualified staff member is also available to serve as a victim advocate as needed. During the comprehensive tour of the facility, the dedicated phones were checked and determined to be in working order; it was confirmed that advocacy services would be provided to the facility when requested.

The interview with the Compliance Manager; review of the Affiliation Agreement, policy, and other printed materials and posted information confirmed that the residents have access to victim advocacy services. The interviews with the residents, Director, and Compliance Manager and observations during the comprehensive facility tour support that residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents/legal guardian. All residents were aware of how and when they could communicate with their parents/legal guardian and that attorneys and/or court workers could visit the facility. The residents interviewed shared that they had someone on the outside they could report allegations of sexual abuse to, if needed.

### **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 Third Party Reporting policy contains the information regarding third-party reporting of sexual abuse or sexual harassment. Third-party reports may be made on the facility’s website. The website contains PREA related information including the reporting of allegations of abuse. Third Party Reporting information is posted in the facility accessible to visitors. Interviews with direct care staffs revealed that they are aware of their obligation to receive and submit reported allegations from third-parties. The acceptance of a staff’s receipt of a third-party report is demonstrated through the documentation regarding the allegations reported during this audit period. Staff members are aware that they are to document all verbal reports and the review of reports confirms this procedure. Residents are aware of the meaning of a third-party reporting and how it can be done.

### **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 Zero Tolerance policy address this standard and support that staff must immediately report all allegations of sexual abuse and complete a written report; staff members are mandatory reporters. The policies provide guidance to staff in their reporting duties and prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigations, and other security and management decisions. The review of the documentation regarding the allegations during this audit period revealed that the policy was followed for reporting the allegations.

Direct care staff members interviewed provided information on how to report allegations of sexual abuse and sexual harassment and that the expectation is that verbal reports received are documented as soon as possible. Staff and residents are aware that allegation reports can be made anonymously and by a third-party and will be reported as required by policy if these allegations are made to facility staff. The direct care, medical and mental health staffs interviewed acknowledged that they are mandated reporters. Based on interviews with the Clinical Supervisor and the Nurse and a review of documentation, residents are informed of the staffs' duty to report.

Administrative investigations are investigated by the facility staff and may be investigated by ODYS Office of the Chief Inspector. Allegations that are criminal in nature are investigated by the Ross County Sheriff's Office. The policy, staff interviews and documentation reveal that notifications regarding allegations of sexual abuse will be made immediately, including to the courts; appropriate child welfare agency; and parents/legal guardians. Staff members do not reveal 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.

### **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 Zero Tolerance policy provides that staff protect the residents which may involve moving a resident to a different housing unit. The interviews with the direct care staff and the Director revealed that protective measures must be taken immediately and will include separating the the victim from the perpetrator and reporting the situation to a supervisor. The facility's practices demonstrate that they are able to reassign rooms and living units as needed and as part of the staff's efforts to keep residents safe.

### **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 or From Other Confinement Facilities (PREA) policy provides that upon receiving an allegation that a resident was sexually abused while confined in another facility, the Director will notify the head of that facility within 72 hours and will document the notification. The interview with the Director ensures that the allegations would be investigated according to the PREA standards. In the past 12 months, there was no reported allegations of sexual abuse that occurred in another facility. Documentation was reviewed regarding a resident's allegation of sexual harassment that occurred in another facility. An incident report was completed and notifications were made as required.

#### **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 Zero Tolerance policy addresses this standard and outlines staffs' responsibilities as first responders which include the action steps for responding to an incident or allegation of sexual abuse that include separate the alleged victim from the alleged abuser; call for help; and take the appropriate steps for the preservation of any evidence. The staff interviews revealed their awareness of the policy requirements including requesting that the alleged victim does not wash; brush their teeth; change clothes; wash; or do anything that may destroy evidence as supported by staff training.

#### **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 coordinated response plan is incorporated in the Zero Tolerance policy and the section provides guidance to staff regarding the actions to take when there is an alleged incident of sexual abuse or sexual assault. The role of individuals and the steps to be taken in response to an incident or allegation is detailed within the policy and supports an effective facility response. Staff members are aware of their duties in response to an incident or allegation of sexual abuse as determined by training records and the interviews.

#### **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 any 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.**

The Zero Tolerance policy provides that no resident or employee who reports an allegation and/or cooperate with an investigation will suffer retaliation from other residents or other employees. The Compliance Manager serves as the retaliation monitor and was interviewed regarding his role. The policy identifies protection measures that may be utilized to monitor for retaliation when a resident or staff member reports sexual abuse or sexual harassment or if they cooperate with an investigation. The policy and the staff member indicated that protection measures would include room and/or dormitory reassignments, emotional support and status checks.

According to the Compliance Manager, the monitoring occurs for at least 90 days for staff members and longer if it is deemed necessary and the monitoring is ongoing regarding residents. The interview further indicated that items that would be monitored to assess retaliation for residents include but are not limited to disciplinary reports and score sheets for the behavior management system. Items that would be monitored for staff include but are not limited to the review of denial for a possible promotion; and overtime work. There has been no incident of retaliation within the past 12 months as indicated through the interview and the review of documented status checks conducted by the Compliance Manager.

### **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; isolation is not used at this facility. Each dormitory has a recessed area/room that has no door and is staff monitored for the use of time out periods.

### **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 Administrative Investigations and Reporting to Youth policy addresses this standard. The facility has two administrative investigators, the Compliance Manager and Clinical Supervisor. Administrative investigations may also be conducted by the Ohio Department of Youth Services (ODYS), Office of the Chief Inspector. Criminal investigations are conducted by the Ross County Sheriff’s Office and sustained allegations will be referred for prosecution as confirmed through the training and staff interview.

Investigations are not terminated solely because the source of the allegation recants the allegation. There is an investigation pending with the Ross County Sheriff’s Office. The allegation has been substantiated as an inappropriate relationship with a youth by the ODYS Office of the Chief Inspector and the facility determined there were policy violations by the staff and she was terminated.

The facility investigators have received the training, PREA: Investigating Sexual Abuse in a Confinement Setting, through the National Institute of Corrections. The Clinical Supervisor discussed, during the interview, the tenets in conducting an administrative investigation. The policy, review of investigative reports, and the interview supports that the facility maintains all written reports pertaining to investigations.

The staff interview confirmed that the training topics included:

- \*techniques for interviewing juvenile sexual abuse victims;
- \*proper use of Miranda and Garrity warnings;
- \*sexual abuse evidence collection in a confinement settings; and,
- \*the criteria and evidence required to substantiate a case for administrative or prosecution referral.

### **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 Administrative Investigations and Reporting to Youth policy and the staff interview support that the facility imposes a standard of a preponderance of the evidence for determining whether allegations of sexual abuse or sexual harassment are substantiated. Reviewed administrative investigative documents support this premise.

### **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 Administrative Investigations and Reporting to Youth policy addresses this standard. A review of the document informing a resident of the results of an investigation was reviewed which informed the resident of the outcome of an investigation. The allegation was explained and the resident was informed of the administrative findings and that the allegation was referred to law enforcement for an investigation. The resident was also informed of the staff member’s termination.

The memorandum contained the signatures of the Compliance Manager and the resident and the date. The memorandum also identified the possible findings regarding the results of an investigation and defined each one; substantiated, unsubstantiated or unfounded. The written document included that the resident would be informed of the outcome of the criminal investigation and any subsequent actions. The notification to the resident was also documented in the resident’s case notes. The Director remains abreast of the investigations through serving as the primary contact person with the investigative agencies.

### **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.**

The Zero Tolerance policy addresses this standard and provides for staff disciplinary sanctions up to and including termination for violating the PREA policies regarding sexual abuse or sexual harassment. The facility reports that in the past 12 months, there has been one staff member to violate the policies related to sexual abuse or sexual harassment.

There was no staff member disciplined, short of termination, regarding the PREA policies during this audit period. The substantiated administrative findings of an investigation regarding a staff member resulted in termination and all notifications were made according to the requirements of the policy and the standard. This situation was confirmed

through document review and the interview with the Director. The policy provides guidelines for disciplining staff, aligned with the intent of the standard.

### **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 Zero Tolerance and Volunteer policies address the corrective actions regarding any contractor or volunteer engaging in sexual abuse of residents. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse. According to the Director, when a contractor or volunteer engages in sexual abuse with a resident, the services will be terminated and the Ross County Sheriff’s Office will be notified and all notifications will be made as required by policy. Contractors and volunteers document acknowledgement of the PREA training. A review of documentation, and interviews conducted with the Director and a volunteer supported that the PREA training occurs.

### **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 Zero Tolerance policy and Youth Handbook provides that residents are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the resident engaged in resident-on-resident sexual abuse. It is reported that during the past 12 months, there has not been an allegation of resident-on-resident sexual abuse. Residents found in violation of facility rules are subject to sanctions pursuant to this administrative process.

The interview with the Director indicated that a resident who has perpetrated sexual abuse would subsequently be transferred back to the Ohio Department of Youth Services and subsequently placed in another facility. According to the interviews conducted with the Nurse and the Clinical Supervisor, follow-up medical and mental health services would be provided at the facility for the victim.

The behaviors that residents may be disciplined for including PREA related behaviors are addressed in the Youth Handbook. A review of the Handbook support that disciplinary sanctions have been developed to be commensurate with the nature and circumstances of a violation. The residents are informed of the disciplinary process and disciplinary actions for unacceptable behaviors including sexual abuse and sexual harassment. 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 and the resident interviews confirmed that the residents are fully aware of this information. The facility prohibits all sexual activity between residents and considers that sexual activity constitutes sexual abuse only if it is determined that the activity was coerced.

### **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 Screenings policy and the Confidentiality policy address this standard. When a resident discloses prior victimization or abusiveness during the intake screening process, a follow-up meeting will be provided with a mental health or medical practitioner within 14 days of the intake screening. A review of documented encounters by mental health and the staff interview revealed that residents who disclose during the risk screening process will generally receive a follow-up meeting with mental health the same day.

According to policy, no information regarding sexual abuse history is to be shared with other staff unless it is required for security and management decisions. Informed consent will be obtained for residents over 18 years old prior to the healthcare personnel reporting information disclosed about prior sexual victimization that did not occur in an institutional setting. The facility utilizes Informed Consent/Limitation of Confidentiality and HIPPA Acknowledgement Forms.

### **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 Access to Emergency Medical and Mental Health Services (PREA Addendum) policy provide for 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 investigation. The interviews with the Nurse and the Clinical Supervisor confirmed that a victim of sexual abuse will receive immediate and unimpeded access to emergency medical treatment and crisis intervention services and that the nature and scope of these services would be determined according to their professional judgment.

Policies and procedures exist for contacting medical and mental health staff if they are not in the facility at the time of a sexual abuse incident or allegation of sexual abuse. Staff interviews confirmed their awareness of the the methods to implement for

protecting residents and for obtaining emergency services. The staff interviews also confirmed and policy supports that timely information would be provided to a victim regarding sexually transmitted infection prophylaxis. The interviews and review of policy and other documentation confirmed that the services provided at the facility are consistent with the community level of care and that immediate medical treatment and crisis intervention services will be provided if there is an incident or allegation of sexual abuse. Secondary materials regarding medical and mental health encounters and the treatment services are maintained.

### **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 Assessment policy addresses this standard and provides for ongoing medical and mental health evaluation and treatment, where appropriate, for sexual abuse victims and abusers. The policies and interviews with the Nurse and Clinical Supervisor support ongoing medical and mental health care within the facility and will include follow-up medical and mental health services as indicated. The interviews with the staff; review of policy and other documentation; and observations of regular staff encounters with residents observed during the sight visit support that the services provided in general 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. All treatment services will be provided at no cost to the victim and whether or not the victim identifies the perpetrator or cooperates with the investigation and according to the Clinical Supervisor. The interview also supported that a mental health evaluation of all known resident-on-resident abusers will be conducted on the same day of admission or the next business day.

### **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 Administrative Investigations & Reporting to Youth policy addresses this standard and identifies the staff members that would make up the incident review team. Details regarding the role of the incident review team are provided by the policy and the Director, who serves on the team, is aware of the requirements. According to the the interview with the Director, the incident reviews occur at least 30 days after the conclusion of the investigation.

The interview with the Director also provided that the team considers adequacy of the staff coverage; staff supervision; monitoring technology; any need for policy changes; etc. A review of the meeting minutes from an incident review demonstrated that the

activities of the meeting are documented and include recommendations. Documentation was also reviewed that verified that a recommendation made was implemented through a subsequent staff meeting. The Director ensures that the recommendations of the incident review team will be implemented and that when they are not, the reasons will be documented.

### **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 Sexual Abuse Data Collection (PREA) policy address this standard and provides that the facility will maintain data for allegations of sexual abuse, including data gathering necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. A review of the report and the interview with the Compliance Manager support that the review of collected data of incidents occur.

The facility 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 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.

### **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.**

The Sexual Abuse Data Collection (PREA) policy addresses this standard including the review of data for the development of corrective actions and it provides for the posting of an approved annual report on the facility’s website. Data review occurs and corrective actions are implemented as indicated. A review of the Facility PREA Vulnerability Assessment Recommendations report; annual report; and observations during the comprehensive facility tour confirmed that data review and the implementation of corrective actions occur.

The policy and practice provide for a review of the data to use the information to identify and address any opportunities for improvement related to staff training; resident education; and policies and procedures related to sexual abuse prevention, detection and response. Review of documentation and interviews confirm that an annual report is documented and is accessible to the public through the facility’s website. The annual 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 Sexual Abuse Data Collection (PREA) policy address this standard and provides that the incident-based and aggregate data and other related documents are securely retained, which was observed during the site visit. The policy also provides for the required data to be maintained for at least 10 years after the date of its initial collection. 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

August 10, 2017

Auditor Signature

Date