

PREA AUDIT REPORT INTERIM FINAL

JUVENILE FACILITIES

Date of report: June 29, 2016

Auditor Information			
Auditor name: Shirley L. Turner			
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Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: June 13, 2016			
Facility Information			
Facility name: Oakview Juvenile Residential Center			
Facility physical address: 67701 Oakview Road, St. Clairsville, OH 43950			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 740-695-3500			
The facility is:	<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		
Facility type:	<input type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Other
Name of facility's Chief Executive Officer: John Rowan			
Number of staff assigned to the facility in the last 12 months: 25			
Designed facility capacity: 24; provide housing for 16			
Current population of facility: 6			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 13-17			
Name of PREA Compliance Manager: Misty Touville		Title: Treatment/Licensing Director	
Email address: mtouville@oakviewrc.org		Telephone number: 740-695-3500	
Agency Information			
Name of agency: Oakview Juvenile Residential Center			
Governing authority or parent agency: <i>(if applicable)</i> Executive Board of Judges			
Physical address: 67701 Oakview Road, St. Clairsville, OH 43950			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 740-695-3500			
Agency Chief Executive Officer			
Name: John Rowan		Title: Executive Director	
Email address: jrowan@oakviewrc.org		Telephone number: 740-695-3500	
Agency-Wide PREA Coordinator			
Name: Misty Touville		Title: Treatment/Licensing Director	
Email address: mtouville@oakviewrc.org		Telephone number: 740-695-3500	

AUDIT FINDINGS

NARRATIVE

The Oakview Juvenile Residential Center is a minimum security facility that is staff secured, located in St. Clairsville, Ohio and serves as an alternative to placing adjudicated male felony offenders in an Ohio Department of Youth Services (ODYS) correctional facility. The design capacity of the facility is 24; however the population is maintained at 16. The facility is licensed by the Ohio Department of Job and Family Services (ODJFS) to provide services for 16 residents. In addition to being licensed by ODJFS, the facility is accredited by the American Correctional Association (ACA). The Executive Board of Judges serves as the governing board of the facility and is made up of a group of juvenile court judges from Belmont, Harrison, Noble, Monroe, Jefferson, and Guernsey counties.

The facility offers a comprehensive program consisting of individualized treatment plans; pro-social skills development; individual, family and group counseling; substance abuse counseling; relapse prevention; and transition services. A referral packet for each resident is reviewed by the facility's treatment team to determine the suitability of the program for the youth. Consideration for placement in the Oakview Juvenile Residential Center is based on the youth and parent(s) ability to participate in treatment; the youth's ability to function in the residential facility environment; and the facility's ability to provide treatment services for the youth's particular pattern of delinquent behavior. The length of stay for residents is six to eight months.

Medical services are provided and coordinated by a part-time Registered Nurse who is also provides on-call services to the facility. Forensic medical examinations will be conducted at the Belmont County Hospital or, depending on the need, Akron Children's Hospital. A medical screening is conducted by the nurse on each resident upon their admission to the facility. Mental health services are provided, through a contract with The Village Network, by a Licensed Social Worker who is at the facility three days per week. Psychological and psychiatric services are also provided through The Village Network. Education services are provided through a contract with the Ohio Valley Educational Service Center and all classes are taught by certified teachers. Library services are provided to the residents and include an array of materials that may be used for individual reading and school reports. Case management and social services are provided and coordinated by the Case Manager. Youth Leaders and Supervisors ensure the proper management and supervision of the residents during the programming activities and provision of services. It was observed that staff members provide direct supervision to the residents on the living units and throughout the facility's program operations.

The implementation of the Daily Reinforcement System helps to shape the residents' behavior throughout each day. The System has been designed to allow staff to deliver reinforcements and sanctions to address negative behavior and encourage positive behavior. The reinforcements for positive behavior include verbal praise; a daily incentive; the Point Store; Reinforcement Raffle; and Family Raffle Ticket Box. A monthly drawing of raffle tickets is held and the winners may receive points to be used toward a purchase from the Point Store. Raffle tickets are also used to encourage family participation in program activities and are awarded to a family for participation in an approved facility activity such as family therapy and visitation.

All residents must complete 50 community service hours and the hours are documented and sent to the court. Residents may earn home and community passes when they achieve a certain level within the program. The weekend passes range from one hour to 48 hours. Community passes include recreation and enrichment activities such as sporting events and movies. Residents are involved in weekly house meetings where they discuss ways the living conditions could be improved; voice any concerns; and solve problems as a group. Life skill sessions are scheduled several times per week. Through the life skill sessions the residents are exposed to practical learning opportunities such as how to do laundry; how to complete a research paper; and how to cook.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Oakview Juvenile Residential Center is situated on five acres of land approximately five miles from downtown St. Clairsville. It is also approximately 120 miles east of Columbus, Ohio and 15 miles west of Wheeling, West Virginia. The facility is approximately 13,216 square feet of area. The mission of the program is “to make a positive and instrumental difference in the lives of youth by providing rehabilitative treatment to meet their individual and collective needs.” The attractive entrance to the facility contains a lobby and reception area where visitors may sign in/out. Beyond the primary entrance area are administrative offices; conference room; dining room/kitchen; closets; and maintenance office. A hallway leads to the intake area; medical clinic; command center; living units; classrooms; and gymnasium with an adjacent exercise room. There is a range of recreation equipment and leisure time games and supplies for the residents to use. The exercise room contains a variety of weight lifting and cardiovascular equipment.

The three living units have eight single occupancy rooms and the units surround the central command area. Each living unit contains a day room area with tables, chairs, and a television. A laundry room, two bathrooms with showers and a water fountain are located on each unit. The single occupancy rooms contain a bed, desk, and storage for clothing and personal items. The Rec Room is located on one of the living units and is used to reward positive behavior. It contains a sofa and related seating; television; VCR; game stations; and a ping pong table. The facility is very clean and well-maintained. The command center contains monitors for viewing various areas of the facility and there is an unobstructed view into each of the three living units. A staff desk is situated near the front entrance into each living unit leading from the command center. The offices of the Case Manager and Shift Supervisor and the Resource Room are located adjacent to the command center. A telephone is located on each unit for the residents to directly report, through the abuse reporting hotline, allegations of sexual abuse and sexual harassment.

Mirrors and all-day burning lights have been placed in closets and storage areas to increase visibility and keep residents safe. Additionally, signs are posted throughout the facility indicating areas where residents are not allowed or areas where residents may enter only when accompanied by staff. Appropriate space exists in the facility for counseling sessions and visitation. The living units and the entrance lobby contain PREA reporting information. The outside grounds has a full-length basketball court and a volley ball court. Cameras are strategically placed outside as well as inside of the facility and may be monitored from master control and administrative offices. Twelve youths were admitted to the facility during the past year. There are 25 staff currently employed at the facility who may have contact with the residents and the number of staff in this category who were hired during the past 12 months is four.

SUMMARY OF AUDIT FINDINGS

The notifications of the site visit were posted in various parts of the facility prior to the site visit. Photographs were taken of the posted notices and forwarded to this Auditor. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive and mailed. After a review of the information, notes were sent to the ODYS statewide PREA Coordinator requesting clarification on some of the information provided and additional information and a response from the facility was provided. The Treatment/Licensing Director serves as the PREA Coordinator for the Oakview Juvenile Residential Center and the ODYS statewide PREA Coordinator, PREA Administrator, provides guidance regarding the PREA audit process.

The site visit was conducted June 13, 2016 and Flora Boyd, Certified PREA Auditor, assisted during the visit. The Treatment/Licensing Director greeted the auditors and the ODYS PREA Administrator upon arrival to the facility. Prior to the entrance meeting, two staff members were interviewed from the overnight shift. After those interviews were completed an entrance meeting was held with the Executive Director, Deputy Director, Treatment/Licensing Director, and the ODYS PREA Administrator. A comprehensive tour of the facility was conducted by the management team at the conclusion of the entrance meeting. The tour covered all areas of the facility including living units; classrooms; medical clinic; gymnasium; work-out room; outside grounds; offices; storage areas; resource room; command center; and intake area. During the tour, staff members were observed directly monitoring residents while they were in school. The facility utilizes a camera system; mounted mirrors; and all-day burning lights in certain areas to enhance and support the direct supervision provided by staff.

A total of six residents were in the facility on the day of the site visit; all were interviewed. Six direct care staff members were interviewed that covered each shift. There were 14 specialized staff interviews conducted and included a contractor. The interviews with staff members and residents revealed that they received initial PREA training and refresher training. Staff members were knowledgeable of their duties and responsibilities as they relate to PREA. The residents interviewed shared their familiarity with the meaning and purpose of PREA. The residents were clear on how to contact victim advocacy services and they are aware of the services that may be provided if they ever need them.

The supporting documentation for each standard was provided in organized and neat folders during the site visit and additional documentation was provided as requested. A close-out meeting was held at the conclusion of the site visit and a summary of the audit findings was provided. The facility staff included in the meeting were the Executive Director; Deputy Director; Treatment/Licensing Director; Case Manager; and the ODYS PREA Administrator. Additional ODYS central office staff, the Bureau Chief of Quality Assurance & Improvement and the Bureau Chief of Community Facilities, participated in the close-out meeting by telephone.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

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

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy FO-3D-04-2-10 provides the facility’s overview of zero-tolerance for all forms of sexual abuse and sexual harassment and outlines the approach to preventing, detecting, and responding to such conduct. There are a host of other facility policies which are supportive of the zero-tolerance approach and outline the strategies for addressing the components of the PREA standards: prevention and responsive planning; training and education; risk screening; reporting; official response following a resident report; investigations; discipline; medical and mental care; and data collection and review. Prohibited behaviors, sanctions for those who participate in such behaviors and related definitions are included in the policies. The Treatment/Licensing Director serves in the role of PREA Coordinator, reporting to the Executive Director, as verified by staff interviews and the documented facility organization chart. The PREA Coordinator expressed in her interview that she has sufficient time and authority to manage and coordinate the facility’s efforts in complying with the PREA standards and explained her process of applying the standards.

Standard 115.312 Contracting with other entities for the confinement of residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

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

Policy FO-3D-04-2-10 provides for the required staffing ratios of one staff to eight residents during the waking hours and one staff to 16 residents during the sleeping hours. The Policy also requires that if a deviation from the staffing ratios occurs, the deviation and the surrounding circumstances are to be documented. The facility has been able to maintain the PREA required staffing levels in anticipation that the standard will go into effect October 1, 2017. The facility is licensed to house 16 residents and a review of documentation, staff interviews and observations provide that an adequate level of staffing is provided. The Executive Director explained how he ensures adequate coverage at all times by reviewing the schedule with the Deputy Director on a weekly basis and with the PREA Coordinator once a month.

Staffing levels are based on factors such as the make-up of the population; licensing requirements; general practices for juvenile residential facilities; the number of supervisory staff; and program activities. The average daily number of residents since August 20, 2012 is 11 and the average daily number of residents on which the staffing plan was predicated since that time is 16. The staff handbook is provided to each employee of the facility and it provides an overview of identified policies and the programs and benefits offered. It is included in the handbook that direct care staff and shift supervisors may be required to work mandatory overtime when their relief does not show up for work or during an emergency. The Executive Director confirmed that there has not been a deviation from the staffing requirements during this audit period.

An annual staffing plan assessment is conducted and documented by the Treatment/Licensing Director who also serves as the PREA Coordinator and it evaluates components that include the level of staffing, prevailing staffing patterns; and assesses the deployment of cameras. A review of the meeting agenda of administrators and supervisors, held in January 2016, revealed the inclusion of the discussion of staffing plan and the assessment. Policy FO-3D-04-2-10 provides for unannounced rounds to be conducted on each shift. The administrative staff and supervisors have been identified to conduct the unannounced rounds and are required to document such rounds for each shift. A review of documentation and an interview with the Deputy Director revealed that the unannounced rounds occur during each shift. The practice is that staff does not alert other staff when the rounds occur.

Direct care staff has to provide prior notification of at least two hours when they are unable to report to work as assigned. A staff member already working would be assigned to hold-over or another staff member may be called in to ensure that coverage is maintained. An Administrator is on-call to the facility seven days a week, 24 hours a day and will assist in coordinating any required coverage. The administrators are properly trained to provide coverage if emergency coverage is needed. An assessment is conducted annually by the Ohio Department of Youth Services PREA Administrator which reviews the physical plant regarding practices and physical barriers that may impact the protection of residents from sexual abuse and sexual harassment. A written report, Facility PREA Vulnerability Assessment Recommendations, was provided to the facility by the PREA Administrator which provided guidance on the improvements that needed to be made to continuously improve the protection of residents, including but not limited to the addition of mounted mirrors and the posting of signs regarding restrictions of residents in certain areas. The report also stated that during the vulnerability assessment staff members were in all areas where the residents were and that no residents were observed to be in the identified restricted areas. The facility has used the report to enhance the monitoring of residents.

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.

Policies FO-3A-05 and JS-5A-01-13 address this standard and per the policies, staff does not conduct strip, pat-down or visual body cavity searches of residents. Policy FO-3A-05 outlines how a search is conducted. During the admission process, the youth removes his clothing and passes it to staff and is provided facility clothing to put on. The youth's clothing and shoes are searched and the bathroom is searched to ensure that the youth has not left contraband behind. The routine search is referred to as a personal search where a resident is instructed to empty his pockets, remove his shoes, etc.

The staff receive training in conducting cross-gender, transgender and intersex pat-down searches. The staff training includes the viewing of the video, Guidance in Cross-Gender and Transgender Pat Searches. The training is documented by each participant signing and dating the Training Event Record. This form also contains the learning objectives of the training and the date the training was provided. The facility reports that during the past year there have been no cross-gender visual body cavity searches or cross-gender pat-down searches of residents and this was confirmed through staff and resident interviews. The policies and procedures are implemented that ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by the opposite gender. The staff and resident interviews, a review of the policies, and the information provided during the tour regarding staff duties confirmed the practices. As shared by staff and residents, only one resident at a time is allowed in the bathroom on the living unit or on the hall, which are designed to provide the expectation of privacy for each resident.

Staff members of the opposite gender are directed by policy to announce their presence when entering the housing units, where residents may be showering, changing clothes or performing bodily functions. There is a red button that female staff will push prior to entering the living areas to alert the residents of their presence. Some staff and residents interviewed stated that in addition to using the button, female staff will also announce verbally when they are in the area. Resident and staff interviews revealed that the button is used each time a female staff member enters the living unit. Staff members are prohibited by policy from searching transgender or intersex residents to determine the resident's genital status. The staff interviews confirmed their knowledge regarding the prohibition of searching of such residents solely to determine their genital status and related that, where it is unknown, learning this information would be part of a broader medical examination conducted by the medical staff in private..

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.

Policy FO-3D-03 require support services for residents with disabilities and who are limited English proficient and provides that the services will be provided as needed. The facility has a contract with the Ohio Valley Educational Service Center (OVESC) which includes the related support services. The policy and a letter signed by the Director of Special Education for OVESC confirmed that the agency will provide interpreters, hearing specialists, vision impaired specialists, and an audiologist to ensure access to services that will provide disabled residents the opportunity to participate in PREA education sessions and report allegations of sexual abuse and sexual harassment. The facility does not rely on resident interpreters or resident readers, per policy, which was confirmed by interviews with staff. The facility has the resident handbook printed in Spanish, an audio resident handbook, and a PREA education video in Spanish. The hotline number for advocacy services may also be accessed in Spanish. The facility reports that no residents have been used as interpreters, readers or in any way to provide interpretive services during this audit period.

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.

Policies AM-1C-08-09 and AM-1C-10 provide the details regarding the hiring process, coordinating and reviewing background checks, and the grounds for termination, in accordance with each section of the standard. State and federal criminal background checks are conducted on new employees as evidenced from a review of completed documentation that also includes the Electronic Sex Offender Registration and Notice system and driver license checks. There was evidence of background checks being conducted on employees and contractors and in the five-year period for employees. A review of a sample of personnel records, review of the policies, and the interview with the Treatment/Licensing Director confirmed that the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire an employee or contractor or to promote an employee.

The interview process for new hires includes the inquiry about whether the potential hire may have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, institution or juvenile facility; convictions of engaging in or attempting to engage in sexual assault; civilly or administratively adjudications regarding the aforementioned. The interview with the Treatment/Licensing Director and a review of a sample of personnel records confirmed that the practices meet the requirements of the standard. In the past 12 months, there have been two new hires who have contact with residents that had criminal background checks conducted and there were no new contractors hired during this time. Policy provides that staff has a continuing duty to report related misconduct and there is further provision that material omissions of such conduct or providing false information will be 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.

No expansions have been made to the facility since August 2012. Staff supervision is supplemented with a camera system which was updated with significant additions and enhancements during this audit period. Additional cameras and servers were installed and some existing cameras were replaced. The system also has the capability to retain videos in the server for 45-60 days, depending on the amount of information stored. Monitoring can be conducted from the cameras at the command center and recorded video may be accessed from the systems room and the offices of the Executive Director, Deputy Director, Treatment/Licensing Director, and the Office Manager.

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.

Policy FO-3D-04-2-10 address this standard. The facility has identified and trained staff that will conduct administrative investigations. The facility staff who conduct administrative investigations have received training through the National Institute of Corrections. The Belmont County Sheriff's Office is responsible for conducting investigations of allegations that may be criminal in nature. The Policy provide the guidelines for the protocols of all PREA related investigations. A Memorandum of Understanding (MOU) exists between the facility and the Belmont County Sheriff's Office which states that the Sheriff's Office will provide response services regarding allegations of sexual assault and sexual abuse. The MOU provides that the Sheriff's Office will follow a uniform evidence protocol that is appropriate for youth and is aligned with the facility's policies and the standard. The MOU commits the Sheriff's Office to using investigators who have received special training in sexual abuse investigations involving juvenile victims, including proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria and evidence required to substantiate a case for prosecution referral. Training certificates were reviewed belonging to the investigator from the Sheriff's Office who will conduct the PREA investigations. The documentation showed completion of courses such as: Sexual Assault Investigation, which is advanced training at the Ohio Peace Officer Training Academy; Sexual Assault Training through the victim advocacy agency, Tri-County Help Center; and Lust Homicide & Sexual Predator Investigations through the Columbus Division of Police Regional Training. The Belmont County Children Services office may also be contacted regarding sexual abuse.

There is a MOU with the Belmont Community Hospital Emergency Room for forensic examinations to be conducted at that facility at no cost to the victim, conducted by a Sexual Assault Nurse Examiner which is aligned with the facility policy. The MOU states that a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. It further states that the protocol used is age appropriate and is adapted from or based on the most recent edition of the United States Department Of Justice's Office of Violence Against Women publication. The hospital also commits to making a victim advocate available from a rape crisis center, if requested. No forensic exams have been conducted during this audit period.

Victim advocacy services that will be provided are documented in a Memorandum of Understanding with the Tri-County Help Center. The services that will be provided to residents, as outlined in the MOU and verified by the agency's Executive Director, include accompaniment and support to the victim through the forensic examination and the investigatory interviews; crisis intervention services; provide options for resources; and provide follow-up services. The Tri-County Help Center may be contacted for services by the victim, Belmont County Sheriff's Office and/or the Belmont Community Hospital. Information regarding advocacy services is provided to the residents during the intake process and is posted in each living unit. Interviews with all of the residents revealed their knowledge of the availability and the type of services provided by the advocacy agency if they are ever needed. It was confirmed that the Tri-County Help Center has received no calls regarding any incidents of sexual assault or sexual harassment from the facility.

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.

Policy FO-3D-04-2-10; identified and trained facility investigators; MOU with the Belmont County Sheriff's Office; and staff interviews ensure that allegations of sexual assault and sexual harassment will be referred for administrative or criminal investigations as required. The facility reports that during the past 12 months there were no allegations of sexual abuse or sexual harassment. The Policy directs staff to report verbal or written allegations immediately to their supervisor and to document the receipt of verbal allegations by the end of their shift. An incident report form exists to document significant incidents.

The staff interviews confirmed the requirement of documentation of verbal allegations of sexual abuse or sexual harassment. Additional internal forms including the PREA Criminal Investigation Checklist have been created to ensure that investigations are conducted and that

the proper contacts are made. Agency policy and other information regarding reporting allegations of sexual assault and sexual harassment are available on the facility's website and within the facility, accessible to the public.

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.

Policy AM-1D-1-13 provides that all staff receive PREA related training and provides information on the type of training required. The training is tailored to the population served. Employees are not reassigned from other facilities. A review of the training materials, including a training roster and staff interviews confirmed that the required training occurs. Additionally, staff sign an acknowledgement form that indicates that they received and understand the training. All random staff interviewed reported receiving initial PREA training and refresher training to remain knowledgeable and aware of current issues. Training on the PREA requirements are conducted annually and a refresher or update may be conducted as needed. A review of the training material and interviews with staff verify that the training includes the zero-tolerance policies; staff responsibilities; the right for staff and residents to be free from retaliation; the dynamics of sexual abuse and sexual harassment; and the other required topics of the standard.

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.

Policy AM-1D-1-13 requires that volunteers and contractors who have contact with residents be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to any allegation. A review of training rosters, training logs, and signed acknowledgement forms revealed that contractors receive the required training. Volunteers also receive the PREA training when they are involved with the facility. The acknowledgement form also informs the person in receipt of the training of the consequences when the policies are not adhered to. The training was evidenced through an interview with a contractor who understands zero-tolerance regarding sexual abuse and sexual harassment and how to report those incidents.

Standard 115.333 Resident education

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy JS-5A-01-13 provides that all residents admitted to the facility receive information about the facility's zero-tolerance policies, including how to report allegations of sexual assault or sexual harassment and the right to be free from retaliation for reporting. Residents receive PREA education verbally and in writing upon admission to the facility and are provided with related materials. Within 10 days of admission the residents receive more detailed information verbally and by watching a video. The PREA related information is also contained in the resident handbook. A review of the education materials, staff interview, and the resident interviews demonstrate that the PREA education sessions are age appropriate and thorough. The Case Manager is responsible for conducting the PREA education sessions with the residents. The residents print and sign their names on a training rosters and sign an acknowledgement statement, both indicating receipt of the PREA education information.

The facility has the capability of providing the PREA education in formats accessible to all residents, including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. The facility has the resident handbook printed in Spanish; the education video is in Spanish; and there are videos for the hearing impaired. A letter signed by the Director of Special Education for the Ohio Valley Educational Service Center confirm that the agency will provide interpreters, hearing specialists, vision impaired specialists, and an audiologist to ensure access to services that will provide disabled residents the opportunity to participate in PREA education sessions. PREA information is posted in each living unit and other areas of the facility. Interviews with direct care staffs support that residents are not used as interpreters or readers for other residents.

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.

Policy FO-3D-04-2-10 addresses the required training of facility staff who conduct administrative investigations and provide that the Belmont County Sheriff's Office has trained personnel in their Sexual Assault Investigative Unit. The facility maintains the training certificates for the investigative staff who have completed the National Institute of Corrections course, PREA: Investigating Sexual Abuse in a Confinement Setting. A Supervisor was interviewed who will conduct PREA related administrative investigations and her interview and her certificate of participation indicated that she had received the required training.

The Memorandum of Understanding with the Belmont County Sheriff's Office states that the Sheriff's Office will use investigators who have received special training in sexual abuse investigations involving juvenile victims, including proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria and evidence required to substantiate a case for

prosecution referral. A sample of training certificates were reviewed belonging to an investigator of the investigations unit with the Belmont County Sheriff's Office who will conduct the PREA investigations at the facility. The certificates were for the following training: Sexual Assault Investigation, advanced training at the Ohio Peace Officer Training Academy; Sexual Assault Training through the victim advocacy agency, Tri-County Help Center; and Lust Homicide & Sexual Predator Investigations through the Columbus Division of Police Regional Training.

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.

Policy FS-4C-01 require medical and mental health staff members to receive the initial training and the specialized training developed for medical and mental health personnel. The specialized training is obtained through completion of online training through the National Institute of Corrections. Training certificates were reviewed for the providers of nursing and mental health services. The nurse's certificate was for the completion of PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting and the certificate for the provider of mental health services confirmed the course of PREA: Behavioral Health Care for sexual Assault Victims in a Confinement Setting. The interviews with the Registered Nurse and the Licensed Social Worker supported that they had received the training. Forensic examinations are not conducted at the facility. These examinations will be conducted at the Belmont Community Hospital emergency room by a Sexual Assault Nurse Examiner (SANE). The SANE staff who will be performing the forensic examinations is certified by the Forensic Nursing Certification Board and the certification is for adolescents and adults.

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.

Policy 3D-04-2-10 requires that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents be conducted on each resident admitted to the facility within 24 hours of their arrival and that an objective screening instrument be used. The screening instrument, Vulnerability Assessment, is used by the Case Manager to assess and obtain information that will assist staff in reducing the risk of sexual abuse by or upon a resident. Although an instrument was used to assess, as well as reassess risk, it was recommended that it be enhanced with revisions to increase its objectivity. The staff was very receptive and implemented a corrective action

to revise the Vulnerability Assessment. The use of the revised instrument has been implemented and the document has been reviewed by this Auditor. The improved instrument provides increased measures and weights in determining a resident's risk level of sexual victimization or abusiveness. The instrument continues to provide for the reassessment of a resident's risk level due to an incident of sexual abuse; a referral or request that is made; or when there is new information that bears on the resident's risk of sexual victimization or abusiveness. The Case Manager conducts informal reassessments with each resident during their weekly level review meeting.

The screening instrument obtains personal information that includes but is not limited to prior sexual victimization or abusiveness; the resident's identification as gay, straight, bisexual, transgender, or intersex; intellectual or developmental disabilities; the resident's concern for his own safety; age; and gender non-confirming appearance or manner. The Case Manager obtains the required information to complete the assessment through a review of related paperwork; reviewing information gleaned from a preliminary screening she conducts while the youth are in detention; and parent interviews. The Case Manager shared that she asks direct questions and probes as she needs to when completing the Vulnerability Assessment. The interviews with the Case Manager and residents and a review of documentation verified that initial risk screenings and reassessments are being conducted for all residents. The initial risk screening is conducted within 24 hours of admission to the facility.

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.

Policies 3D-04-2-10 and FO-3E-04 provide guidance to staff on how the information obtained from the screening instrument is used. Information gleaned from the screening instrument is intended to assist staff in determining housing and program assignments with the goal of keeping all residents safe and free from sexual abuse. The Case Manager shared during the interview how the information is used in determining housing and program activities. Staff and resident interviews and observations confirmed that isolation is not used at this facility. During this audit period, there were no allegations made regarding sexual abuse or sexual harassment and no residents were determined to be at risk of sexual victimization.

Policy Fo-3E-04 prohibits placing gay, bisexual, transgender, or intersex residents in separate housing based solely on such identification or status; assignments will be made on a case-by-case basis. Additionally, the Policy prohibits considering gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive and provides for consideration of the resident's concern for his own safety. The Case Manager is familiar with the Policy requirements and that a transgender or intersex resident will be reassessed at least twice a year to review any threats to safety experienced by the resident. Transgender and intersex residents will shower separately; all residents shower separately. The design of the two bathrooms on each unit which contain one shower stall each and the facility practice ensures that all residents shower separately.

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.

Policy FO-3E-03 provides for multiple internal ways for a resident to report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation that may lead to abuse. Residents may talk to any staff member; submit a grievance form with their name and date on it; or submit a written note in a sealed envelope for delivery to administrative staff. The facility provides a designated youth telephone on each unit for unfettered access to residents for directly reporting, through the sexual assault hotline, allegations of sexual abuse or sexual harassment. The Policy provides that staff interference with the resident using the designated phone can result in disciplinary action. Residents have access to writing utensils, paper, and the forms for completing written requests and submitting allegations of sexual abuse and sexual harassment. Staff members are required to document verbal reports received from residents prior to end of their shift.

Information regarding resident reporting is posted in each living unit and in other locations of the facility. Resident interviews revealed that they are aware of the different ways they can report and are aware that reports will be received from anonymous or third-party reporting of sexual abuse and sexual harassment. Staff interviews revealed that they are aware of the resident reporting methods and how staff can anonymously and privately report allegations of sexual abuse and sexual harassment. Staff members are informed of resident reporting methods through policy, training and posted information. The facility does not hold residents solely for civil immigration purposes.

Standard 115.352 Exhaustion of administrative remedies

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy FO-3D-07 addresses the grievance process and provides that an administrative process is used in dealing with grievances and provides details regarding any third-party assistance to the resident and how to appeal the initial decision in response to the grievance. The Policy provides that there is no time limit for filing a grievance related to an allegation of sexual abuse and residents are not required to use an informal process or give the grievance to any staff member regarding such allegations. The residents have access to grievance forms, writing materials and the locked grievance box. The Policy contains the timelines regarding the grievance procedure including that a final decision is provided within 30 days of the initial filing of the grievance and an extension of up to 30 days that the facility may claim, with written notice to the resident.

Information regarding the grievance process is provided to the resident verbally and in their handbook. Interviews with residents revealed that they are aware that they are not required to use an informal grievance process or otherwise attempt to resolve a PREA related issue with staff. The emergency grievance process entails the resident placing his name and date on the grievance form and checking a box indicating his having been sexually abused or a concern about being sexually abused. An emergency grievance is immediately provided to the Deputy Director. The Policy states that residents will be disciplined for filing a grievance only when it is determined that it was filed in bad faith. No grievances have been completed during this audit period alleging substantial risk of imminent sexual abuse. During the resident interviews, all residents stated that the grievance could be used for reporting an allegation of 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.

Policy FO-3D-01-02 provides residents 24-hour access to outside victim advocacy services. Emotional support services will be provided to victims of sexual abuse by the Tri-County Help Center, a victim advocacy agency located in St. Clairsville. The agency is accessible through the provided hotline number. The contact information is provided in the Memorandum of Understanding (MOU); to the resident during intake; and is posted in each unit on the wall by the dedicated youth phone used for reporting sexual abuse. Residents are also provided written and verbal information regarding the services offered by the Tri-County Help Center and information posted in the living units outlines the services provided. A review of the training roster, posted information and interviews with residents confirmed residents’ receipt of victim advocacy information, including the limitations of confidentiality and the reporting process. A sign is posted on the wall at the youth telephone on each unit that is used to access the hotline and victim advocacy services that reads, “Telephone Calls May Be Monitored.”

The services that will be provided to residents by the Tri-County Help Center, as outlined in the MOU and verified by the agency’s Executive Director, include accompaniment and support to the victim through the forensic examination and the investigatory interviews; crisis intervention services; options for resources; and follow-up services. The Tri-County Help Center may be contacted for services by the victim; facility staff; Belmont County Sheriff’s Office; or Belmont Community Hospital. Interviews with and all of the residents revealed their knowledge of the availability and the type of services provided by the advocacy agency if they are ever needed. Facility policies and practices; interviews with the Executive Director and all residents; and observations provide that residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents or legal guardian. No allegations of sexual abuse or sexual harassment from the facility have been reported to the Tri-County Help Center during this audit period.

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.

Policy FO-3E-03 provides for third-party reporting of sexual abuse and sexual harassment. Third-party reporting information is posted on the facility’s website. Information on how to report allegations of sexual abuse and sexual harassment is posted in the facility, accessible to staff, residents and visitors. Third-party reporting forms are maintained in the lobby available to employees, contractors, visitors, and the general public. Staff and resident interviews confirmed their knowledge of the meaning of third-party reporting and how it may be done. All residents interviewed could identify someone that did not work at the facility that they could report to about sexual abuse or sexual harassment.

Standard 115.361 Staff and agency reporting duties

- Exceeds Standard (substantially exceeds requirement of standard)

- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy FO-3E-03 and State statute require all staff members to immediately report all allegations of sexual abuse to the Executive Director or his designee and to document reported allegations prior to the end of their shift. The facility staff members are also required by Policy to report allegations that were made anonymously or by a third-party. The mental health and medical providers initially inform residents of their duty to report. Written policy provide direction to staff regarding reporting duties and prohibits staff from revealing any information related to a sexual abuse report to anyone, other than those persons required to make treatment, investigation, security or administrative decisions. Administrative investigations are investigated by facility investigators and allegations that are criminal in nature are referred for investigation by the Belmont County Sheriff's Office. A review of policy and dedicated forms and staff interviews ensure that proper notifications will be made within 24 hours, including the parents/legal guardians unless there is documentation for non-notification; child welfare system case worker where indicated; attorney or legal representative where there is court jurisdiction. Staff sign an Abuse and Neglect Statement acknowledging their understanding of their responsibility for reporting suspected incidents of abuse and neglect and that they understand the related facility policies and the State law.

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.

When information is received in a grievance collected by the Case Manager or Supervisor that a resident is subject to a substantial risk of imminent sexual abuse the Executive Director or on-call administrator is immediately contacted, per Policy FO-3D-07. Random staff revealed during interviews that immediate measures to protect a resident include close monitoring; contacting immediate supervisor; notifying the Executive Director or on-call administrator; and separating resident by putting him in another room or unit. The Executive Director stated that an identified perpetrator would be removed from the facility. During the past 12 months, no residents were identified as subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

Policy FO-3E-03 provides that upon the facility receiving an allegation that a resident was sexually abused while confined in another facility, the Executive Director will notify the agency/facility where the alleged abuse occurred and will also notify the appropriate investigative agency. Policy provides that the notification is made as soon as possible but no later than 72 hours of receipt of the allegation. The allegation would be documented on a Significant Incident form by facility staff. During the past 12 months, there were no allegations of a resident being sexually abused while confined in another facility.

Standard 115.364 Staff first responder duties

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy FO-3D-04-2-10 contains the first responder duties and outlines the requirements of the first responder including separate the victim from the abuser; preserve and protect the scene; and request that the alleged victim does not take any action that would destroy physical evidence. Staff interviews with staff members who would serve as first responders and non-security staff revealed that they are aware of their duties. The non-security staff who may act as a first responder knew to request that physical evidence be preserved and to contact direct care staff for assistance. During this audit period there has not been an incident or an allegation of sexual abuse or sexual harassment.

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.

Policy FO-3-D-04-2-10 provides guidance to staff regarding the actions to take in responding to an incident of sexual abuse. The facility has a written Plan for Coordinated Response to Sexual Abuse or Assault that supports the Policy. The Plan outlines, in a charted format, steps to be taken in response to an incident of sexual abuse. The Policy and the Plan identify the staff positions required for an effective facility response, such as the Executive Director; direct care staff; management staff; medical and mental health practitioners; and investigators. Staff interviews revealed that they are aware of their duties in response to an incident of sexual abuse or sexual assault.

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 have collective bargaining.

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.

Policy FO-3D-04-2-10 provides direction regarding protection against retaliation from others for residents and staff who report sexual abuse or sexual harassment or cooperate with investigations. The Policy includes the areas to monitor such as housing changes for the resident victim or abuser; staffing assignments; job performance; and the incident report log. Checklists have been developed to document and track retaliation monitoring and they are aligned with the Policy. The PREA Coordinator, Deputy Director and the Case Manager have been identified as being responsible for retaliation monitoring. The Policy provides for disciplinary action if retaliation is identified.

Retaliation monitoring will be conducted for at least 90 days, longer if needed, following a report of sexual abuse or sexual harassment. The Deputy Director was interviewed regarding retaliation monitoring and he expressed various measures that would be taken to protect residents and staff from retaliation such as housing changes and contacting the Ohio Department of Job and Family Services. He added that retaliation monitoring regarding a resident will continue throughout his stay in the facility. The facility reports that there have been no incidents or allegations of sexual abuse or sexual harassment during this audit period.

Standard 115.368 Post-allegation protective custody

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

This standard is not applicable. Segregation is not used in this facility.

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.

Policy FO-3D-04-2-10 provide the requirements for conducting administrative and criminal investigations including referral for prosecution; retention of reports; staff cooperation with investigations, and those reports made by third-parties and anonymously. Administrative investigations will be conducted by the facility investigators who have been identified as the Executive Director; Deputy Director; Treatment/Licensing Director (PREA Coordinator); Case Manager; and a Shift Supervisor. The investigations that are criminal in nature will be investigated by the Belmont County Sheriff's Office, as confirmed through a review of the Memorandum of Understanding (MOU) which is aligned with the facility policy and the standard. The MOU provides that the facility will make the effort to remain informed about the progress of the investigation conducted by the Sheriff's Office.

If there is an allegation of sexual abuse or sexual harassment occurring at the facility, the following observations and documentation demonstrate that it will be investigated promptly, thoroughly and objectively: current facility practices; training for the facility investigators and the law enforcement investigator; and the MOU with the Belmont County Sheriff's Office. The facility's Policy and the MOU require that an investigation not be terminated solely because the source of the allegation recants the allegation. The Policies, MOU and interviews with the Youth Leader Supervisor and the Executive Director provide information that ensures that administrative and criminal investigations will be conducted in accordance with the requirements of the Policy and standard.

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.

Policy FO-3D-04-2-10 provides that the administrative and criminal investigations will be conducted using no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The facility investigators are familiar with the concept of a preponderance of the evidence.

Standard 115.373 Reporting to residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy FO-3E-03 provides for the resident to be informed that the investigation has been concluded and the outcome of whether it was determined to be substantiated, unsubstantiated or unfounded. Where the facility did not conduct the investigation, the results will be obtained from the Belmont County Sheriff's Office as provided in the Policy, MOU and on the notification form to the resident. Following the completion of an investigation, the resident is notified of the findings in writing through the Youth Notification of Findings form. The documented notification on the customized form contains entries that ensure that all required elements of the notification are made including informing the resident of the outcomes of the accused staff or resident.

The Youth Notification of Findings form requires the signatures of the staff making the notification and the resident. In a situation where an investigation will be conducted by the Belmont County Sheriff's Office, the Executive Director will remain abreast of the investigation through contact with the Sheriff's Office as provided for in policy and the MOU and as stated in interviews with the Executive Director and the PREA Coordinator. The facility reports no allegations of sexual abuse or sexual harassment.

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.

Policy AM-1C-13 provide that staff members are subject to disciplinary sanctions up to and including termination for violations of sexual abuse or sexual harassment policies. All terminations for violations of sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, will be reported as required to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies. The Policy also provides that disciplinary sanctions for violations relating to sexual abuse or sexual harassment, other than engaging in sexual abuse, will be commensurate with the act committed; the staff member's disciplinary history; and the similar history of other staff. During this audit period, no staff member has been terminated or disciplined due to substantiated findings of an investigation regarding allegations of sexual assault or sexual harassment. There have been no allegations or incidents of sexual abuse or sexual harassment.

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.

Policy AM-IC-13 addresses this standard regarding PREA policy violations by contractors and volunteers. The Policy requires that when a contractor or volunteer engages in sexual abuse with a resident, contact with resident would be prohibited and contact made with law enforcement, unless the activity was clearly not criminal, and relevant licensing bodies. The Policy provides that appropriate remedial measures will be taken and further contact prohibited if there are violations of other PREA related policies. The acknowledgement statement for contractors and volunteers reminds them of this information. During the past 12 months, there have been no contractors or volunteers who have been reported for a violation of PREA policies. The interview with the Executive Director confirmed the contents of the Policy.

Standard 115.378 Disciplinary sanctions for residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy FO-3C-03-05 address this standard and provide that residents may be subject to disciplinary sanctions only after formal proceedings regarding resident-on-resident sexual abuse. Residents found in violation of facility rules are subject to sanctions pursuant to a formal administrative process or following a criminal finding of guilt. The Policy also provides that the disciplinary sanctions be commensurate with the nature and circumstances of the abuse committed; the resident's disciplinary history; similar histories of other residents; and consideration of mental disabilities or mental illness contributing to the behavior.

The Policy and the interviews with the mental health and medical providers revealed that a resident's participation in treatment services are not required for him to access programming or education. 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. Additionally, when an allegation is unsubstantiated, a resident will not be disciplined or considered to have made a false report if the allegation was made in good faith. During this audit period, there were no investigations conducted regarding allegations of sexual abuse or sexual harassment.

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.

Policy FO-3D-04-2-10 address this standard and requires that when a resident discloses prior victimization or abusiveness during the intake screening process, a follow-up meeting is provided with a mental health or medical practitioner. When these disclosures are made, a Progress Note Form will be completed by the Case Manager and forwarded to the medical or mental health practitioner within 14 days of the intake screening as prescribed by Policy and according to staff. The Policy states that any information related to sexual victimization or abusiveness occurring in an institutional setting is limited to medical and mental health providers and other staff as required to inform treatment plans and security management decisions.

Clinical records are maintained by mental health and medical staffs that document the services provided to residents. The facility has an informed consent form, Consent to Disclose for Youth Age 18 and Over, that may be utilized to report prior sexual victimization that did not occur in an institutional setting and the resident is 18 years or older. The facility reports that during the past 12 months, no residents disclosed prior victimization or previously perpetrated sexual abuse during the screening process.

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.

Policy FO-3D-04-2-10 and the Memorandum of Understanding (MOU) with the Belmont County Hospital Emergency room ensure that timely and unimpeded emergency medical and mental health services regarding sexual assault 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 medical and mental health providers were aligned with the Policy and the MOU and they stated that emergency services will be provided based on the practitioners' professional judgment. The medical and mental health service providers provide treatment and crisis intervention services and both agree that the delivery of these services are based on their professional judgment.

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.

Policy FO-3D-04-2-10 ensures medical and mental health evaluations and treatment, where appropriate, for sexual abuse victims and abusers. The medical and mental health care may include follow-up services; treatment plans; and referrals for continued care following their release from the facility, transfer or placement to another facility. The mental health and medical services are consistent with the community level of care based on observations, a review of sample records, and interviews with the medical and mental health providers.

The Policy, Memorandum of Understanding with the Belmont County Hospital Emergency Room, and the interview with the medical provider confirmed that resident victims will be offered tests for sexually transmitted infections as medically appropriate. The documents also contain the information that all treatment services will be provided to the victim at no cost to the victim. Policy FO-3D-04-2-10 states that the facility will attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health staff. The interview with the mental health provider indicated that there is the capability for the mental health evaluation services through the contract with her agency for mental health services. Currently, each resident receives a mental health evaluation within the first week of admission.

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.

Policy FO-3E-02 provides details regarding the role of the incident review team and identifies the team members that would conduct the review of the incident where the allegation was either substantiated or unsubstantiated. The incident reviews are to generally occur within 30 days of the conclusion of the investigation. The incident team members have been identified as the Executive Director; Deputy Director; Treatment/Licensing Director who serves as the PREA Coordinator; Case Manager; and Shift Supervisors. Most of the members of the team are also trained to conduct administrative investigations. A form has been developed that would capture the the required considerations while assessing the incident. The form requires documentation of the considatations by the team such as the need to change policy or practice; motivation factors that may have contributed to the incident; physical barriers; adequacy of staffing levels; and adequacy of monitoring technology.

Interviews with the Executive Director and the Deputy Director and a review of the dedicated forms support the guidelines for the incident review process outlined in Policy FO-3E-02. The forms provide the tracking of the review process activities; recommendations for improvement; and indication whether the recommendations were implemented. The interviews and the documentation that support the standard also revealed the understanding of the purpose and role of the team and the incident review process. There have been no allegations or incidents of sexual abuse or sexual harassment during this audit period.

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.

Directions for collecting accurate uniform data for every allegation of sexual abuse and the requirements of the annual report for aggregated data are outlined in Policy FO-3E-02. A review of the Significant Incident Summary for 2015 shows the collected data of significant incidents and provides areas to include data regarding sexual assaults which there are not any for the past year. The facility has the capacity to collect data for allegations of sexual assault, sexual harassment and sexual misconduct and create the required reports. The agency aggregates incident-based data at least annually as evident by a review of the Significant Incident Summary and a completed Survey of Sexual Violence. Upon request, as stated in Policy, the facility will provide the related data from the previous calendar year to the United States Department of Justice no later than June 30th. A review of the reports and interviews with the Executive Director and the Treatment/Licensing Director confirmed the data collection activities.

Standard 115.388 Data review for corrective action

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy FO-3E-02 provides for internal monitoring of the data to assess and improve the effectiveness of the PREA related policies, training and practices. The assessment will include identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report. The annual report is documented and it indicates that there have been no allegations or incidents of sexual abuse or sexual harassment during this audit period. The report is constructed to provide comparison of the data from the previous year. The annual report is approved by the Executive Director and is made available to the public on the facility’s website. Identifying information is not included in the posted reports.

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.

Policy FO-3E-02 addresses data storage, publication and destruction and provides for the required data to be maintained for 10 years unless a state, federal or local law requires otherwise. The incident-based and aggregate data and other related documents are securely stored in the

facility's file room which is accessible by the Executive Director; Deputy Director; Treatment/Licensing Director who also serves as the PREA Coordinator; and the Case Manager. The aggregated data is available to the public through the facility's website and it does not contain any personal identifiers.

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

June 29, 2016

Auditor Signature

Date

