PREA Facility Audit Report: Final

Name of Facility: Franklin County Community Based Correctional Facility
Facility Type: Community Confinement
Date Interim Report Submitted: 07/13/2020
Date Final Report Submitted: 01/05/2021

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Ramona Wheeler	**Date of Signature:** 01/05/2021

AUDITOR INFORMATION	
Auditor name:	Wheeler, Ramona
Email:	ramona.wheeler@alvis180.org
Start Date of On-Site Audit:	02/27/2020
End Date of On-Site Audit:	02/28/2020

FACILITY INFORMATION	
Facility name:	Franklin County Community Based Correctional Facility
Facility physical address:	1745 alum creek dr, columbus, Ohio - 43207
Facility Phone	
Facility mailing address:	

Primary Contact	
Name:	Shawn Beasy
Email Address:	shawnbeasy@franklincountyohio.gov
Telephone Number:	6145807914

Facility Director	
Name:	Jacki Dickinson
Email Address:	jackidickinson@franklincountyohio.gov
Telephone Number:	6145254607

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Health Service Administrator On-Site	
Name:	Mark Wilson
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Facility Characteristics	
Designed facility capacity:	200
Current population of facility:	192
Average daily population for the past 12 months:	195
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Both females and males
Age range of population:	n/a
Facility security levels/resident custody levels:	minimum
Number of staff currently employed at the facility who may have contact with residents:	58
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	6
Number of volunteers who have contact with residents, currently authorized to enter the facility:	140

AGENCY INFORMATION	
Name of agency:	Franklin County Board of Commissioners
Governing authority or parent agency (if applicable):	
Physical Address:	373 S. High Street 26th Floor, Columbus, Ohio - 43215
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Shawn Beasy	**Email Address:**	shawnbeasy@franklincountyohio.gov

AUDIT FINDINGS

Narrative:
The auditor’s description of the audit methodology should include a detailed description of the following processes during the pre-audit, on-site audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor’s process for the site review.

Background

Franklin County Community Based Correctional Facility (FCCBCF) started in 1993. Agency overesight was by an established judicial governing board, which consisted of court judges representing Common Pleas courts in Franklin County. In 2007, FCCBCF separated from the courts (i.e., judges), and a civilian board became the facility governing board (FGB); judges who led the agency became the judicial advisory board (JAB).

Jacki Dickinson was originally hired in 2001 by a previous, long-time Executive Director (ED). Ms. Dickinson left the agency in 2010. In 2014, Ms. Dickinson returned to FCCBCF as deputy director over all indirect services (HR, IT, Food Services, Training, Fiscal, Records). She was instrumental in preparing the agency for its first PREA audit in 2014. In 2016, she became the agency's Interim ED in 2016, and became permanent ED in 2018.

FCCBCF is considered as a government entity, but staff are not considered as County [government] employees. Employees are covered under Ohio Public Empoyee Retirement System (OPERS).The agency is funded through a ($6.2 million) grant from the Ohio Department of Rehabilitation and Correction (ODRC). The board approves the agency's pay structure. FCCBCF is accredited by the American Correctional Association (ACA), ,and has always operated at its current location, 1745 Alum Creek Drive, Columbus, Ohio 43207. The facility is a 200-bed, co-ed minimum security correctional facility. Based on the agency's structure, the auditor utilized the PREA standards for Community Confinement facilities.

This audit is the facility's third audit cycle. Prior PREA audits were conducted in 2014, and 2017. This auditor did not conduct the facility's 2014, or 2017 PREA compliance audits.

Admission

Cognitive-based Therapy (CBT) is the primary modality utilized for resident programming. The facility receives referrals from Common Pleas Courts, or ODRC via email. An interview is scheduled with the referred individual via video conference; or in-person at the facility, at the jail, or Probation Department. Most residents are classified as Community Control. If they are unsuccessful, the Sheriff or Probation Officer will pick them up and take them to jail. There’s a revocation hearing, and the judge, or other sentencing authority, can order the person to prison, another CBCF, or FCCBCF may accept them back after a set period of time. The facility’s first priority is Community Control residents, followed by Post-Release Control (PRC) (for parole violations) if bed space is available. Average length of stay at FCCBCF is 4-5 months.

Contract Procurement

On 8/28/2019, FCCBCF Deputy Director/PREA Coordinator Shawn Beasy contacted Ramona Wheeler via email regarding conducting a PREA audit, based on the established PREA audit cycle. Several emails were exchanged to consider auditor and FCCBCF schedules, and the requirement by the ODRC that all PREA audits of Ohio correctional facilities, be completed before March 1 of each audit cycle year.

A Memorandum of Understanding (MOU) between FCCBCF and DOJ-certified PREA auditor Ramona Wheeler was submitted to the facility on 12/2/2019; Executive Director Jacki Dickinson, signed the MOU on 12/17/2019. The signed MOU was emailed to the auditor on 12/17/2019, with an onsite audit period of 2/27-28/2020. The MOU agrees that the PREA Online Audit System (OAS) would be utilized for uploading pertinent documentation, and completion of the audit. The agreed upon review period for compliance was calendar year 2019 (i.e., January 1, 2019 through December 31, 2019).

On 2/7/2020, the auditor received a confirmation email from the PREA Resource Center that the OAS had generated the online audit tool for the FCCBCF audit. The PREA onsite visit at the FCCBCF was conducted on February 27-28, 2020. During the onsite audit, the auditor was provided with a resident census, which reflected 192 residents at FCCBCF. The auditor conducted a practice-based PREA audit, relying on a triangulation of the evidence provided during the pre-audit, onsite audit, and post-audit phases. Triangulation of the evidence requires the auditor to analyze:

- Policies and procedures
- Supportive documentation in the Pre-Audit Questionnaire (PAQ)
- Statements from random and targeted residents
- Random and specialized staff interviews
- Facility site observations

A PREA compliance audit seeks to discover a facility's institutionalization of the PREA standards, thus, taking compliance of standards beyond the existence of policies and procedures; measuring compliance by the facility’s demonstration of how established policies and procedures are followed on an ongoing, consistent basis. The auditor reviewed FCCBCF policies/ procedures, documentation and information from calendar year 2019. Additional information was provided by the PREA coordinator in hard copy files, divided by each PREA standard.

Pre-Onsite Phase/Notice of Audit Posting and Timeline

The FCCBCF is accredited by the American Correctional Association. Under the Prison Rape Elimination Act (PREA), the facility is categorized as a community-based correctional facility (CBCF). The compliance audit is based on national PREA standards for Community Confinement Facilities. The PREA audit was conducted in three phases:

1. Pre-onsite audit;
2. Onsite audit; and,
3. Post-onsite audit phase.

During the Pre-audit phase, the auditor communicated the auditing process via email. This included instructions for posting audit notices in conspicuous locations throughout the facility. The notice advises residents and staff that a PREA audit of the facility is scheduled, and provides contact information to reach the auditor for confidential communication, and reporting allegations of sexual abuse, sexual harassment, as well as resident and staff retaliation for reporting, or cooperating in an investigation.

On 1/10/2020, the auditor notified the PREA coordinator to post Audit Notices in the facility, as part of the pre-audit phase. The auditor provided instructions, via email, and attached PREA Audit Notices, in English and Spanish. The PREA coordinator was instructed to:

- Post the notices in the facility no later than 1/17/2020;
- Print postings on bright-colored paper
- Post in the Control Room area, and all areas where the notices would be visible to staff, visitors, and residents.

On 1/13/2020, the auditor received via email from FCCBCF PREA coordinator Shawn Beasy, photos of PREA notices. The email indicated notices were posted in the following facility locations:

- Male and Female building entrances
- Male and Female visitation areas
- All Male and all Female dorms
- All Male and all Female restrooms
- Male and Female dining areas
- Male and Female classrooms
- Male and Female Intake areas
- Medical wing
- Male and Female dayrooms

On 1/31/2020, the auditor received an automated email from the PREA Resource Center, indicating FCCBCF completed the electronic submission of the PAQ. Pre-audit calls and communication occurred throughout the pre-audit phase. Purpose and topics of the calls included:

- introductions
- discussion of new PREA template forms (e.g., PREA Form 1.1)
- expectations of the upcoming onsite audit
- discuss issues, concerns with the PREA Online Audit System (OAS)
- discuss logistics regarding working space, internet access, interviewing room and work hours
- discuss the auditor's need for unfettered access and unimpeded access to the facility to complete the onsite audit phase
- discuss needed investigative files, employee files, and resident files upon the auditor's arrival.

On 2/7/2020, the auditor received from the agency PREA Coordinator a PREA-specific audit form via email attachment:

- PREA Form 1.1 - PREA Interviews: Specialized Staff, and Specialized Inmates
- Form 5H - PREA Audit Request for Information: Allegations and Investigations Overview

The auditor provided six PREA Interview Protocol forms from the national PREA Resource Center website, as reference and preparation material:

- Agency Head
- Random Staff
- Facility director
- PREA coordinator
- Residents (random, and targeted populations)
- Specialized staff
- Request for Facility Lists

Request for Facility Lists

The auditor requested the following lists from the PREA coordinator:

- complete resident roster
- list of residents with disabilities
- list of residents who are limited English proficient
- any residents who identify as Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI)
- residents who reported past sexual abuse during incarceration
- residents who reported sexual victimization during risk screening
- complete staff roster with specialized staff names
- all contractors and volunteers who have contact with residents
- all allegations of sexual abuse and sexual harassment
- all investigative reports of allegations of sexual abuse and sexual harassment
- all hotline calls for outside reporting of sexual abuse and sexual harassment allegations in the last 12 months.

Also requested was a list of youthful residents and residents in segregation and isolation. FCCBCF responded that they do not house youthful residents.

Number of Sexual Abuse and Sexual Harassment Allegations

FCCBCF submitted completed PREA Sexual Harassment allegation files to the auditor via secure email. The PREA Incident and Investigation form, submitted on 2/13/2020, indicated there have been two allegations of resident-on-resident sexual harassment (one included sexual abuse) in 2019, and one allegation of staff-on-resident sexual harassment in 2019; two allegations of staff-on-resident sexual abuse. The outcomes of the five sexual allegations in 2019 were:

- Substantiated = 3: 1 resident-on-resident sexual harassment; 1 staff-on-resident sexual abuse; 1 staff-on-resident sexual harassment

- Unsubstantiated = 1:1 resident-on-resident sexual harassment and sexual abuse
- Unfounded = 1: 1 staff-on-resident sexual abuse

External Contacts

The FCCBCF does not contract with a community-based resource related to sexual abuse services. Resident victims are referred to one of two local hospitals: Grant Hospital, or OSU East Hospital for medical services. The facility does not have a documented Memorandum of Understanding (MOU) with either hospital. Both are community hospitals, which will receive patients, regardless of theiri ability to pay. The Franklin County Sheriff Department transports residents to either hospital, if/when an allegation necessitates medical services resulting from resident sexual abuse.

The auditor reached out to one identified community resource via telephone, which FCCBCF identified as an entity, to which residents may privately, and confidentially report allegations of sexual abuse. The Ohio Department of Rehabilitation and Corrections (ODRC) provides a hotline number for residents at any Ohio-based community correctional facility to report sexual abuse, or sexual harassment. The auditor tested the phone system during the onsite facility review, and successfully connected with the message line for reporting PREA allegations.

Research

Prior research regarding FCCBCF was conducted. The FCCBCF website, https://cbcf.franklincountyohio.gov/, was reviewed. The site PREA page provides a historical summary of PREA as a law. The sites contains the FCCBCF Zero Tolerance policy, past PREA annual reports, PREA audit report (2017).

The auditor conducted internet research about FCCBCF, which produced several articles regarding programming offered to residents. There were no articles or findings specific to PREA, sexual abuse or sexual harassment at FCCBCF. The auditor reviewed Mandatory Reporting laws; it was found that Ohio does not have defined confidential communications. Ohio mandatory reporting laws protect minor children, and elderly citizens who may be victims of any type of abuse, or neglect.

Onsite Audit Phase/Interviews

On 2/26/2020, the auditor communicated via phone, with the PREA coordinator, requesting that 3rd Shift staff are made aware of the PREA auditor's arrival at approximately 5:30AM. The auditor arrived on 2/27/2020, at approximately 5:15AM. Upon arrival, the auditor checked in at the facility Control Room, was provided a visitor badge. The auditor interviewed the 3rd shift staff prior to the PREA coordinator’s arrival.

Upon the PREA coordinator’s arrival, the auditor reviewed logistics for the audit, as well as the schedule and escorts for the onsite review later in the day. The PREA coordinator identified himself as the designee to accompany the auditor through the facility site review. The PREA coordinator provided to the auditor a Franklin County Community Based Correctional Facility Employee List. The list identified staff by Name, and position/title. At the time of the onsite audit, FCCBCF employed 54 staff. The Employee list contained the following information:

- Employee name
- Position/Title
- Shift

The PREA coordinator verbally reviewed the roster with the auditor, providing shift/schedules. He identified the following positions as Contractor(s) (not on the Employee List):

- Food service staff = 4 (1 supv., 3 cooks)
- Physician = 1
- Maintenance staff = 2

The PREA coordinator stated the following do not exist at FCCBCF:

- SAFE/SANE practitioner(s)
- Mental Health, practitioners

The PREA coordinator advised the auditor, regarding volunteers, that FCCBCF has 140 volunteers who provide the following services, on varied scheduled days/times:

Spiritual:

Bible Studies
Church Services
Baptisims (during specific months)

12 Step Programs:

AA Meetings
NA Meetings
Al-Anon

The auditor selected for interview the following 13 staff:

- Volunteers = 2 (only 1 was present during onsite audit)
- Full-time security staff, representing 1st, 2nd, and 3rd shifts = 6
- Specialized staff = 4
- Random non-security staff = 3

Security staff are classified as Resident Advisors. Shift Coordinators supervise RA’s on their assigned shift. The methodology of selecting random staff was for a diverse cross section of staff. The auditor selected direct line and supervisory staff of varying positions, posts and rank. The auditor did not interview contract medical staff, as the doctor is in the facility one day per week, which did not align with the onsite audit dates. Maintenance contract staff were not interviewed, as they were not in the facility during the onsite audit. Additional interviews were not completed due to inclement weather that developed late on Day 1 of the onsite audit. Road closures due to snow, ice, resulted in adjustments in the interview schedule, and staff availability.

Contractors, and Volunteers receive PREA training, and sign a CONTRACTOR, VOLUNTEER PREA Acknowledgement form, which covers the agency’s Zero Tolerance policy, reporting procedures, and accountability.

The auditor interviewed the following Specialized Staff:

- Agency Head
- PREA Coordinator/Deputy Director
- PREA Investigator (also Unit Manager)
- Intake staff
- Human Resources staff (Business Adminstrator)
- Staff responsible for retaliation monitoring

The auditor was able to ask staff questions on:

- the agency's zero tolerance policy;
- training;
- reporting protocols;
- first responder duties, coordinated response plan;
- grievance procedures;
- investigation protocols;
- confidentiality;
- retaliation monitoring;
- risk screening;
- resident protection from abuse;
- LGBTI policies and procedures;
- data collection, annual reports;
- staffing plans, resident monitoring;
- reporting to other confinement facilities;
- disciplinary procedures;
- searches;
- opposite gender announcements; cross-gender supervision policies.

Based upon the resident population of 192 at the facility on Day 1 of the onsite audit, the PREA Auditor Handbook specifies that a minimum of 20 resident interviews must be conducted; a minimum of 10 random resident and 10 targeted resident interview are required. The auditor utilized the an unoccupied office near the control room as a private location for conducting resident interviews. A conference room in the administrative office was availed to the auditor as a private working space. The auditor selected the residents to interview, and conducted the following number of resident interview during the onsite phase of the audit:

- Random residents = 18 (12 male; 6 female)
- Targeted residents = 2 (1 male; 1 female)

The breakdown of targeted resident interviews:

- One female resident who identifies as LGBTI (Bisexual)
- One male resident who identified as LGBTI (Gay)

There was no resident or staff retaliation for reporting and allegation, or cooperating in an investigation.

The facility did not house the following resident populations:

- who identified as transgender or intersex;
- who are blind, deaf, or hard of hearing;
- who are Limited English Proficient (LEP), or have a cognitive disability.

On Day 2 of the onsite audit, there was no change in resident population; the auditor used the same Resident Roster for random, and targeted resident interviews. The auditor conducted interviews in accordance with the PREA Compliance Audit Instrument Guide and the Auditor Handbook for effective strategies for interviewing staff and residents. Male and female residents were asked to discuss their experience with:

- PREA-related education;
- allegation reporting requirements;
- communication with staff;
- knock and announcements
- grievance procedures;
- searches, including pat, strip, cross-gender, and body cavity;
- housing unit concerns
- limits to confidentiality;
- outside supportive services;
- resident safety;
- retaliation, and disciplinary sanctions.

At the beginning of the onsite audit, the auditor was led by the PREA coordinator on a facility site review, including outer perimeter areas. The site review observations included:

- Male and female housing units (including two segregated units);
- Main control room;
- Male, and Female resident common spaces/lounge areas;
- Kitchen;
- Resident dining rooms;
- Staff offices;
- Education/classrooms;
- Male, and female visitation areas;
- Male and female laundry areas;
- Property storage areas;
- Male, and female shower/bathrooms;
- Outdoor recreation area.

During the onsite audit, the auditor engaged informally in conversations with staff, including kitchen staff, and residents. Residents have the ability to move freely in the facility dayroom(s) unaccompanied, except for areas designated with signage as ‘restricted’, and/or ‘authorized personnel’. The auditor observed resident phone(s) in the facility. The facility posts PREA posters containing reporting information near the resident phones. The auditor was provided a private space, in which confidential interviews with residents, and staff were conducted.

The facility has a total of 57 full-time staff members including a Facility Deputy Director who is the operational head of the facility, and whom reports to the Executive Director. The auditor was able to engage formally, and informally with agency leadership during the onsite visit, which includes:

Jacki Dickinson, Executive Director (Agency Head)
Shawn Beasy, Deputy Director (PREA Coordinator)

Part-time staff were not interviewed due to absence on the onsite audit dates, or not having regular contact with residents.

Processes and Areas Observed
The FCCBCF resident Intake process for newly admitted residents begins with an assessment, including PREA-specific assessment, and a follow-up orientation. Assessments are conducted by Case Facilitators, who also provide resident case management. The auditor was unable to observe an Intake, as none were scheduled at the time of the audit.

The Intake Specialist stated during her interview that many residents come from jail, and are not familiar with PREA. The auditor observed the Intake staff utilized a PREA Screening tool to conduct the PREA assessment. The screening tool is divided into six sections:

- **Identifying data** - resident demographic information; sexual orientation; disability
- **Glossary of definitions** – provides screeners with information to review with new residents on how sexual harassment by residents, versus staff are defined; includes definitions of transgender, intersex, and gender non-conforming
- **Offense history** - determines whether residents have previous incarceration, violent offenses, and sex offenses.
- **Abuse history** - identifies whether residents have experienced prior sexual abuse during incarceration, or been identified as sexually abusive; asks residents about past trauma, or anger issues
- **Resident/staff Assistance Assessment** - documents special accommodations, recommended follow-up due resulting from screening information
- **Classification** - identifies residents as: a) Possible Victim; b) Possible Predator; c) None

The resident’s assigned case facilitator completes the 30-day re-screening. The Unit Manager approves recommended special accommodations.

The entry intake staff informs residents of rules, logistics for new residents. Residents wear jeans, khakis, or black slacks, with polo shirt of an assigned color, which changes as program phases progress:

- Purple (orientation phase)
- Gold (programming)
- Blue (advanced programming, more free time, stay up later, access to the discovery zone, job seek)
- Green (Reentry (final) phase; employment allowed).

Residents must meet program criteria in order to progress to the next phase/color. During the facility site review, the auditor observed residents comment to the PREA coordinator that they were getting their Blue shirt, or Green shirt.

The auditor did not observe a female intake, as none arrived during the onsite audit dates.

Specific Areas Observed

The male resident wing is divided into 'Halls':

- **A Hall** - 20 pods of 3-5 beds each; 10 each on main, and upper level
- **B Hall** -11 beds, including two bunks
- **K Hall** - 37 beds, next to A Hall; contains open, single and bunked beds on two sides. Side 1 contains 12 beds (4 single, 8 bunks); Side 2 (divided by a restroom and laundry)

A-Hall has an upper and main level room layout, which is the same on each level. All doors are kept open, and residents have to be dressed at all times in the Hall. If a female staff covers the desk, no other female staff have to announce as it is already established that a female staff is in the Hall. Case Facilitators, Unit Manager occupy four offices on the main floor. The coverage/ security desk is in the open Hall and faces the rooms. Two cameras at each end covers the Hall, and is monitored via control room; an (single) open center staircase accesses upper level rooms.

Four phones located on main floor requires money to place a call, except for hotline, ODRC numbers. The area contains a small bulletin board on main level. The auditor observed three Zero Tolerance posters on the wall in the main level, only one of which is near a phone; the other two are next to each other and in English and Spanish. A large bulletin board contained PREA audit notices and zero tolerance posters in English and Spanish.

The auditor tested resident phones. Phone 1 was tested, requires a PIN for the message center. The PREA coordinator stated he doesn’t know where those calls go, that it isn't an internal system. The auditor was prompted to press '1' to place a call, and enter a PIN number. A resident offered to demonstrate, and placed a call to the SARNCO hotline. The resident went to his call account on the phoe system panel, and no call was logged or charged.

The Hall resident restroom contains:

- 4 sinks and mirrors
- 3 toilets with half stall doors
- 1 shower with 4 shower heads and solid curtain.

A-Hall Upper area: the resident restroom is same as lower level. A Zero Tolerance poster was observed on the upper-level bulletin board in English and Spanish.

A (locked) laundry room was observed through a windowed door. The room contains one washer, and two dryers; an inside closet contains cleaning products for resident chores, known as "details". A resident confirmed that there is no charge to wash clothes. A resident approached to hear the PREA coordinator's response as to when they can do laundry. The resident did not dispute the PREA coordinator's explanation of the laundry schedule.

The Fire Exit is a *blind spot*, which is covered by a mirror in the stairwell, and offers a line of sight at bottom of stairs and coming up the stairs. A locked area that requires a key-card provides staff access to K-Hall. A camera at bottom of the stairwell captures two doors: one to the A-Hall main level; a second that accesses the K-Hall main level. An identified *blind spot* under the stairwell is filled with three wide file cabinets to restrict use of the space.

Recreation: The Exit door leads to a large, outdoor recreational area with cameras at each end. The area offers two basketball hoops, open seating. The wiring above the perimeter fence keeps the area secure.

K Hall is located next to A-Hall, and contains an open dorm with 37 single and bunked beds. The main side houses beds 1 - 12 (4 single, 8 bunks). Section 2 is divided by the resident restroom, and laundry room.

Laundry room: is unlocked, with one washer, two dryers.

The resident restroom contains:

- 2 full stalls with doors
- 2 urinals
- 3 sinks and mirrors
- 1 shower with 4 heads, PREA compliant shower curtains

Exercise equipment is located in front of restroom area, near an open sitting area. Two cameras in the main sitting area are near the security desk and above a case facilitator office. Windowed wall and door to B Hall, but door is locked. Bank of 4 phones, bulletin board with zero tolerance poster next to phone bank. Fire exit leads to outdoor recreation area. Main level right side has 11 beds, two at bunks; no camera in the area, line of sight from far camera in main sitting area. *Upper area*: contains seven single beds, one bunk. Resident lockers on the wall opposite side of beds aleviate blind spots. A center 360-degree camera observed on the ceiling above the main sitting area has a partial view of the Upper Level.

The *resident restroom* contains*:*

- 2 toilet stalls with full doors
- 3 sinks and mirrors
- 2 urinals
- 1 shower with 4 heads (PREA compliant curtain)

A solid locked door was used for paper storage, and currently not in use. The auditor observed a Zero Tolerance poster on the wall outside case facilitator offices, but not accessible without staff sight via security desk and/ or office window in the door. Resident forms are in a mounted wall rack. A Zero Tolerance poster is located on the upper level between the resident restroom and storage room.

B Hall - Designed the same as A-Hall. An inside window in K-Hall case facilitator office provides a line of sight to B Hall's main area. The bulletin board on the main level has Zero Tolerance posters in English and Spanish, thugh not near reisident phones. No PREA posters were observed on the Hall's upper level. PREA audit notices were observed posted on bulletin board; a rack of forms next to the security desk includes grievance forms. Sinks and a microwave are accessible for residents to heat up purchased Commissary foods. Recreation equipment is located in the center of Hall's main level near a stairwell. The main level laundry room is locked, with a window in the door.

The resident restroom contains:

- 2 toilets with half stall doors,
- 2 urinals
- 3 sinks with mirrors
- 1 shower with 4 heads, and a solid shower curtain.

An *Upper Level* contains 10 rooms with 3 beds each.

The Upper Level Resident Restroom contains:

- 2 short stall toilets
- 2 urinals (one not working)
- 4 sinks and mirrors
- 1 shower with 4 heads and solid shower curtain.

Three cameras on the lower level includes a 360-degree camera centeren the main level. No cameras were observed on upper level.

Women's Wing

C Hall - 39 beds - The auditor observed four cameras which cover the main open area. Two are located on the dorm side, at a secondary entrance to classrooms, and one above the laundry room. Two cameras are on the room side above the sink: microwave area and one above the pass-through next to the security desk.

Housing - the Women's wing is situated with both dorm and room sleeping areas. The auditor observed:

- 5 rooms, 3 with 5 beds, 1 with six beds, one with seven beds
- Open area, with a group room, three case facilitator offices
- 1 small sink area with microwave for Commissary food;

Recreation: A TV is mounted in the open area, with multiple tables, chairs that provide seating to watch movies, play games, etc.

The *Resident restroom* contains:

- 4 toilets w/ half doors (one is ADA accessible)
- 6 sinks with mirrors divided by a wall with 3 on each side; one side has toilets, the other has two showers, each with two shower heads, each with a solid shower curtain; one shower has a handicap rail.
- 1 dispenser for sanitary products; Zero Tolerance posters are posted in English and Spanish inside the restroom.

A bulletin board has Zero Tolerance posters, and PREA audit notices.

Laundry - the room has window in the front wall and two large windows in the door. The room contains one washer, two dryers.

A second *restroom* contains:

- 4 sinks and mirrors
- 2 single-person showers
- 4 toilets with full stalls.

The auditor observed a Zero Tolerance poster in English and Spanish posted inside the restroom.

Three clear storage units house games, education materials. A metal cabinet is locked and marked as a 'property closet'. Exercise equipment is located in the open, common area.

Dorm sleeping area - An open dorm to the left of the security desk contains 11 single beds, no bunks. Zero Tolerance posters are posted on the dorm far wall. Lockers are located on the wall next to exercise equipment. A camera is located at the dorm entrance.

Programming Hallway

Opposite the Women's Wing exit is a locked two-door room for resident property, linens. The hallway has Zero Tolerance posters in English and Spanish. The locked exit at end of hall leads to a garden area maintained by female residents. To the right is a solid locked door with resident shirts and clothing: indigent residents are provided with clothes to wear.

The Programming hallway contains six classrooms and/or testing room. The space is used by male and female residents at separate times, and is accessible through two different entryways. A five-drawer cabinet in the hallway contains staff uniform wear; a second locked five-drawer cabinet contains binders. A single-person restroom is marked for 'Staff Only'. A second restroom is marked for 'Staff Only'. The hallway opens to the left, leadng to a small outer sitting area, and right to a hallway containing 16 Staff lockers on the right and mounted file cabinets on the left; each is labeled with contents (e.g.,forms, used by residents). The hallway opens into the foyer, outside the library/Discovery Center.

Onsite Documentation Review/Conclusion
During the onsite, and post-onsite audit phases, the auditor reviewed 43 files:

- 20 Resident files (10 males, 10 females) reviewed for risk screening records, disciplinary records; history of sexual victimization or abusiveness, and the facility's response to such reports (if such exists)
- 13 Employee files reviewed of positions at all levels, from line security staff, to supervisory, managerial, and leadership levels; reviewed training records, completed criminal background checks
- No Contractor files were accessible for review during the audit
- 5 Volunteer files, including training records, completed criminal background checks
- 5 administrative investigation files related to resident sexual harassment, and sexual abuse (2019)

There were no medical, or mental health records to review, as the facility does not provide such services in-house. Staff training records were reviewed to confirm staff received required PREA training. It is noted that no PREA training was conducted after 2017, due to program transitions at the facility. The PREA coordinator indicated in-house PREA training will resume in 2020.

On 2/28/2020, the auditor met with the PREA coordinator, and Agency Head to thank the facility staff for being welcoming, cooperative, and courteous during the onsite audit. The auditor expressed that compliance efforts were noticeable, and visible. Many of the residents speak highly of facility staff, who show care and concern for their wellbeing. Residents trust that they can reach out to a staff member, should there be a concern for their sexual safety, and staff would help them through the situation.The PREA coordinator escorted the auditor through all areas of the facility, including maintenance office, locked maintenance, storage, and supply rooms. All areas marked as restricted were locked, with the exception of those observed in use during the site review (e.g., cleaning supply closets).

AUDIT FINDINGS

Facility Characteristics:
The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate or resident population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

During the facility site review, the auditor was lead by the PREA coordinator, and Executive Director (Agency Head) (intermittently) through all areas of the facility. During the onsite audit, FCCBCF house 192 men and women residents, and 57 staff. The facility organization is structured such that the Deputy Director (also PREA Coordinator) oversees the operational components of the facility, while the Agency Head manages the finance office, and Quality Assurance. The Agency Head has final authority of the facility.

FCCBCF utlizes Cognitive-Based Therapy (CBT) modality for resident programming, developed by the University of Cincinnati (UC). The specific type of programming is determined on an individual basis, and is established by each resdent's assigned case facilitator, and programming staff (e.g., education, re-entry). Residents are required to complete all aspects of their program in order to be successfully released from the program. During residents' 4-5 months program, s/he participates in one or more of the following:

Cognitive Behavioral Interventions – A Comprehensive Curriculum (CBI-CC) - a 18-week program to help residents identify, and address "thinking errors", which often lead to criminal behavior.

Aggression Replacement Training® (ART) - a 10-week program to assist residents whose ORAS score is High, and those who have known anger management issues.

Anger Management - a 10-week program, which helps residents understand what drives aggressive behavior, and provides guidance on ways to effectively control negative thinking, and subsequent violent, or criminal behavior.

Cognitive Behavioral Interventions for Substance Abuse (CBI-SA) - an 11-week program for residents who are moderate to high risk for substance abuse, based on established assessment results.

Cognitive Behavioral Interventions for Offenders Seeking Employment (CBI-EMP) - a six-week program, which focuses on job-readiness skills, including how to effectively deal with difficult people/situations in ways that do not create a negative impact on job opportunities, and employment retention.

The Epictetus Club - an 8-week program, specifically for high-risk male residents, and founded on principles of Greek philsophy, focuses residents to broaden their thinking beyond themselves, and deal with life's challenges through a greater understanding self, and what drives their thinking and behavior.

Low Risk Skill Streaming - a program specific to residents classified as Low Risk, and only in

the FCCBCF program for 90 days; the program focuses participants on skill-building, and preparing for reentry/employment planning.

FCCBCF provides additional programs such as GED preparation; 12-Step meetings, and religious study and services through volunteers from local churches, and the community at-large.

Facility Site Review

The facility Site Review was led by the PREA coordinator. The Agency Head joined a portion of the review and coversation, answering questions, and sharing program details. During the conversation, Ms. Dickinson shared that she personally facilitates a group with residents. She explained that the facility went through a program curriculum re-design in 2017 from Responsible Adult Culture (RAC) to UC-based Comprehensive Curriculum (CC) programming. The top 5 administrators each conduct a Pre-treatment program on a different focus:

- program rules
- behavior chain
- cost-benefit analysis
- goal-setting.

Week 4 begins core programming. Being directly involved in resident programming allows residents to know agency leaders, and for agency leaders to stay informed of resident issues, concerns. It also makes leaders more accessible to residents.

Facility Characteristics

Front entry

The auditor was "buzzed in" by Central Control Room staff, and entered the Administrative Office area on the right (door not locked). The Administrative area consists of eight (8) workstation cubicles occupied by intake facilitators (3); HR, Fiscal staff. The Deputy director/ PREA Coordinator, Executive Director (ED/Agency head), occupy offices. The ED's office is next to a conference room with exit doors at each end of the room; the rear exit leads to a small kitchenette, across from which are two single-person restrooms. An exit door leads to the facility's Programming hallway, and is the access to the fire exit that goes outside to a fenced-in area on the right side of the building.

The Law Enforcement Agencies Data System (LEADS) room contains video equipment for burning, recording video footage. The facility uses the Vicon Net Workstation System for video surveillance throughout; surveillance cameras do not have audio capacity, although some areas have intercoms so announcements can be heard, but no recording.

The auditor observed an external camera, which spans a small parking lot for administrative staff, and a picnic area with four raised flower gardens. The PREA coordinator explained that female residents can access the area during warm weather months; a church sometimes conducts baptism via a portable tub/pool that the church provides. Church services are held weekly in the cafeteria year-round. The last baptism is usually in October or November, then not

until March.

Staff and resident terminated files are retained in locked files cabinets along the back wall of the office. Active employee HR files are retained in the HR Generalist's office, and are locked. PREA investigative files are retained in the PREA coordinator’s office. A small copy room is to the left of the front reception desk of the administrative office. The front reception area has a large clear window into the main foyer, opposite the control room.

Front lobby

Visitors enter and check-in, including external counselors. The area contains a single-person Men and Women’s restroom. Small lockers hold visitor belongings not permitted in the facility. According to the PREA coordinator, smaller lockers will soon be used for staff cellphones. There’s a money machine to add money on a resident account. There is no money maximum; the system is accessible via phone, or website (mobile accessible).

The front lobby contains a bulletin board. The auditor observed displayed:

- facility job postings
- PREA poster with Sexual Abuse Resource Network of Central Ohio (SARNCO) information (community resource)
- PREA audit notices in English and Spanish, printed on brightly colored pink paper.

After hours, staff sign out keys, visitors can sign-in via control room slide-out box. Resident pat-down searches are conducted in a wait room with resident lockers to the left. There is also a COTA bus rack with various bus route brochures. CPR dummies, manuals are in unlocked cabinets. The auditor observed a pat search, which included removal of socks, shoes, checking mouth. An Alco-sensor machine is also in the room, next to an expandable file of Itinerary Verification forms, divided by each case facilitator name. Residents place completed forms in the file and staff check it daily and place the slips in the case facilitator mailbox. Zero Tolerance postings are on the wall in English and Spanish, as well as Ohio Department of Rehabilitation and Correction (ODRC) hotline and SARNCO hotline and mailing address.

Control Room

The auditor observed hanging on the wall sets of shackles, transport belts that prevent front cuffed residents from raising arms above waist level during transports. Vehicle, medical, maintenance, kitchen keys are inside a locked box; a second box contains buttons for door access in case of a power outage and doors won’t unlock electronically. One security staff (RA) is stationed at the Control Room; two monitors show live video footage throughout the facility. The Control Room contains 43 cameras, including outside cameras. Nine walkie-talkie chargers sit on a bookshelf along with a chargeable flashlight. A single-person restroom is accessible from inside the control room. Two camera monitors have a 64-camera capacity each at any given time. A third monitor identifies all electronically-controlled doors, and shows a lock symbol indicating if the doors are locked or unlocked.

Speaker symbols identify where intercoms are located, and can be accessed individually from the Control Room to hear and speak. An RA on shift explained that any loud noise in an area will

trigger a red alarm so the staff can give attention to the area. A binder is maintained for approved resident rides. Two additional monitors are not active due to a previous PREA allegation, and staff writing their statement based on what the camera shows. Staff are buzzed-out when exiting the control room.

Cafeteria

The auditor observed three cameras on opposite corners of the room, which provides a complete line of sight. The cafeteria consists of 12 tables of five, which provide seating on individual chairs. Residents enter the area escorted and a second staff is stationary, and greets residents as they enter. After meal times, a small resident cleaning team comes in and cleans tables, sweeps, for the next group of residents. When all meals are complete, a more detailed cleaning is completed, as the space is also used for Groups, other purposes through the day and evening.

A TV monitor is mounted on the wall for programming, and family activities (e.g., movie night). Residents pick up prepared meal trays. A pull down window provides access to turn in dirty trays for dishwashing on the opposite side. Residents prepare, serve on the Food Line; they only need to be approved by Medical staff to work in the kitchen. No credential or experience is required.

The facility Food Service is outsourced to, and supervised by, Trinity foods. A (contract) Food manager, and three cooks oversee daily food service operations, along with 7-9 resident workers, who man the food line, and clean the kitchen. Residents are not permitted in food storage alone, but no staff enters with them. A hot meal is included with each served meal. A dietician signs-off on the menu. Food alternatives are available for residents with dietary restrictions or religious observances (e.g., no pork). The nurse provides a weekly list of residents with specific meal restrictions; the auditor observed one with seafood restrictions and a 'no pork' restriction.

Food staff are required to complete New Employee Orientation (NEO) when hired, and in-service with staff, as required. Trinity trains the Food manager; she trains cook staff, and FCCBCF trains everyone. No PREA notices were observed inside the kitchen area, only food related notices regarding cleaning, and proper food requirements. The Food Manager's office has an inside window in the office wall and door. ServSafe certificates and Wage/hour postings are visible. A nearby Janitor closet was identified as a known blind spot, although visible from an outside camera as to who goes inside. The Staff restroom was tested and was locked. A Zero Tolerance poster is in the cafeteria in English. A locked door with a window contains three lockers that are padlocked containing cleaning chemicals. A floor buffer, paper storage are inside a locked room with a solid door. A solid door with a special square key hole contains the hot water tank. A double-door contained pipes, plumbing, and is locked. An Outgoing Mail box is located at the entrance of the food line and is locked. The facility Administrative Assistant checks daily for 'Call cards' from residents. A second box next to the TV monitor goes directly to the ED office. Residents stated during informal conversation that the boxes are known as "snitch boxes", and no one uses them because they are out in the open. Residents stated they would report a PREA allegation to a staff person before using the boxes in the cafeteria.

Commissary

During the facility site review, the ED stated that residents are permitted to spend up to $75/ wk. on Keefe food orders. Co-pays from medical, Commissary, and phones fund the purchase, and upkeep of facility exercise equipment, state ID's for residents, medication (reimbursed), recreation equipment, gloves, hats, extra paper, pencils. Once programming is complete, money is used for a pizza party; an earned lunch with ED up to $15 pp.; GED graduation. The space doubles as computer lab (Discovery Center) for residents, library (donated books).

A door to the left of A-Hall was identified as the maintenance (contractor) hallway, accessible via key card to the office and main boiler room. No cameras are inside, but the hallway camera picks up entry and exits. The Maintenance area loops to an adjacent electrical room, locked with key card access only. A far left door accessed the kitchen; far right door exits to an outdoor trash area with bulk items (old TVs, mattresses); facility vehicles are parked in a small, nearby parking lot.

Resident Housing Units

Male Wing

A-Hall: 20 "pods" on upper a lower levels (10 each) of 3-5 beds each; room doors are kept open, and residents have to be dressed at all times in the Hall. Female staff in the area announce once; no other female staff have to announce, as it is already established a female is in the Hall. One small bulletin board is located on main level (no PREA poster observed), three Zero Tolerance posters are on the wall on the main level. One PREA poster is observed near a phone, the other two are next to each other and in English and Spanish. A large bulletin board has PREA audit notices and Zero Tolerance posters in English and Spanish.

Phone 1 was tested, requires a PIN for the message center. The PREA coordinator doesn’t know where those calls go, not internal. The auditor was prompted to" press 1" to place a call, and enter a PIN number to complete. A nearby resident completed a call to SARNCO hotline, which was completed; the resident went to his call account (accessed with a PIN number), no call was logged or charged.

Main floor Restroom:

- 4 sinks and mirrors
- 3 toilets with half stall door
- 1 shower with 4 shower heads and solid curtain.

A-Hall, Upper area: restroom is same as lower level, shower curtain is approximately 4-5 inches from the floor. Zero Tolerance poster on upper level bulletin board is in English and Spanish. A locked door with window leads to a laundry room with: 1 washer, 2 dryers; an inside closet contains cleaning products for resident cleaning "details". Residents are not charged to wash clothes.

The Fire Exit is a known blind spot. A two-way mirror in the stairwell provides a line of sight at bottom of stairs and coming up. Locked area with key accesses K-Hall. A camera at the bottom of the stairwell captures two doors, one to A-Hall's main level, a second to K-Hall main level.

Blind spot under stairwell is inaccessible due to three wide file cabinets restricting use of the space. Exit door goes to large recreational area with cameras at each end.Outside, two basketball hoops, seating; wiring above the fence.

K-Hall: next to A Hall; contains 37 open single, and bunked beds. Main side houses 1 - 12 beds, 4 single, 8 bunks; section 2 is divided by restroom and an unlocked laundry room with a washer 2 dryers. A restroom offers privacy with two full stalls with doors, in addition to 2 urinals, 3 sinks and mirrors, one shower with 4 heads. The auditor noted the shower curtains are PREA-compliant, with a solid center, and clear upper and lower (below knee) sections. Exercise equipment is accessible in front of the restroom area, near an open sitting area. Two cameras in the main sitting area near the security desk and above case facilitator office. Windowed wall and door to leads to B-Hall, but door is kept locked. A bank of four resident phones, bulletin board with Zero Tolerance poster were observed next to the phone bank. The Fire Exit leads to an outdoor recreation area. The Main level, right side contains 11 beds, including two bunks. A camera was observed in the area, offering a line of sight from a far camera in main sitting area.

K-Hall Upper area: left side has 7 single beds, 1 bunk. Lockers on the wall on opposite side of beds, alleviate blind spots. The Center 360-degree camera on ceiling above main sitting area has partial view of upper level. A locked storage room with solid door contains old medical files, resident files. The restroom contains two toilet stalls with full doors, 3 sinks and mirrors, two urinals, 1 shower with 4 heads; shower curtains are PREA compliant. Behind a solid locked door was space previously used for paper storage, currently not in use. Zero Tolerance poster on wall outside case facilitator office, but not accessible without staff sight via security desk and/or office window in the door. Resident forms are in mounted wall rack. Zero Tolerance poster was observed in upper level between restroom and storage room.

B Hall
Designed same as A-Hall. Window in K-Hall case facilitator office sees into B-Hall's main area. A bulletin board on the main level has Zero tolerance posters in English and Spanish; posters are not near resident phones; no PREA posters were observed on upper level. PREA audit notices are posted on bulletin board rack of forms next to the security desk includes grievances (although such is not used to report PREA allegations). Sinks and a microwave are accessible for residents to heat up purchased Commissary foods. Recreation equipment is located in the center of the main level near stairwell. A main level laundry room is locked, with an inside window in the door.

Restroom: 2 toilets with half stall doors, 2 urinals, 3 sinks with mirrors; 1 shower with 4 heads, solid curtain.

B-Hall Upper level includes 10 rooms with 3 beds each. The resident restroom contains two short-stall toilets, two urinals, 4 sinks and mirrors, one shower with 4 heads and solid curtain.

Three cameras on the lower level include a 360-degree camera in the center of the main level. No cameras were identified on the upper level.

C Hall (women) 39 beds
Four cameras cover the main open area with multiple tables and chairs. Two cameras are located on the *dorm* side, at the secondary entrance to classrooms, and one above the laundry room. Two cameras are on the *room* side above the sink: microwave area and one above the

pass-through next to the coverage desk. The room side contains five rooms: three with five beds, one with six beds, one with seven beds.

The open area contains a Group room and three case facilitator offices; a small sink area with microwave for Commissary food; double doors open to Recreation area. A TV is mounted in the open area; tables and chairs provide seating to watch movies, play games, etc.
Restroom: 4 toilets each with half (waist high) doors, one is ADA accessible; 6 sinks with mirrors divided by a wall with 3 on each side; one side has toilets, the other has two showers, each with two shower heads, and solid shower curtains; one shower had a handicap rail. One dispenser for sanitary products; Zero Tolerance posters in English and Spanish were observed inside the restroom. A bulletin board has Zero Tolerance posters, and PREA audit notices.

The Laundry room has window in front wall and two large windows in the door; one washer, two dryers.
A second restroom has 4 sinks and mirrors, 2 single-person showers, four toilets with full stalls. A Zero Tolerance poster in English and Spanish inside the restroom was observed.

Three clear storage units stores games, education materials. A metal cabinet is locked and marked as a "property closet". Exercise equipment is located in the open/common area.

An open dorm area to the left of the security desk contains 11 single beds, no bunks. Zero Tolerance posters are posted on the dorm far wall. Lockers are located on the wall next to the exercise equipment. A camera is located at the dorm entrance.

Programming

Opposite the Women's Wing exit is a locked, two-door room for resident property, bed linens. The auditor observes along the Hallway Zero Tolerance posters in English and Spanish. A locked exit at the end of C-Hall leads to a garden area, maintained by female residents. To the right is a solid locked door, the space is used to store resident shirts and clothing; indigent residents are provided with clothes to wear.

The programming hallway contains six classrooms and/ or testing room. The space is used by male and female residents, at designated times, and is accessible through two different entryways. A five-drawer cabinet in the hallway stores staff uniform wear; a second locked five-drawer cabinet contains binders. Two single-person restrooms are marked for "Staff Only". The Hallway opens to the left to a small outer sitting area, and right to a hallway with 16 Staff lockers on the right and mounted file cabinets on the left, each labeled with contents (forms, used by residents). The hallway loops into the facility foyer, outside the library/ Discovery Center.

The auditor was provided unrestricted access to all facility rooms, spaces, offices, resident housing units; kitchen, and dining areas. Staff were courteous, accommodating, and cooperative throughout the auditor's facility site review.

AUDIT FINDINGS

Summary of Audit Findings:
The OAS will automatically calculate the number of standards exceeded, number of standards met, and the number of standards not met based on the auditor's compliance determinations. If relevant, the auditor should provide the list of standards exceeded and/or the list of standards not met (e.g. Standards Exceeded: 115.xx, 115.xx..., Standards Not Met: 115.yy, 115.yy).
Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	0
Number of standards met:	41
Number of standards not met:	0

The auditor determined that the facility was non-compliant with the following 11 standards:

115.213

115.215

115.216

115.217

115.241

115.242

115.265

115.267

115.273

115287

115.288

The facility was found to be compliant with all remaining standards. Determinations were made using a triangulation of the evidence provided in hard copy, via email, interviews with random and target residents, random and specialized staff, OAS uploaded documentation, onsite observations.

The facility Corrective Action Plan was completed on 1/5/2021. Based on evidence provided during the 180-day Corrective Action period, the auditor finds the facility to be in full compliance with all required PREA standards.

Standards

Auditor Overall Determination Definitions

- Exceeds Standard
  (Substantially exceeds requirement of standard)

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

- Does Not Meet Standard
  (requires corrective actions)

Auditor Discussion Instructions

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.

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: PREA 2. Agency Table of Organization Interviews: 1. PREA Coordinator Findings: 115.211(a) The facility PAQ indicates there is a zero tolerance policy against resident sexual abuse, and sexual harassment. The PAQ provided policy SUP12 as supportive documentation. The policy outlines the agency's implementation approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Policy Section I. includes a description of agency prevention strategies to reduce and prevent sexual abuse and sexual harassment of residents by training all newly hired employees, and providing basic, ongoing training related to the agency's Zero Tolerance policy. Policy Section II. includes a description of resident assessments, and re-assessments to identify residents who may be known, or suspected victims of sexual abuse, as well as known, or suspected sexual abusers. The section protects residents from disciplinary sanction(s), should they not wish to answer assessment questions. Policy Section III. includes a description of agency detection strategies, including providing residents with a documented Resident Hadbook containing their rights, and steps to maximize their sexual safety. The section advises on steps for first responders; monitoring practices for residents who report and/or staff who may cooperate during an investigation. Additionally, procedures are in place as actionable steps for implementing policy guidelines. Policy Section IV. describes agency investigative processes and procedures for PREA-related allegations, which are investigated by internal administrative designees or external law enforcement, if criminal in nature. Policy Section V. outlines the treatment and care residents receive, including gender-specific care for female residents. The section describes internal, and community-based resources available to residents who have the need, and desire for emotional, mental, and/or physical support and assistance. Policy Section VI. outlines the agency's practice for determining allegation outcomes, including consequences for allegations reported in bad faith, and administrative and/or criminal action against staff when sexual abuse allegations are substantiated Policy Section VII. includes how allegation outcomes are reported to residents, and differences as it relates to allegations involving other residents, or staff (including contractors, and volunteers). Policy Section VIII.

	furthers the agency's reporting strategies, including data collection, annual reporting of findings and corrective actions; and, records retention. Based on the evidence provided, the facility meets this provision. 115.211(b) The facility PAQ indicates it employs or designates an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. Policy SUP12 establishes that FCCBCF identify a PREA coordinator, which should be in a leadership position in the organization. The facility provided in the PAQ a Table of Organization as supportive documentation. The organizational structure identifies the facility Deputy Director as the PREA coordinator. The Deputy Director reports directly to the agency Executive Director, and is second in command. The PREA coordinator stated during his interview that he has sufficient time and authority to carry out his role. Other operational responsibilities are carried out through supervision of managerial staff assigned to specific areas of the agency's operation. During his interview, he stated he has been the PREA coordinator since 2018; he's been with FCCBCF since 2013. During interview with the agency executive director, she stated the PREA coordinator and she work together, and meet on PREA implementation, and compliance matters, including recommendations to further efforts to ensure resident sexual safety. During the onsite audit phase, the PREA coordinator greeted the auditor, and identified himself as the auditor's POC while onsite. This person led the auditor on the onsite facility review, answered all questions, and provided requested information. The PREA coordinator's office is located in the administrative wing of the facility, near the management team, and executive director. This places the PREA coordinator in line with what reflects on the organization chart as "upper-level" staff. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.212	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire Interviews: 1. Agency Head Findings: 115.212(a) The facility PAQ indicates it does not contract with other facilities for the confinement of their residents. The facility indicated on the PAQ that N/A is the applicable response to this standard. During the onsite audit, the agency Executive Director confirmed during his interview that the organization does not contract with an outside entity for the confinement of residents. The FCCBCF is a 200-bed Community Based Correctional Facility (CBCF), and serves Franklin county, Ohio. FCCBCF is a secure treatment facility, which provides a local alternative to prison with the primary purpose of rehabilitation for non-violent male and female felony offenders. Based on the evidence provided, the facility meets this provision. 115.212(b) The facility does not contract with other facilities for the confinement of residents. The agency Executive Director explained in her interview that she has been the Executive Director since 2018 (interim ED since 2016). She worked for the agency from 2001 - 2010, and returned as Deputy Director in 2014. She stated she led the agency's effort to implement PREA at FCCBCF, including preparing for, and completing its first audit in 2014. The facility was established in 1993. The facility is governed by a civilian governing board, and judicial advisory board, consisting of judges who represent Franklin County. The facility operates one location, where the onsite audit was conducted. The auditor did not observe evidence of other facilities under FCCBCF's jurisdiction, which is, or may be operated through a contract with an external entity. The Executive Director stated during her interview that FCCBCF does not contract with an outside entity for the confinement of residents. Based on the evidence provided, the facility meets this provision. 115.212(c) The facility PAQ indicates that only in emergency circumstances in which all reasonable attempts to find a private agency or other entity in compliance with the PREA standards have failed, may the agency enter into a contract with an entity that fails to comply with these standards. In such a case, the public agency shall document its unsuccessful attempts to find an entity in compliance with the standards. During the pre-audit phase, the PREA coordinator did not provide to the

	auditor any contracts with an external entity for housing residents. No contract(s) or other agreement(s) was provided in the PAQ; the facility responded in the PAQ that it does not contract with external entities for the confinement of residents. During the onsite audit, the Executive Director stated in her interiview that FCCBCF provides services at the current location; no outside entity is contracted for housing FCCBCF residents at another location. The auditor interviewed 14 staff during the onsite interview. No staff indicated that FCCBCF operates, or contracts for the confinement of residents, at another location. Based on the evidence provided, the facility meets this provision. Based on evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.213	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP1: Security Policies & Procedure/Staff Scheduling 2. Sample facility shift rotation schedule 3. Work Stoppage and Staffing Plan (PREA staffing plan) Interviews: 1. Deputy Director/PREA coordinator Site Review Observations: 1. Physical layout of the facility Findings: 115.213(a) The facility PAQ indicates FCCBCF has a PREA Staffing Plan. Document *Work Stoppage and Staffing Plan* (PREA staffing plan), and a sample shift schedule document, were provided as supportive documentation. The Work Stoppage and Staffing Plan document indicates in the Staffing Plan section that the facility has an established staffing minimum to ensure the sexual safety of residents: 1. There is at a minimum, five (5) Resident Advisors (security staff) per shift 2. There are two (2) male, and two (2) female RA's on the schedule on a weekly basis 3. Unit Supervisors serve as back-up if no RA is available on shift 4. RA's remain on shift until a replacement arrives The auditor observed the facility's main control room during the onsite audit. The control room contains video monitors throughout the facility. Based on observation, and confirmed by the PREA coordinator, the facility has 43 cameras. including those with outside views. Staff stated two monitors have the capacity of 64 camera each.Two monitors were off; cameras view areas in the female wing, where an allegation was made. The DVR continues to record, although the cameras are not on inside the control room. During the onsite interview with the PREA coordinator, he stated FCCBCF has a documented PREA staffing plan, which is reviewed annually with management staff. He explained the PREA coordinator is responsible for maintaining the PREA staffing

plan. The PREA coordinator serves in a dual capacity, and is the facility Deputy Director, and also oversees the facility's accreditation by the American Correctional Association (ACA). In this capacity, he ensures facility compliance with American Correctional Association (ACA) standards, a national accrediting entity for correctional facilities and institutions. He was able to articulate how the staffing plan is utilized to reduce vulnerability (e.g., prior sexual abuse victim, or abuser) through a structured staffing rotation schedule, and pattern.

The auditor interviewed six (6) specialized staff during the onsite audit, who were in supervisory and managerial positions. Six of six stated they participated in staff meetings, during which the facility staffing plan was reviewed. Given a staffing plan was provided, and six of six staff in supervisory and managerial roles, and whom would have an opportunity to provide input on the development and content of a PREA staffing plan, the conclusion is that such is an accurate statement in the context of PREA standard 115.213. Based on the evidence provided, the facility meets this provision.

115.213(b)
The facility PAQ indicates deviations from the established PREA staffing plan is "not applicable", as the facility does not deviate from what is documented in the PREA staffing plan. The PREA coordinator stated during his interview that he oversees the PREA staffing plan. If there were a reason to deviate from it, he would communicate it with the Agency Head. The PREA coordinator stated during an informal conversation with the auditor that line and management staff are very supportive, and flexible with their schedules. It is common for a supervisor to cover on a shift if a staff person is going to be absent, so other line staff can maintain their days off. One of the supervisors stated during his interview that "...we all work together to make sure everything is covered." During the onsite audit, the auditor observed the number of security staff on each shift coincided with the established PREA staffing plan. Unit coordinators and managers covered RA schedules on Day 2 of the onsite audit, as there were call-offs due to inclement weather. Based on the evidence provided, the facility meets this provision.

115.213(c)
The facility PAQ indicates the facility PREA staffing plan is reviewed at least annually. The facility provided no supportive documentation to support the PAQ response. During his interview, the PREA coordinator stated the Agency Head is the "gatekeeper" of the facility staffing plan. He stated personnel, staffing levels are reviewed during each management team meeting, not just annually. He and the Agency Head formally review the staffing plan on an annual basis.

The PREA coordinator was able to articulate during his interview the components of the staffing plan that are reviewed with supervisory and management staff. However, no evidence was provided to substantiate that the stated annual reviews take place, or when. No evidence (e.g., board meeting notes, staff meeting notes) that the staffing plan is reviewed with management and line staff, at least annually. The Work Stoppage and Staffing Plan document has an affirmation statement, and signature line at the end of the document. The copy uploaded in the PAQ is not

	signed. Based on the evidence provided, the facillity does not meet this provision. Based on evidence provided, the facility does not meet this standard. Corrective Action: 1. Document annual PREA staffing plan reviews, when such is a meeting topic internally, and/or at board meetings. 2. Document what aspects of the staffing plan is reviewed in each meeting (e.g., the need for monitoring technology; staffing requests; facility vulnerabilities). Recommendation: 1. Review The Moss Group's(TMG) ***Developing and Implementing a PREA-Compliant Staffing Plan***, located on the PREA Resource Center's website, in order to maximize content of the Staffing Plan. ***FACILITY RESPONSE:*** The facility created a documented PREA Staffing Plan Review form, which verifies actions taken regarding the Plan, throughout the year: • The staffing plan – The Leadership team consisting all supervisors and management staff will meet at least quarterly to discuss the overall staffing model for the facility. The overall strength of Operations, Programming, and other support staff are updated as needs arise. • The facility's video monitoring systems and other monitoring technologies. • Any other relevant factors: including key control and monitoring of movement of staff and residents, transportation policies (i.e., who transports residents and if another agency transports, how safety is ensured); how contractual and volunteer staff are supervised; procedures for emergencies that might lead to a staff shortage. The PREA Staffing Plan Review form requires signatures by the agency executive director, and deputy director/PREA coordinator, as well as Unit supervisors, Unit Managers, HR, and Business Office staff. A date line is provided for each signature, which provides a time perspective to the review. A completed PREA Staffing Plan Review form was provided as evidence of the institutionalization of the review process. All signatures required were observed on the document, and dated 11/16/2020. Based on the evidence provided, the facility is now in compliance with this standard. **Review**: FCCBCF PREA Staffing Plan Review form

115.215	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP04: Facility Searches Interviews: 1. Non-Medical Random Staff Site Review Observations: 1. Auditor site observations of Operational Procedures Findings: 115.215(a), (b) The facility PAQ response indicates a staff manual or instrument body cavity search is only conducted when reasonable cause exists that a weapon or contraband is being concealed and when authorized by the CBCF Director or designee. The PAQ response also states that the facility does not permit crossgender strip searches of residents. The auditor reviewed the facility staffing plan, which requires, at minimum, one female, and one male staff on each shift. If a female staff is not available to conduct a required strip search, or pat search, the staff on the current shift is required to work over-time, or a non-security staff will cover until the next female staff arrives. The same is true for male strip searches. The PAQ indicates there have been no cross-gender searches. The PREA coordinator provided a sample Strip Search Form as supportive documentation. The form documents strip searches conducted between 11/8/2019 - 11/15/2019. The form indicates staff conducted 130 strip searches were logged during the noted dates. The form reflects male and female resident strip searches. There is no evidence that cross-gender searches were conducted. Based on the evidence provided, the facility meets provision (a) of this standard. The facility PAQ response indicates that as of August 20, 2015, or August 20, 2017 for a facility whose rated capacity does not exceed 50 residents, the facility shall not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Facilities shall not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision. FCCBCF policy SUP04 states the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. The facility PAQ indicates no cross-gender pat searches of female residents have occurred, and no exigent circumstance(s), which would justify conducting a cross-gender female

	resident search. The PREA staffing plan indicates that female residents at FCCBCF are searched only by female staff. The PREA coordinator provided a New Hire Orientation Outline as supportive documentation. The outline includes detailed search procedures. The document states two staff are required when strip searches are conducted: **"*Strip searches - ...One staff member is to conduct the search and the other staff is to serve as a witness and is watching the staff member conduct the search. The staff member serving as the witness may be of the opposite sex however they must ensure they are unable to see the resident.*"...** The auditor interviewed seven (7) female residents during the onsite audit. Of the 7 interviewed, 100 percent of the residents stated they have not experienced, or witnessed, a female resident strip searched by a male staff. All residents articulated an understanding that cross-gender strip searches are not permitted. All residents stated there is always a female staff in the facility. The facility PAQ indicates it does not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision. During the onsite audit, the auditor did not observe any female residents being held from programming or other outside opportunities due to lack of female staff available to conduct a strip search, or pat search. The auditor interviewed nine random security and nonsecurity staff during the onsite audit. All staff, male and female, stated a resident would not be held from access to regularly available programming or other outsie opportunities due to female staff being unavailable to conduct a required search. Based on the evidence provided, the facility meets provision (b) of this standard. 115.215(c) The facility PAQ indicates that the facility does not document all cross-gender strip searches and cross-gender visual body cavity searches, or cross-gender pat-down searches of female residents. The facility referenced the search policy as supportive documentation. Policy SUP04 states FCCBCF does not conduct cross-gender strip searches or pat downs. During the facility site review female staff were observed monitoring the female wing of the facility. The auditor observed male supervisory staff passing through the common area; no cross-gender strip searches or cross-gender body cavity searches, or cross-gender pat-down searches of female residents were observed. The auditor interviewed 7 random female residents. No resident stated they experienced being strip searched, or pat searched, or a visual body cavity search, by a male staff. Based on the evidence provided, the facility meets this provision. 115.215(d) The facility indicated in the PAQ that policies and procedures are in place, which enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances. Policy SUP04 was provided as supportive

documentation. Policy section III., *Resident Rights Regarding Searches* states:

"***... This requires staff members of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions or changing clothing.***"

Policy SUP04 requires staff of the opposite gender to announce themselves when entering the client dorm area, or restroom. The auditor interviewed 13 male random residents, and 7 female random residents during the onsite audit. All female residents stated male staff are good about announcing themselves when entering their wing. They also stated male staff do not enter their restrooms. One resident stated the supervisor will ask, "Everyone decent?", or will instruct to close the restroom door, before walking past their dorm/sleeping area. All male residents stated in their interview that female staff announce themselves when entering the men's wing. During the facility site review, the auditor observed a male manager enter the female wing, and announced himself loudly ("Male on the floor"). Based on the evidence provided, the facility meets this provision.

115.215(e)
The facility PAQ indicates the facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Policy SUP04 was provided as supportive documentation. The policy states in section III., B.:

"***...If the resident's genital status is unknown, it may only be determined during conversations with the resident, by reviewing medical records or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitoner.***"

During the PREA coordinator's interview, he stated no residents self-identified as transgender or intersex. During random staff interviews, six of six security staff stated they are not aware of the facility housing transgender, and intersex residents. The PREA coordinator stated the facility has not had a transgender or intersex resident. During a review of 20 resident files, the auditor found no evidence of a resident classified as, or whom self-identifies
as transgender or intersex. The auditor did not observe a resident Intake during the onsite audit. The PREA coordinator stated no new intakes were scheduled at the time of the onsite audit. Resident screening information observed by the auditor provides residents the ability to self-identify as a transgender or intersex. Based on the evidence provided, the facility meets this provision.

115.215(f)
The facility PAQ indicates 58 percent of staff were trained on how to conduct crossgender pat-down searches in a professional and respectful manner. Policy SUP04 was provided as supportive documentation. The policy states:

	"*CBCF staff is trained in how to conduct all searches of residents in a professional and respectful manner, and in the least instrusive manner possible, consistent with security needs.*" The auditor reviewed the CBCF New Employee Orientation schedule from December 2019. According to the five-day orientation schedule, the PREA coordinator facilitates on Day 2, a one-hour session, which covers emergency plan/procedures and safety tour; Supervision; and Weapon control. The Supervision session includes facility searches, pat down searches, strip searches, and shake downs. A Powerpoint presentation, titled Search and Seizures, was presented as training documentation. The Searches portion of the sesson indicates that only staff who conduct a strip search, and the resident being searched are to observe the search. The presentation does not cover the information in the orientation outline regarding strip search procedures (i.e., opposite gender staff permitted as a witness). No evidence was provided regarding who attended the December 2019 orientation training. The auditor reviewed 12 employee files. No training records were provided as supportive documentation of employee training. The auditor interviewed nine random security and non-security staff (Resident Advisors). All staff indicated training only occurs during New Employee Orientation. Procedures for searches is covered via video, and review by the PREA coordinator. A unit manager stated during interview that the orientation is thorough enough for staff to perform their job duties. No security staff indicated they did feel prepared, or knowledgeable of their job duties. Nine of nine security and non-security staff stated there is no training for transgender or intersex searches. The PREA coordinator stated during interview that there have been no transgender clients. He stated routine PREA refresher training has be side-lined since the facility re-vamped resident programming in 2017. He stated plans are underway to re-establish routine PREA training in March 2020. Based on the evidence provided, the facility does not meet this provision. Based on the evidence provided, the facility does not meet this standard. Corrective Action: 1. Develop and implement staff training regarding searches of transgender and intersex residents, (despite not having transgender or intersex residents in the facility). 2. Include in New Hire training, and PREA refresher training how to conduct crossgender patdown searches in a professional and respectful manner; ensure such is documented (i.e., signed, dated employee attendance forms). Recommendation: 1. Utlilize training sources such as National Institute of Corrections (NIC), PREA Resource Center archives for training curricula on searches of transgender and intersex residents.

	FACILITY RESPONSE: The facility has implemented a standardized training to guide staff on how to conduct crossgender patdown searches, and searches of transgender and intersex residents in a professional and respectful manner. The facility provided to the auditor five signed training acknowledgment forms and agenda, as documented evidence that such training has been institutionalized in practice: new hire orientation training, and general PREA staff refresher training sessions include video, and powerpoint training, developed by The Moss Group, and is available on the PREA Resource Center's website. Based on evidence provided, the facility is now in compliance with this standard. **Review:** Policy SUP04 Facility Searches FCCBCF Training Acknowledgment form Guidance on Cross-Gender and Transgender Pat Searches (video) (PRC website 6.8.2015) Staff training documents

115.216	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy ADM07: Process for Referral, Acceptance, Rejection, and Termination 2. FCCBCF website Interviews: 1. Agency Head 2. Random Staff Site Review Observations 1. Dorm/housing unit common areas, control room, case facilitator office areas, common areas, public entrance to building, and visitation 2. Posted materials, English and Spanish 3. FCCBCF Resident Handbook Findings: 115.216(a) The facility PAQ indicates the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The PAQ states the facility complies with this provision. Policy ADM07 was provided as supportive documentation of compliance with this provision. Policy section VII., A. 3. states: "***3. Ambulatory, wheelchair mobile, emotionally stable, and capable of fully participating, comprehending, and engaging in the program;***" The facility commented in the PAQ, "***CBCF admission criteria requires all residents to be capable of communicating needs, see attached policy.***" The Agency Head explained during her interview that eligibility criteria requires residents be able to communicate; the same applies to someone with significant medical issues. If accepted, staff spend extra time with them (LEP; literacy issues) reviewing the handbook and where resources are. Common Pleas court sends a list of interpreters, which can provide deaf, vision, or interpretation services. Those staff who screen new potential residents will report recommendations what may be required to serve the population.The agency has no documented Memorandum of Understanding (MOU) with a specific organization, or company to provide assistance with resident interpretation needs, hearing or vision assistance, or language translation service. The PREA coordinator provided a list of multiple resources,

provided by the courts, should interpretive services be needed. The auditor identified resources for interpretive/translation services, hearing, vision assistance.

The FCCBCF website states in the Resident Information tab that the facility allows resident phone service thorugh IC Solutions. The website explains telecommunication provisions via live links to the company's brochure. The auditor tested the links, which did not open the company's brochure, but re-directed back to the website's Program page. During the onsite facility review, the auditor observed PREA posters in each resident Hall: A, B, K (men); C (women). Each Hall contains one or more (depending on size, room structure) bulletin board. At least one bulletin board contained PREA posters, and PREA audit notices in English and Spanish, and printed on bright pink paper. The auditor observed PREA posters in the men's and women's cafeteria, and restrooms; control room, waiting area. Resident phones provide the option of English or Spanish communication. Based on the evidence provided, the
facility meets this provision.

115.216(b)
The facility indicated in the PAQ that the agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Policy ADM07 was provided as supportive documentation. The facility provided in the PAQ the PREA poster printed in Spanish, as additional supportive documentation. During the facility site review, the auditor observed Spanish versions of the poster throughout the facility. The PREA Coordinator works closely with the Intake staff to identify any resident with disabilities. Policy section VII., A. 3. states, in part that residents must be:

"***...capable of fully participating, comprehending, and engaging in the program;***"

The PREA coordinator, and Agency Head stated in interviews that interpretive services would be utilized, if needed, through court resources. The PREA coorodinator stated that if someone were very limited in their English proficiency, their needs may be beyond what what the program can provide.
During random resident interviews (male and female), no residents were identified as limited in English proficiency (LEP). The auditor reviewed 20 resident files (10 male, 10 female). No files indicated a resident was identified as limited in English proficiency. The PREA coordinator stated during his interview they would contact one of the nterpretive service providers on the list, if such were needed. Based on the evidence provided, the facility meets this provision.

115.216(c)
The facility PAQ indicated FCCBCF policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-responder duties under §115.264, or the investigation of the resident's allegations. The agency documents

	the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. The PAQ indicates there have been no instances in the past 12 months where resident interpreters, readers, or other types of resident assistants have been used. The PREA coordinator provided a hard copy listing of service providers, whom/which offer translation, and/or interpretation services. He stated during informal conversation that arrangements would be made in advance, if they knew someone was coming into the program who would require language assistance. During the onsite facility review, the auditor tested the resident phones for PREA reporting. The phone system provides options for English, or Spanish. During random security staff interviews, six of six random staff stated they wouldn't utilize a resident to interpret for another resident. During her interview, the Agency Head explained to the auditor that pre-admission reviews are conducted by Intake staff before a resident is accepted to FCCBCF. If there were a significant language barrier, the facility would have to consider whether FCCBCF is an appropriate placement. The facility would not likely accept someone who could not speak English, or understand English in written form. During random resident interviews, none of the 20 residents presented as having a need for interpretive services, or identified as Limited English proficient (LEP). Based on the evidence provided the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended. Recommendation: 1. Ensure all staff who engage with residents are aware of how to request interpretive services for residents, should such be deemed beneficial to the resident.

115.217	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy HR1: Recruitment, Selection, Promotion and Transfers 2. 12 Staff files 3. FCCBCF Policy HR6: Staff Performance Reviews Interviews: 1. Business Administrator (HR staff) 2. Deputy Director/PREA Coordinator 3. Findings: 115.217(a) The facility PAQ indicates there is a policy that prohibits hiring or promoting anyone, or enlists the services of any contractor who: (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. Policy HR1 was provided as supportive documentation of the facility's hiring, including contractors, and promotional practices. The policy affirms the language in this provision. The HR staff stated in her interview that questions related to sexual conduct are not on the employment application, but are documented during the interview. FCCBCF has a specific job application form. The auditor observed that the agency's job application form does not contain questions related to sexual conduct. The HR staff stated reference checks include the three components of this provision for candidates with prior experience in a prison, jail, lockup, community confinement facility, juvenile facility or ther institution (as defined in 42 U.S.C. 1997). The auditor observed the PREA statement in 12 of 12 employee files. The HR staff stated promotional questions are asked that include disclosure related to sexual abuse, and sexual harassment. The auditor observed seven employee files that reflected promotions. Seven of seven files contained signed PREA affirmation forms. During the onsite audit, the auditor inquired about contractors, and volunteers. The auditor interviewed a volunteer/intern during the onsite audit. He stated he attended New Employee Orientation along with regular staff, which included review of PREA guidelines, and the agency's zero tolerance policy. He stated he signed an acknowledgement form, verifying that PREA policies and

procedures were reviewed and understood.
The agency Table of Organization, and identified the following positions noted as contractors:

- Food Service staff: One (1) full-time Food Service Coordinator; Three (3) full-time Cook
- Medical staff: One (1) Physician
- Maintenance staff: Two (2) full-time maintenance workers

The auditor did not interview the contractors. There were no medical or mental health contractors in the facility during the onsite audit dates. The HR manager stated in her interview that contractors are required to complete the same paperwork as regular employees. The auditor reviewed all seven contractor files. All files contained PREA Acknowledgment forms for contract staff. Based on the evidence provided, the facility meets this provision.

115.217(b)
The facility PAQ indicates the agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residentsit complies with this provision. Policy HR1 was provided as supportive documentation of compliance. Policy HR1 states the facility will not not hire or promote anyone who has been "***...Civilly or administratively adjudicated to have engaged in sexual abuse or sexual harassment, and considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with the residents.***"

During the onsite audit, the HR staff stated sexual harassment would be a determining issue on whether to hire, or promote someone. The agency would have the record regarding an internal candidate, so the situation would be reviewed. If a reference check result indicated an new hire was involved in sexual harassment, it's possible the person could be hired, but not likely.

The auditor reviewed 12 employee files, one volunteer file, and seven contractor files. One employee had been promoted in 2019. There was no evidence of the facility hiring or promoting anyone who was involved in alleged sexual harassment. There was no evidence that the promoted employee received discipline, including sexual harassment of a resident. The auditor was provided information on the seven contract staff who provide food service, maintenance, and medical services. All files contained PREA Acknowledgment forms, affirming the contractor has not been involved in alleged sexual
harassment. Based on the evidence provided, the facility meets this provision.

115.217(c)
The facility PAQ indicates all job candidates to submit to and pass a criminal background check. Policy HR1 is provided as supportive documentation. The policy indicates the facility conducts criminal background checks, and driving record check. The facility conducts its own background checks via the state of Ohio's Law

Enforcement Automated Data System (LEADS). There is no cost to access the system. During the onsite audit, the PREA coordinator stated no printed record of background checks are contained in employee files, as such is prohibited under the LEADS certification agreement. The agreement prohibits anyone not trained, and certified to access the system. The auditor observed notes in employee files indicating background checks were cleared.

The auditor reviewed 12 employee files during the onsite audit. Of the 12 files reviewed, none, or zero percent, contained ackground checks, which coincide with the time of hire. Based on the evidence provided, the facility does not meet this provision.

115.217(d)
The facility PAQ states WCCCF requires contractors who have access to residents to submit to and pass a criminal background check. The reviewed seven volunteer files during the onsite audit. Of the seven contractor files reviewed, none contained background check documentation.

The Table of Organization indicates there are seven contractors whom have access to residents. The HR staff stated in her interview that the facility follows the same process for contractors as for staff. The contract maintenance staff, or physician were not onsite during the PREA onsite audit. The auditor reviewed all contract staff files. As with staff, due to restrictions of the LEADS agreement, no files contained background check documentation. Based on the evidence provided, the facility does not meet this provision.

115.217(e)
The facility PAQ indicates criminal background checks are conducted at least every five years. Policy HR1 was provided in the PAQ as supportive documentation. Policy Section I., H. states:

"*3. The CBCF will conduct a criminal background record check on current employees at least every five years or have each employee complete an annual acknowledgement to capture PREA-related information.*"

The auditor reviewed 12 employee files while onsite. Of the 12 files reviewed, one contained a follow-up background check. However, based on the employee's date of hire, a five-year follow-up background check would have been due in 2017. The employee's file indicated the follow-up background check was completed in 2020, two years past the five-year follow-up period. a second file indicated the five-year follow-up background check is not due until July 2020. Based on the evidence provided, the facility does not meet this provision.

115.217(f).
The facility PAQ indicates FCCBCF asks all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative

duty to disclose any such misconduct. The auditor verified that FCCBCF has a standardized employment application form for hiring staff who have access to, and engage with residents. The form does not ask applicants about any past sexual misconduct. Policy HR6 was provided as additional supportive documentation. Policy Section I., B. states:

"***5. The supervisor also asks the employee directly about previous sexual msconduct as part of the performance review. The employee provides his/ her signature indicating compliance with PREA-related policies and procedures (PREA 115.217).***"

The auditor observed documented, structured interview questions in employee files. All interview questionnaires includes questions of past sexual conduct to affirm the requirements in section (a) of this standard. The auditor observed that this document is utilized for volunteers whom have access to, or engage with residents. Employee files which contained performance evaluations, also included documented contiuning affirmation that the employee has not engaged in sexual harassment, or sexual abuse of residents.

The HR staff stated the facility conducts institutional reference checks on job candidates who have prior experience at a correctional facility, or other institution. She further stated the facility imposes upon staff a continuing affirmative duty to disclose any such misconduct. The auditor reviewed 12 employee files during the onsite audit. The auditor observed in 12 of 12 files institutional reference check documentation. One employee file where the employee was promoted included a signed affirmation that the employee has not engaged in sexual harassment, of sexual abuse. The HR staff stated in her interview that criminal background checks are updated every five years. The auditor did not observe actual background checks in employee files, due to the LEADS agreement; one file indicated the five-year follow-up background check was conducted two years past the five-year period. Based on the
evidence provided, the facility does not meet this provision.

115.217(g), (h)
The facility PAQ indicates material omissions related to the disclosure of prior sexual conduct is cause for termination. Policy HR1 was provided as supportive documentation. Policy Section I., D. 4 states:

"***4. Providing false or incomplete information may be grounds for disqualification of the application process or termination of employment.***"

The HR staff stated there have been no terminations based on material omissions during the hiring of new staff, or promotion of current staff. The auditor reviewed 12 employee files during the onsite audit. The auditor was not provided any terminated files of former employees who were terminated due to material omission(s) discovered during the hiring process, or any time during employment at FCCBCF.

Interview response from the HR staff affirmed that they would inform another potential employing agency, if asked, regarding a substantiated case for sexual

abuse or harassment involving a former employee of FCCBCF. The potential employing agency would be advised to submit a Public Records Request in order to received the requested information. Based on evidence provided, the facility meets this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:
1. Develop an official document on agency letterhead, to affirm applicant (including staff, contractors, and volunteers), and follow-up criminal background checks were conducted. The form will include the applicant/employee's name, position/title, date of background check, and result. The form should be signed by the staff who conducted (LEADS certified) the background check, and approved by the Deputy Director, or Executive Director.

2. Establish a method to ensure employees due for a five-year follow-up criminal background check complete on their anniversary date, but no longer than within the year such is due.

3. Ensure institutional reference checks are conducted for job candidates with training or experience in any institutional entity, as defined in 42 U.S.C. § 1997.

FACILITY RESPONSE:

The facility has created an internal verification form to document criminal background check results via the LEADS. Completed forms for four new hires, and one update (current staff) were provided to the auditor as evidence that the form has been implemented. The facility provided as supportive documentation policy HR01, which requires institutional reference checks when job candidates identify previous correctional, institutional work experience. During the Corrective Action period, four (4) new hires have been processed with the newly-created background check form, and one (1) institutional reference was conducted. No previous institutional employer indicated job candidate was involved in a PREA allegation.

Based on evidence provided, the facility is now in compliance with this standard.

Review:

FCCBCF Background Check verification form

Institutional Reference check documentation

Reference check documentation

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. Facility layout with 43 camera locations Interviews: 1. Agency Head 2. Deputy Director/PREA Coordinator Site Review Observations: 1. Main public entrance, administrative offices; resident Dayroom, housing dorms, control room, common areas, recreation area (outside), cafeteria (not an all-inclusive list; see the report narrative for more information) Findings: 115.218(a) The facility PAQ indicates the facility has acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later. During the onsite audit the Agency Head stated in her interview that FCCBCF has not undergone, nor is there a plan for new construction, or rennovation. She stated if there were any construction, the facility would have to grow upward, as there is no space for expanding outward. Anything new would be to completely separate men and women. Based on the interview with the Agency Head, the auditor concludes the PAQ response was marked in error. During the onsite audit, the PREA coordinator was able to show the video monitoring system, and how footage can be captured onto a DVD. The control room contains two monitors that covers 43 cameras, including views on the outside perimeter. Camera monitors (2) have a monitoring capacity of up to 64 cameras each at one time. A third monitor shows all doors that are controlled electronically; a lock symbol indicates whether doors are locked or unlocked. Speaker symbols indicate where intercoms are located, and can be accessed individually from the control room to hear and speak. Any loud noise in an area will trigger a red alarm so staff can give attention to the area. Two additional monitors are not active due to a previous PREA allegation and staff writing their statement based on what the camera shows. The female wing has its own control room. Four cameras cover the main open area. Two are located on the dorm side, at the secondary entrance to classrooms, and one

	above the laundry room. Two cameras are on the room side above the sink: microwave area and one above the pass-through next to the coverage desk. Based on the evidence provided, the facility meets this provision. 115.218(b) The facility indicates in the PAQ no new monitoring technology has been installed. The PREA coordinator did not provide to the auditor a schematic of the facility, including camera locations. The Agency Head stated in her interview that there have been no modifications of technology at the facility. Based on the evidence provided, the facility, by default, meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.221	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. MOU: Sexual Abuse Resource Network of Central Ohio (SARNCO) 2. PREA Victim Support Person training certificate(s) 3. Letter from Franklin County Sheriff re: Criminal Investigations 4. FCCBCF Policy SUP12: PREA Interviews: 1. PREA coordinator 2. Random Staff Findings: 115.221(a) The facility PAQ indicates the facility conducts administrative investigations of reported allegations of resident sexual abuse, when such is not deemed to be criminal. The facility provided policy SUP12 as additional supportive documentation. Policy section IV., A. states: **"*A. The CBCF shall ensure an administrative investigation is completed for all allegations of sexual abuse and sexual harassment.*"** The facility provided a signed letter from the Franklin County Sheriff, affirming it will serve as the investigating entity related to reported allegations of sexual abuse. During interviews with six random operations/security staff, all consistently stated they would take the following steps: • Separate the victim from the abuser • Secure the area • Call the Sheriff's Office to collect any physical evidence • Contact the supervisor, deputy director/PREA coordinator The facility identified PREA Investigators via PREA Form 1.1, Section h. The facility provided training certificates of staff who have received PREA Investigator training in the past 12 months. One investigator stated during interview that he attended PREA investigation training in January 2020, facilitated by Impact Justice. he had not been tasked previously to be an investigator prior to the training; heh as not had allegations to investigate since receiving the training. If there is evidence that a crime has been committed, he would notify the PREA coordinator that law enforcement is needed. Based on the evidence provided, the facility meets this provision.

115.221(b)
The facility PAQ indicates it does not house youth. Auditor observation indicates there are no youth housed at this facility. Policy SUP12 indicates a uniform evidence protocol is used that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The PAQ indicates the Franklin County Sheriff Department would be contacted in the event physical evidence existed related to an allegation of sexual abuse.
During interview with the facility PREA coordinator, he stated staff do not handle physical evidence. If such exists, the facility would treat the matter as a crime, and notify the Sheriff Department to handle the matter. Six of six random Resident Advisors stated during interviews that they would contact the Sheriff Department if there was potential or identified physical evidence related to a report of sexual abuse. Based on the evidence provided, the
facility meets this provision.

115.221(c)
The facility PAQ indicates it offers to resident sexual abuse victims access to a forensic medical examination. Policy SUP12, section V., B. states:

"*B. The CBCF offers all victims of sexual abuse access to forensic medical examinations outside the facility, without financial cost, where evidentiary or medically appropriate.*"

The facility uploaded in the PAQ a signed MOU between Sexual Abuse Resource Network of Central Ohio (SARNCO) and FCCBCF. The MOU has been effective since 2017. The MOU indicates SARNCO will assist to ensure SAFE/SANE staff will conduct forensic examinations, where applicable. During the onsite interview, the facility medical coordinator (Nurse) stated SAFE/SANE exams are not conducted at the facility. If a resident requested or required medical attention related to a sexual abuse, the Sheriff Department would refer and arrange for a SAFE/SANE examination at the local hospital. He stated that there was a sexual abuse case in the past 12 months; the victim was referred for a SAFE/SANE examination.

The facilitiy PAQ indicates there was one reported allegation of sexual abuse in the past 12 months, involving a female resident and a male staff. The PREA coordinator provided the auditor investigative files during the onsite audit. The auditor interviewed the reporting staff, who affirmed the Sheriff Department responded to the reported sexual abuse, conducted an investigation, and assisted the victim. The staff indicated the resident was a willing participant, that the conduct was not forced.

The facility PAQ indicates FCCBCF has designated, trained PREA Victim Support Person(s). Training certificates of specialized training on 8/21/2015, and 10/26/2019 by the ODRC was provided as supportive documentation. The auditor interviewed a Victim Support Person, who was able to articulate
the VSP role with respect to providing resident victims of sexual abuse emotional support, including accompanying the resident victim to the hospital, referrals for services not provided by FCCBCF. The PREA coordinator identified documentation

related to a state-wide rape crisis center resource, which is available upon request. The document lists established rape crisis centers in Ohio counties, including contact/hotline numbers. Based on the evidence provided, the facility meets this provision.

115.221(d), (e)
The facility PAQ indicates FCCBCF has designated trained PREA Victim Support Persons (VSP). FCCBCF provided signed training certificates for staff identified as the agency's PREA Victim Support Person(s) as supportive documentation. The training for this role was completed in 2015, and 2019. Training was provided by the Ohio Department of Rehabilitation and Corrections (ODRC), and the content has been accepted for meeting this provision. The identified staff have signed, dated certificates of completion of the training in their employee file. Based on the evidence provided, the facility meets this provision.

The auditor interviewed a Victim Support Person, who was able to articulate the VSP role with respect to providing resident victims of sexual abuse emotional support, including accompanying the resident victim to the hospital, referrals for services not provided by FCCBCF. The PREA coordinator identified documentation related to a state-wide rape crisis center resource, which is available upon request. The document lists established rape crisis
centers in Ohio counties, including contact/hotline numbers. Based on the evidence provided, the facility meets this provision.

115.221(f)
The facility PAQ indicates to the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section. The facility uploaded in the PAQ a documented, signed letter from the Franklin County Sheriff Department, which states it will conduct criminal investigations. The PREA coordinator stated during his interview that the facility conducts administrative sexual abuse investigations. Policy SUP12 states:

"***A. The CBCF shall ensure an administrative investigation is completed for all allegations of sexual abuse and sexual harassment (PREA 115.222, PREA 115.271). CBCF staff that conduct sexual abuse investigations receive training in conducting such investigations in confinement settings. The CBCF maintains documentation of such training (PREA 115.234).***"

The policy states if the alleged sexual abuse is deemed to be criminal, the Sheriff Department will conduct a criminal investigation. The facility shall request that they follow the investigator protocols as list in policy 115.221. The Agency Head stated during interview that FCCBCF has a positive relationship with the Sheriff Department, and they are trained to deal with sexual abuse criminal investigations. She further stated they will share any necessary information or documentation to ensure the facility is in compliance with PREA. The auditor observed the letter from the Sheriff Department is signed by the Agency Head, and Sheriff's Chief Investigator. Based on the evidence provided, the facility meets this provision.

	115.221(g) The auditor is not required to audit this provision. 115.221(h) The facility PAQ indicates that for the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general. Policy SUP12 states in section V., C.: "***C. The CBCF Clinical Manager makes available to the victim a victim's advocate from a rape crisis center. If a rape crisis center advocate is not available, the Clinical Manager makes available a qualified staff of a community agency that provides such advocacy. Treatment services are provided to the alleged victim without financial cost and regardless of whether the alleged victim names the abuser or cooperates with the investigation. The Clinical Manager is responsible for documenting all efforts to secure services (PREA 115.221, PREA 115.253).***" FCCBCF provided signed training certificates for staff identified as the agency's PREA Victim Support Person(s). The training for this role was completed in 2015, and 2019. Training was provided by the Ohio Department of Rehabilitation and Corrections (ODRC), and the content has been accepted for meeting this provision. The identified staff have signed, dated certificates of completion of the training in their employee file. Based on the evidence provided, the facility meets this provision. Based on the overall evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended for this standard.

115.222	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a determination of compliance: Documents: 1. Pre-Audit Questionnaire 2. FCCBCF Policy SUP12 3. Resident files 4. FCCBCF website: https://cbcf.franklincountyohio.gov/ Interviews: 1. Agency Head 2. Investigative staff (also Unit Manager) Site Review Observations: 1. No observations made specific to this standard Findings: 115.222(a) The facility PAQ indicates that the agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The PAQ indicates there have been five allegations of sexual sexual abuse in the past 12 months. The PREA coordinator provided documentation related to each case. The allegations were as follows: • One allegation of staff-on-resident sexual harassment was reported verbally to a staff • One allegation of resident-on-resident sexual harassment reported in writing (call card) to staff • One allegation of resident-on-resident sexual abuse was reported verbally to a staff • One allegation of staff-on-resident sexual abuse was reported verbally to a staff • One allegation of staff-on-resident sexual abuse was reported verbally by a staff witness The documentation indicates one of the allegations were criminally investigated. All of the 2019 cases were closed. One allegation of resident-on-resident sexual harassment was received in January 2020. The documentation indicates the following outcomes: Substantiated: 3 Unsubstantiated: 2 Unfounded: 0

The PAQ provided policy SUP12 as supportive documentation. Policy section IV., A. states:

"*A. The CBCF shall ensure an administrative investigation is completed for all allegations of sexual abuse and sexual harassment (PREA 115.222, PREA 115.271).*"

The PREA coordinator provided to the auditor investigative files for five sexual harassement and sexual abuse allegations received in 2019, and 2020. The files contain evidence that staff identified in PREA Form 1.1 as investigative staff, conducted the administrative investigations on behalf of FCCBCF. The allegation of staff sexual abuse of a resident in 2019 was referred to the Franklin County Sheriff Department for investigation. The remaining allegations were investigated administratively. Appendix A: PREA AUDIT - Agency Investigative Matrix identifies Franklin County Sheriff's Department as the responsible entity for conducting criminal investigations of resident sexual abuse at FCCBCF. Based on the evidence provided, the facility meets this provision.

115.222(b)
The facility PAQ indicates it has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. Policy SUP12 Section IV., E. states:

"*E. At any time that CBCF administration determines the possibility that a criminal investigation is necessary, the Franklin County Sheriff's Office is consulted.*"

FCCBCF and the Franklin County Sheriff has documented that the Sheriff Department will provide law enforcement investigation services for sexual abuse or offenses that may occur at FCCBCF.

The auditor observed the facility's zero tolerance policy posted on the agency's website:
https://cbcf.franklincountyohio.gov/Prea.

During the onsite interview, the facility investigator, identified on the PREA Form 1.1, stated the facility internally conducts administrative investgations, which, if substantiated, is turned over to the Franklin County Sheriff's Department for criminal investigation. The staff-on-resident sexual abuse allegation was submitted to the Franklin County Sheriff Department for criminal investigation. Based on the evidence provided, the facility meets this provision.

115.222(c)
The facility PAQ indicates FCCBCF policy describes the responsibilities of both the agency and the investigating entity. Policy SUP12 states in Section IV., A.:

"*A. The CBCF shall ensure an administrative investigation is completed for*

	***all allegations of sexual abuse and sexual harassment (PREA 115.222, PREA 115.271). CBCF staff that conduct sexual abuse investigations receive training in conducting such investigations in confinement settings. The CBCF maintains documentation of such training (PREA 115.234).*"** The auditor observed evidence of the Sheriff's Department conducting criminal investigations related to resident sexual abuse. The PAQ indicates there were five allegations in 2019, and 2020. The files conains the month of each allegation, and the method used to report. The agency imposed administrative action in two substantiated allegations. The auditor observed evidence of one investigation being turned over to the Sheriff Department for criminal investigation. The auditor interviewed the reporting staff of the staff-on-resident sexual abuse allegation, who confirmed the Sheriff Department conducting a criminal investigation. The evidence indicates the agency took administrative action related to its determination of the facts. Based on the evidence provided, the facility meets this provision. 115.222(d) Auditor is not required to audit this provision. 115.222(e) Auditor is not required to audit this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended. Recommendation: Post on the agency website contact information to report alleged resident sexual abuse, sexual harassment, or retalliation.

115.231	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy TR3: Continuing Training 2. Staff training records Interviews: 1. Random Staff Site Review Observations: 1. PREA Signage throughout the facility Findings: 115.231(a) The facility PAQ indicates that FCCBCF provides training on its zero tolerance policy for sexual abuse and sexual harassment during staff orientation. Policy TR3 Continuing Training was provided as supportive documentation. Policy section I., A. states: ***"A. New full-time employees who have regular/direct contact with the residents are required to receive 120 hours of training during their first year of employment. A minimum of twenty-four (24) hours must be relevant to evidence-based practices and service delivery (DRC-General 49). At a minimum, additional training covers th following areas:*** ***...12. Sexual harassment, sexual abuse/assault intervention and the following other information related to the Prison Rape Elimination Act (PREA):..."*** The policy goes on to cite the 10 elements required of zero-tolerance policy content, as stated in this PREA standard provision: *a. The facility's zero-tolerance olicy for sexual abuse and sexual harassment;* *b. How to fulfill responsibilities under the CBCF's sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;* *c. Resident's right to be free from sexual abuse and sexual harassment;* *d.The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;* *e.The dynamics of sexual abuse and sexual harassment in confinement;* *f. The common reactions of sexual abuse and sexual harassment victims;*

	g. How to detect and respond to signs of threatened and actual sexual abuse; *h. How to avoid inappropriate relationships with residents;* *i. How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and* *j. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.* The PREA coordinator stated no PREA training beyond NEO has been offered in 2019. The auditor observed no evidence of required training in employee files since 2017. All training completed for each employee was from New Employee Orientation (NEO). Based on the evidence provided, the facility meets this provision. 115.231(b) The facility PAQ states gender-specific training is provided to staff, as the facility serves male and female adult populations. During the onsite review, the auditor observed female residents in the facility. Resident files supported that there are female residents at FCCBCF. The PREA coordinator stated that only female staff work with female residents. The auditor did not observe male staff on any shift in the female wing during the onsite audit. The auditor observed female staff working on the male wing. *Dynamics of Sexual Abuse* addresses gender differences related to symptoms, behaviors of male versus females in confinement whom have experienced sexual abuse. Based on the evidence provided, the facility meets this provision. 115. 231(c) The facility PAQ indicates that all current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies. The facility provided a sample of sexual abuse and sexual harassment refresher training as supportive documentation. The PAQ states PREA refreshers are conducted every two years, and is a requirement for all employees who engage with, or have access to residents. The training provided reflects employee sexual harassment, and discrimination training. The auditor observed no evidence that resident sexual abuse, and sexual harassment training was provided after 2017. The PREA coordinator stated during his interview that PREA training, other than NEO, has been paused, due to program transitions that requires significant training to implement. He stated PREA training is planned to resume in March 2020. Based on the evidence provided, the facility does not meet this provision.

	115.231(d) The facility PAQ indicates that the agency shall document, through employee signature or electronic verification, that employees understand the training they have received. The auditor observed no evidence of PREA training outside NEO. The auditor reviewed 12 employee files, and training records. 12 of 12 training files reflected no PREA training, or PREA training refresher courses were completed in 2018, or 2019. Based on the evidence provided, the facility does not meet this provision. Based on the overall evidence provided, the facility does not meet this standard. Corrective Action: 1. Re-establish PREA training for all employees who engage with, or have access to residents. 2. Provide PREA refresher training to staff whom haven't received training, since their NEO training. 3. Document attendance, and written confirmation that employees understand the information presented. **FACILITY RESPONSE:** The facility has developed and implemented a general PREA staff refresher training, required of all employees who engage with, or have access to residents. All employees hired prior to the PREA onsite audit dates have completed PREA staff refresher training. The training curriculum provided confirms the training covers FCCBCF's Zero Tolerance policy and procedure. Signed training acknowledgment forms were provided as supportive documentation that the facility has institutionalized its process. Training forms stated that staff completed, and understood the training provided. Based on the evidence provided, the facility is now in compliance with this standard. Review: PREA Staff Refresher training Employee training documents

115.232	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. FCCBCF Volunteer Packet 3. PREA Contractor, Volunteer Orientation Interviews: 1. PREA Coordinator 2. Business Administrator (HR staff) 3. Formal and informal interviews with staff and contractor Findings: 115.232(a) The facility PAQ indicates it provides PREA training for volunteers and contractors. Three documents were provided as supportive documentation: • Volunteer Packet - contains explanation of FCCBCF population; program offerings; types of volunteer service • Volunteer Orientation/Policies and Procedures Acknolwedgement form - verifies a volunteer has completed orientation, and reviewed operational policies and procedures, including PREA. The form is signed, dated by the volunteer, and staff • FCCBCF Visitor Sign-in Sheet 2019 - sample sheet provided, which identifies contractor, volunteers, and visitors; includes date, name/signature, visitor badge number The HR staff stated during her interview that volunteer files are not maintained by the human resources office. Rather, the Sr. Program Manager maintains files for volunteers (including student interns) and contract staff. She further explained that the LEADS system is used for volunteers and contract staff criminal background checks, the same as regular staff. The auditor did not interview any volunteers or contract staff during the onsite audit dates; however, the auditor observed a volunteer facilitating an evening session with male residents. The auditor interviewed one of two student interns during the onsite audit. The intern stated he completed NEO with staff, and that PREA policies and procedures were discussed. He was able to articulate the agency's zero-tolerance policy, first responder duties, and to whom he would report an allegation. Policy TR3 states that part-time, and contract staff are required to complete training, based on the number of hours they work. The facility Table of Organization indicates that facility food service staff are contract workers. The Kitchen

	Coordinator (supervisor) stated in an informal discussion during the facility site review that Food staff go through orientation when hired, along with regular staff. They participate in regular in-service with staff throughout the year. Trinity (food vendor) provides training for the Kitchen coordinator; she trains food service staff; and CBCF trains all food service workers on operational policies and procedures, including PREA. The Kitchen coordinator was able to articulate the agency's zero-tolerance policy, and first responder duties. The PAQ indicates FCCBCF has 140 volunteers on its roster. The PREA coordinator stated many are from two churches that offer religious study, and services. Some volunteer on a regular basis, while others only on occasion. During the facility site review, the PREA coordinator identified an outer picnic area next to a small staff parking lot. He stated that one of the church volunteer groups brings a portable pool, and conducts baptism in the space during warm weather months. The last baptisms are in October, or November, an resume the following March. Weekly church services are conducted all year. The PAQ indicates volunteers and contractors complete the same orientation training as staff. The auditor observed signed documentation regarding the agency's zero tolerance policy. The volunteer file contains a checklist as verification that all required documentation is included in the file. The auditor identified on the agency's Table of Organization a part-time contractor who provides medical services to residents: Physician - in the facility one day per week; works under contract; provides general, routine medical services based on resident request(s): prescribes medication, as needed. Does not provide medical services related to sexual abuse.The auditor did not interview the physician, as he was not in the facility during the onsite audit dates. Based on the evidence provided, the facility meets this provision. 115.232(b) The facility PAQ indicates volunteers and contractors receive PREA training on the agency's zero-tolerance policy. A Contractor and Volunteer orientation document, Volunteer Packet, and Visitor Sign-in sheet were provided as supportive documentation. As with staff (115.231), volunteers and contractors receive PREA training during orientation training. The auditor interviewed a volunteer (intern), who stated he completed NEO along with staff, and that the training included the agency's zero-tolerance policy, and how to report allegations of resident sexual abuse and sexual harassment. The (contractor) Kitchen coordinator stated during informal discussion with the auditor that she, and food service workers attend the facility's NEO upon hire. She was able to articulate reporting procedures, and the agency's zero-tolerance policy. The HR staff stated during interviews that employees, volunteers, and contractors complete the same training in order to work with, or have access to residents. Based on the evidence provided, the facility meets this provision. 115.232(c) The facility PAQ indicates it maintains training documentation that confirms

	volunteers and contractors who received training on the facility's zero-tolerance policy regarding sexual abuse and sexual harassment, understood the training received. The facility provided signed 'Volunteer Orientation and Policies and Procedures Acknowledgement' form as supportive documentation. The auditor did not review contractor files during the onsite audit. Inclement weather (snow storm) limited the auditor's time onsite, and the availability of staff with access to files. During the facility site review, the (contractor) Kitchen coordinator stated she, and all food service workers (all contractors) complete New Employee Orientation upon hire, along with regular FCCBCF staff. She was able to articulate what the agency's zero-tolerance policy meant as it relates to resident sexual safety. She stated her company, Trinity, provides additional training. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.233	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Resident files 2. Resident Handbook 3. Policy ADM07: Process for Referral, Acceptance, Rejection, and Termination Interviews: 1. Intake Staff 2. Random Residents Site Review Observations: 1. Intake Process 2. PREA signage in the facility Findings: 115.233(a) The facility PAQ indicates that residents receive information at the time of intake about the agency's zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. The PAQ states there were 483 residents admitted to FCCBCF between 1/1/2019 and 12/31/2019. The facility provided the Resident Handbook as supportive documentation. The facility provided a sample signed Receipt of Resident Handbook form. The receipt document contains all sections of the Handbook, which are reviewed by the resident and case facilitator. Each signs off on each section reviewed. The auditor observed the PREA section on page 13 of the handbook. The section covers: • the agency's zero-tolerance policy, • how residents can report incidents or suspicions of sexual abuse or sexual harassment • residents' right to be free from sexual abuse and sexual harassments, and retaliation for reporting such incidents • FCCBCF's policies and procedures for responding to reported incidents. During the onsite audit, the auditor interviewed 20 residents (13 male; 7 female). Of the 20 residents interviewed, all, or 100 percent, stated they received the Resident Handbook as part of the admission process, and that their assigned case facilitator reviewed the information with them. The auditor did not observe a resident Intake during the onsite audit, as none were incoming during the onsite audit dates. A review of resident files verified receipt of

the Resident Handbook. Based on the evidence provided, the facility meets this provision.

115.233(b)
The facility PAQ indicates 483 residents were received in the program from 1/1/2019 through 12/31/2019. FCCBCF has one location; all residents are new intakes entering the program through a jail supervised release program, court-referred program, or parole/probation office(s). Policy ADM07 states eligibility criteria in Section VII., A.:

"***...3. Ambulatory, wheelchair mobile, emotionally stable, and capable of fully participating, comprehending, and engaging in the program;...***"

The policy indicates pregnant women may be accepted in the FCCBCF program, provided their expected due date is after the end date of her program. the policy outlines criteria, for which referrals are not accepted, including:

- 10. Physical, intellectual, or mental health disability where reasonable modifications or policies, practices, or procedures will not mitigate the risk of a direct threat to the health or safety of others.
- 14. Offenders who are severely developmentally disabled;

The PREA coordinator stated in his interview that an Intake Analyst conducts pre-admission interviews with potential residents prior to recommending them for acceptance. If someone were deaf, or visually impaired, or with other physical or mental disability, the FCCBCF admission criteria may prohibit them from acceptance. The auditor interviewed an Intake Analyst during the onsite audit. The analyst stated she prepares a Defendant Eligibility Summary (DES) that says if a referral is eligible for the CBCF program. The information is submitted to the Executive Director for approval. Once the resident is admitted, the Entry Intake staff, program and security determines bed assignment, and develops a program plan. if any accommodation were needed, the Executive Director would need to approve it. Therefore, the auditor concludes that not providing PREA-related information to individuals who may require special accommodation is based on the program eligibility criteria. Based on the evidence provided, the facility meets this provision.

115.233(c)
The facility PAQ indicates it provides to all residents education in formats accessible to those who are: limited English proficient, deaf, visually impaired, have limited reading skills, or otherwise disabled. Policy ADM07 indicates individuals with the stated needs of this provision may not meet eligibility requirements for the FCCBCF program. Therefore, such provisions would not be necessary. During her interview, the Intake Analyst stated she refers recommended referrals to the Executive Director for approval. If approved, an Entry Intake staff conducts resident intakes immediately upon their arrival. If
a resident had need of assistance, or if they knew prior to the resident's arrival the resident had some type of physical disability, the Executive Director would meet

with PREA coordinator to arrange the appropriate accommodation. During the auditor's review of 20 resident files, no resident was identified as disabled. Based on the evidence provided, the facility meets this provision.

115.233(d)
The facility PAQ indicates that the assistance or accommodation(s) provided to residents is documented. The PREA coordinator stated in his interview that residents can communicate needed assistance or accommodation(s) during resident orientation. The orientation process includes an explanation of the programs and services. The auditor observed in the Resident Handbook an overview of what new residents can expect of the orientation process. The Agency Head stated during her interview that the Intake pre-screening interview would likely identify any special assistance of accommodation an individual may require. Should it be determined the need exceeds the scope of the FCCBCF program, the Intake Analyst would not recommend the referral. If she were to approve an accommodation, the PREA coordinator would communicate with facility management how a resident's accommodation would be met. Of the resident files the auditor reviewed, 20 out of 20 did not indicate the resident(s) requested information be provided in any particular format. Based on the evidence provided, the facility meets this provision.

115.233(e)
The facility PAQ indicates resident-related key information is readily available and accessible to all residents through posters, resident handbooks, or other written formats. The auditor observed in the Resident Handbook phone numbers and instructions for reporting sexual abuse, or sexual harassment. During the facility site review, the auditor observed posters in English and Spanish, which contained information related to zero-tolerance, and ways to report allegations of sexual abuse, or sexual harassment, including retaliation. The FCCBCF Resident Handbook contains reporting
information:

- to staff, in writing, or verbally
- to the Sr. Operations Manager via Call Card, located in a locked box in the cafeteria
- to the Sr. Operations Manager via phone: (614) 525-4620
- to the PREA hotline to an external PREA reporting source (ODRC 24 hr. hotline), located on posters throughout the facility.

The PREA coordinator stated oral and written information shall be given to all residents upon their arrival, which explains the agency's zero-tolerance policy regarding sexual assault, sexual abuse, sexual harassment, and retaliation. Residents were able to articulate during random interviews where pertinent information is located in the facility, or to whom they go to obtain key information. Residents stated during random interviews that they
knew important information is in their 'Handbook', which is provided by the Case Facilitator when they first arrive, should they have a need to report sexual abuse or sexual harassment, or retaliation. Based on the evidence provided, the facility

	meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.234	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Employee training records Interviews: 1. PREA investigator Findings: 115.234(a) The facility PAQ indicates that In addition to the general training provided to all employees pursuant to § 115.231, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. During the pre-audit phase, the PREA coordinator submitted PREA Form 1.1, containing a list of specialized staff. An attachment to the form contains a list of five (5) staff identified as special investigators. The PREA coordinator stated he, and the other four staff completed specialized investigations training between 2015, and 2020. The earliest training, in January 2015, was conducted by The Moss Group (TMG) Investigative consultants. Later training included PREA specialized investigations training conducted by Ohio Department of Rehabilitation and Correction (ODRC). A curriculum was provided, which reflects all provisions of this standard are met. The certificate of completion in their employee files serves as supportive documentation of the staff's roles as PREA investigators. The Two-day TMG training included a half-day "Train-the-trainer" session. The Agency Head completed this training, in addition to the Investigator traininig. Based on the evidence provided, the facility meets this provision. 115.234(b) The facility PAQ affirms that the specialized investigations training meets all requirements of this provision: techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The training curriculum was made available in hard copy. The Auditor verified the training to be comprehensive and thorough. One of the PREA investigators, and PREA coordinator were able to articulate during interviews the content of the specialized investigations training. Based on the evidence provided, the facility meets this provision. 115.234(c) The facility PAQ indicates specialized training documentation of agency investigators is maintained. The facility provided five training certificates as

	supportive documentation to verify such training has been received. During the onsite audit, the auditor observed the same documents in the PREA investigator(s) and PREA coordinator employee files. Based on the evidence provided, the facility meets this provision. 115.234(d) The Auditor is not required to audit this provision. Based on the overall evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.235	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. Employee Roster Site Review Observations: 1. Medical Unit onsite at FCCBCF Findings: 115.235(a) The facility PAQ indicates it ensures that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: (1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. A training certificate for PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting was provided as supportive documentation. One full-time staff is identified in the PAQ who serves in the facility's medical unit. The PREA coordinator stated in-house medical staff do not conduct SAFE/SANE exams, or other medical services related to sexual abuse. The staff is required to complete the same training as other staff, due to their interaction with residents. The auditor observed the training was provided by the National Institute of Corrections; three Continuing Education Credits (CEUs) were provided for completing the training. During the pre-audit phase, the facility provided to the Auditor PREA form 1.1, which lists two individuals as medical and mental health staff: a staff Nurse, and Physician (contractor). During the onsite audit, the Nurse stated in his interview that he is a FCCBCF employee. He stated he receives PREA-related training the same as other staff. He stated he completed PREA training. He stated if a female was concerned about pregnancy related to sexual abuse, he would coordinate, if desired, emergency contraception, OB/GYN specialists; someone from the Health Dept will assist if needed. Information is provided on a case-by-case basis. There are PREA posters they can be referred to for other options. He was able to articulate the agency's zero tolerance policy, first responder duties, search procedures, and mandatory reporting requirements. he indicated the (contract) physician would report PREA allegations to the PREA coordinator for appropriate referral for SAFE/ SANE exams, or other related medical needs. The Nurse stated he works in concert with the facility PREA coordinator, as needed, were there to be an actual resident sexual abuse that requires, or for which, the resident requests medical services.

	Based on the evidence provided, the facility meets this provision. 115.235(b) The facility PAQ indicates medical staff, or contractor(s) do not conduct forensic examinations at FCCBCF. During the onsite interview, the staff Nurse stated he would facilitate a resident being taken to a local hospital, and ensure any forensic examination is conducted by a SAFE/SANE practitioner. However, it is likely the Sheriff Department would be involved, and take the necessary steps for the resident to be examined by a SAFE/SANE. The auditor reviewed 20 resident files. No file contained notes or reference of a medical or mental health referral to the contract, or internal medical staff, or to an external medical or mental health provider, related to an allegation of sexual abuse. The PREA Form 1.1 lists Grant Hospital and OSU-East Hospital as the location(s) residents are taken, or referred to, for SAFE/SANE forensic xaminations. During the onsite audit, there is no evidence of SAFE/SANE direct medical examinations being provided at this facility as it relates to sexual abuse. Based on the evidence provided, the facility meets this provision. 115.235(c) The facility PAQ indicates it maintains training records of PREA-related training for medical or mental health practitioners. The Nurse in the facility's medical unit was listed on the NIC training certificate. The facility Nurse stated in his interview that he receives PREA training, as do other staff. Based on the evidence provided, the facility meets this provision. 115.235(d) The facility PAQ indicates there is one medical practitioner (Nurse) employed at FCCBCF as staff, and that the provision requirement of 115.232 is being met. Evidence of PREA training was provided that internal medical practitioners receive training as required in standard 115.232. Agency intake procedures requires residents at FCCBCF receive medical or mental health services, beginning with health screenings at the time of initial Intake. During the onsite audit, the internal (staff) medical practitioner (Nurse) was onsite, and identified himself as the facility medical coordinator/nurse. During his interview, he stated to the auditor that he has worked as staff at FCCBCF for approximately 1 year. He stated there is a contract medical/physician, who works one day per week at the facility. The physician was not present at the time of the onsite facility audit. Based on the evidence provided, the facility meets this provision. Based on evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.241	Screening for risk of victimization and abusiveness
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. Resident files Interviews: 1. Staff that conduct risk assessments (entry Intake staff) 2. Random residents Findings: 115.241(a) The facility PAQ indicates that all residents are assessed during intake for their risk of being sexually abused by other residents or sexually abusive toward other residents. The facility uploaded policy SIR1 as supportive documentation. This policy deals with the court referral process, and FCCCBCF's resident elilgibility criterion. The policy does not address the intake process when residents arrive at the facility, including PREA risk assessment procedures. The PREA coordinator provided policy SUP12 as supportive documentation. The policy states in section II., A.: **"*A. The CBCF Intake Case Facilitators are responsible for reviewing each resident's history and screening each resident within 72 hours of arriving at the facility to determine if characteristics of either being sexually aggressive or characteristics of a potential victim exist. When assigning rooms to new residents, the Intake Case Facilitator will take into consideration the characteristics of both the sexually aggressive resident and the characteristics of residents who may be targeted as potential sexual victims.*"** The auditor did not observe a resident intake during the onsite audit. The auditor reviewed 20 (13 male; 7 female) resident files. All files contained PREA Screening Assessment forms. Screening forms give consideration to: At a minimum, the following criteria to assess residents for risk of sexual victimization: a. Whether the resident has mental, physical, or developmental disability; b. The age of the resident; c. The physical build of the resident; d. Whether the resident has previously been incarcerated; e. Whether the resident's criminal history is exclusively nonviolent;

f. Whether the resident has prior convictions for sex offenses against an adult or child;
g. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming
h. Whether the resident has previously experienced sexual victimization; and
i. The resident’s own perception of vulnerability.

The PREA Screening form asks all questions outlined in policy 115.241. The auditor did not observe a female resident intake. The PREA coordinator stated there were no scheduled female intakes during the onsite audit period. Of the 20 residents interviewed, 20 stated they received an initial risk screening within the first 24 hours of arrival at the facility. All resident files contained signed screening/intake documents. Based on the evidence provided, the facility meets this provision.

115.241(b)
The facility PAQ indicates intake screenings are ordinarily completed within 72 hours of arrival. Policy SUP12 is listed on the PAQ as supportive documentation of screening timelines. Policy SUP12 states all residents shall be screened upon admission. The auditor reviewed 20 resident files. All files indicated the facility consistently conducts intake screenings within the required 72-hours of arrival. During the onsite audit, the auditor interviewed 20 residents. Of 20 residents interviewed, 20 stated they completed an intake screening, and were asked questions about their sexual orientation, gender identity, and if they have been sexually victimized during incarceration, or at any other time. The PREA coordinator did not identify a resident as having been sexually abused during incarceration. Based on the evidence provided, the facility meets this provision.

115.241(c)
The facility PAQ indicates it uses an objective screening instrument for screening residents for sexual victimization, or past sexual abusiveness. Policy SUP12 affirms this assertion. The facility provided a sampling of 10 screening documents of intake screenings. The auditor reviewed the same documentation in 20 resident files, during the onsite audit. The PREA coordinator stated during his interview that the risk screening instrument is objective, that all residents are asked the same PREA screening questions. The risk screening instrument is not scored, but questions are weighted. Depending on responses, resients are identified as 'possible victim', 'possible predator', or 'none', if the resident has no history of sexual abuse, or sexual abusiveness. Based on answers to the screening questions, residents are classified as: a) potential victim, b) potential abuser, or c) no classification. Of the 20 screening instruments reviewed, all, or 100 percent, indicate 'none' as the PREA classification. Based on the evidence provided, the facility meets this provision.

115.241(d)
The facility PAQ indicates that intake screenings shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: (1) Whether the resident has a mental, physical, or developmental disability; (2) The age of the resident; (3) The physical build of the resident; (4) Whether the resident has previously been incarcerated; (5) Whether the resident's criminal history is

exclusively nonviolent; (6) Whether the resident has prior convictions for sex offenses against an adult or child; (7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the resident has previously experienced sexual victimization; and (9) The resident's own perception of vulnerability. FCCBCF policy SUP12 states in Section II. E.:

"***E. The CBCF will disseminate information within the facility only as needed regarding responses to questions asked during the assessment(s) in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents (PREA 115.241).***

The auditor was able to identify all nine elements of the standard provision in the facility's PREA screening instrument. The screening instrument requires all residents to be asked the same questions. During the interview, the PREA coordinator stated they haven't had someone identified as sexually abusive. If such were identified, they would likely be placed in general population, if a high risk (for sexual victimization) person was already assigned to a segregated housing room. Based on the evidence provided, the facility meets this provision.

115.241(e)
The PAQ indicates that intake screenings shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive. this provision is met. The PREA Intake Screening form provided as supportive documentation indicates that the screening considers, when known to the agency, all criteria outlined in this provision. The Case Facilitator stated during informal conversation that such questions are asked of all incoming residents. During the onsite audit, the auditor did not observe a resident Intake. The Case Facilitator stated that housing/bed placements are decided upon on a case by case basis. Based on the evidence provided, the facility meets this provision.

115.241(f)
The facility PAQ indicates residents are re-screened in no more than 30 days from the resident's arrival at the facility. The PREA coordinator provided the Admission policy as supportive documentation. The policy section II., B. states:

"***B. A follow up assessment is completed by the permanent Case Facilitator within 30 days.***"

The Auditor reviewed 20 resident files (13 males; 7 female residents). All 20 files contained an initial, and rescreening within 30 days of the resident's arrival date. The re-screening usually occurs during week two, and is conducted by the assigned counselor. Of 20 files reviewed, 20 files contained a re-screening in 15-30 days from the date of the initial screening. Based on the evidence provided, the facility meets this provision.

115.241(g)
The facility PAQ indicates it will conduct resident risk screenings due to: a referral, a request; an incident of sexual abuse; or receipt of additional information that bears

on the residents risk of sexual victimization or abusiveness. The PREA coordinator provided policy SUP12 as supportive
documentation. The policy states in Section II., C.:

"*C. A resident will be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual abusiveness or victimization.*"

The PAQ indicates the facility has received five (total) allegations of sexual abuse and sexual harassment in the past 12 months. Review of five investigative files provided evidence that allegations of sexual abuse, or sexual abusiveness have been received in the past 12 months. The auditor found evidence of reassments conducted due to: a referral, a request; an incident of sexual abuse; or receipt of additional information that bears on a resident's risk of sexual victimization or abusiveness. During onsite interviews, the Case Facilitator who conducts the initial screening, or counselor, who conducts the 30-day re-screening, did not state they have used the screening form for any other reason, outside of the initial screening, and re-screening, within 30 days of arrival.

The auditor reviewed five investigative files related to reported sexual abuse or sexual harassment. There was no evidence that the residents were reassessed due to the alleged incident. During random resident interviews, 20 of 20 residents stated their counselor conducted a second screening 2-3 weeks after the initial intake. No residents related to the reported allegations were in the FCCBCF program at the time of the onsite audit. Based
on the evidence provided, the facility does not meet this provision.

115.241(h)
The facility PAQ indicates it does not discipline residents for refusing to answer, or for not disclosing complete information in response to questions asked pursuant to paragraphs (d) (1), (d)(7), (d)(8), or (d)(9) of this section. the PREA coordinator provided policy SUP12 as supportive documentation. Policy Section II., D. states:

"*D. Residents may not be disciplined for refusing to answer or for not disclosing complete information in response to questions asked. The PREA coordinator stated during his interview that residents are not disciplined for refusing to answer risk screening questions.*"

During the auditor's review of 20 resident files, none indicated a sanction or other violation(s) related to a resident's refusal to answer risk screening questions, or provide requested information. During random interviews of 20 residents, none stated they refused to answer PREA screening questions. Based on the evidence provided, the facility meets this provision.

115.241(I)
The facility PAQ indicates appropriate controls are in place to control the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Policy SUP12 was provided as

supportive documentation. The policy states in Section II. E.:

"***E. The CBCF will disseminate information within the facility only as needed regarding responses to questions asked during the assessment(s) in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents (PREA 115.241).***"

The PREA coordinator stated resident information is accessible on a need to know basis. Case Facilitators maintain files of residents on their caseload. Information is secure, whether electronically maintained, or in hard copy. He stated that he (deputy director), Unit Management, and asigned Case Facilitator have access to resident information; the entry Intake staff who conducts the initial PREA assessment does not have access to the tool. During the facility site review, the auditor observed in the Administrative Office client files, and staff files in locked cabinet drawers. Based on the evidence provided, the facility meets this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective action:
1. Develop a process whereby residents undergo a PREA reassessment due to: a referral, a request; an incident of sexual abuse; or receipt of additional information that bears on the residents risk of sexual victimization or abusiveness.

2. Document the purpose of the reassessment, and include it in investigative files, when conducted due to an incident of sexuall abuse.

3. Ensure that PREA staff refresher training for staff who conduct risk assessments includes utilizing the PREA screening form due to: a referral, a request; an incident of sexual abuse; or receipt of additional information that bears on the residents' risk of sexual victimization or abusiveness.

FACILITY RESPONSE:

The facility has developed and implemented a process, which alerts Case Facilitators to conduct a PREA re-assessment due to:

- a referral
- a request
- an incident of sexual abuse
- or, receipt of additional information that bears on the residents risk of sexual victimization or abusiveness.

The revised process/form requires an explanation of the circumstance that triggered such re-assessment to be conducted. Completed Intake forms with the update process were provided as supportive documentation. The PREA coordinator stated via email to the PREA auditor that 141 intakes have been completed in 2020, utilizing the updated form.

Based on evidence provided, the facility is now in compliance with this standard.

	Review: Resident PREA Re-assessment form Employee training documents

115.242	Use of screening information
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Resident risk assessments 2. Resident files 3. FCCBCF Policy SUP12: Admission Interviews: 1. PREA coordinator 2. Staff that conduct risk assessment (Case Facilitator) 3. Random residents Site Review Observations: 1. Housing area 2. Program area Findings: 115.242(a) The facility indicates in the PAQ that risk screening information is used for the five purposes outlined in this provision. The PREA coordinator provided policy SUP12 as supportive documentation. The agency policy does not include a procedure as to how screening information informs housing assignments, bed assignments, work assignments, education assignments, or program assignments. The PREA screening form allows for documenting accommodation(s) provided to a resident, or how such accommodaton may be authorized. The auditor reviewed 20 resident files during the onsite audit. None of the files contained special accommodations related to PREA-related information, or other basis. One resident identified for prior sexual abuse during incarceration stated during his interview that he did not require, or request any special accommodation at FCCBCF. A male resident who identifed a gay stated the facility did not assign their bed space based on this information, nor is there a 'gay section'. A female resident who identified as bi-sexual stated sexual orientation is a nonissue at FCCBCF; residents are not permitted to be physically close, or desplay verbal, or physical attraction toward another resident. When asked, they stated they feel safe at the facility, and has not had any negative experience during his stay. Based on the evidence provided, the facility meets this provision. 115.242(b) The facility PAQ indicates the agency makes individualized determinations about how to ensure the safety of each resident. The facility Case Facilitator commented during interview that if a concern would be voiced by a resident, staff

would consider the information received before making housing, programming, etc. decisions. During the interview, the Case Facilitator stated the facility does not have a documented process to ensure the safe housing of transgender/intersex populations. She stated the facility has not housed a transgender/intersex resident. During the interview with the agency PREA
coordinator, he stated he, along with the facility executive director, intake staff, and case facilitators would work together to ensure clear communication and understanding of special accommodations a transgender or intersex resident may require.

The PREA coordinator stated transgender and intersex residents are housed on their "legal gender classfications". This does not provide an opportunity to make individualized determinations on housing transgender and intersex residents. The auditor's review of 20 resident files did not result in finding that special accommodation was recommended related to resident housing, education, programming, or bed assignment. Based on the evidence provided, the facility does not meet this provision.

115.242(c)
The facility PAQ indicates it makes housing assignment decisions for transgender or intersex residents on a case-by-case basis. The PREA coordinator stated during his interview that he would review the policy with staff if a transgender or intersex resident was approved for admission at FCCBCF.
He stated the facility has not received a transgender or intersex resident. He stated if someone were referred, they could be housed in one of the segregated housing rooms if privacy was desired for personal care, although that would not be a preferred option. He stated a resident who was identified as an Victim would not be housed in the same dorm as a resident with a history of abusiveness. Control room staff, as well as staff on the floor ensure
behavior is appropriate, and residents are safe.This does not provide an opportunity to consider housing transgender and intersex residents on a case-by-case basis.

This standard provision states, "If an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard.' Based on the evidence provided, the facility does not meet this provision.

115.242(d)
The facility PAQ indicates housing placements and programming assignments for transgender or intersex residents are based on the residents' own views with respect to his or her own safety. Policy SUP12 was provided as supportive documentation. The policy does not state how housing decisions for transgender and intersex residents are determined. The auditor interviewed nine security and non-security staff during the onsite audit. Of the nine, all stated there has been training related to how to safely house transgender or intersex residents, or how such decisions would be made. Housing transgender or intersex residents on the basis of anatomy alone does not comply with this standard. Based on the evidence

	provided, the facility does not meet this provision. 115.242(e) The facility PAQ indicates that the facility has provisions in place for transgender or intersex residents to shower separately from other residents. The PREA coordinator stated there is a policy related to working with transgender or intersex residents. No policy was provided for review, which indicates shower options for transgender or intersex residents. The Risk Assessment identifies transgender, and intersex as Sexual Orientation categories. The assessment does not provide Gender Identity as a category. The tool allows for documenting special accommodations for a resident as a result of the risk screening. There is no evidence of accommodations related to housing/bed assignments, education, and programming for transgender or intersex residents. The facility did not have any residents during the time of the onsite audit, who self-identified as transgender or intersex. Based on the information provided, the facility does not meet this provision. 115.242(f) The facility PAQ indicates that it does not place LGBTI residents in dedicated housing solely on the basis of the resident's gender identity or sexual orientation. During interviews of 20 residents, two residents - one male, and one female, identified as LGBTI. During interviews with the auditor, each resident stated they were not assigned to a particular housing dorm based on their sexual orientation. Each stated staff, and residents are respectful and they feel safe at FCCBCF. The auditor reviewed 20 resident files, 18 of which indicated sexual orientation as ‘straight’. None indicated a resident self-identifies as transgender man, or woman. The PREA coordinator stated the facility has housed LGBTI residents (i.e., gay, bi-sexual), and that housing determinations are not based on this information. He reiterated that residents know cameras are in the dorms, which reduces potential inappropriate behavior, such as sexual harassment, or sexual abuse. There are no cameras in restrooms or showers; however, there are always same gender staff of all shifts, whom can, and would make frequent checks in restrooms and shower areas to minimize resident sexual miscoduct. Based on the evidence provided, the facility meets this provision. Based on the evidence provide, the facility does not meet this standard. Corrective Action: 1. Revise the Risk Assessment tool to differentiate Sexual Orientation from Gender Identity; document on the tool the Case Facilitator's basis for recommending special housing or programming accommodation for residents classified as a 'possible victim', or 'possibe abuser', or ihis/her perception of a resident's sexual orientation, or gender identify. 2. Develop a procedure for obtaining approval for recommended accommodation(s), and how such is communicated with the resident; ensure approval is documented, as well as the basis for denying a recommended accommodation. 3. Update policy SUP12 to explicitly state, in policy and practice that FCCBCF does not assign residents to a male or female facility on the basis of anatomy alone.

	Ensure all staff are trained to understand considerations for making transgender or intersex resident housing determinations. 4. Document in policy and practice that a transgender or intersex resident's own views with respect to his or her own safety is considered for housing placements and programming assignments. 5. Document what considerations are given to transgender or intersex residents related to housing, and programming assignment, and how such determination coincides with the residents' own views with respect to his or her own safety. 6. Ensure all applicable staff (e.g., facility management, Case Facilitators, PREA coordinator) are trained on how to appropriately consider factors unique to transgender or intersex populations, when assigning housing placements and programming. Recommendation: 1. Review and consider resources and recommendations in PREA Standards in Focus related to standard 115.242, via the national PREA Resource Center website (prearesourcecenter.org). ***FACILITY RESPONSE:*** The facility has revised policy SUP12, Sections F. G., to state: "***F. A transgender or intersex resident's own view with respect to his or her own safety is considered for housing placements.*** ***G. Considerations that are given to transgender or intersex residents related to housing and how the housing determination coincides with the residents' own views with respect to his or her own safety are documented on the assessment.***" The PREA Risk Assessment form has been revised, with an added 3rd check box to denote the purpose of the assessment is a "re-assessment". The last section, Resident/staff Assistance Assessment", includes an added question, "Has a PREA allegation, or other issue occurred, which warranted a re-assessment?" An explanation is required for affirmative responses. Staff training has been conducted to institutionalize how/when staff are to consider factors unique to transgender or intersex populations, when assigning housing placements and programming. Based on the evidence provided, the facility is now in compliance with this standard. **Review:** Policy SUP12 PREA Risk Assessment Employee training documents

115.251	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. FCCBCF Resident Handbook 3. Resident Poster for Reporting Interviews: 1. Random residents 2. Random staff 3. PREA coordinator Site Review Observations: 1. PREA signage throughout the facility Findings: 115.251.(a) The facility PAQ indicates residents have multiple internal ways for residents to report: • sexual abuse and sexual harassment • retaliation by other residents or staff for reporting sexual abuse and sexual harassment • staff neglect or violation of responsibilities that may have contributed to such incidents. The PAQ provided no response to this standard in the OAS. The PREA coordinator provided policy SUP12 as supportive documentation. The policy states in Section III.: ***“A. Residents will be encouraged to report all acts of sexual harassment and/or sexual abuse. Information regarding how to report such allegations is contained in the Resident Handbook, which is discussed during Basic Training, and on posters throughout the facility.*** ***B. Residents can report any incident in the following ways:*** 1. ***Verbally to any staff member that they feel they can talk to about the incident.*** 2. ***In writing to any staff member*** 3. ***By contacting the PREA Coordinator directly, whether in writing or by phone*** 4. ***By calling the provided third party phone number.*****"**

During the onsite audit, the auditor observed Zero Tolerance posters in common areas throughout the facility. The poster listed multiple ways residents can report allegations. Posters were printed in noticeable gray and orange; posters were printed in English and Spanish. In addition to options cited in policy, the poster included additional ways to report:

1. **Submit a grievance, or a sick call slip**
2. **Verbal, or written reports to any staff volunteer, contractor or medical or mental health staff**
3. **Tell a family member, friend, legal counsel, or anyone else outside the facility. They can report on your behalf by callling (614) 728-3398 (ODRC 24 hr. PREA hotline)**
4. **Call the 24/7 Helpline (614) 267-7020 (SARNCO)**

Calls may be anonymous. During random resident interviews, 20 of 20 male, and female residents stated they knew there is a phone number listed on dorm posters they could call to privately report a PREA allegation. They stated they could verbally report an allegation to any staff, or the PREA
coordinator. No resident stated he didn't know of any way to report a PREA allegation.

During random staff interviews, nine security and non-security staff stated residents could report PREA allegations to them, and they would report it to their immediate supervisor, and the agency PREA coordinator. Staff were able to articulate information on the resident posters. Based on the evidence provided, the facility meets this provision.

115.251(b)
The facility PAQ indicates it provides at least one way for residents to report sexual abuse or sexual harassment to a public entity or office that is not part of the agency; that such entity or office is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials; and that such entity or office allow residents to remain anonymous upon request. The PAQ provided no response to this standard in the OAS.

During the facility site review, the auditor observed a PREA Hotline number (614-728-3399) on a Zero Tolerance poster in the Family Room bulletin board. The auditor tested the number, which went to ODRC's PREA hotline. A recorded message instructs callers to leave a message and a contact phone number, and someone will respond within 24 hours.

During random resident interviews, residents knew they could obtain information for outside allegation reporting in the resident Family Room bulletin board in their respective Hall, or in the Resident Handbook, which they stated is provided to them during intake orientation. Based on evidence provided,
the facility meets this provision.

	115.251(c) The facility PAQ affirms that staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties, and that such are promptly documented. The PAQ provided no response to this standard in the OAS. Policy SUP12 states allegations may be reported to any staff member, as well as a third party. The Zero Tolerance poster includes two external options, and multiple internal options for reporting allegations of sexual abuse: the ODRC hotline, and SARNCO message line. The auditor tested the ODRC reporting line at (614) 728-3399. A recorded message identified the number as a reporting line for sexual abuse or sexual harassment. The auditor was given the option to leave a message. The PREA coordinator stated residents are not charged for making a call to this number. During random resident interviews, 20 of 20 male and female residents articulated at least one example of how they could report a PREA allegation to a third party. Examples included the hotline number(s) on the Zero Tolerance poster, as well as reporting to a friend or family member. Residents who cited internal reporting options stated they would report to the PREA coordinator. Based on the evidence provided, the facility meets this provision. 115.251(d) The facility PAQ indicates that staff may privately report sexual abuse and sexual harassment of residents. The PAQ provided no response to this standard in the OAS. Policy SUP12 states in Section I., in part: ***“A. As part of the new hire orientation, all new CBCF staff is informed of the facility’s zero-tolerance for sexual abuse and sexual harassment and are trained on how to avoid and report sexual abuse and/or sexual harassment. ...*****"** During random staff interviews, nine of nine security and non-security staff stated they know how to privately report a PREA allegation, that the options for residents are also available to them. One volunteer (intern) who was interviewed during the onsite audit stated he understood that options for staff also apply to them. During the facility site review, the auditor observed a Zero Tolerance poster on the wall outside the Administrative Office area of the facility. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.252	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. Pre-Audit Questionnaire (PAQ) 2. WCCCF Policy 115.252 Interviews: None Findings: 115.252(a) - (g) The facility PAQ indicates it does not have administrative procedures to address resident grievances regarding sexual abuse. Policy SUP12 was provided as supportive documentation. Policy S states SUP12 in section III.: "***C. The CBCF does not have procedures for addressing resident grievances regarding sexual abuse. Reports of sexual harassment and sexual abuse are handled immediately and not through the resident grievance process (PREA 115.252).***" FCCBCF's grievance procedure is not used for reports of sexual abuse or sexual harassment. All reports of sexual abuse or sexual harassment are to follow the established First Responders Flow Chart (PREA 115.264). Investigations of alleged sexual abuse or sexual harassment are handled by the Franklin County Sheriff Department. The auditor reviewed 20 resident files. There was no evidence of residents utilizing a grievance process for reporting alleged sexual abuse or sexual harassment. The PREA coordinator stated in his interview that FCCBCF does not have an administrative procedure to address resident grievances regarding sexual abuse. Based on the evidence provided, the facility is exempt from this standard. Corrective action: No corrective action is recommended.

115.253	Resident access to outside confidential support services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF MOU with Sexual Abuse Resources Network of Central Ohio (SARNCO) 2. FCCBCF Policy SUP12: Admission Interviews: 1. Random residents 2. Targeted resident (Prior sexual abuse) Findings: 115.253(a) The facility PAQ indicates clients are provided access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, or State victim advocacy or rape crisis organizations. The PREA coordinator provided policy SUP12 as supportive documentation. The policy states in section III.: "***C. The CBCF Clinical Manager makes available to the victim a victim's advocate from a rape crisis center. If a rape crisis center advocate is not available, the Clinical Manager makes available a qualified staff of a community agency that provides such advocacy. Treatment services are provided to the alleged victim without financial cost and regardless of whether the alleged victim names the abuser or cooperates with the investigation. The Clinical Manager is responsible for documenting all efforts to secure services (PREA 115.221, PREA 115.253).***" A signed Memorandum of Understanding (MOU) was provided as supportive documentation. The PREA coordinator provided a document, which lists community-based resources, and rape crisis centers throughout Ohio. The list contains addresses and phone numbers, and email addresses, in alphabetical order, by County. During the facility site review, the auditor observed on PREA posters an external PREA hotline number (614-728-3399). The auditor tested the number from each of the resident phones in male and female Family Room areas. All calls were successful, with a recorded message from the Ohio Department of Rehabilitation and Corrections' Division of Parole and Community Services. The message states there will be a call back within 24 hours. Upon request, residents would be assisted with locating a community-based resource, which provides emotional support for victims of sexual abuse. Based on the evidence provided, the facility meets this

	provision. 115.253(b) The facility PAQ indicates that clients are informed of any communication monitoring. During the facility site review, the Auditor observed signage posted on the wall above resident phones. The signage is conspicuous, and advises that calls may be monitored. During the facility site review, the auditor requested a resident to demonstrate the phone system, as it relates to reporting an allegation. The resident entered a PIN number to access the system. He explained that they have an account, on which money is place to cover the cost of phone calls. The PREA coordinator stated residents are not charged for external calls to the PREA hotline, and calls can be confidential. The resident placed a call to the hotline number; no request was made regarding a charge for the call. The resident logged into his phone account, which did not reflect the hotline call, or a fee for the call the resident placed. Based on the evidence provided, the facility meets this provision. 115.253(c) The facility PAQ indicates FCCBCF has a memorandum of understanding (MOU) or other agreement(s) with a community service provider that is able to provide residents with confidential emotional support services related to sexual abuse. The PREA coordinator provided to the auditor a signed MOU between FCCBCF and SARNCO. The agreement states it will provide FCCBCF residents emotional support services related to sexual abuse. The entity serves as a direct service provider, referral source, for those who experience sexual abuse, and sexual assault. If a resident expressed a desire to connect with a community-based entity outside Central Ohio, SARNCO's network offers referrals throughout the state, and nationally. The facility can also utilize the listing of Ohio-based service providers, which is provided by ODRC. During resident interviews, 20 of 20 residents stated that PREA posters say information for outside rape crisis centers is available. Most residents stated they have not sought the information for lack of need. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.254	Third party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. FCCBCF website 2. PREA Hotline (614-728-3399) Interviews: 1. Random residents 2. Random staff Findings: 115.254(a) The facility PAQ indicates it provides third-party reporting options for reporting allegations of sexual abuse and sexual harassment. The facility did not respond to this standard in the PAQ. The PREA coordinator provided to the auditor a listing of Ohio-based rape crisis centers. He stated the information is made availabe to residents, upon request. During the facility site review, the auditor observed PREA Zero Tolerance posters throughout the facility, including restrooms. The poster lists the ODRC 24-hour hotline number as an external contact for reporting sexual abuse or sexual harassment allegations. The auditor interviewed 20 random residents during the onsite audit. All residents stated during random interviews they were aware that posted hotline numbers could be provided to a third-party (e.g., friend, family member), who could report on their behalf, an allegation of sexual abuse. Residents commented that they are comfortable reporting internally. The auditor observed a posted PREA Zero Tolerance poster in the main hallway near the visitor area. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.261	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making a compliance determination: Documents: 1. FCCBCF Policy SUP12: Admssion Interviews: 1. Deputy director/PREA coordinator 2. Random staff Findings: 115.261(a) The facility PAQ indicates all staff are required to report any knowledge of resident sexual abuse or harassment, retaliation, or regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation. The PAQ provided policy SUP12 as supportive documentation. Section III. states: "***E. The CBCF protects all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.***" The auditor interviewed nine security and non-security staff during the onsite audit. Of nine interviewed, all random staff respondents named their immediate supervisor, and/or the PREA coordinator as individuals, to whom they would report a PREA allegation. Based on the evidence provided, the facility meets this provision. 115.261(b) The facility PAQ states it requires staff to always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions. The facility provided policy SUP12 as supportive documentation. The policy states in section III., D.: "***5. The staff member then notifies the PREA Coordinator , who shall inform the Director. In the absence of the PREA Coordinator, the report is to be made immediately to the Director (PREA 115.251). Staff is not to reveal any information related to a sexual abuse report to anyone unless necessary (PREA 115.261).***" Random staff stated during interviews that their immediate supervisor and/or PREA coordinator is who they would direct reports, and information, and that such is not to be shared with anyone. During the onsite interview with the facility Nurse, he

	stated he would report to the PREA coordinator, any resident report or disclosure of sexual abuse. Based on the evidence provided, the facility meets this provision. 115.261(c) The facility PAQ indicates that unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services. The PREA Form 1.1 lists one medical practitioner who works at FCCBCF as a contractor. The auditor interviewed the facility Nurse (staff) during the onsite audit. The Nurse stated he assures residents of HIPPAA compliance, and the exceptions for who can review files. He reports information to the shift supervisor and PREA coordinator; the Sheriff will notify EMS, if needed. He provides to the PREA coordinator, or other mandated entity, reports of sexual abuse, even if it was prior to admission at FCCBCF. Based on the evidence provided, the facility meets this provision. 115.261(d) The facility PAQ states there are no residents at FCCBCF under age 18. The facility website states it is an adult facility. During the onsite audit, no residents were identified as under age 18. The auditor reviewed 20 resident files. Of the 20 resident files reviewed, all indicated the resident was older than age 18. Based on the evidence provided, the facility meets this provision. 115.261(e) The facility PAQ indicates all allegations are reported to designated staff, including third-party reports. Policy SUP12 states: "***5. The staff member then notifies the PREA Coordinator, who shall inform the Director. In the absence of the PREA Coordinator, the report is to be made immediately to the Director (PREA 115.251).***" The facility provided for the auditor's review five sexual harassment, and sexual abuse investigative files from 2019. Random staff and random residents stated they would report allegations of sexual abuse to their immediate supervisor, and/or case facilitator. The PREA coordinator is listed as one of four special investigators, and has received specialized training specific to PREA related allegations. Based on the evidence provided, the facility meets this provision. Based on the overall evidence provided, the facility meets this standard. Corrective Action: No corrective action recommended.

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission Interviews: 1. Deputy Director/PREA coordinator 2. PREA investigator (Unit Manager) 3. Random staff Findings: 115.262(a) The facility PAQ indicates the facility will take immediate action to protect a resident at risk of imminent sexual abuse. Policy SUP12 was provided in the PAQ as supportive documentation. Policy section III., E. states: "***1. If necessary, housing changes or transfers for resident victims or abusers will be made, alleged staff or resident abusers will be removed from contact with victims, and emotional support services will be provided for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.***" The policy section provided does not apply to this standard provision. Action steps the facility may take in response to concerns for resident(s) who fear retalilation is a lesser issue than '*imminent sexual abuse*'. An imminent risk is when facts indicate an identified abuser has a plan, or has somehow made it know the alleged victim is a target; the alleged abuser has communicated the intent to seek out the alleged victim for the purpose of sexually abusin him or her. Conversely, a resident may voice concern about retaliation, but such fear or concern may, or may not be valid, or true. Nonetheless, one of the 2019 investigations resulted in the resident being relocated to a different housing Hall, due to the alleged victim's fear of retaliation. The facility considered the fear to be valid, and responded in a manner, which protected the alleged victim. During the facility site review, segregated housing rooms were observed, which is located in the medical, and intake area. The segregated rooms contain a toilet. Residents placed in segregated housing may be placed on an early or late shower schedule to remain separate from the general population. The auditor observed that this area can be monitored from the control room, to ensure resident safety, and facility security. Based on the evidence provided, the facility meets this standard. Corrective Action:

	No corrective action is recommended.

115.263	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission Interviews: 1. Agency head 2. PREA coordinator Findings: 115.263(a) The facility PAQ indicates if a resident reports having been sexually abused while confined at another facility, the head of the facility will be notified. Policy SUP12 was provided as supportive documentation. The policy states in Section III.: "***F. Should a resident disclose, while he/she is a resident of the CBCF, that he/she was sexually abused while confined in another facility, this disclosure is to be immediately reported to the PREA Coordinator who will immediately report such disclosure to the Director. The Director will have the PREA Coordinator contact and report same to the head of the facility in which this abuse allegedly occurred. This contact is to be made no later than 72 hours from receipt of the disclosure. The PREA Coordinator is responsible for documenting this contact (PREA 115.263).***" During an interview with the Agency Head (Exec. Director), she stated the PREA coordinator drafts responses to such an allegation. She stated the PREA coordinator informs her of the situation and she signs the notice, which is sent to the applicable facility. PREA standard 115.263(a) states the facility head shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. According to policy, as well as interview response, the Agency Head (Exec. Director) delegates the responsibility of drafting notices to another agency to the PREA coordinator. It was also stated the PREA coordinator would send the signed notice to the facility where the reported sexual abuse allegedly occurred. During the onsite audit the auditor interviewed 20 residents (13 male, 7 female). No female residents stated they were sexually abused while confined at another facility. No male residenst stated they were sexually abused while confined at another facility. The auditor reviewed 20 resident files; there was no evidence that prior sexual abuse was disclosed during a resident's initial intake screening. Based on the evidence provided, the facility meets this provision. 115.263(b) The facility PAQ indicates another facility would be notified within 72 hours after

receiving an allegation of previous sexual abuse. Policy SUP12 is provided as supportive documentation. Policy Section III. states, in part:

"***F. ...This contact is to be made no later than 72 hours from receipt of the disclosure. The PREA Coordinator is responsible for documenting this contact (PREA 115.263).***"

The facility provided a notice of prior sexual abuse reported by a FCCBCF resident, which allegedly occurred in 2017, while at another facility. The resident disclosed during her Intake/PREA assessment that she experienced prior sexual abuse by another resident while incarcerated . Included, as additional evidence, is a written response by the facility's agency head. Based on the evidence provided, the facility meets this provision.

115.263(c)
The facility PAQ indicates that FCCBCF shall document that it has provided such notification. Policy SUP12 states:

"***F. ...The PREA Coordinator is responsible for documenting this contact (PREA 115.263).***"

The PAQ indicates FCCBCF has not received an allegation of sexual abuse reported in the last 12 months, while a resident was at a previous facility. The auditor reviewed 20 resident files during the onsite audit.The auditor did not observe evidence of a documented notice that an allegation at another facility was reported by a FCCBCF resident. The auditor interviewed 13 male residents, and 7 female residents; no resident indicated she/he disclosed prior sexual abuse during incarceration, or at another community-based confinement facility. During the onsite audit, the auditor interviewed nine security and non-security staff. Of nine staff, none indicated that a resident alleged, or disclosed prior sexual abuse while incarcerated. Based on the evidence provided, the facility meets this provision.

115.263(d)

The facility PAQ indicates the facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. The facility provided policy SUP12 as supportive documentation. Section IV. states, in part:

"***A. The CBCF shall ensure an administrative investigation is completed for all allegations of sexual abuse and sexual harassment (PREA 115.222, PREA 115.271). ...***"

The PREA coordinator stated during hiis nterview that, should the facility receive a report from another facility that a former resident alleged being sexually abused while at FCCBCF, they would treat is as if the resident were still there, and request a full investigation. He stated FCCBCF has received no reports from another facility that a former FCCBCF resident reported that he or she was sexually abused while at

	FCCBCF. The auditor conducted an internet search for sexual abuse allegations at FCCBCF. The search results found no articles related to sexual misconduct at FCCBCF. The PREA coordinator provided to the auditor five investigative files for review. None were regarding allegations made by a former FCCBCF resident who reported to another facility that he or she was sexually abused while at FCCBCF. Based on the evidence provided, the facility meets this provision. Based on the overall evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.264	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-audit Questionnaire (PAQ) 2. FCCBCF Policy SUP12: Admission 3. Resident files 4. Staff training records Interviews: 1. Security staff who are first responders 2. Non-security staff 3. Agency Head Findings: 115.264(a) The facility PAQ indicates that upon learning of a reported allegation of resident sexual abuse, the first security staff member to respond to the report is required to: separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence; and the same requirement for the alleged abuser. Policy SUP12 was provided as supportive documentation. Policy Section III. states, in part: "***D. Upon learning of an allegation that a resident was sexually abused, the staff member responds by:*** 1. ***Separating the alleged victim and abuser;*** 2. ***Preserving and protecting any crime scene until appropriate steps can be taken to collect any evidence;*** 3. ***If the abuse occurred within a time period that still allows for the collection of physical evidence, the staff member requests that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and*** 4. ***If the abuse occurred within a time period that still allows for the collection of physical evidence, the staff member ensures that the***

***alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating (PREA 115.264). ...*"**

The facility uploaded in the PAQ a *PREA Response Plan Flowchart*. The flowchart illustrates action steps to be taken by security, and nonsecurity staff who are first responders. The flowchart includes action steps regarding the alleged abuser and alleged victim. The PREA coordinator stated the flowchart is reviewed in orientation, and staff in-person PREA training. The auditor found no evidence of internal PREA training in 2019, outside New Employee Orientation (NEO).

During six RA/security staff interviews, one security staff stated she would report an allegation of sexual abuse to the immediate supervisor, and PREA coordinator. The staff gave specific steps to take:

- to ensure any physical evidence is not contaminated;
- separating the victim from the abuser.

Six of six random staff (line security staff on each shift) all stated during interviews, reports of sexual abuse would be reported to their immediate supervisor, and PREA coordinator. Six of six RA staff stated allegations would be reported to the Sheriff Department if there was potential physical evidence related to an alleged sexual abuse. The PREA coordinator stated the alleged abuser would be placed in one of the segregated units until the Sheriff arrived, and took further action. Security staff articulated the appropriate action steps related to the alleged abuser.

The Agency Head stated during her interview that they would call the court, or probation officer, and have an order prepared for the Sheriff; and have the alleged abuser removed from the facility during the investigation. Additional charges would be brought against the abuser; the Sheriff Dept. would conduct a criminal investigation. The victim would be transported to Grant, or OSU Hospital. The PREA coordinator stated PREA refresher training is expected to resume in March 2020, that additional training has been side-lined since 2017, due to an overhaul of agency's core programming strategy. Based on the evidence provided, the facility meets this provision.

115.264(b)
The facility PAQ indicates if a first responder is a non-security staff, they are required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. Policy SUP12 does not differentiate between security, and non-security staff related to reported allegations of sexual abuse. The facility uploaded in the PAQ a PREA Response Plan flowchart as supportive documentation. The flowchart illustrates action steps for any staff who are first responders to a PREA allegation. Three non-security staff were interviewed;

	each staff articulated that they would separate the alleged victim and abuser, and contact the PREA coordinator. The alleged victim would be returned to general population, and the alleged abuser would be placed in one of the segregated housing rooms until the Sheriff arrived. The alleged victim, if he or she remained in the facility, could be monitored in the dorm area via surveillance camera. If there was a strong indication the incident occurred as reported, the Sheriff's Office would be called to arrest the alleged abuser, and begin a criminal investigation. The resident would be asked if he or she needed medical attention. Six of six random security staff, who may be first responders, articulated all of the required first responder steps. The auditor reviewed five investigative files; three of the five were identified as allegations of sexual abuse in the past 12 months. Based on the evidence provided, the facility meets this provision. Based on the overall evidence, the facility meets this standard. Corrective Action: No corrective action recommended. Recommendation: Clarify in policy SUP12 action steps for non-security staff who may be a first responder to a report of resident sexual abuse.

115.265	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Pre-audit Questionnaire (PAQ) 2. FCCBCF Policy SUP12: Admission Interviews: 1. Deputy Director/PREA coordinator Findings: 115.265(a) The PAQ response indicates the facility has in place a coordinated response, which includes a facility staffing plan that demonstrates the institutionalization of PREA-related procedures and protocols as part of the overall safety of the facility, and residents' sexual safety. The facility PREA Response Plan Flowchart was provided as supportive documentation.The PREA coordinator referenced the flowchart, and staffing schedule as its institutional plan for the overall safety of the facility, and residents' sexual safety. The facility did not provide a documented plan that demonstrates the institutionalization of PREA-related procedures and protocols as part of the overall safety of the facility, and residents' sexual safety. PREA form 1.1, provided by the PREA coordinator during the pre-audit phase, lists the identified positions in section k. of the document, which make up the Sexual Abuse Incidet Review Team: • Agency Head (Executive Director) • Deputy Director/PREA Coordinator • Senior Program Manager • Unit Manager • Unit Supervisor During the onsite audit, the (available) members of the team were interviewed. Four of five team members acknowledged being on the incident review team. The auditor reviewed five investigative files related to allegations of sexual abuse, and sexual harassment in 2019. Of the five investigative reports, one contained documentation related to the convening of the Incident Review Team. Four of five investigative reports contained witness statements, allegation information from the alleged victim, and summary reports by the assigned internal investigator. The PREA coordinator stated during his interview that a key method of ensuring resident safety is the use of surveillance cameras throughout the facility. The auditor observed in investigative files, descriptive information based on surveillance camera footage. During his interview, the PREA coordinator articulated how, where cameras

	exist and are utilized, areas are to be monitored. The auditor observed areas in the facility marked with ‘authorized personnel only’, or similar signage in areas identified as blind spots. Based on the evidence provided, the facility does not meet this standard. Corrective Action: 1. Develop an institutional plan, which identifies and defines, at minimum, key components, which make up the facility's coordinated response. 2. Utilize *How to Develop a PREA-Compliant Staffing Plan*, created by The Moss Group (TMG), for a full list of components to be included in a PREA-compliant staffing plan; resources, and best practices. The guide can be accessed on the national PREA Resource Center website (prearesourcecenter.org). ***FACILITY RESPONSE:*** The facility's PREA Staffing Plan includes an "Institutional Plan" section, which outlines key action steps, positions responsible for each step, and which coincide with the Coordinated Response flowchart. Supportive documentation was provided to the auditor as evidence that the updated PREA Staffing Plan has been reviewed with all employees who engage with, or have access to residents. Based on the evidence provideded, the facility is now in compliance with this standard. **Review:** PREA Staffin Plan Employee training documents

115.266	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: (policies, directives, forms, files, records, etc.) 1. FCCBCF Policy HR1 Interviews: 1. Agency head 2. Random staff Findings: 115.266 (a) The facility PAQ indicates that neither the agency nor facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Thus, they are not restricted in the disciplinary process of staff members that have violated sexual abuse/sexual harassment policy or limited in their ability to remove staff sexual abusers. Policy HR1 was reviewed as supportive documentation. The policy states: "***The CBCF Director has the final authority for all personnel actions.***" The Agency Head corroborated during her interview that there is no collective bargaining agreement or other agreement between FCCBCF and any entity. Interviews with 13 random and specialized staff also supported this information. Based on the evidence provided, the agency, by default, meets this provision. 115.266(b) The auditor is not required to audit this provision. Corrective Action: No corrective action is recommended.

115.267	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in make the compliance determination: Documents: (policies, directives, forms, files, records, etc.) 1. FCCBCF SUP12: Admission 2. Facility physical layout Interviews: 1. Agency head 2. Deputy Director/PREA coordinator 3. Designated Staff Member Charges with Monitoring Retaliation Findings: 115.267 (a) The facility indicated in their response to the PAQ that there is a policy which will protect residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigation from retaliation. Policy SUP12 was provided in the PAQ as supportive documentation. The auditor reviewed policy SUP12 to determine if it provides protection for residents and staff who report sexual abuse or harassment. Section III. states: "***E. The CBCF protects all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.***" The facility PREA coordinator provided PREA Form 1.1, which identified the following positions as responsible for retaliation monitoring of residents and staff who report sexual abuse or sexual harassment: • Sr. Program Manager • Two Unit Managers The PAQ identifies the same positions as staff responsible for retaliation monitoring. PREA form 1.1 was provided during the pre-audit phase. Based on the evidence provided, the facility meets this provision. 115.267(b) The facility PAQ indicates that the agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The

facility provided policy SUP12 as supportive documentation. Policy Section III., E:

"***1. If necessary, housing changes or transfers for resident victims or abusers will be made, alleged staff or resident abusers will be removed from contact with victims, and emotional support services will be provided for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.***"

The PREA coordinator provided five investigative files for the auditor's review. The auditor observed evidence in one of five files that retaliation monitoring was conducted; the alleged victim was re-located to a different Hall to ensure there would be no retaliation toward the reporting resident. The auditor reviewed 20 random resident files (10 male, 10 female residents). There was no evidence of reported sexual abuse in the past 12 months. The residents identified in the five allegations were not in the FCCBCF program at the time of the onsite audit. Based on the evidence provided, the facility meets this provision.

115.267(c)
The facility PAQ indicates that for at least 90 days following a report of sexual abuse, the agency shall monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. FCCBCF Policy SUP12 states in Section III., E.:

"***2. The CBCF will continue to monitor the conduct and treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation.***"

The auditor interviewed a facility retaliation monitor, who explained the PREA coordinator would notify her if a situation required monitoring. She stated retaliation monitoring includes:

- Check on them regularly; ask if they’re okay, if there’s anything they need;
- Place on a lower tier (males); see if they want outside resources;
- Review cameras;
- Look for Call Cards;
- Observe for signs of bullying, getting a lot of tickets;
- struggling with moving through Phases.

Retaliation monitoring will usually last throughout the resident's stay, even if it goes beyond the 90-day monitoring period. She, and/or the Sr. Program Manager will

conduct periodic reviews of video surveillance footage, particularly if the alleged abuser/harasser is still in the facility.

An analysis of the evidence indicates the facility provides the necessary practice of monitoring retaliation for victims of sexual abuse and sexual harassment. Through interviews, and document review, it is noted that staff interviewed who are charged with monitoring retaliation are familiar with retaliation time frames and methods to protect residents who report sexual abuse, or staff who report retaliation. Based on the evidence provided, the facility meets this
provision.

115.267(d)
The facility PAQ indicates that in the case of residents, such monitoring shall also include periodic status checks. The PREA coordinator provided five investigative files for the auditor's review. According to the PREA coordinator, and staff who are responsible for retaliation monitoring, periodic status checks are conducted throughout the resident's program, whether it is less than, or more than, 90 days. Additionally, the practice of conducting periodic status checks of residents to monitor the conduct and treatment, is addressed in policy SUP12. Based on the above evidence the facility meets this provision.

115.267(e)
The facility PAQ indicates that if any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. The standard requires the facility to take appropriate action for any other person who may have cooperated in an investigation, and fears retaliation. The auditor interviewed a staff who is responsible for retaliation monitoring. The staff stated they would assure a resident or staff who feared retaliation that their safety is a priority. Monitoring a resident who feared retaliation would include routine monitoring of video footage, and possibly phone calls. Staff who express concern of retaliation could be reassigned to another area, or shift. When they suspect retaliation, chain of command is followed, and the PREA coordinator is notified and/or Agency Head, and will handle the situation from there. Policy SUP12 states in Section III. E.:

"***3. If any other individual who cooperates with an investigation expresses a fear of retaliation, the CBCF will take appropriate measures to protect that individual against retaliation.***"

Based on the evidence provided, the facility meets this provision.

115.267(f)
The Auditor is not required to audit this provision.

Based on the evidence provided, the facility meets this standard.

Corrective Action:
No corrective action is recommended.

115.271	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. Facility layout document 3. Staff training records Interviews: 1. PREA Investigator 2. Deputy Direcor/PREA coordinator Facility Site Review Findings: 115.271(a) The facility PAQ indicates the agency/facility has a policy related to criminal and administrative agency investigations. Policy SUP12 is provided as supportive documentation. Policy SUP12 states in Section IV.: **"*A. The CBCF shall ensure an administrative investigation is completed for all allegations of sexual abuse and sexual harassment (PREA 115.222, PREA 115.271).*"** The PREA coordinator stated during interview that actions regarding allegations of sexual abuse first go through him; the process moves forward from there. The facility has a documented letter of commitment from the Franklin County Sheriff's Department, which establishes the Sheriff's Department as the investigative entity for PREA allegations at FCCBCF, which appear to be criminal in nature. The PREA coordinator stated the facility received four allegations of sexual harassment and sexual abuse in 2019, and one allegation in 2020. The auditor reviewed all five investigative files. Of the five files reviewed, one was referred to the Sheriff's Department. The facility stated in response to PREA §115.222 that FCCBCF conducts administrative investigations, when allegations are deemed to not be criminal. According to the HR staff, if the identified abuser is a staff member, they would be placed on administrative leave with pay until the investigation is complete. If the alleged abuser is a resident, he or she would be temporarily removed/arrested, and housed in the local jail, until the investigation is complete. Such was corroborated by the Agency Head during her interview. Based on the evidence provided, the facility meets this provision. 115.271(b) The facility PAQ indicates that where sexual abuse is alleged, the agency shall use

investigators who have received special training in sexual abuse investigations pursuant to §115.234. Training for the PREA coordinator, and the three listed investigators on PREA Form 1.1 was verified through supporting documentation (training certificates) located in their personnel files. The investigators, and PREA coordinator files contained certificates dated 7/23/19 from PREA Investigator specialized training, facilitated by the Ohio Department of Rehabilitation and Correction (ODRC). The curriculum of
the training was provided, and meets all aspects required of specialized training for PREA investigations. Policy SUP12 states PREA investigations are conducted by qualified staff within the Franklin County Sheriff's Department. During interviews, the investigator stated she attended PREA investigations specialized training in 2019. Based on the evidence provided, the facility meets this provision.

115.271(c)
The facility PAQ indicates Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. Policy SUP12 states in Section III., D.:

"*D. Upon learning of an allegation that a resident was sexually abused, the staff member responds by: ...*

***2. Preserving and protecting any crime scene until appropriate steps can be taken to collect any evidence;*"**

During the facility site review, the auditor observed cameras in the facility main security hub, which covered internal and external areas throughout the facility. The facility PREA coordinator stated during interview that physical or circumstantial evidence would likely be collected as part of a criminal investigation, and would be handled by the Sheriff's Dept. Access to an area deemed to contain evidence in an investigation would be prohibited until
clearance is received by the Sheriff's Dept. Based on the evidence provided, the facility meets this provision.

115.271(d)
The facility PAQ indicates that when the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The PREA coordinator stated during his interview that they do not conduct compelled interviews, that such is handled by the Sheriff Department. Policy SUP12 states in section IV.:

"*E. At any time that CBCF administration determines the possibility that a criminal investigation is necessary, the Franklin County Sheriff's Office is consulted.*"

The facility provided a 2019 investigative file to confirm that compelled interviews occurred during an investigation, or if such were deemed to be an

obstacle for subsequent criminal prosecution. The documentation provided indicated that Sheriff's Departent has been consulted with in regards to a reported allegation of sexual abuse. During interviews, the PREA coordinator, and Agency Head stated there have been five PREA allegations in the past 12 months. Based on the evidence provided, the facility meets this standard.

115.171(e)
The facility PAQ indicates that the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. Policy SUP12 is provided as supportive documentation.
The policy summary states:

"*A violation of this type by a resident shall be considered a major rule violation and grounds for immediate termination from the Franklin County CBCF. A violation by staff is grounds for termination from employment. A violation by a contractor or volunteer is grounds to discontinue the services(s) of the contractor or volunteer. In addition, said violation may be reported to appropriate law enforcement and may result in prosecution.*"

The facility provided five investigation files for review, related to allegations of sexual abuse and sexual harassment in the past 12 months. During interviews, the PREA coordinator stated the agency does not conduct polygraph tests, nor does it use any other truth-telling device during PREA investigations. During resident interviews, no resident expressed ever being asked to take a polygraph test, and 20 of 20 residents interviewed
stated they had not experienced sexual victimization during incarceration, or while at FCCBCF. Based on the evidence provided, the facility meets this provision.

115.271(f)
The facility PAQ indicates administrative investigations: (1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The auditor reviewed five administrative investigative files related to sexual harassment and sexual abuse in 2019, and 2020. The documentation included detailed accounts of staff actions, behaviors, including information obtained from video surveillance footage. Allegations were documented by staff based on verbal reports, and written statements, and/or Call Card(s) by the alleged victim, and witnesses, when applicable. The facility responded in PREA standard 115.221 that all allegations deemed as criminal are investigated by the Franklin County Sheriff's Department. In standard 115.222, the facility stated if an allegation is deemed to not be criminal, the agency conducts an administrative investigation. The facility provided five investigative files to

corroborate that the facility's administrative investigation practice coincides with agency policies. Based on the evidence provided, the facility meets this provision.

115.271(g)
The facility PAQ indicates criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Policy SUP12 states in Section VII.:

"***F. The CBCF retains written reports regarding sexual harassment or sexual abuse for as long as the alleged is incarcerated or employed by the facility plus five years.***"

The PREA coordinator provided to the auditor a documented, signed letter of service from fhe Franklin County Sheriff Department. The letter establishes the Sheriff's Department as the investigating entity for allegations of sexual misconduct. The PREA coordinator provided to the auditor five investigative files for review. One file from 2019 included information indicating a criminal investigation was conducted by the Franklin County Sheriff Department. The auditor reviewed 20 resident files during the onsite audit. Of the 20 resident files reviewed onsite, none contained documentation related to allegations
of sexual abuse, or retaliation.

The auditor reviewed five administrative investigation files from 2019 related to resident-on-resident, and staff-on-resident sexual harassment. Two substantiated allegations involving staff indicate on staff was terminated for sexual harassment of a resident; one staff was arrested by the Franklin County Sheriff Department. The file does not indicate if the case was submitted to, or reviewed by, the county Prosecutor's office, or if there was a conviction. None of the residents identified in the five sexual harassment allegations were in the FCCBCFprogram at the time of the onsite audit. During the onsite audit, the auditor interviewed the reporting staff in the sexual abuse case. She corroborated that staff informed her the day following the allegation, staff informed her that the Sheriff arrested the alleged staff abuser at the facility.

Review of 13 staff personnel files did not result in any findings of disciplinary action, or other legal action against staff for resident sexual abuse and/or sexual harassment, retaliation, or evidence of any criminal charges for past sexual abuse, sexual harassment, or retaliation. Based on the evidence provided, the facility meets this provision.

115.271(h)
The facility PAQ indicates that substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. Policy SUP12 states:

"***F. If the allegation against a staff member is substantiated, the Director will follow disciplinary action as cited in CBCF Policy# HR13: Staff Disciplinary, Appeal, & Grievance Procedures (PREA 115.276). The Director***

or designee will also report the allegations to the Franklin County Sheriff's Office. If no response is received within two weeks, the information is forwarded to the Franklin County Prosecutor's Office (PREA 115.222, PREA 115.271)."

The auditor reviewed four investigative files related to PREA allegations receive in the past 12 months, and one allegation in 2020. There were no records in resident files of court cases stemming from allegations of sexual abuse and /or harassment, or retaliation. The PREA coordinator stated during interviews that the facility received one PREA related allegation, which was deemed to be criminal, and referred for prosecution. The Agency Head stated the facility has had five PREA-related allegations in the past 12 months. Based on the evidence provided, the facility meets this provision.

115.271(i)
The facility PAQ indicates that the agency shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Policy SUP12 was uploaded in the PAQ as supportive documentation. The policy states in Section VII.:

"***C. The CBCF maintains sexual abuse data collected for at least 10 years after the date of the initial collection (PREA 115.289).***"

The PREA coordinator, and Agency Head stated there have been five allegatons of sexual abuse, or sexual harassment in the past 12 months. The PREA coordinator provided information on five sexual harassment allegations from 2019, and one from 2020; no allegation reports prior to 2015 were provided to demonstrate records remain on file. The auditor conducted an internet search of potential articles related to sexual abuse cases at FCCBCF. The search produced no evidence of PREA related allegations prior to 2015. There was no evidence that the facility received allegations of sexual abuse, sexual harassment, or retaliation before 2015. Based on the evidence provided, the facility meets this provision.

115.271(j)
The facility PAQ indicates that the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. Policy SUP12 was uploaded in the PAQ as supportive documentation. The policy states:

"***B. Following a resident's allegation that a staff member committed sexual abuse against the resident, the CBCF subsequently informs the resident (unless the allegation was determined to be unfounded) whenever:***

1. The staff member is no longer working on the resident's living unit;
2. The staff member is no longer employed at the facility;
3. The staff member has been indicted or convicted on a charge related to sexual abuse within the facility.
.

	C. Following a resident's allegation that he or she has been sexually abused by another resident, the CBCF subsequently informs the alleged victim whenever the CBCF learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility. ***D. All such notifications or attempted notifications are documented.*****"** The PREA coordinator provided five investigation files related to resident sexual abuse, and sexual harassment by another resident, and by staff for the auditor to review. In all cases, the facility concluded the investigation prior to the resident's departure. In the case turned over to the Franklin County Sheriff, the resident was released from the FCCBCF program, while the Sheriff Department conducted its criminal investigation. Based on the evidence provided, the facility meets this provision. 115.271(k) The auditor is not required to audit this provision. 115.271(l) The facility PAQ indicates that when outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. The PREA coordinator stated during interviews that he would stay in contact with the Sheriff's Department who would provide updates on a regular basis. The PREA coordinator, and Agency Head made similar comments during their interviews. Based on the evidence provided, the facility meets this provision. Based on evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.272	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: 115.272(a) The facility PAQ indicates it imposes a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment can be substantiated. Policy SUP12 was provided as supportive documentation. The policy states: "***D. The CBCF shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated (PREA 115.222, PREA 115.271).***" The auditor reviewed five investigative files. There was no evidence that agency investigative staff applied a standard higher than a preponderance of evidence to determine allegation outcomes. Based on evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.273	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. 20 Resident files Interviews: 1. Investigative staff (Case Facilitator) 2. 20 Random resident interviews Findings: 115.273(a) The facility PAQ indicates there is a policy that ensures residents who report allegations of sexual abuse or sexual harassment are informed of the outcome (substantiated, unsubstantiated, unfounded). The PREA coordinator provided policy SUP12 as supportive documentation. Policy SUP12 states: ***"A. Following the investigation, the resident is informed as to whether the allegation was determined to be substantiated, unsubstantiated, or unfounded. If CBCF staff did not conduct the investigation, the information is requested from the investigative agency in order to inform the resident."*** The PAQ indicates there have been five allegations of sexual abuse, and/or sexual abuse in harassment in the past 12 months. There was no evidence in any of the five investigative files that a resident received a documented notice of whether the resident's allegation was determined to be substantiated, unsubstantiated, or unfounded. The resident roster provided to the auditor at the onset of the onsite audit did not include the five residents who reported sexual harassment, or sexual abuse by another resident or staff in 2019. During the onsite interview with the Investigator (Unit Manager), she stated if a resident terminated prior to the conclusion of a PREA investigation, the outcome notice would be handled by the PREA coordinator, if known. If the Sheriff's Office conducts the investigation, the PREA coordinator will request that the alleged victim be notified of the outcome. During the onsite audit, there were no residents identified as having reported an allegation of sexual abuse or sexual harassment. Of 20 residents interviewed, none stated they have reported an allegation of sexual abuse or sexual harassment; one stated they were aware of the report of alleged sexual abuse in the facility related to the "laundry room" case. The auditor verified that one of the five investigatve files provided

	involved alleged staff sexual misconduct in the facility commercial laundry room. During random staff interviews, six of six employees stated they were aware of reported allegations of sexual abuse, and sexual harassment in the past 12 months. During the onsite audit, the auditor reviewed 20 resident files. No files included documented evidence of sexual harassment, or sexual abuse. The investigative files were provided by the PREA coordinator. Based on the evidence provded, the facility does not meet this provision. 115.273(b) The faclity PAQ indicates that, when an outside agency investigates a reported allegation of sexual abuse, the facility cooperates with the outside investigators, and endeavors to remain informed about the progress of the investigation. The PAQ indicates there were five reported allegations of sexual abuse in the past 12 months. No residents were identified as having reported sexual abuse at FCCBCF. None of 20 residents interviewed stated they have reported sexual harassment, or sexual abuse while at FCCBCF; one resident was aware of a reported allegation of staff sexual abuse at FCCBCF. Of the 13 staff interviewed, all expressed knowledge of allegations of sexual abuse at FCCBCF, and that the staff involved were terminated. During her interview, the Agency Head stated FCCBCF and the Franklin County Sheriff's Department have a positive relationship. Allegations of sexual abuse would be dealt with as a criminal case, and the Sheriff's Office takes the lead, and keeps her abreast of the outcome. Based on the evidence provided, the facility meets this provision. 115.273(c) The facility indicates in the PAQ that residents are informed of allegation outcomes regarding staff sexual abuse against a resident. Policy SUP12 states: **"*B. Following a resident's allegation that a staff member committed sexual abuse against the resident, the CBCF subsequently informs the resident (unless the allegation was determined to be unfounded) whenever:* *1. The staff member is no longer working on the resident's living unit;* *2. The staff member is no longer employed at the facility;* *3. The staff member has been indicted or convicted on a charge related to sexual abuse within the facility.*"** Three investigative files were provided for review during the onsite audit. The auditor was informed there have been reported allegations of resident sexual abuse by a staff in the past 12 months. During interviews with 20 residents (13 male, 7 female), no residents stated they were the victim of sexual abuse by staff. The Investigator stated during her interview that she has conducted sexual abuse investigations related to two residents, in the past 12 months. The investigative files reviewed did not contain evidence that the residents were informed of the outcome. Based on the evidence provided, the facility does not meet this provision.

115.273(d)
The PAQ indicates that following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: 1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or 2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. All such notifications or attempted notifications shall be documented. Policy SUP12 was provided as supportive documentation. The policy states in Section VII.:

"***C. Following a resident's allegation that he or she has been sexually abused by another resident, the CBCF subsequently informs the alleged victim whenever the CBCF learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility.*** "

The PREA coordinator provided two investigative files to review of resident sexual abuse or sexual harassment against a resident within the facility. The PAQ indicates there have been two reported allegations of resident sexual abuse against another resident in the facility have been received in the past 12 months. The Agency Head, and PREA coordinator both stated during interviews that the facility has received two reported allegations of resident sexual abuse by another resident in the past 12 months. Both investigative files indicated that the investigations were administrative investigations, and did not result in criminal charges. Based on the evidence provided, the facility meets this provision.

115.273(e)
The PAQ indicates all residents are notified in writing of the outcome of an allegation of sexual abuse. Policy SUP12 states:

"***D. All such notifications or attempted notifications are documented.***"

There were five investigative files to review; none contained evidence that the alleged victim was notifiedof the outcome, verbally, or in writing. The auditor reviewed two allegations of resident-on-resident sexual harassment. In each case, the auditor was not provided with detailed documentation as demonstration of compliance. Based on the evidence provided, the facility does not meet this provision.

115.273(f)
The auditor is not required to audit this provision.

Based on the evidence provided, the facility does not meet this standard.

CORRECTIVE ACTION:

1. Create a template form for notifying residents of whether allegations of sexual abuse are: substantiated, unsubstantiated, or unfounded.
2. Maintain in investigative files, a copy of resident notifications, or attempted

notifications (verbal or written), of the allegations outcome.

3. Maintain in investigative files, evidence of whether the facility attempted to mail to the resident (if out of the FCCBCF program) the outcome notice indicating whether the allegation was substantiated, unsubstantiated, or unfounded.
4. Maintain in investigative files, evidence of whether the facility attempted to notify residents of criminal charges, indictments, or convictions, should such be the outcome, or status, of a PREA-related case.

FACILITY RESPONSE:

The facility has developed and implemented a resident Outcome Notification form. The new form identifies when an allegation was submitted, the nature of the allegation, and outcome - substantiated, unsubstantiated, or unfounded. The facility maintains a copy of the notice in investigative files, along with proof that such was issued via U.S. Mail, if the resident is no longer at FCCBCF. Residents are notified of criminal charges, indictments, or convictions, should such be the outcome, or status, of a PREA-related case. A signed PREA Victim notification to a (former) resident, signed by the PREA coordinator, was provided as supportive documentation. Based on evidence provided, the facility is now in compliance with this standard.

Review:

Resident PREA Outcome Notification

115.276	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. Employee Roster 3. 13 Human Resources files Interviews: 1. Human Resources Manager Findings: 115.276(a) The facility PAQ indicates staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Policy SUP12 was provided as supportive documentation. Section VI. states: "***F. If the allegation against a staff member is substantiated, the Director will follow disciplinary action as cited in CBCF Policy# HR13: Staff Disciplinary, Appeal, & Grievance Procedures (PREA 115.276). The Director or designee will also report the allegations to the Franklin County Sheriff's Office. If no response is received within two weeks, the information is forwarded to the Franklin County Prosecutor's Office (PREA 115.222, PREA 115.271).***" The HR staff stated during her interview that FCCBCF has disciplined staff, up to and including termination, due to alleged sexual abuse, or sexual harassment against residents. The auditor reviewed three PREA investigative files involving staff. Of the three, two resulted in employee termination, one including criminal charges. Based on the evidence provided, the facility meets this provision. 115.276(b) The facility PAQ indicates that termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Policy SUP12 states that termination is the presumptive disciplinary sanction for staff who engage in sexual abuse. The policy summary states: "***A violation of this type by a resident shall be considered a major rule violation and grounds for immediate termination from the Franklin County CBCF. A violation by staff is grounds for termination from employment. A violation by a contractor or volunteer is grounds to discontinue the services(s) of the contractor or volunteer. In addition, said violation may be reported to appropriate law enforcement and may result in prosecution.***"

	The HR staff stated during her interview that immediate termination would be imposed, should it be substantiated that a staff engaged in sexual abuse. The auditor reviewed three PREA investigation files involving staff. Two of the three cases resulted in staff terminations. Based on the evidence provided, the facility meets this provision. 115.276(c) The PAQ indicates that disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Policy SUP12 Section VI. states: "***D. If the allegation against a resident is substantiated but not a criminal law violation, the Director will determine how to proceed via in-house sanctioning, up to and including termination from the program (PREA 115.278).1.***" The HR staff stated in her interview that clear, intentional sexual abuse, or harassment would definitely warrant termination. If a situation wasn't clear, the employee's employment history would be reviewed in conjunction with the allegation, to determine if the allegation is plausible. In some cases, automatic termination may not be the most appropriate action. The auditor observed three PREA investigation files that involved staff. One of three did not result in termination. The HR staff stated allegations, and actions by the agency are considered on a case-by-case basis. Based on the evidence provided, the facility meets this provision. 115.276(d) The facility PAQ indicates that all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Polixy SUP12 was provided as supportive documentation. The policy states in Section VI.: "***E. If the allegation against a resident is substantiated and is of criminal misconduct, the Director shall proceed with termination from the facility per policy and procedure. The Director or designee will also report the allegations to the Franklin County Sheriff's Office.***" Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.277	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission Interviews: 1. Agency Head Findings: 115.277(a) The faciity PAQ indicates that any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Policy SUP12 was provided as supportive documentation. Policy SUP12 states, in part: "***... A violation of this type by a resident shall be considered a major rule violation and grounds for immediate termination from the Franklin County CBCF. A violation by staff is grounds for termination from employment. A violation by a contractor or volunteer is grounds to discontinue the services(s) of the contractor or volunteer. In addition, said violation may be reported to appropriate law enforcement and may result in prosecution.***" The HR staff stated the facility director (PREA coordinator) and/or Agency Head are the designees for contractors and volunteers. The facility director stated during his interview that he would likely be the designee to notify the Sheriff's Office, or relevant licensing bodies regarding sexual abuse of a resident by a contractor or volunteer. There were no contractors or volunteers identified by the facility director, or Agency Head, with whom the facility discontinued services, due to violation of agency sexual abuse and sexual harassment policies. Based on the evidence provided, the facility, by default, meets this provision. 115.277(b) The facility PAQ indicates that the facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Policy SUP12 states: "***... A violation of this type by a resident shall be considered a major rule violation and grounds for immediate termination from the Franklin County CBCF. A violation by staff is grounds for termination from employment. A***

	violation by a contractor or volunteer is grounds to discontinue the services(s) of the contractor or volunteer. In addition, said violation may be reported to appropriate law enforcement and may result in prosecution."does not contain evidence as to how the facility complies with this provision." The facility director (PREA coordinator) stated during his interview that FCCBCF has not taken any remedial measures toward contractors or volunteers for violating sexual abuse or sexual harassment policies. No records of discontinued contractors or volunteers were provided for the auditor's review. The auditor was provided one volunteer application that was denied, due to the person's criminal background, which involved sex offenses. Based on the evidence provided, the facility, by default, meets this provision. Based on evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.278	Disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy RRD3: Resident discipline 2. Resident files 3. Agency Table of Organization Interviews: 1. Facility Director (PREA Coordinator) Findings: 115.278(a) The facility PAQ indicates residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-onresident sexual abuse. Policy SUP12 is provided as supportive documentation. The policy states in Sectin VI.: "***D. If the allegation against a resident is substantiated but not a criminal law violation, the Director will determine how to proceed via in-house sanctioning, up to and including termination from the program (PREA 115.278).*** ***E. If the allegation against a resident is substantiated and is of criminal misconduct, the Director shall proceed with termination from the facility per policy and procedure. The Director or designee will also report the allegations to the Franklin County Sheriff's Office.***" During the past 12 months, there were two allegations (involving the same resident) with an administrative finding of resident-on-resident sexual harassment that occurred at the facility, and there were no criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility. During the onsite review, the auditor interviewed 20 residents (13 male, 7 female). None of the residents interviewed stated they received a violation or sanction, but were aware of other residents receiving such, for resident-on-resident sexual harassment. The Resident Handbook contains a Sanction Grid, which advises residents of consequences for negative behaviors. The grid list four levels of violation, with Level 1 being minor, and Level 4 as major violations. The auditor identified in the Sanction grid that resident-on-resident sexual harassment is a Level 3 violation; sexual contact, whether or not such is consensual, is a Level 4 violation. The auditor reviewed two PREA investigative files involving sexual harassment. Both cases involved the same resident. The auditor observed evidence that the resident was

terminated from the FCCBCF program, due to multiple complaints of sexual harassing behavior. Based on the evidence provided, the facility meets this provision.

115.278(b)
The facility PAQ indicates that sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. The Resident Handbook indicates sexual harassment is a Level 3 violation; sexual abuse is a Level 4 violation. The auditor observed two resident-on-resident investigation files. The auditor identified the alleged harassing resident is the same person in each case. The first violation resulted in the resident being transferred to a different dorm/Hall; the second violation of sexual harassment resulted in the resident's termination from the FCCBCF program.
states:

During interviews with 20 random male and female residents, none indicated having received a Level 4 violation for inappropriate sexual contact. A review of resident files did not result in identifying resident violations or sanctions related to sexual abuse of another resident. The auditor did not review "terminated files" of former residents; documentation related to PREA violations were provided for the auditor's review. The facility director stated that a substantiated allegation of sexual abuse would result in the resident's termination from FCCBCF's program. Based on the evidence provided, the facility meets this provision.

115.278(c)
The facility PAQ indicates the disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Policy RRD3 was provided as supportive documentation. The policy does not include in the disciplinary process whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The facility director stated during his interview that a substantiated resident abuser would be terminated from the FCCBCF program; someone with severe mental health issues would not be accepted in the FCCBCF program. He stated that the totality of the event, and what violations, if any, occurred, would be considered. The auditor reviewed 20 resident files; none contained residents identified as mentally disabled. However, the auditor noted files where, during the resident screening process, residents self-disclosed mental health issues, such as:

- depression
- anxiety
- bi-polar disorder

Based on the evidence provided, the facility meets this provision.

115.278(d)
The facility PAQ indicates that If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. Policy SUP12 outlines in Section V. how alleged victims are offered, or provided therapy, counseling, or other interventions. The policy does not include if, or how, such interventions are offered, or provided for an offending resident.

During the onsite interview with the facility Nurse, he stated that if a resident were sexually victimized, he would coordinate with the PREA coordinator to ensure the resident received appropriate medical services. He stated that he, nor the contracted physician, provide direct services related to resident sexual abuse. The physician was not in the facility during the onsite audit. Of the five investigative files reviewed, one indicated the alleged victim was referred by the Sheriff Department for medical examination related to the alleged sexual abuse.The resident was taken to a hospital; FCCBCF does not conduct SAFE/SANE exams at the facility. Based on the evidence provided, the facility meets this provision.

115.278(e)
The facility PAQ indicates that the agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.the facility only disciplines residents for sexual conduct with staff if it determines the staff did not consent. The facility commented in the PAQ that there have been no incidents of this nature at FCCBCF. The facility Sanction Grid lists 'Inappropriate sexual contact' as a Level 4 violation, which may result in termination of the resident from the FCCBCF program.

There were no resident files reviewed, which indicated the resident engaged in nonconsensual sexual conduct with a FCCBCF staff. Of the five investigative files reviewed, one contained a violation related to sexual conduct with staff. The security staff who reported the incident stated the staff stated the sexual contact was consensual. The case was reported to the Franklin County Sheriff Department for criminal investigation. Based on the evidence provided, the facility, by default, meets this provision.

115.278(f)
The facility PAQ indicates that for the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.
The auditor reviewed 20 random resident files during the onsite audit. No files contained violations or sanctions related to reported allegations made in good faith, even if the allegation was not substantiated. The auditor reviewed five PREA investigative files. One allegation involvng staff was not substantiated. The auditor found no evidence the facility imposed disciplinary action upon the alleged victim.

	Based on the evidence provided, the facility meets this provision. 115.278(g) The PAQ indicates that an agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. FCCBCF prohibits sexual conduct between residents. The facility Sanction Grid was provided as supportive documentation. "Inappropriate sexual contact. Consensual sex acts" are listed as Level 4 violations, and may result in termination from the FCCBCF program. The facility director stated during his interview that surveillance cameras in the resident Halls have full view of the dorm common area, and room entrances. In addition to control room staff, each Hall contains Case Facilitator offices, security staff posted in the center of the Hall common area. Such is a strong deterrent against sexual conduct between residents. The auditor observed during the facility site review cameras in all resident Halls. The auditor observed from the facility control room how video can be isolated in specific areas of the facility, including resident Halls. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.282	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. 20 Resident files Interviews: 1. Random and Targeted resident interviews 2. Staff who reported sexual abuse Findings: 115.282(a) The facility PAQ indicates that resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. Policy SUP12 was uploaded as supportive documentation. The policy states in section A.: "***B. The CBCF offers all victims of sexual abuse access to forensic medical examinations outside the facility, without financial cost, where evidentiary or medically appropriate (PREA 115.221, PREA 115.282).***" The PREA coordinator provided to the auditor a written agreement between FCCBCF and SARNCO. The agreement is signed by the Agency Head, and the SARNCO director. FCCBCF is linked with two local hospitals: Grant, and OSU East, although there is no written MOU between the hospital(s) and FCCBCF. The PREA coordinator stated during his interview that the Sheriff Department will arrange for forensic medical treatment/examination, if such is warranted. The auditor interviewed a security staff who reported an incident of resident sexual abuse by a staff. The reporting staff corroborated that the Sheriff 's Department transported the resident to a local hospital for a forensic medical examination. The auditor interviewed 20 residents during the onsite audit. The auditor reviewed 20 resident files. No files contained information related to medical services received related to sexual abuse. Of the 20 residents interviewed, none stated they experienced sexual abuse while at FCCBCF. Based on the evidence provided, the facility meets this provision. 115.282(b) The facility PAQ indicates that if no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first

responders shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners. Policy SUP12 was uploaded as supportive documentation. Section V. states, in part:

"***C. The CBCF Clinical Manager makes available to the victim a victim's advocate from a rape crisis center. If a rape crisis center advocate is not available, the Clinical Manager makes available a qualified staff of a community agency that provides such advocacy. ...***"

The PREA coordinator stated during his interview that FCCBCF has experienced allegations of sexual abuse at FCCBCF in the past 12 months. The auditor interviewed six (6) security staff, whom all stated there have been allegations in the past 12 months. The auditor reviewed five investigation files; one contained evidence, which indicated a resident required, or sought medical attention related to sexual abuse. Based on the evidence provided, the
facility meets this provision.

115.282(c)
The PAQ indicates that resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Policy SUP12, section V. states:

"***B. The CBCF offers all victims of sexual abuse access to forensic medical examinations outside the facility, without financial cost, where evidentiary or medically appropriate (PREA 115.221, PREA 115.282).***"

The facility PREA coordinator provided to the auditor a file where the resident victim of sexual abuse received access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The facility reported in the PAQ that there have been two sexual abuse allegations at FCCBCF in the past 12 months. The auditor reviewed 20 resident files. There was no evidence of a resident requesting, or being provided information about and timely access to emergency contraception and sexually transmitted infections prophylaxis. Based on the evidence provided, the facility meets this provision.

115.276(d)
The facility PAQ indicates that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Policy SUP12 was provided as supportive documentation. The policy states in Section V.:

"***C. The CBCF Clinical Manager makes available to the victim a victim's advocate from a rape crisis center. If a rape crisis center advocate is not available, the Clinical Manager makes available a qualified staff of a community agency that provides such advocacy. Treatment services are***

	***provided to the alleged victim without financial cost and regardless of whether the alleged victim names the abuser or cooperates with the investigation. The Clinical Manager is responsible for documenting all efforts to secure services (PREA 115.221, PREA 115.253).*"** The auditor interviewed 20 residents (13 male, 7 female) during the onsite audit. None of the residents stated they have received medical services related to sexual abuse. No resident stated they reported an allegation of sexual abuse during incarceration, or while at FCCBCF. The resident identified in the sexual abuse allegation was no longer in the program at the time of the onsite audit. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.283	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy 115.283: Ongoing Medical and Mental Health Services 2. FCCBCF MOU: SARNCO 3. 20 Resident files (10 male, 10 female) Interviews: 1. PREA Coordinator 2. Facility Nurse 3. Random Resident Interviews Findings: 115.283(a) The facility PAQ indicates the facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The facility provided policy SUP12 as supportive documentation. Section V. of the policy states, in part: "***B. The CBCF offers all victims of sexual abuse access to forensic medical examinations outside the facility, without financial cost, where evidentiary or medically appropriate (PREA 115.221, PREA 115.282).*** ***C. The CBCF Clinical Manager makes available to the victim a victim's advocate from a rape crisis center. If a rape crisis center advocate is not available, the Clinical Manager makes available a qualified staff of a community agency that provides such advocacy. Treatment services are provided to the alleged victim without financial cost and regardless of whether the alleged victim names the abuser or cooperates with the investigation. The Clinical Manager is responsible for documenting all efforts to secure services (PREA 115.221, PREA 115.253).***" The facility has a MOU with SARNCO. SARNCO agrees to provide pertinent referrals, and counseling services to support victims of sexual abuse. During onsite interviews, the Case Facilitator stated if a resident disclosed prior sexual abuse, and physical evidence may still be present, the PREA coordinator would be notified, and the Sheriff Department would be contacted to begin a criminal investigation. The facility Table of Organization indicates there is a physician on contract with FCCBCF. The PREA coordinator stated in his interview that the physician does not

	provide direct medical services to residents as it relates to sexual victimization. The facilityNurse stated during his interview that he does not provide direct services related to sexual victimization. Rather, he would report such, if disclosed, to the PREA coordinator, and assist with determining the best course of action, if other than contacting the Sheriff Department. If the resident was under the jurisdiction of the Ohio Department of Rehabilitation and Correction (ODRC), the institution, from which the resident came, would be notified. Based on the evidence provided, the facility meets this provision. 115.283(b) The facility PAQ indicates that the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility provided a MOU with SARNCO as supportive documentation. The MOU states SARNCO will conduct assessments, evaluations, and provide referral services for relevant treatment, and recommended after-care. SARNCO will assist and support the resident as long as such is needed, and desired, including after the resident is released from FCCBCF's program. The facility PAQ indicates there have been no allegations of sexual abuse, whereby the victim required medical attention, and follow-up service. The auditor found no evidence in 20 resident files, reflecting sexual abuse during prior incarceration, and the need for medical attention. Based on the evidence provided, the facility meets this provision. 115.283(c) The facility PAQ indicates that the facility shall provide such victims with medical and mental health services consistent with the community level of care. The facility Nurse stated in his interview that residents are referred to Grant or OSU East hospital, if the situation is not handled by the Sheriff Department. He stated the hospital will treat FCCBCF residents no different than any other patient. The PREA coordinator stated during his interview that mental health referrals would come through the hospital, if necessary. He would ensure transportation, or other logistics are arranged, should the resident return to the facility after receiving medical attention. There were no medical or mental health records to review, as the PREA coordinator stated the resident who received medical services related to staff sexual abuse, was released from the program. The hospital does not provide the facility medical records, but the resident would bring to the facility any instructions from the treating physician, so the facility can properly coordinate any needed follow-up care or treatment. The auditor reviewed 20 resident files, and found no evidence of resident(s) receiving medical or mental health services related to an allegation of sexual abuse. Base on the evidence provided, the facility meets this provision. 115.283(d) The facility PAQ indicates that resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. Policy SUP12 was

	provided as supportive documentation. Section V. of the policy states: "C. The CBCF Clinical Manager makes available to the victim a victim's advocate from a rape crisis center. If a rape crisis center advocate is not available, the Clinical Manager makes available a qualified staff of a community agency that provides such advocacy. Treatment services are provided to the alleged victim without financial cost and regardless of whether the alleged victim names the abuser or cooperates with the investigation. The Clinical Manager is responsible for documenting all efforts to secure services (PREA 115.221, PREA 115.253)." The auditor interviewed seven female residents during the onsite audit. None of the seven residents stated they experienced sexual abuse while incarcerated. None of the residents stated they have requested a pregnancy test due to concerns related to sexual abuse while incarcerated. The PREA coordinator stated during his interview that a sexual abuse allegation involving a female resident was investigated in 2019. The resident received medical services, but was released from the FCCBCF program. Based on the evidence provided, the faciility meets this provision. 115.283(e) The facility PAQ indicates if pregnancy results from the conduct described in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Policy SUP12 was provided as supportive documentation. The policy does not specifiy what information the facility provides to female residents who may become pregnant due to sexual abuse. Policy ADM07 states in section VII. C. that FCCBCF will accept pregnant woment as long as their program completion date is prior to their expected date of delivery. The auditor interviewed seven female residents during the onsite audit. None of the seven residents stated they experienced sexual abuse while incarcerated. None of the residents stated they have requested information about and timely access to all lawful pregnancy-related medical services due to sexual abuse while incarcerated. The PREA coordinator stated during his interview that there has been an allegation of sexual abuse from a female resident in the past 12 months, but the case was handled by the Sheriff Department. He stated pregnancy would not have been a concern, based on the initial report. Based on the evidence provided, the faciility meets this provision. 115.283(f) The facility PAQ indicates that resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. Policy SUP12 was provided as supportive documentation. Section V. of the policy states: "***B. The CBCF offers all victims of sexual abuse access to forensic medical examinations outside the facility, without financial cost, where evidentiary or medically appropriate (PREA 115.221, PREA 115.282).***"

	The PREA coordinator stated in his interview that sexual abuse allegations that require medical exams would likely be investigated as a criminal case, by the Sheriff Department; they handle the medical services a resident may require. The auditor interviewed seven female residents during the onsite audit. None of the seven residents stated they experienced sexual abuse while incarcerated. None of the residents stated they have requested information about, or access to tests for sexually transmitted infections related to sexual abuse while incarcerated. Based on the evidence provided, the facility meets this provision. 115.283(g) The faclity PAQ indicates that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Policy SUP12 was provided as supportive documentation. Section V. of the policy states: **"*B. The CBCF offers all victims of sexual abuse access to forensic medical examinations outside the facility, without financial cost, where evidentiary or medically appropriate (PREA 115.221, PREA 115.282).*"** There were no financial records to review related to medical services a female resident(s) received related to sexual abuse. No resident interviewed indicated they were financially responsible for medical costs related to sexual abuse. The auditor reviewed 20 resident files during the onsite audit. No files contained medical financial responsibility documentation stemming from medical services received related to sexual abuse. The auditor was provided with investigative files related to resident sexual abuse. The PREA coordinator stated in his interview that FCCBCF turned the case over to the Franklin County Sheriff as a criminal investigation. The PREA coordinator provided to the auditor PREA investigation files to review. One of five involved medical services for the alleged victim. There was no evidence that the victim was financially responsible for the cost of services received. Based on the evidence provided, the facility meets this provision. 115.283(h) The PAQ indicates the facility shall 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 practitioners. Policy SUP12 indicates efforts to provide services to the alleged victim(s); the policy does not reference mental health evaluation for known resident abusers. During the onsite audit, the auditor reviewed 20 resident files. None of the files identified a resident as an alleged sexual abuser. None of the investigative files the auditor reviewed involvled resident-on-resident sexual abuse. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.286	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Sexual Abuse Investigative file 2. FCCBCF Sexual Abuse Incident Review Report form Interviews: 1. Deputy Director (PREA Coordinator) 2. Agency head Findings: 115.286(a) The facility PAQ indicates that the facility conducts a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The PREA coordinator provided five investigative files for the auditor to review. Four allegations were from 2019; one from 2020. One of five allegations was a substantiated allegation, which was investigated as a criminal case. The auditor observed a completed Sexual Abuse Incident Review Report form as part of the investigative file. The document outlines the details of the allegation: • Nature of the allegation • How the allegation was reported • Victim information • Description of the incident • Victim care • Classification of the allegation • Reason for determination • Review Team • Identify if any staff actions or failures to act contributed to the abuse • Recommendations The facility director stated during his interview that all factors are taken into consideration, that the investigative process begins with the PREA investigator, who submits the initial report to him. The PREA coordinator stated that he prepares and reviews with the team investigative information, and documentation in order to ensure all facts were considered when determining the outcome, unless it is determined the Sheriff Department should be contacted to investigate the allegation as a criminal case. Based on the evidence provided, the facility meets this provision. 115.286(b)

	The facility PAQ indicates that such review shall ordinarily occur within 30 days of the conclusion of the investigation. The Incident Review form identifies the timeline of the allegation, from incident date, investigation start and end dates. The auditor reviewed the Incident Review form related to a sexual abuse allegation involving a staff person. The form indicates the investigation as 'ongoing', as it was turned over to the Franklin County Sheriff Department. The PREA coordinator stated during his interview that he would convene the SART meeting, and prepare the incident review report. The auditor confirmed such, as the form lists the PREA coordinator as the person who completed the report. Based on the evidence provided, the facility meets this provision. 115.286(c) The facility PAQ indicates the review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The PREA coordinator provided PREA Form 1.1, which identifies the Incident Review team. The auditor verified the person listed as the investigator is listed on Form 1.1, as is the PREA coordinator as part of the Incident Review team. Based on the evidence provided, the facility meets this provision. 115.286(d) The facility PAQ indicates that the review team shall: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA Coordinator. The PREA coordinator is listed as part of the SART. The PREA coordinator stated during his interview that recommendations are discussed, and a final decision is made. This is due to the PREA coordinator, and agency head being SART participants. The PREA coordinator stated during his interview that he brings all the facts of a case to the meeting. The Agency Head stated during her interview that she and her leadership work together as a team, although she has the final authority to implement anything that would be decided. The auditor reviewed five investigation files from 2019 and 2020. Based on the evidence provided, the facility meets this provision. 115.286(e) The facility PAQ indicates that the facility shall implement the recommendations for improvement, or shall document its reasons for not doing so. The Incident Review

	form was provided as supportive documentation. The auditor identified that the form includes committee findings, and any recommendations for improvement. The Sexual Abuse Review is submitted to the Executive Director. The PREA Coordinator implements the recommendations outlined on the Sexual Abuse Incident Review form for improvement or documents reasons for not doing so. Based on the evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.287	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Dept. of Justice Form SSV-3 2. PREA Investigation Packet Interviews: None Findings: 115.287(a) The facility PAQ indicates the agency collects accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions. The facility provided policy SUP12 as supportive documentation. The policy states in Section VII.: ***A. The CBCF collects data for every allegation of sexual abuse using a standardized instrument and set of definitions. The data is aggregated and includes information necessary to complete the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. Upon request, the CBCF provides the data from the previous year to the Department of Justice by June 30th of every year (PREA 115.287).*** The PREA coordinator provided DOJ Form SSV-3 as supportive documentation. Also provided is a letter from the US Department of Justice, dated 7/15/2016, requesting FCCBCF to complete, and submit the form for Census purposes. The PREA coordinator stated the facility has not be selected to submit the form since 2016. Based on the evidence provided, the facility meets this provision. 115.287(b) The facility PAQ indicates the agency shall aggregate the incident-based sexual abuse data at least annually. The PREA coordinator provided the 2019 Annual Report as supportive documentation. The report indicates there was one allegation in 2019. The auditor reviewed four allegations from 2019, which were provided by the facility PREA coordinator. Policy SUP12 states in Section VII: "***B. The CBCF prepares an annual report of its findings and corrective actions.***": Based on the evidence provided, the facility does not meet this provision.

115.287(c)
The facility PAQ indicates the incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The facility uploaded the agency's Outcome Measures report for 2019 as supportive documentation. The spreadsheet-style report captures data for each month related to PREA allegations, and outcomes. The columns total after the December month, to provide annual statistics. The auditor observed that the spreadsheet captures all information in the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The data indicates there were reported allegations of sexual abuse during the year 2019, which coincides with interview responses from the Agency Head, and PREA coordinator. Based on the evidence provided, the facility meets this provision.

115.287(d)
The facility PAQ indicates the agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The facility reported two allegations of resident-on-resident sexual harassment in 2019; two allegations of staff-on-resident sexual abuse; one allegation of staff-on-resident sexual harassment. The 2019 Outcome Measures Report data coincides with information reported via investigative files provided to the auditor. Based on the evidence provided, the facility meets this provision.

115.287(e)(f)
The facility PAQ indicates the agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. These provisions are not applicable, as the agency does not contract for the confinement of its residents. The auditor observed a letter from the US Department of Justice to the Agency Head. The letter, dated July 15, 2016, requests that FCCBCF submit data from the Survey of Sexual Violence, version SSV-3. The PREA coordinator stated the facility has not been contacted by the US Department of Justice since 2016. Based on evidence provided, the facility meets this provision.

Based on evidence provided, the facility does not meet this standard.

Corrective Action:
1. Ensure annual report data coincides with investigative files.

FACILITY RESPONSE:

The facility has corrected the 2019 PREA Annual report, which coincides with actual investigations. The corrected annual report was provided to the auditor as supportive documentation. Based on the evidence provided, the facility is now in compliance with this standard.

Review:

Annual PREA report

115.288	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. Agency website 3. 2019 Annual Report on Sexual Abuse Data FY19 4. 2020 PREA Audit Documents Interviews: 1. Agency Head 2. PREA coordinator Findings: 115.288(a) The PAQ indicates that the agency shall review data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: (1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. The facility provided the 2019 Annual Report on Sexual Harassment and Sexual Abuse as supportive documentation. The report contains aggregate data on the number of PREA allegations, and findings. The report contains a summary of what the data reflects, and efforts going forward to ensure resident sexual safety. The facility provided, as evidence of efforts to identifying problem areas, and taking corrective action, five PREA allegations from 2019, and 2020. Two cases involved alleged inappropriate behavior by a resident toward resident; three cases involved allege inappropriate behavior by an employee toward a resident. One substantiated case involving an employee was referred to the Franklin County Sheriff Department for criminal investigation. The PREA coordinator indicated that institutional reference checks have been expanded to all previous employers. The auditor observed during the facility site review security cameras covering C-Hall (women) turned off (DVR still records), in order to prevent voyuerism by control room staff. The PREA coordinator stated it resulted from complaints received from female residents of being 'watched' by male staff in the control room. Based on the evidence provided, the facility meets this provision. 115.288(b) The facility PAQ indicates that such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an

assessment of the agency's progress in addressing sexual abuse. Policy SUP12 was provided as supportive documentation. The policy states in Section VII.:

"***B. The CBCF prepares an annual report of its findings and corrective actions.***

1. Such report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the facility's progress in addressing sexual abuse."

The FCCBCF 2019 Annual Report on Sexual Abuse and Sexual Harassment was uploaded as supportive documentation. The report provides aggregate data of PREA allegations in 2019. The report concludes with a narrative of improvements, which support efforts to increase resident sexual safety at FCCBCF. The report does not compare 2019 with 2018 data; it does not state if there were allegations in 2018. Based on the evidence provided, the facility does not meet this provision.

115.288(c)
The facility PAQ indicates that the agency's report shall be approved by the agency head and made readily available to the public through its Web site or, if it does not have one, through other means. The facility provided policy SUP12 as supportive documentation. The policy states in Section VII., B.:

"***2. The report is approved by the Director and made readily available to the public through its website or other means (PREA 115.288)***"

The facility provided in the PAQ its web site as evidence of compliance: https://cbcf.franklincountyohio.gov/. The auditor reviewed the web site and identified the agency's annual report posted on the agency's PREA page, with other relevant information. Based on the evidence, the facility meets this provision.

115.288(d)
The facility PAQ indicates that the agency does not redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. The facility provided policy SUP12 as supportive documentation. The policy does not state that Personal Identifying Information (PII) will be redacted from published reports involving PREA allegations. The auditor observed the facility's 2019 Annual Report on Sexual Abuse and Sexual Harassment. The auditor observed that the format of the report does not contain PII, but is an aggregated data report of PREA allegations and outcomes. Based on the evidence provided, the facility, by default, meets this provision.

Based on the evidence provided, the facility does not meet this standard.

Corrective Action:
1. Include in the Annual Report of Sexual Abuse and Sexual Harassment comparative data of the current, versus previous year. If, in either year, there were no allegations of sexual abuse, or sexual harassment, the report, at minimum

	should articulate that such is the case. ***FACILITY RESPONSE:*** The facility corrected the 2019 PREA Annual report, and adjusted data comparison with prior years. The corrected 2019 Annual report, and data comparison with prior years, was provided to the auditor as supportive documentation. Based on evidence provided, the facility is now in compliance with this standard. **Review:** 2019 PREA Annual Report (Corrected)

115.289	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. FCCBCF Policy SUP12: Admission 2. FCCBCF website: https://cbcf.franklincountyohio.gov/ Interviews: 1. PREA coordinator Findings: 115.289(a), (b), (c) The PAQ indicates that the agency shall ensure that data collected pursuant to § 115.287 are securely retained. The facility provided policy SUP12 as supportive documentation. The PREA coordinator corroborated that he collects and maintains sexual abuse data and creates the annual report; keeping the data secured in "under lock and key" in his office. He articulated that he creates the annual report, and, should there be reported allegations of sexual abuse, would do so in a manner that did not include personal identifiers. The agency has no private facilities under its control but indicated in the PAQ that its aggregated sexual abuse data is made readily available on its website. The auditor verified that publication of agency data via the annual report, is currently available on the agency website.. The PREA auditor verified the link to the agency website is: https://cbcf.franklincountyohio.gov/. Based on evidence provided, the facility meets provisions a-c. 115.289(d) The facility PAQ indicates that the agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. FCCBCF policy SUP12, section VII. states: "***C. The CBCF maintains sexual abuse data collected for at least 10 years after the date of the initial collection (PREA 115.289).***" The facility reported five allegations of sexual abuse, or sexual harassment were received in the last 12 months. The auditor observed during the onsite audit, locked files in the PREA coordinator's office, containing allegations of resident investigative files.Therefore, the facility meets this provision. Corrective Action: The auditor recommends no corrective action.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Emails regarding Notice of PREA audit Interviews: 1. PREA coordinator Onsite facility review (not exclusive): 1. Administrative offices 2. Control room 3. Men's A, B, K Halls 4. Women's C Hall 5. Men's wing, including programming, upper and lower sleeping rooms 6. Women's wing, including programming, and sleeping dorms and rooms 7. Kitchen 8. Resident dining room 9. Intake/medical Unit 10. Resident inventory storage 11. Resident attire storage (shirts provided by FCCBCF) 12. Segregated housing units 13. Library/computer lab 14. Classrooms 15. Operational supervision offices 16. Case Facilitator offices (in assigned Halls) Findings: 115.401(a) The faciity PAQ indicates that during the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once. The agency website indicates PREA audits were conducted in 2015, and 2017. Based on the established three-year audit cycle, the facility would be audited in 2020. The current audit is the facility's third audit cycle. Based on the evidence provided, the facility meets this provision. 115.401(b) The facility PAQ indicates that during each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited. This PREA compliance audit is the third audit cycle for the facility. The FCCBCF operates one location, which was audited in 2015, and 2017. The current PREA compliance audit was conducted at the same facility as the 2015, and 2017 PREA audits. Based

on the evidence provided, the facility meets this provision.

115.401(h)
The facility PAQ indicates that the auditor shall have access to, and shall observe, all areas of the audited facilities. During the onsite audit, the PREA coordinator guided the auditor through all areas of the facility, including but not limited to:

- Administrative office
- Control room
- Men's Dayroom
- Women's Dayroom
- Men's wing, including programming, and sleeping dorms and rooms
- Women's wing, including programming, and sleeping dorms and rooms
- Kitchen
- Resisdent dining room
- Intake/medical Unit
- Resident inventory storage
- Resident attire storage (shirts provided by FCCBCF)
- Segregated housing units
- Library/Computer Lab
- Classrooms
- Operational supervision offices
- Case Facilitator offices (men's, and women's)

Based on the evidence provided, the facility meets this provision.

115.401(i)
The facility PAQ indicates that the auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information). The PREA coordinator was identified as the designee for uploading relevant documentation, and information in the PREA Online Audit System (OAS). Documentation was submitted during the pre-audit, and onsite audit phases. Based on the evidence provided, the facility meets this provision.

115.401(m)
The facility PAQ indicates that the auditor shall be permitted to conduct private interviews with residents. During the onsite audit, the PREA coordintor provided a space in the administrative office conference room as a work space. An unused office was provided for the auditor to conduct private interviews with male, and female residents. Male and female residents did not indicate any issue with the location of the interviews as it relates to their ability to speak freely, and openly. Based on the evidence provided, the facility meets this provision.

115.401(n)
The facility PAQ indicates that residents shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. During the pre-audit phase, the PREA coordinator submitted to the auditor photos of PREA audit notices (provided by the auditor)

	posted throughout the facility. The photos were submitted via email dated 1/18/ 2020. The notices were printed on brightly colored pink paper. Notices were posted in English, and Spanish, and provided contact information for sending confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. During the facility site review, the auditor observed PREA audit notices conspicuously posted in identified locations: • Facility main lobby • Staff Break room • Male and Female building entrances • Male and Female visitation areas • All Male and all Female Halls (A, B, K; C) • All Male and all Female restrooms • Dining room • Male and Female classrooms • Male and Female Intake areas • Medical wing • Male and Female dayrooms • Male, Female visitation areas The identified locations coincide with the PREA coordinator's email to the auditor, six weeks prior to the onsite audit. Based on evidence provided, the facility meets this provision. Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making the compliance determination: Documents: 1. Agency website, listed as: https://cbcf.franklincountyohio.gov/ Findings: 115.403(f) The agency has published on its website its most recent PREA Final Audit Report, dated 12/12/17. The auditor was able to access the report, posted under a live link on the agency's website PREA page, listed as "View Audit Report". Based on the evidence provided, the facility meets this standard. Corrective Action: No corrective action is recommended.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities, including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na

115.212 (c)	**Contracting with other entities for the confinement of residents**	
	If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	na

115.213 (c)	**Supervision and monitoring**	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)	yes
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents)	yes
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes

115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?	yes
115.215 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status?	yes
	If the resident’s genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.215 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes

115.216 (a)	Residents with disabilities and residents who are limited English proficient	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication	yes

	with residents with disabilities including residents who: Have intellectual disabilities?	
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.216 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?	yes

115.217 (a)	Hiring and promotion decisions	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes

115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.217 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes

115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.218 (a)	**Upgrades to facilities and technology**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes

115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes

115.221 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)	yes
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	yes
115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.222 (b)	Policies to ensure referrals of allegations for investigations	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes

115.231 (a)	Employee training	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes

115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.232 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes

115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency’s zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes

115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	no
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	no
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	no
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes

115.234 (b)	Specialized training: Investigations	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a).)	yes

115.235 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.235 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	yes
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes

115.241 (d)	Screening for risk of victimization and abusiveness	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?	yes

115.241 (e)	**Screening for risk of victimization and abusiveness**	
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?	yes
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?	yes
115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident's risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?	yes
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?	yes

115.241 (i)	**Screening for risk of victimization and abusiveness**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents?	yes
115.242 (a)	**Use of screening information**	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes

115.242 (c)	**Use of screening information**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems?	yes
115.242 (d)	**Use of screening information**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes

115.242 (f)	**Use of screening information**	
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes

115.251 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes

115.252 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	na
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	na
115.252 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
	Does the agency ensure that: such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
115.252 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	na
	If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension is 70 days per 115.252(d)(3)), does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	na
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	na

115.252 (e)	Exhaustion of administrative remedies	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident’s decision? (N/A if agency is exempt from this standard.)	na

115.252 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	na
	Does the initial response and final agency decision document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	Does the initial response document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
	Does the agency’s final decision document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	na

115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.253 (c)	**Resident access to outside confidential support services**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes

115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.261 (c)	**Staff and agency reporting duties**	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes

115.261 (e)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators?	yes
115.262 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.263 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.264 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.264 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.265 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes

115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	no
115.267 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes

115.267 (c)	Agency protection against retaliation	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency:4. Monitor resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes

115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.267 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.271 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/ facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
115.271 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?	yes
115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes

115.271 (d)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.271 (e)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.271 (g)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.271 (h)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes

115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct and form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.273 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes

115.273 (c)	Reporting to residents	
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident’s unit?	yes
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.273 (d)	**Reporting to residents**	
	Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes

115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.276 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes

115.277 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
115.278 (a)	**Disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?	yes
115.278 (b)	**Disciplinary sanctions for residents**	
	Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
115.278 (c)	**Disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior?	yes

115.278 (d)	**Disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits?	yes
115.278 (e)	**Disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.278 (f)	**Disciplinary sanctions for residents**	
	For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.278 (g)	**Disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.282 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes

115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.282 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes

115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	yes
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	yes
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility 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 practitioners?	yes

115.286 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.286 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes

115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.287 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.287 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.287 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na

115.288 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.288 (b)	**Data review for corrective action**	
	Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse?	yes
115.288 (c)	**Data review for corrective action**	
	Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.288 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes

115.289 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	na
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes

115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes