PREA Audit: PREA AUDITOR'S FINAL SUMMARY REPORT

Community Confinement Facilities

Name of facility:	**Community Assessment & Treatment Services, Inc. (CATS)**
Physical address:	**8411 Broadway Ave, Cleveland, OH 44105**
Date report submitted:	**February 28, 2015**
Auditor Information	
Name:	**Michelle Bonner**
Address:	**1629 K St NW, Suite 300, Washington, DC 20006**
Email:	michelle@michellebonner.com
Telephone number:	**202-489-7184**
Date of facility visit:	**July 29-30, 2014**
Facility Information	
Facility mailing address: (if different from above)	**same**
Telephone number:	**216-441-0200**
The facility is:	**Private, not for profit**
Facility Type	**Alcohol or Drug Rehabilitation Center/Halfway House**
Name of Facility Head:	**Roxanne Wallace**
Title:	**Executive Director**
Email address:	**rwallace@communityassessment.org**
Telephone number:	**216-441-0200**
Name of PREA Compliance Manager (if applicable)**: Nicholas Wieder (formerly Lou LaMarca)**	
Title:	**CQI Manager/PREA Coordinator**
Email address:	**nwieder@communityassessment.org**
Telephone number:	**216-441-0200**

Agency Information	
Name of Agency:	**Ohio Department of Rehabilitation and Correction**
Governing authority or parent agency: (if different from above)	
Telephone number:	
Agency Chief Executive Officer	
Name:	**Gary C. Mohr**
Title:	**Director**
Email address:	**Gary.Mohr@odrc.state.oh.us**
Telephone number:	**614-752-1164**
Agency-Wide PREA Coordinator	
Name:	**Dennis McHugh**
Title:	**Community Corrections PREA Liaison**
Email address:	Dennis.McHugh@odrc.state.oh.us
Telephone number:	

AUDIT FINDINGS

NARRATIVE: [The auditor should provide a summary of the audit process that includes the date of audit, who was in attendance, a description of sampling procedures and staff and residents interviewed, areas of facility toured as part of the audit, etc.]

Michelle Bonner, an independent contractor certified by the United States Department of Justice (DOJ) to conduct audits of community confinement facilities to assess their compliance with the DOJ-adopted standards of the Prison Rape Elimination Act of 2003 (PREA), conducted an onsite audit of the residential facility of the Community Assessment and Treatment Services, Inc. (hereinafter, "CATS"), 8411 Broadway Ave, Cleveland, OH, on July 29-30, 2014. During the audit, 135 residents were present at the facility, 50 of whom were women.[1] At that time the facility employed 63 staff members, 44 of whom had regular contact with

[1] Per resident census provided, "Client Information and Phase Movement Log", each for women and for men, both dated July 29, 2014.

residential clients.[2] (CATS also serves as many as 90 people in its outpatient programs.) The residential program is supervised by the Ohio Department of Rehabilitation and Correction (ODRC).

Auditor Bonner arrived at the facility at 8:40am and met with Lou LaMarca, CQI Director and PREA Coordinator, and Administrative Assistant Nick Wieder. After a brief introduction and explanation of the audit, as well as meeting Executive Director and Founder Roxanne Wallace, Auditor Bonner received a tour of the facility by PREA Coordinator, Administrative Assistant, and Facilities Manager Tom Hebebrand. First the group toured the programming area and women's wing for an hour. Then the group suspended the tour so that the Auditor could interview the Executive Director. During this time, Auditor also spoke with Assistant Director Dan Cratcha about the auditing process. Afterwards, the tour group continued to tour the rest of the facility, to include men's two dorm areas, kitchen and dining area, administration, attic, intake, and back to administration. During the tour, Auditor inspected all closets, restrooms, storage areas, and maintenance areas, in addition to residential, office, and programming areas. Tour was about three hours total.

In addition to the Executive Director and Assistant Director, Auditor Bonner interviewed the following staff one-on-one pursuant to specialized staff and general staff interview protocols:

- Two Resident Advocates
- Three Counselors
- Program Manager
- PREA Coordinator/CQI Director
- HR Director
- Clinical Director
- Intake Manager
- RA Supervisor
- Volunteer (Student Intern)

Auditor also spoke with other staff members during the tour of the facility, including the Kitchen Manager, other Resident Assistants, and Counselors.

Auditor Bonner also interviewed 12 residents, chosen by dorm area, sexual identity, age, work assignment, and mental illness. Of the 12, four women were interviewed. The residents were each interviewed in a private setting akin to a legal visit.

In addition to tour and interviews, the audit consisted of review of documents, including, but not limited to:

- Employee files – five new hires, three terminated employee files, two existing employee files, review accordion of background checks on all current employees;

[2] Per CATS Organizational Chart dated July 28, 2014, and reviewed with CQI Director/PREA Coordinator Lou LaMarca for staff who have contact with residents.

- Security logs containing information on rounds/head counts and shift information;
- PREA related documents, such as screening and reassessment forms, training logs, education acknowledgements, specialized training certificates;
- Documents related to PREA complaints and investigations.

Auditor Bonner spent 12.5 hours onsite during the first day; ten hours the next. Near the end of the second day, a closeout session was held during which Auditor reviewed some of her initial impressions. Then she continued to meet with the PREA Coordinator and conduct additional resident interviews prior to leaving.

DESCRIPTION OF FACILITY CHARACTERISTICS: [The auditor should include a summary describing the facility.]

CATS is located at 8411 Broadway Ave in southeast Cleveland, Ohio. While CATS started providing services in 1990, it moved male residential program and administrative offices to Broadway Ave in 2003. The female program started in 1995, but the female wing of the Broadway Ave facility was completed in 2010. Now CATS is building another addition to the facility that will contain an additional 60 beds which may be under ODRC supervision (and, therefore, under PREA). This newest addition is expected to be completed in September 2014 at the earliest (at time of final report, no report that new addition is open to residents under PREA); and it is not included in this PREA audit.

Starting with the north building (the addition completed in 2010), the main entrance is now located here, on the west side of the building. On the left there is an entrance to a group room used by outpatient clients and residents, which has no camera. Then there is the front desk, which is staffed from 7am to 3pm, and has a monitor to view cameras covering the entryways and front halls. Diagonally across from the front desk and opening to the lobby is the Residential Services Office, which is staffed during working hours and from 3pm to 11pm. There is camera coverage for this room, and a first responder flyer behind the staff chair. Also to the right of the front entrance is an area with restrooms and janitor closet, the entrances to these are covered by a camera. There are also two counselors' officers that have doors with windows and good chair placement (resident chairs visible from windows), with a sprinkler room and data room where no residents are allowed.

The hall behind the front desk is covered by a camera and contains a file archive room (no residents enter here), outpatient counselors' offices (all with windows to the hall), and staff mailboxes. Further down the hall are four female counselors' offices, with windows as well. There is a camera on the exit door near these offices. However, there is no camera on the doors of the two classrooms that are also behind the front desk, nor are there cameras within the classrooms. There are windows near the doors to these classrooms, but one cannot see the entire rooms from these windows.

There is a camera on the locked entrance to the Female Unit. To the right of the entrance is the dining room, which has frosted covering over windows, but two cameras inside the space. There is also a dry storage area where staff take food out, not residents; and it is kept locked. The female dorm itself consists of "cubes": spaces separated by half-walls, each with 2-4 beds with lockers in each. There are cameras in the dorms; and the policy is that women change only in restrooms. Also, male staff do not

view cameras of the Female Unit. The restroom contains four shower stalls, with colorful outer curtains and clear inner curtains beyond the changing area within each stall. Toilet stalls have doors. There were first responder and auditor visit notice in the restroom. Auditor instructed facility to replace this signage with PREA signage applicable to residents.

The resident advisor (RA) station is a room after the dining area and entrance to the dayroom. Residents are not allowed in the station area, which contains computer monitor for the cameras in the unit. There is a first-responder notice and a camera in this station area. Across from the station, there are pay phones with PREA phone information so that women may contact the facility, ODRC, ADAMHS (Alcohol, Drug Addiction and Mental Health Services), or Cleveland Rape Crisis Center, all free of charge. The TV room, or dayroom, is outside of the RA Station. There is no camera coverage in this room; and entire room cannot be seen from RA Station. Off of the dayroom is the female case manager's office and laundry room. There is no camera in the laundry room, which is out of sight of the RA Station and other offices. Given that staff does rounds, a mirror could assist in the laundry room.

Down the hall leading south from the new building to the old, there is camera coverage of the entrances to two group rooms on the right, a data room with offices on the right and the old lobby area. The administrative area begins at the end of this hall and continues down a perpendicular hall, also covered by a camera. At the end of the administration hall to the left are the admissions waiting room (which now has a camera post-audit), food storage, a counselor's office and a door to the attic that was unlocked at the time. Right down a small hall is the urinalysis restroom and an unused nurses' station; this hall now has camera coverage. Right again is the urinalysis processing room, which does have camera coverage, technical services office (where no residents are allowed) and the Facilities Manager's office at the end of the hall. There is also an intake room, which has not window, but the door remains open when in use. Auditor indicated that PREA signage should be added to the intake room.

The kitchen borders the men's area, with service line facing the large atrium that acts as the male dining area and group area. The service line area is covered by one of the three cameras in the atrium, and a camera covers the kitchen prep area. After the audit, the facility added a camera to cover the walk way to the long walk-in cooler. Off the atrium is a gym area with camera, and there is a recreation area/smoking yard covered by three cameras outside.

The men's Therapeutic Community (TC) Unit consists of the same "cubes" with half walls with beds and lockers in each. There are cameras on each end of the long dorm area, as well as a camera over the door down the hall as one enters the unit, and a camera covering side hall where counselors' officers are located. There is no camera for the unit's group room. The shower has five heads, but there are individual toilet stalls with doors. There is a resident advisor (RA) station at the end of the hall before entering the men's Residential Treatment Program (MRTP) hall of cubes. Between the two halls also is an open area with laundry machines and pay phones with PREA signage nearby. There are first responder, SANE information, and PREA signage on the RA Station glass. There is only one camera down the longer MRTP dorm hall; and there are cameras down the two short perpendicular halls that contain counselors' offices that have old doors with no windows, group rooms (which need cameras), and restrooms. After leaving the men's area, there is no camera down the hall leading to the walkway between buildings.

SUMMARY OF AUDIT FINDINGS: [The auditor should include a summary statement of the overall audit findings. E.g.: On March 1, 2013 X number of site visits were completed at facility XYZ in X County, Maryland. The results indicate....Facility X exceeded X of standards; met X of standards; X of standards were not met.]

The PREA Coordinator of CATS contacted Auditor Bonner in February 2014, soon after the first certifications for community confinement facility auditors were released, eager not only to start the audit process, but to gain knowledge on how to properly implement the PREA standards. Between then and the onsite audit July 29-30, the facility adopted PREA policies, trained staff, educated residents, and, as a result, made CATS a safer facility against sexual abuse and harassment. There were sexual abuse and sexual harassment incidents that occurred before and during this PREA policy development period, but the facility has shown progress in its response to these incidents. With additional training and continued vigilance, CATS can become a model of PREA implementation in a community confinement facility.

CATS' mission is "to provide high quality, cost effective, holistic, evidence-based interventions addressing the chemical dependency, mental health, and social justice needs of a diverse clientele;" and it has been doing so for nearly 25 years. Currently, CATS has about 150 residents, and it is about to expand to accept 60 more. Therefore, it is imperative that the facility becomes comfortable with the PREA standard before it increases its residential population. For example, a resident assistant reported that, while he goes through PREA when he goes through the handbook during orientation, he admitted that he does inform them of their right to report, but "I don't go too much farther than that because I don't want to scare anybody." Staff at all levels need to thoroughly understand and fully present PREA information to all residents in the facility.

Unlike many other community based correctional facilities, CATS has five staff persons designated as Special PREA Investigators, and they review cases as a team, with one being appointed the lead. The team approach is attractive in that there are potentially different staff with different roles providing different perspectives to one case. However, CATS have many staff who have worked in this treatment environment for many years, whose approach is seemingly client centered, but such approach has had the potential of derailing PREA investigations. For example, a staff-on-resident sexual abuse incident occurred in November 2013, and the staff (who are now Special PREA Investigators) "offered police involvement, but the client declined." The facility has since reported the incident to police, but the alleged perpetrator was rumored to be working at another correctional facility at the time of the onsite audit.

Since the Nov. 7, 2013 incident, the facility has reported two other sexual abuse (resident-on-resident) incidents to the police; but they still let the resident decide whether to get the police involved before contacting law enforcement. With more time and training, the staff will more fully understand their reporting duties under PREA so that sexual abuse can be eradicated in its facility.

During the onsite audit, the Auditor reviewed a written report made in May 2014 from staff member that a resident verbally reported repeated sexual harassment from another resident by being called "faggot" and taunted for his sexual identity. The report

was determined by the facility to be a hate crime, and was not considered sexual harassment at that time. The Auditor did explain to the PREA Coordinator the importance of recognizing and investigating such reports as sexual harassment and to respond to reports of sexual harassment in the facility, not just to reports of sexual abuse. Since the audit, staff and the incident review team have received additional PREA training, including training on sexual abuse and harassment, reporting requirements, and special investigator training.

During the week before the onsite audit, facility received an anonymous complaint of sexual abuse by staff member. The anonymous resident reported to a volunteer who did not share with resident the limits of confidentiality. Facility did conduct an administrative investigation and reported the complaint to the police. However, the experience revealed that the facility needed to modify its training information for volunteers and its information provided to residents regarding limits of confidentiality when they report incidents of sexual abuse or sexual harassment.

In this modern era, video monitoring has become an essential tool in helping to prevent and detect sexual abuse and sexual harassment. Post-audit the facility obtained additional cameras for areas the Auditor prioritized based on the location of the November 2013 staff-on-resident sexual abuse and areas interviewed staff agreed were hard-to-monitor areas. Additional cameras are recommended in group rooms, at least one other uncovered hall, in female wing's TV room and at the far end of the MRTP dorm, per Auditor and monitoring staff suggestions. The Description of Facility, above, makes mention of such areas in more detail for consideration.

The facility took quick corrective action on many items during the onsite visit, such as making sure the phone numbers to outside services were free to call, improving PREA signage, clearing windows for better sight lines, and locking the attic door. In the months after the onsite audit, CATS continued to make improvements in its training and implementation of PREA to better ensure the sexual safety of its residents.

Number of standards exceeded:	**0**
Number of standards met:	**38**
Number of standards not met:	**0**
Number of standards N/A:	**1**

FOLLOWING INFORMATION TO BE POPULATED AUTOMATICALLY FROM AUDITOR COMPLIANCE TOOL:

PREVENTION PLANNING	
Overall Determination:	**§115.211 -- Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract.
The facility has a written policy outlining how it will implement the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.
The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment.
The policy includes sanctions for those found to have participated in prohibited behaviors.
The policy includes a description of facility strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.
(b) The facility employs or designates an upper--level, facility--wide PREA coordinator.
The PREA coordinator has sufficient time and authority to develop, implement, and oversee facility efforts to comply with the PREA standards in all of its community confinement facilities.
The position of the PREA coordinator in the facility's organizational structure: Manager of CQI, reports PREA issues directly to the Chief Operating Officer and Clinical Director (former PREA Coordinator and Manager of CQI). The Executive Director allows her executive staff to control the daily operations of the facility and will soon retire from this position.

Overall Determination:	**§115.212 -- Contracting with other entities for the confinement of residents.**
	Exceeds Standard (substantially exceeds requirement of standard)
N/A	**Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)
	Does Not Meet Standard (requires corrective action)
	Auditor Comments (including corrective actions needed if does not meet standard):

Overall Determination:	**§115.213 -- Supervision and monitoring.**
	Exceeds Standard (substantially exceeds requirement of standard)
✔	**Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)
	Does Not Meet Standard (requires corrective action)
	Auditor Comments (including corrective actions needed if does not meet standard): Auditor reviewed staffing plan, camera location documents, conducted site tour, interviewed staff, and received additional documents pertaining to the purchase of additional cameras per Auditor's suggestions for increased safety.

(a) The facility develops and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring to protect residents against sexual abuse. Since the audit, the facility has added additional cameras in the kitchen, in the urinalysis bathroom hallway, and the admissions waiting area to increase protection of residents from sexual abuse and sexual harassment, based in part on reported incident of staff-on-resident sexual abuse in the kitchen in 2013. The staffing plan was predicated on 143 residents, but has, on average, 136 residents.
(b) The facility reports no deviations from the staffing plan.

Overall Determination:	**§115.215 - Limits to cross--gender viewing and searches.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Auditor reviewed facility policies, interviewed resident supervisory staff, and reviewed staff logs for verification of the information below.

(a)The facility does not conduct cross--gender strip or cross--gender visual body cavity searches of residents.
(b) The facility does not permit cross--gender pat--down searches of female residents. Male staff are instructed to call for female staff to conduct pat-down searches of female residents.
(c) The facility does not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision.
(d) Facility has implemented policies and 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 (this includes viewing via video camera). Male staff do not view cameras in the female unit.
Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit.
(e) Facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.
(f) All security staff have received training on conducting cross--gender pat--down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

Overall Determination:	**§115.216 - Residents with disabilities and residents who are limited English proficient**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Auditor reviewed policies and other documentation, conducted site tour, and interviewed staff to ascertain information below.

(a) The facility has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The staff have been instructed in training to contact the Cleveland Sight Center or the Cleveland Hearing and Sound Center. Also, staff are instructed to show the NIC video on PREA for those who have difficulty reading.

(b) The facility has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has a memorandum of understanding (MOU) with H-I Translating & Interpreting. MOU states "client is responsible for payment of any services not negotiated and approved in advance" by the facility and H-I. Would a resident have to pay if needed PREA emergency translation services, arguably needed without time for pre-approval? During site visit, PREA coordinator assured Auditor that resident would not have to pay for such services to report PREA incident or concern.

(c) Facility 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--response duties under § 115.264, or the investigation of the resident's allegations.

Overall Determination:	**§115.217 - Hiring and promotion decisions.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Auditor reviewed pre-audit documents, and, onsite, interviewed facility's HR director and reviewed background checks of current employee, new hire files, random current employee files, and files of those terminated in the past year. In this review Auditor found two incidents of PREA related activity, for which both employees were terminated: one staff-on-resident sexual abuse and one staff inappropriate interaction with a resident (staff and resident meeting in attic storage area).

(a) Facility policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting 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);
- 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
- Has been civilly or administratively adjudicated to have engaged in the activity described above.

(b) Facility policy requires the consideration of 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 residents.

(c) Facility policy requires that before it hires any new employees who may have contact with residents, it

- conducts criminal background record checks, and
- consistent with federal, state, and local law, makes 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.

(d) Facility policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. At the time of the audit, no contractors had contact with residents.

(e) Facility policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents.

(f) The facility 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 for hiring or promotions. While there is no written indication that the facility imposes upon employees a continuing affirmative duty to disclose any such misconduct, HR director gave example of dismissal of employee who failed to disclose non-PREA misconduct between annual reviews and indicated that the same would happen for PREA-related misconduct.
(g) Facility policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.
(h) Unless prohibited by law, the facility shall 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.

Overall Determination:	**§115.218 - Upgrades to facilities and technology.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Since onsite audit, facility has installed at least three additional cameras per Auditor's recommendations.

(a) The facility is in the process of a substantial expansion or modification to existing facilities since August 20, 2012. However this expansion, to include 60 additional beds, will not be completed in time to be part of this year's PREA audit.
(b) The facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. Specifically, since the onsite audit July 29-30, 2014, the facility has installed additional cameras in the kitchen area, in the urinalysis bathroom hallway, and in the admissions waiting room area.

RESPONSIVE PLANNING	
Overall Determination:	**§115.221 - Evidence protocol and forensic medical examinations**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Policies reviewed during document review reflect standard. During onsite audit, Auditor instructed the facility to report all sexual abuse that may be even suspected to be criminal in nature to the Cleveland Police Department. The facility did not do so in November 2013, but by June 2014, the facility was reporting such information to the police.

(a) The facility is responsible for conducting administrative sexual abuse investigations (including resident--on--resident sexual abuse and staff sexual misconduct).
Cleveland Police Department is responsible for criminal investigations.
(b) When conducting a sexual abuse investigation, the facility investigators have been trained to follow a uniform evidence protocol. The protocol was adapted from or otherwise based on the most recent edition of the DOJ'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.
(c) The facility offers to all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs).
When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations.
The facility documents efforts to provide SANEs or SAFEs.
(d) The facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means. These efforts are documented. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community--based organization or a qualified facility staff member. The facility has an MOU with the Cleveland Rape Crisis Center to provide victim advocate services.
(e) If requested by the victim, a victim advocate, qualified facility staff member, or qualified community--based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and

provides emotional support, crisis intervention, information, and referrals.

Overall Determination:	**§115.222 - Policies to ensure referrals of allegations for investigations.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Corrective action was required during the 180 days for this standard. While the facility did report allegations of sexual abuse to the police in June and July of 2014, it did not report an incident in Nov. 2013 because the inmate victim declined police involvement. The incident has since been reported to the police and staff have been retrained by ODRC regarding reporting duties.

(a) The facility ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident--on--resident sexual abuse and staff sexual misconduct).
(b) The facility 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, unless the allegation does not involve potentially criminal behavior. Facility policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the facility website or made publicly available via other means.
The facility documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.
(c) Cleveland Police Department is responsible for conducting criminal investigations; and such publication describes the responsibilities of both the facility and the investigating entity.

TRAINING AND EDUCATION	
Overall Determination:	**§115.231 - Employee training.** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Facility had two instances where it clearly showed it did not understand its reporting duties with regards to sexual abuse and sexual harassment: (1) when it did not understand the limits of confidentiality when resident reports allegation of sexual harassment, and (2) when it did not understand that it was to report a criminal sexual assault allegation to police after collecting evidence (statements) from victim and witnesses in support of the allegation. Corrective action included additional training for the PREA Coordinator and entire staff, which was implemented on Nov. 20. 2014. Auditor also instructed facility to provide staff refresher information on PREA standards.

(a) The facility trains all employees who may have contact with residents on the following matters.

(1) Its zero--tolerance policy for sexual abuse and sexual harassment;

(2) How to fulfill their responsibilities under facility sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;

(3) Residents' rights to be free from sexual abuse and sexual harassment;

(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;

(5) The dynamics of sexual abuse and sexual harassment in confinement;

(6) The common reactions of sexual abuse and sexual harassment victims;

(7) How to detect and respond to signs of threatened and actual sexual abuse;

(8) How to avoid inappropriate relationships with residents;

(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and

(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

(b) Training is tailored to the gender of the residents at the facility. Employees who are reassigned from facilities housing the

opposite gender are given additional training.
(c) All staff employed by the facility, who may have contact with residents, were trained or retrained in PREA requirements.
Between trainings, the facility provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment. "Any policy changes would be presented at all-staff meeting" does not constitute refresher information about current PREA policies. That would be only new information. Auditor instructed facility to incorporate opportunities to provide refresher information to staff throughout the year.
The frequency with which employees who may have contact with residents receive refresher training on PREA requirements is one PREA training per year.
(d) The facility documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

Overall Determination:	**§115.232 - Volunteer and contractor training**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Auditor reviewed documents and interviewed volunteers during onsite audit. Audit was satisfied that volunteers received and understood PREA training they received. There was an incident in July 2014 about which a volunteer received a report that the alleged victim wished to remain anonymous. Volunteers were retrained on their limits on confidentiality.

(a) All volunteers and contractors who have contact with residents have been trained on their responsibilities under the facility's policies and procedures regarding sexual abuse/harassment prevention, detection, and response.
(b) The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents.
All volunteers and contractors who have contact with residents have been notified of the facility's zero--tolerance policy regarding

sexual abuse and sexual harassment and informed how to report such incidents.
(c) The facility maintains documentation confirming that volunteers/contractors understand the training they have received.

Overall Determination:	**§115.233 - Resident education.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): SUBSTANTIAL COMPLIANCE: Follow up with orientation staff to make sure they are adequately reviewing the PREA information contained in the handbook. A good way to make sure that all residents are getting the same review and information is to show the PREA inmate video to all residents during orientation.

(a) Residents receive information at time of intake about the 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, and regarding facility policies and procedures for responding to such incidents.
(b) The facility provides residents who are transferred from a different community confinement facility with refresher information referenced in 115.233(a).
(c) Resident PREA education is available in accessible formats for all residents including those who are: limited English proficient, deaf, visually impaired, otherwise disabled, or have limited reading ability.
(d) The facility maintains documentation of resident participation in PREA education sessions.
(e) The facility ensures that key information about the facility's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The PREA information is located on the back page of the resident handbook, visible to anyone who turns it over, without having to flip through it.

Overall Determination:	**§115.234 - Specialized training: Investigations.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): PREA Auditor instructed facility to arrange for ODRC and/or PREA Resource Center to provide more intensive training for the five staff members designated as special PREA investigators at the facility, especially regarding "criteria and evidence required to substantiate a case for administrative action or prosecutorial referral." Three of the five received this special training from ODRC 10/2/2014. The new PREA Coordinator (Manager of CQI) received such training in January 2015 from ODRC.

(a) Facility policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.
(b) Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.
(c) The facility maintains documentation showing that investigators have completed the required training.
The facility has five staff members who have completed the required training: PREA Coordinator, Clinical Director, Associate Director, RA Supervisor, and Administrative Assistant. All completed the NIC PREA Special Investigations online training. The five investigators meet as a team, though the PREA Coordinator will assign one investigator to take the lead on each investigation.

Overall Determination:	**§115.235 - Specialized training: Medical and mental health care.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): See below.

(a) The facility has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The Clinical Director insures that all LPCC's, LISW's, LPC's and LSW's employed at the facility complete the "Behavioral Health Care for Sexual Assault in a Confinement Setting" course through the National Institute of Corrections (NIC).
(b) The facility does not presently have any medical staff at this facility, therefore, none to conduct forensic exams.
(c) The facility maintains documentation in the form of training certificates showing that mental health practitioners have completed the required training.
(d) Mental health care practitioners also receive the training mandated for employees under § 115.231.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS	
Overall Determination:	**§115.241 - Screening for risk of victimization and abusiveness.** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Document review, onsite audit document review and interviews of staff and residents confirmed that the facility was in compliance with this standard.

(a) The facility has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.
(b) The policy requires that all residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.
(c) Risk assessment is conducted using an objective screening instrument.
(d) The intake screening considers, 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.

(e) The intake screening considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing residents for risk of being sexually abusive.

(f) The policy requires that the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening.

(g) The policy requires that a resident's risk level 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 victimization or abusiveness.

(h) The policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) questions regarding:

- Whether or not the resident has a mental, physical, or developmental disability;
- Whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming;
- Whether or not the resident has previously experienced sexual victimization; and
- The resident's own perception of vulnerability.

(i) The facility implements 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.

Overall Determination:	**§115.242 - Use of screening information.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): From document review, onsite tour, and interviews, Auditor learned that those residents deemed at risk of victimization are placed in beds nearer to the staff stations in the units.

(a) The facility uses information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.
(b) The facility makes individualized determinations about how to ensure the safety of each resident.
(c) The facility makes housing and program assignments for transgender or intersex residents in the facility on a case--by--case basis.
(d) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.
(e) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.
(f) The facility does not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such 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 such residents.

REPORTING	
Overall Determination:	**§115.251 - Resident reporting** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has established procedures allowing for multiple internal ways for residents to report privately to facility officials about:

- Sexual abuse or sexual harassment;
- Retaliation by other residents or staff for reporting sexual abuse and sexual harassment AND
- Staff neglect or violation of responsibilities that may have contributed to such incidents.

In addition to reporting to staff and PREA Coordinator, residents can report via a locked grievance box, via phone, or via third party.
(b) The facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility. Residents are able to report to ODRC, ADAMHS, or Cleveland Rape Crisis Center, toll free, by phone.
(c) The facility has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing,

anonymously, and from third parties.
Staff are required to document verbal reports immediately.
(d) The facility has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Staff can report privately and directly to the PREA Coordinator. Staff are informed of this procedure via staff training and dissemination of facility policy.

Overall Determination:	**§115.252 - Exhaustion of administrative remedies**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): SUBSTANTIAL COMPLIANCE: Modify policy to better reflect the standard to ensure that if an extension of decision making time is needed, that the resident is informed of that and for how long (see below).

(a) The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse.
(b) Facility policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred.
Facility policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse.
(c) Facility policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint.
Facility policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.
(d) Facility policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. Indeed, the facility policy considers all grievances regarding sexual abuse and/or harassment as "emergency" and shall provide an initial response within 48 hours, and shall issue a final facility decision within as soon as possible.
However, there is no indication that the facility always notifies the resident in writing when the facility files for an extension,

including notice of the date by which a decision will be made.
(e) Facility policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. Facility policy and procedure requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the facility documents the resident's decision to decline.
(f) The facility has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Facility policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Facility policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final facility decision be issued within five days.
(g) The facility has a written policy that limits its ability to discipline a-- resident for filing a grievance alleging sexual abuse to occasions where the facility demonstrates that the resident filed the grievance in bad faith.

Overall Determination:	**§115.253 - Resident access to outside confidential support services**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): In addition to documentation and interviews, Auditor learned that the facility provided access via hotline number to Cleveland Rape Crisis Center (in addition to the MOU). However, during the onsite audit, Auditor discovered that the call to the Center was not free and required resident code to connect. While there, the facility corrected this problem with the phone contractor to allow for free, untraced access.

(a) The facility provides 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) for Cleveland Rape Crisis Center and ADAMHS; and
- Enabling reasonable communication between residents and these organizations in as confidential a manner as possible.

(b) The facility informs residents, prior to giving them access to outside support services, of the extent to which such

communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. This information is contained in the PREA Information Sheet provided to residents at intake and posted throughout the facility.
(c) The facility maintains a memorandum of understanding (MOUs) with the Cleveland Rape Crisis Center, which is able to provide residents with emotional support services related to sexual abuse.

Overall Determination:	**§115.254 - Third party reporting.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Policy and posters onsite reflect this. Continue to ensure that residents receive and understand that third party reporting is an option.

The facility provides a method to receive third--party reports of resident sexual abuse or sexual harassment: third parties can email, call, or mail written report to facility's PREA Coordinator.
The facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents by posting the information on its website: http://www.communityassessment.org/PREA.html.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT		
Overall Determination:	**§115.261 - Staff and agency reporting duties**	
	✔	**Exceeds Standard** (substantially exceeds requirement of standard) **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action)
		Auditor Comments (including corrective actions needed if does not meet standard): Document review, onsite tour, and staff interviews confirm compliance with the below sections of the standard.

(a) The facility requires all staff to report immediately and according to facility policy:

- Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the facility.
- Any retaliation against residents or staff who reported such an incident.
- Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

(b) Apart from reporting to designated supervisors or officials and designated state or local service agencies, facility policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

(c) 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.

(d) If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the facility shall report the allegation to Cuyahoga County Protective Services under applicable mandatory reporting laws.

(e) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

Overall Determination:	**§115.262 - Agency protection duties.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): There were no reports under this standard, so there was no documentation. However, policies and interviews with staff indicate a clear understanding of the standard.

When the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). In the past 12 months, there have been no times the facility determined that a resident was subject to substantial risk of imminent sexual abuse.

Overall Determination:	**§115.263 - Reporting to other confinement facilities.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): In the past 12 months, there have been no allegations the facility received that a resident was abused while confined at another facility. Therefore, there was no documentation of implementation of the standard. Staff interviews indicate an understanding of the standard.

(a) The facility has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred.

In the past 12 months, there have been no allegations the facility received that a resident was abused while confined at another facility.
(b) Facility policy requires the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.
(c) The facility would documents that it has provided such notification within 72 hours of receiving the allegation.
(d) While indicated verbally, the facility policy does not explicitly require that allegations received from other facilities/agencies are investigated in accordance with the PREA standards.

Overall Determination:	**§115.264 - Staff first responder duties.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Staff did not follow first responder duties in the Nov. 7, 2013 staff-on-resident sexual assault. Since onsite audit, per PREA Auditor instruction, staff have been re-trained on the first responder duties and signed acknowledgement of such. Also, first responder duties were posted in staff areas during the onsite tour.

(a) The facility has a first responder policy for allegations of sexual abuse. The facility policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

(1) Separate the alleged victim and abuser;
(2) Preserve and protect 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, 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; and
(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, 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.

(b) Facility policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

- Request that the alleged victim not take any actions that could destroy physical evidence; and/or
- Notify security staff.

Overall Determination:	**§115.265 - Coordinated response.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Document review, onsite tour, and staff interviews confirm compliance with the standard since the time of the audit.

The facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

Overall Determination:	**§115.266 - Preservation of ability to protect residents from contact with abusers.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard):

The facility has NOT entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012.

Overall Determination:	**§115.267 - Agency protection against retaliation.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has 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.
The facility designates staff member(s) or charges department(s) with monitoring for possible retaliation:

- Nicholas Wieder, PREA Coordinator/CQI Director,
- Lou LaMarca, Clinical Director, or
- Veronica Bridgeman, RA Supervisor.

(b) The facility 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.
(c) The facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff for 90 days at a minimum. The facility acts promptly to remedy any such retaliation. The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need.
The facility reports no incidents of retaliation having occurred in the past 12 months.
(d) In the case of residents, such monitoring shall also include periodic status checks.
(e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.
(f) An facility's obligation to monitor shall terminate if the facility determines that the allegation is unfounded.

INVESTIGATIONS	
Overall Determination:	**§115.271 - Criminal and administrative agency investigations.** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): See corrective action stated in 115.234 re additional training for investigators and PREA coordinator. Also, per 115.271(l), below, facility was instructed to report Nov. 7, 2013 report of staff-on-resident abuse to the police and to forward Auditor any information and updates from the police on the Nov. 7, 2013 incident investigation as they come in.

(a) When the facility conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. The facility has a policy related to criminal and administrative facility investigations.
(b) Where sexual abuse is alleged, the facility shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234.
(c) 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.
(d) When the quality of evidence appears to support criminal prosecution, the facility shall conduct compelled interviews only after consulting with Cleveland Police Department as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.
(e) 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.
(f) 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.

(g) 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.
(h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.
(i) The facility 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 facility, plus five years.
(j) The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation.
(k) N/A
(l) 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.

Overall Determination:	**§115.272 - Evidentiary standards for administrative investigations.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): See corrective action stated in 115.234 re additional training for investigators and PREA coordinator.

Three staff members received additional special investigator training from ODRC. The facility will impose a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

Overall Determination:	**§115.273 - Reporting to residents.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): In the past 12 months, two notifications to residents that were provided pursuant to this standard and they were documented.

(a) The facility has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in the facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the facility.
(b) If an outside entity conducts such investigations, the facility requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation.
(c) Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever:

- The staff member is no longer posted within the resident's unit;
- The staff member is no longer employed at the facility;
- The facility learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
- The facility learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

(d) Following a resident's allegation that he or she has been sexually abused by another resident in the facility, the facility subsequently informs the alleged victim whenever:

- The facility learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or
- The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

(e) The facility has a policy that all notifications to residents described under this standard are documented. In the past 12 months: two notifications to residents that were provided pursuant to this standard and they were documented.
(f) A facility's obligation to report under this standard shall terminate if the resident is released from the facility's custody.

DISCIPLINE	
Overall Determination:	**§115.276 - Disciplinary sanctions for staff.** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): In the past 12 months, one staff from the facility has been terminated for violating facility sexual abuse or sexual harassment policies. This termination was later reported to the police after the onsite audit.

(a) Staff is subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies.
(b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.
In the past 12 months, one staff from the facility has been terminated for violating facility sexual abuse or sexual harassment policies.
(c) Disciplinary sanctions for violations of facility policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are 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.
(d) Three staff received additional specialized investigator training from ODRC on 10/2/14; and new PREA Coordinator received specialized training from ODRC (From The Moss Group Curriculum) in January 2015. Going forward, all terminations for violations of facility sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, will be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.
In the past 12 months, one staff from the facility has been reported to law enforcement following their termination for violating facility sexual abuse or sexual harassment policies.

Overall Determination:	**§115.277 - Corrective action for contractors and volunteers.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): Document review, onsite tour, and interviews with volunteers and staff confirm compliance with the standard.

(a) Facility policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.
Facility policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents.
(b) The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of facility sexual abuse or sexual harassment policies by a contractor or volunteer.

Overall Determination:	**§115.278 - Disciplinary sanctions for residents.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard):

(a) Residents are subject to disciplinary sanctions only 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-on-resident sexual abuse.
In the past 12 months, there has been one administrative finding of resident--on--resident sexual abuse that has occurred off-site, but while both were residents of the facility.
(b) Sanctions are not 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. Clients are terminated upon substantiation of perpetrating sexual abuse or engaging in voluntary, consensual sexual activity.
(c) The disciplinary process does not 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. The facility does not accept clients whose cognitive abilities impair their ability to understand and comply with prohibited sexual activity.
(d) The facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. Clients are terminated upon substantiation of perpetrating sexual abuse.
(e) The facility disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.
(f) The facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.
(g) The facility prohibits all sexual activity between residents and disciplines residents for such activity. The facility deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

MEDICAL AND MENTAL CARE	
Overall Determination:	**§115.282 -- Access to emergency medical and mental health services.** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard):

(a) Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided the appropriate response by non--health staff in the event health staff are not present at the time the incident is reported and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

(b) 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.
(c) Resident victims of sexual abuse while incarcerated are 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.
(d) Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Overall Determination:	**§115.283 -- Ongoing medical and mental health care for sexual abuse victims and abusers.** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): In addition to document review, onsite tour and interviews has shown that clinical staff is dedicated to ongoing mental health care/counseling services for residents.

(a) The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents regardless whether they have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The medical evaluation and treatment recommendations shall occur as a physical for each resident. Offers of treatment are recommended as treatment recommendations in this evaluation. The mental health evaluation and treatment recommendations shall occur as part of a larger, bio-social, diagnostic assessment. Offers of treatment are recorded as treatment recommendations in this evaluation.
(b) 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. 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 shall be documented in aftercare plans.
(c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.
(d) Female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests.

(e) If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy--related medical services.
(f) Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.
(g) Treatment services are 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.
(h) The facility does not attempt to conduct a mental health evaluation of all known resident--on--resident abusers, and does not offer treatment. Clients are terminated upon substantiation of perpetrating sexual abuse.

DATA COLLECTION AND REVIEW	
Overall Determination:	**§115.286 - Sexual abuse incident reviews.** **Exceeds Standard** (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): In addition to document review and onsite tour, interviews with members of the incident review team confirm that they do understand their role and this standard.

(a) The facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded.
(b) The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.
(c) The sexual abuse incident review team includes upper--level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.
(d) The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)--(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator.
(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;
(e) The facility implements the recommendations for improvement or documents its reasons for not doing so.

Overall Determination:	**§115.287 - Data collection.**
	Exceeds Standard (substantially exceeds requirement of standard)
	✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)
	Does Not Meet Standard (requires corrective action)
	Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility will collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.
(b) The facility will aggregate the incident--based sexual abuse data at least annually.
(c) The standardized instrument will 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.
(d) The facility will maintain, review, and collect data as needed from all available incident--based documents, including reports, investigation files, and sexual abuse incident reviews.
(e) N/A
(f) The facility will provide the Department of Justice with data from the previous calendar year upon request.

Overall Determination:	**§115.288 - Data review for corrective action.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard): 2014 annual report published, and states corrective action for 2013 staff-on-resident sexual assault incident in kitchen that is not in the 2014 report.

(a) The facility reviews 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, and training, including:

- Identifying problem areas;
- Taking corrective action on an ongoing basis; and
- Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the facility as a whole.

(b) The annual report includes a comparison of the current year's data and corrective actions with those from prior years.
The annual report provides an assessment of the facility's progress in addressing sexual abuse.
(c) The facility makes its annual report readily available to the public at least annually through its website.
The annual reports are approved by the facility head.
(d) When the facility redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility.
The facility indicates the nature of material redacted.

Overall Determination:	**§115.289 - Data storage, publication, and destruction.**
	Exceeds Standard (substantially exceeds requirement of standard) ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) **Does Not Meet Standard** (requires corrective action) Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility ensures that incident--based and aggregate data are securely retained.
(b) N/A – facility does not contract with other facilities.
(c) Before making aggregated sexual abuse data publicly available, the facility removes all personal identifiers.
(d) The facility maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise.

AUDITOR CERTIFICATION: The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the facility under review.	
AUDITOR SIGNATURE	/s/ Michelle Bonner
DATE	February 28, 2015