PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Gentry Residential Treatment Center				
Physical Address: 2001 DYS Drive, Cabool, MO 65689				
Date report submitted: August 26, 2014				
Auditor information: Shirley L. Turner				
Address: 3199 Kings Bay Circle, Decatur, GA 30034				
Email: shirleyturner3199@comcast.net				
Telephone number: 678-895-2829				
Date of facility visit: July 29, 2014				
Facility Information				
Facility Mailing Address: Same as Physical Address				
Telephone Number: 417-962-4344				
The Facility is:	☐ Military	☐ County	☐ Federal	
	☐ Private for profit	☐ Municipal	☒ State	
	☐ Private not for profit			
Facility Type:	☐ Detention	☒ Correction	☐ Other:	
Name of PREA Compliance Manager: Rick Otwell			**Title:**	Youth Facility Mgr.
Email Address: rick.w.otwell@dss.mo.gov			**Telephone Number:**	417-962-4344
Agency Information				
Name of Agency: Division of Youth Services				
Governing Authority or Parent Agency: Department of Social Services				
Physical Address: 419 Knipp Drive, Jefferson City, MO 65102				
Mailing Address: PO Box 447, Jefferson City, MO 65102				
Telephone Number: 573-751-3324				
Agency Chief Executive Officer				
Name: Phyllis Becker			**Title:**	Interim Division Director
Email Address: phyllisbecker@dss.mo.gov			**Telephone Number:**	573-751-3324
Agency Wide PREA Coordinator				
Name: Judy Parrett			**Title:**	Assistant Deputy Director
Email Address: judy.parrett@dss.mo.gov			**Telephone Number:**	573-751-3324

AUDIT FINDINGS

NARRATIVE:

The Gentry Residential Treatment Center is located in a neighborhood in Cabool, Missouri and is operated by the Department of Social Services, Division of Youth Services (DYS). It is a medium security level facility that serves male juvenile offenders between the ages of 13 and 17. The facility capacity is 24. Forty-four residents have been admitted to the facility in the past 12 months.

Thirty-two staff members have been employed at the facility during the past year. On-site medical services, including an assessment of medical needs and sick call, are provided by a full-time Licensed Practical Nurse. The medical oversight is provided by a regional Registered Nurse who visits the facility at least once a month and is on-call. The facility Nurse coordinates the necessary medical services with a local physician. Encounters with a child psychiatrist are scheduled if a resident is taking psychotropic medication and as a need requires. The encounters with the psychiatrist are through the tele-health television system. Education services are provided in the facility by certified teachers.

The program stay is based on the resident completing their personal Comprehensive Individual Treatment Program (CITP). Progress within a resident's CITP determines the resident's length of stay. The Gentry program is composed of two separate groups. Each group has their own assigned treatment team that works with them, assisting each youth in meeting his treatment goals.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The program is located on 14 acres of land and includes the main building, vocational shop, maintenance building, and other storage and utility buildings. The main building includes administrative offices; medical office; kitchen and dining area; library; two classrooms; large conference room; and storage closets. Two housing dormitories are also located in the main building, one on the west wing of the building and the other on the east wing. Located on each wing in the dormitory area are a treatment or dayroom area; bathroom and showers; laundry room; and the Group Leader's office. The acreage provides for various outside physical education, recreation and leisure activities.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various parts of the facility at least six weeks prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to this Auditor, noting their locations. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive, which was received approximately four weeks prior to the on-site audit. The Youth Facility Manager serves as the PREA Compliance Manager.

The on-site audit was conducted July 29, 2014. After meeting with the Youth Facility Manager and other administrative staff, a comprehensive tour of the facility was conducted by three residents, accompanied by one of the Group Leaders. During the tour, staff members were observed to be interacting with the residents during the direct supervision of them. Random staff, specialized staff and residents were interviewed during the on-site audit process. The interviews indicated that staff and residents had received the PREA training. All staff interviewed expressed awareness of their duties and responsibilities with regards to the safety of the residents and PREA compliance. The residents interviewed were knowledgeable about what PREA means and they understood how to report sexual assault and sexual harassment.

The information for the audit process was provided in an organized manner both on the thumb drive and during the on-site audit. A close-out meeting was held at the conclusion of the on-site audit and a summary of the audit findings was provided.

Number of Standards Exceeded: 0

Number of Standards Met: 40

Number of Standards Not Met: 0

Number of Standards Not Applicable: 1

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐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 Comments:

DYS Policy 9.18 provides guidance to staff for implementing the agency's approach to complying with the requirements of the PREA standards including, zero tolerance toward all forms of sexual abuse and sexual harassment. The policy contains definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. Policies 3.8, 3.23, and 9.28 also support this standard. The Youth Facility Manager has been identified as the PREA Compliance Manager.

Standard 115.312 Contract 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 Comments:

The agency has entered into or renewed 12 contracts for the confinement of residents in the past 12 months. Contractors are required to adopt and comply with the PREA standards.

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 Comments:

Policies 9.6 and 9.8 provides for the implementation of a staffing plan with adequate staffing levels to protect residents against sexual abuse; this is confirmed by a review of the Direct Care Staffing Pattern. The facility reports no deviations from the staffing plan in the past 12 months. The annual assessment of the staffing has been conducted to determine whether adjustments are needed in accordance with the standard. A review of the staffing plan is documented, indicating that the staffing ratios are regularly met. The Youth Facility Manager has conducted and documented unannounced rounds of the facility for the maintenance of a safe environment.

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 Comments:

DYS Policy provides for same gender pat-down searches absent exigent circumstances. There have been no cross gender pat-down searches during this audit period. Policy 5.8 prohibits staff from conducting cross-gender strip or cross-gender visual body cavity searches of residents. Policy 9.18 procedures have been implemented that provide for residents to shower, perform bodily functions, and change clothes without being observed by non-medical staff of the opposite gender. Interviews with staff and residents confirm the practices.

Policy 7.2 states that staff shall not search a transgender or intersex resident to determine the resident's genital status. All direct care staff members have been trained on conducting cross gender pat-down searches and searches of transgender and intersex residents.

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 Comments:

DYS contracts for statewide support services to provide residents with disabilities and residents who are limited English proficient with various services so that they may benefit from and participate in resident education regarding PREA. The resident education material and grievance form is available in English and Spanish. Policy 9.18 states that the facility will not rely on resident interpreters, resident readers or any kind of resident assistance except when a delay in obtaining interpreter services would jeopardize a resident's safety. A review of documentation and staff interviews confirmed this practice.

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 Comments:

DYS policy 9.18 provides for annual background checks on all employees and a process that is aligned with the standard. A review of documentation and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are conducted.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒ Standard Not Applicable

Auditor Comments:

The facility does not use any type of electronic monitoring technology for supervision of residents. DYS has not acquired any new facilities since August 20, 2012.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses this standard. DYS does not conduct administrative or criminal investigations of sexual abuse or sexual harassment. Investigations are conducted by Missouri Children's Division Out of Home Investigation Unit (CD-OHI) for residents under the age of 18. They receive reports through their hotline number made by DYS staff, resident, parent/guardian, or third parties. If law enforcement is not already involved, CD-OHI contacts the appropriate law enforcement agency to co-investigate. Allegations of sexual abuse of residents 18 years old and over are referred to the Division of Legal Services Investigation Unit.

Forensic medical examinations will be performed at no financial cost to the victim. There have been no forensic examinations in the last 12 months. A Memorandum of Understanding (MOU) has not been signed; however, there is a documented verbal agreement that victim advocacy services will be provided by the Child Advocacy Center, Inc. Documentation of attempts to secure a MOU with the Child Advocacy Center, Inc. were reviewed and the information was confirmed with the representative from the Center. There is also a qualified agency staff member that can provide crisis intervention if requested.

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 Comments:

Policy 9.18 provides that staff report all allegations of sexual abuse and sexual harassment through the Missouri Children's Division hotline. The appropriate State investigative entity will be contacted and they will contact the local law enforcement agency regarding the investigation of the allegation. There have been no allegations of sexual abuse or sexual harassment reported at the facility during the past 12 months. The DYS website contains information regarding how investigations of allegations of sexual abuse are handled.

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 Comments:

Policy 3.18 provides for the PREA training. The staff training is comprehensive and covers all of the key areas referenced in the standard. A review of the training documentation and the results of staff interviews confirm that training occurs as required.

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 Comments:

Policy 3.18 contains information regarding the training of volunteers and contractors who have contact with residents. Receipt of the training is documented and it contains a review of the agency's zero tolerance policy. The practice was also confirmed through interviews.

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 Comments:

Policy 9.5 requires that residents receive information about the facility's zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The education is presented in a manner that is age appropriate and this was validated by the residents' responses to the interview questions and a review of the documents discussed and provided to the residents. DYS has statewide contracts to provide support services in accessible formats for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled.

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 Comments:

DYS does not conduct administrative or criminal investigations. Documentation exists indicating that PREA requirements for specialized training for investigators who investigate allegation of sexual abuse and sexual harassment in confinement were provided to the appropriate agencies.

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 Comments:

Policies 9.18 and 3.18 address PREA training for staff. A certificate documenting the Nurse's completion of specialized training offered on-line by the National Institute of Corrections was reviewed. The Nurse does not conduct forensic medical examinations.

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 Comments:

Policies 6.7, 9.5, and 9.18 address this standard. A review of documentation and staff and resident interviews confirm that screening for risk of sexual abuse victimization or sexual

abusiveness toward other residents is being conducted on each resident. The initial screening is done during the intake process and residents receive reassessments every six months. This information was also confirmed through staff and resident interviews.

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 Comments:

Policy 9.18 prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. Housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. The facility prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. There have been no residents placed in isolation in the last 12 months because they were at risk for sexual victimization.

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 Comments:

Policy 9.18 provide for internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violations that led to abuse. A resident may file a grievance or a written complaint; write a note; talk to any staff member; and third parties may report allegations to staff. The grievance/complaint and other written requests may be given to staff or placed in the lock box located in the administration area, where the residents have daily access. PREA related information is accessible to the residents.

During the on-site visit it was discovered that the dedicated phone for residents' access to the Missouri Children's Division Child Abuse and Neglect hotline was located in the locked conference room. There was a concern by this Auditor about the dedicated phone being more accessible to the residents and it was discussed during the exit briefing. After the exit briefing and further discussion, a corrective action was taken to designate the phone in each dormitory area as the dedicated phone for the residents to access the hotline.

Missouri State Law provides for staff to report allegations of sexual abuse to the Abuse and Neglect hotline without the need for supervisory approval. Interviews revealed that staff members are aware of their responsibility to report sexual abuse and sexual harassment. They are also aware that they are to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties.

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 Comments:

Residents may put a written complaint in the designated lock box or give the form to a staff member. There have been no complaints relating to sexual abuse or sexual harassment received in the past 12 months. Staff and resident interviews confirmed their knowledge of how to use the locked box to report 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 Comments:

Policy 9.18 requires the facility to provide the residents with access to outside victim advocacy services. Documentation was provided by the facility that support attempts to establish a MOU with the local victim advocacy agency. The agency has agreed to provide services but a MOU has not been signed. Correspondence documents the intent of the agency to provide services to a resident in the facility when requested.

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 Comments:

The DYS website provides the public with information regarding third-party reporting of abuse. Parents receive information about reporting incidents of sexual abuse through their copy of the Resident and Guardian Handbook. The State hotline number and a national hotline number for reporting sexual abuse is provided in the Resident and Guardian Handbook.

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 Comments:

Policy 9.18 and Missouri Revised Statute 210 support this standard. All staff members are mandated reporters. They are to immediately report any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment, retaliation against residents or staff who report any incidents or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff interviews support this information.

Standard 115.362 Agency Protection Duties

□Exceeds Standard (substantially exceeds requirement of standard)

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

□Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses this standard and provides that when the agency or facility learns that a resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. There have been no incidents in the last 12 months where the agency or the facility had to take any action in regards to a resident being in substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to Other Confinement Facilities

□Exceeds Standard (substantially exceeds requirement of standard)

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

□Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 9.18 and 3.8 address this standard. Upon receiving an allegation that a resident was sexually abused while confined in another facility, the PREA Compliance Manager will notify the head of that facility within 72 hours. The PREA Compliance Manager will ensure that the allegation is investigated according to Policy 3.8 and the standard. In the past 12 months, there have not been any allegations of sexual abuse occurring to a resident while he was in another facility.

Standard 115.364 Staff First Responder Duties

□Exceeds Standard (substantially exceeds requirement of standard)

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

□Does Not Meet Standard (requires corrective action)

Auditor Comments:

The DYS First Responder Protocols for Sexual Abuse provide a detailed account of first responder duties and responses. There have been no allegations that a resident was sexually

abused within the last 12 months. Staff interviews confirmed that they are knowledgeable of their first responder duties.

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 Comments:

A review of the written detailed documentation and interviews with staff confirmed that an institutional plan has been developed. The plan coordinates the actions to be taken among facility first responders and other staff in response to an incident of sexual abuse.

Standard 115.366 Preservation of Ability to Protect Residents from Contact with Abusers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The current labor agreement resolution is dated 12/1/2010 -11/30/2013. Documentation was provided which shows that it has been extended through 11/30/14. The State of Missouri Office of Administration and Department of Social Services has entered into an agreement with the Communications Workers of America (CWA) Local 6355, AFL-CIO and the agreement is consistent with provisions of the applicable PREA standards.

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 Comments:

Comprehensive Policy 9.18 and Department of Social Services Policy 2-102 address protection against retaliation. The Youth Facility Manager and the Youth Group Leaders have been identified as the staff members designated with monitoring for possible retaliation. If the conduct is identified the monitoring would be conducted for no less than 90 days; and longer if indicated. Policy 9.18 also instructs staff on reporting incidents of retaliation. There have been no incidents or allegations of sexual abuse within the last 12 months.

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 Comments:

Policies 9.8 and 9.18 address this standard and cover the requirements of how protective custody is to be used. There have been no allegations of sexual abuse or sexual harassment during the last 12 months and not a need for post allegation protective custody.

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 Comments:

According to Policy 9.18, DYS refers criminal and administrative investigations to external agencies. An investigation is not terminated solely because the source of the investigation recants the allegation. Substantiated allegations of conduct that appears to be criminal are referred for prosecution.

Standard 115.372 Evidentiary Standards 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 Comments:

The Missouri Child Welfare Manual states that a standard of preponderance of the evidence or a lower standard of proof is used for determining whether allegations are substantiated.

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 Comments:

Policy 9.18 provides the process for notifying residents, following an investigation, of whether an allegation has been determined to be substantiated, unsubstantiated, or unfounded. There has not been an allegation of sexual abuse in the past 12 months.

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 Comments:

Policy 9.18 provides for disciplinary sanctions for staff to be up to and including termination for violation of the sexual abuse and sexual harassment policies. The policy requires that the violation be reported to local law enforcement. In the past 12 months, no staff has been terminated or has resigned for violating agency PREA related policies.

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 Comments:

Policy 9.18 addresses the corrective actions regarding any contractor or volunteer engaging in sexual abuse of residents. According to policy, they will be reported to local law enforcement unless the activity was clearly not criminal and to relevant licensing bodies. The Policy requires the facility to take remedial measures and prohibit future contact with residents in the case of any violation of the facility's PREA related policies by contractors or volunteers. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative agency for allegations of sexual abuse.

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 Comments:

Policy 9.18 addresses this standard. Any resident found in violation of the facility's zero tolerance policy against sexual assault or sexual harassment will be offered counseling or other interventions designed to address and correct the underlining reasons for their conduct. The Resident and Guardian Handbook identify the rules for the facility. There has been no incident of resident-on-resident sexual abuse in the past 12 months.

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 Comments:

Policy 9.18 states that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Staff interviewed confirmed awareness of the policy and the requirements of the standard.

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 Comments:

Policy 9.18 requires timely access to emergency medical treatment and crisis intervention services for victims of sexual abuse. Treatment services will be provided to every victim. The nature and scope of the services are determined by medical and mental health practitioners according to 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 Comments:

Policy 9.18 provides for ongoing medical and mental health care for sexual abuse victims. It also provides for medical and mental health evaluations and appropriate treatment in accordance with the standard. Care is consistent with the community level of care, which was confirmed by staff interviewed. There have been no sexual assault victims in the past 12 months.

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 Comments:

Policies 9.17 and 9.18 address this standard. There have not been any criminal investigations conducted at the facility during this audit period. The policies will serve as the guide for staff in conducting incident reviews. The incident review team has been identified.

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 Comments:

Policy 9.18 requires the collection of accurate, uniform data for every allegation of sexual assault. DYS has a data collection instrument to answer all questions for the US Department of Justice Survey of Sexual Abuse Violence. A review of the annual report revealed it was completed according to the standard.

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 Comments:

Policy 9.18 addresses this standard. There have been no sexual abuse allegations for this facility within the past 12 months. Policy 9.18 requires the review of data for corrective action to improve the effectiveness of its prevention, protection and response policies, practices and training.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

☐**X** 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 Comments:

Policy 9.18 addresses this standard and requires that data is collected and securely retained for 10 years. The aggregated PREA data is reviewed and all personal identifiers are removed. The Policy also provides for the collection of the data and that the information is made accessible to the public.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of her knowledge and no conflict of interest exists with respect to her ability to conduct an audit of the agency under review.

Shirley L. Turner

Auditor Signature

August 26, 2014

Date