PREA Facility Audit Report: Final

Name of Facility: Woodward Academy
Facility Type: Juvenile
Date Interim Report Submitted: 04/02/2025
Date Final Report Submitted: 07/30/2025

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: Latera M. Davis	**Date of Signature:** 07/30/2025

AUDITOR INFORMATION	
Auditor name:	Davis, Latera
Email:	laterad@yahoo.com
Start Date of On-Site Audit:	02/27/2025
End Date of On-Site Audit:	02/28/2025

FACILITY INFORMATION	
Facility name:	Woodward Academy
Facility physical address:	1251 334th Street , Woodward, Iowa - 50276
Facility mailing address:	

Primary Contact

Name:	Joel Porter
Email Address:	Joel.Porter@wwacademy.com
Telephone Number:	515-438-3538

Superintendent/Director/Administrator	
Name:	Shawn Hollenkamp
Email Address:	Shawn.Hollenkamp@wwacademy.com
Telephone Number:	515-438-3481

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

Facility Health Service Administrator On-Site	
Name:	Heather Hanson
Email Address:	Heather.Hanson@wwacademy.com
Telephone Number:	515-438-3693

Facility Characteristics	
Designed facility capacity:	168
Current population of facility:	121
Average daily population for the past 12 months:	117
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Mens/boys

In the past 12 months, which population(s) has the facility held? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For definitions of "intersex" and "transgender," please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	12-17
Facility security levels/resident custody levels:	Unlocked facility
Number of staff currently employed at the facility who may have contact with residents:	212
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	4
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Vivant Behavioral Healthcare, LLC
Governing authority or parent agency (if applicable):	
Physical Address:	2517 North Great Western Drive , Suite P, Prescott Valley, Arizona - 86314
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	

Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Joel Porter	**Email Address:**	Joel.Porter@wwacademy.com

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

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:	
43	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

Please note: Question numbers may not appear sequentially as some questions are omitted from the report and used solely for internal reporting purposes.

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2025-02-27
2. End date of the onsite portion of the audit:	2025-02-28

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Iowa Casa-email no response JDI-email received response

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	169
15. Average daily population for the past 12 months:	117
16. Number of inmate/resident/detainee housing units:	4
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
23. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	116
25. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	6
27. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
28. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
29. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
30. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	4

31. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
32. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	2
33. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	26
34. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
35. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all residents in the facility. The facility houses male and inmates. The facility was able to utilize data from the risk assessment to identity any targeted populations.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
36. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	222
37. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0

38. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	4
39. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all staff by title and shift.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

40. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	25
41. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☑ Gender ☐ Other ☐ None

42. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. We use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list. This process helps us gather a diverse range of perspectives and ensures that no particular group is either favored or overlooked. Our goal is to obtain an accurate and comprehensive understanding of the environment and conditions from various residents' viewpoints.
43. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
44. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. Typically, we use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list. However, due to the limited number of residents at the facility that were onsite during the audit, the auditor selected all those available while onsite.
Targeted Inmate/Resident/Detainee Interviews	
45. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	14

As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".

47. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Through documentation review and facility report, there were no identified residents in the targeted area.
48. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	6

49. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Through documentation review and facility report, there were no identified residents in the targeted area.
50. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Through documentation review and facility report, there were no identified residents in the targeted area.

51. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Through documentation review and facility report, there were no identified residents in the targeted area.3
52. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	3
53. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Through documentation review and facility report, there were no identified residents in the targeted area.
54. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	2
55. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	3
56. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Through documentation review and facility report, there were no identified residents in the targeted area. The facility does not utilize isolation.

57. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
58. Enter the total number of RANDOM STAFF who were interviewed:	13

59. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
60. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
61. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	No text provided.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
62. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	24
63. Were you able to interview the Agency Head?	◉ Yes ○ No
64. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No

65. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
66. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

67. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☒ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☒ Medical staff ☒ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☒ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☒ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff

	☐ Other
68. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
69. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of CONTRACTORS who were interviewed:	2
b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ☑ Medical/dental ☐ Food service ☐ Maintenance/construction ☑ Other
70. Provide any additional comments regarding selecting or interviewing specialized staff.	No text provided.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

71. Did you have access to all areas of the facility?	(●) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
72. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
73. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
74. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
75. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

76. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	During the site review, comprehensive access was granted to all areas of the facility, allowing for a thorough examination of the environment and operations. Key observations included the following: Facility Access: Unrestricted access to various sections of the facility was provided, facilitating a detailed assessment of living conditions, security measures, and common areas. Operational Observations: Several critical functions were tested and observed, including emergency response protocols, security checks, and daily operational routines. These tests demonstrated the facility's preparedness and adherence to established standards. Interactions and Informal Conversations: Informal conversations with staff, residents, and detainees provided additional insights into the daily operations and the overall atmosphere of the facility. These interactions were valuable in corroborating data obtained from documentation and formal interviews. General Observations: The site review highlighted both strengths and areas for improvement within the facility. Observations on cleanliness, maintenance, and the behavior of staff and residents contributed to a comprehensive understanding of the facility's current state.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

77. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No

78. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	During the audit process, I took several steps to ensure that the documentation reviewed was thorough and representative of the facility's operations: Oversampling Documentation: In certain instances, I oversampled documentation to gain a deeper understanding of specific areas. For example, I reviewed an increased number of training records and unannounced rounds to identify any recurring patterns or issues that might not be evident from a smaller sample size. Barriers to Selecting Additional Documentation: While the facility provided comprehensive access to most documents, there were some challenges encountered: Time Constraints: The limited time available for the audit sometimes posed a challenge in reviewing all the desired documentation in detail. Document Availability: In a few cases, some documents were not immediately available, however provided by the final audit report. Mitigation Strategies: To address these barriers, I implemented several strategies: Prioritization: I prioritized reviewing documents that were most critical to the audit's objectives and sought summaries or overviews where full documents were not accessible. Supplementary Interviews: When documentation was not fully available, I supplemented the review with additional interviews and discussions with staff and residents to fill in the gaps. Request for Additional Information: I requested additional information or clarifications as needed to ensure that the audit findings were accurate and comprehensive. These steps were taken to ensure a thorough and balanced review of the facility’s documentation, ultimately contributing to a more accurate assessment.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

79. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	2	0	2	0
Staff-on-inmate sexual abuse	1	0	1	0
Total	3	0	3	0

80. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	2	0	2	0
Staff-on-inmate sexual harassment	2	0	2	0
Total	4	0	4	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

81. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

82. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	2	0
Staff-on-inmate sexual abuse	0	0	1	0
Total	0	0	3	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

83. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

84. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	2	0	0
Staff-on-inmate sexual harassment	0	1	1	0
Total	0	3	1	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

85. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	3

86. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ◉ No ○ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
87. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	2
88. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
89. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
90. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
91. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

92. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
93. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	4
94. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	( ) Yes (●) No ( ) NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
95. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	2
96. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
97. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
98. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	2
99. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
100. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
101. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	All reported sexual abuse allegations were reviewed.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

102. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff	
103. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	(●) Yes ( ) No
a. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1
AUDITING ARRANGEMENTS AND COMPENSATION	
108. Who paid you to conduct this audit?	(●) The audited facility or its parent agency ( ) My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ( ) A third-party auditing entity (e.g., accreditation body, consulting firm) ( ) Other

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.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Policy: PREA Disciplinary Sanction for Residents (2023) d. Policy: PREA Disciplinary Sanctions for Staff (2023) e. Organizational Chart 2. Interviews: a. PREA Coordinator

	Findings (By Provision): 115.311 (a). An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. · Policy: PREA Zero Tolerance, is dedicated to addressing the agency policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The purpose of the policy to: To establish a process where the facility clients and employees have zero tolerance for sexual abuse and sexual harassment of clients. This policy is reflective of client on client abuse or harassment and staff on client abuse or harassment. The process will include prevention plans that have been communicated to all staff. Employee training will include PREA related definitions and procedures that should an allegation regarding sexual abuse or harassment be made, all employees will know immediate safety plans, attend to and support the victim(s) and promptly initiate the investigative process. This policy is in effect to prevent incidents of sexual abuse and/or sexual harassment and to take prompt, effective and compassionate action if allegations of sexual abuse or harassment are made (p. 1). · Furthermore pages 9-10, provides definitions of prohibited behaviors regarding sexual abuse and sexual harassment. · Policy: PREA Disciplinary Sanction for Residents and Policy: PREA Disciplinary Sanctions for Staff, provides guidance on sanctions for staff and residents for those how have found to have participated in prohibited behaviors. · Policy: PREA Zero Tolerance, includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents (pp. 1-4). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.311 (b). An agency shall employ or designate 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility employs an upper level, agency wide PREA coordinator, “Compliance Manager”. According to the agency organizational chart, the agency PREA coordinator reports to the Executive Director. It was further reported that the PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. · The agency/facility has PREA policies which ensure the sexual safety of facility residents and staff. The agency/facility PREA coordinator has direct access to the head of the agency and regular communication with the senior leadership team. · Agency Organization Chart Interviews: PREA Coordinator: The staff interviewed reported that they have time to manage their PREA-related responsibilities. It was reported that the entire job is dedicated to various components of compliance for the facility. Additionally, there is an assistant that provides additional support as needed to address PREA related responsibilities. The PREA Coordinator is only responsible for providing services to one site. As the PREA Coordinator, continuing education has occurred through meetings hosted by the PREA Resource Center and the PREA Coordinator group to ensure the facility stays compliant. If issues arise we will create a corrective action plan. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.311 (c): Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. Compliance Determination: · According to the PAQ, the agency does not have a PREA Compliance Manager. Interviews: N/A-There is no agency PREA Compliance Manager. Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.312	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.): a. Pre-Audit Questionnaire (PAQ) Findings (By Provision): 115.312 (a). A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The Pre-Audit Questionnaire (PAQ) indicated that the agency has not entered into or renewed contracts for the confinement of residents on or after August 20, 2012, or since the last PREA audit. However, upon further review, it has been determined that the site is contracted by multiple juvenile justice entities. The site does not have a subcontract for the confinement of residents. Corrective Action: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.312 (b). Any new contract or contract renewal shall provide for agency contract

	monitoring to ensure that the contractor is complying with the PREA standards. Compliance Determinations: The facility has demonstrated substantial compliance with this provision of the standard because: · The Pre-Audit Questionnaire (PAQ) indicated that the agency has not entered into or renewed contracts for the confinement of residents on or after August 20, 2012, or since the last PREA audit. However, upon further review, it has been determined that the site is contracted by multiple juvenile justice entities. The site does not have a subcontract for the confinement of residents. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.313	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.): a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2021) c. Policy: PREA Staffing Plan (2023) d. PREA Staffing Plan (2024 and 2025) e. Daily Population Report (12 Months) f. Unannounced Rounds (12 Months)

g. Layout (Dorm Floor Plans)

2. Interviews:

a. Superintendent (Facility Director)

b. PREA Coordinator

c. Intermediate or higher-level staff (2)

3. Site Review

Findings (By Provision):

115.313 (a). The agency shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard for the following reasons:

· The facility indicated in their responses to the Pre-Audit Questionnaire that the agency ensures that each facility it operates develops, implements, and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse.

· Since August 20, 2012, or the last PREA audit, whichever is later, the average daily number of residents: 116.

· Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicted: 116.

· Policy: PREA Staffing Plan provides guidance on the agency process for developing a staffing plan and managing staffing ratios.

· The documented annual staffing plan provides a staffing plan that ensures adequate levels of staffing (2024 Annual Staffing Plan). The plan was last reviewed in February 2025. The auditor reviewed the 2024 and the 2025 staffing plan.

· The facility provided a daily population report for the 1st, 10th, and 20th of the month for the last 12 months, showing the number of residents housed at the facility.

· The facility has cameras to supplement supervision of residents. They are positioned throughout the facility to help eliminate blind spots and to assist in monitoring residents.

· The auditor reviewed the layout of the housing units.

Site Review

· Staffing Patterns and Shifts:

o The auditor observed staffing patterns during all shifts. The facility operates on three shifts across all buildings: three school buildings and one administrative building which encompasses seven housing units. The site houses, programs, and provides educational services for each dormitory separately. Each dorm has the maximum capacity to house 24 residents.

o Day Shift:

§ During the day, the auditor observed appropriate staffing levels in the housing units, with a minimum of four to five staff members in direct care of approximately 15-20 residents at all times, supplemented by a rover. All staff members are trained uniformly and serve as direct care staff. Additionally, the auditor observed that staff were in direct supervision of youth during movement, while in the medical, education, and the mental health area.

§ Programming occurs within the housing units.

§ In the recreation yard, there was at least one staff member for every six residents. The auditor observed staff and youth participating in track training.

§ In the education setting, there was one direct care staff and one teacher for every six residents.

§ The site has one education building that is not operated by the facility and utilized as a community school where youth in the community who is in need of alternative education setting. The residents at the facility do not utilize the building.

o Evening Shift:

§ During the evening shift, residents were supervised on a 1:4 ratio. There were additional staff onsite that are not included in the ratio but in direct supervision of youth. Those staff consist of rovers and supervisors. Direct supervision and line-of-sight monitoring were maintained in each housing area.

o Night Shift:

§ The night shift encompassed sleeping hours. Residents were supervised consistently on all housing units on a 1:16 ration during the sleeping hours.

· Security Measures:

o The auditor observed multiple cameras in the housing units, mental health, and education areas. Cameras were strategically placed to cover all potential blind spots, including entrances, exits, and hallways near bathrooms. Cameras were located throughout all hallways to include the administrative parts of the building, as residents may be present in the building to access medical, intake, and the weight room.

o Residents occupy double or triple occupancy rooms. The room door is to remain

	open unless the resident seeks permission to close to change clothes in their room. Changing clothes typically occurs in the shower area. Through informal conversation with staff, it was reported that residents must ask permission to go into their rooms and into the bathroom area. On the units there is signage indicating expectations and that residents are not allowed in each other's rooms. o The dorms are designed in small H-shaped, facilitating constant monitoring by staff. The facility layout and camera system also allow leadership to remotely monitor the site. o The facility has a program for residents who have committed acts of sexually delinquent behavior. The residents in those units have additional security/motion detector alarms in between the beds. Any movement alerts staff. The auditor tested the process and determined that the movement sends an immediate message in the overheard speaker. o The dorm units have an alarm that sounds when there is movement exiting the dorm units. The facility is not hard-wired and does not have an exterior fence. The facility is located on the grounds of the State Health and Human Services. It is a residential community program. · Audit Observations and Resident Feedback: o No staffing concerns were identified during the onsite audit. The auditor engaged in informal conversations with on-site staff, who confirmed maintaining a 1:4 staff-to-resident ratio during the waking hours and 1:16 during the night hours. Residents reported feeling safe, consistently supervised, and never left unsupervised. Additionally, it should be noted that on two housing units there was one resident that was on the housing unit during day hours while the other residents were in education. The residents were supervised by a one-to-one ratio. Staff were placed in chairs outside of the room; in direct observation. The resident was in the room with the door open. o During informal conversation with the residents, the residents were very engaging and provided the auditor with an overview of the unit, how shower sessions are handled, how many staff are typically with them, the facility rules and how to make reports of sexual abuse or sexual harassment. Interviews: Director/PREA Compliance Manager: When assessing adequate staffing levels and the need for video monitoring we maintain an 8:1 ratio at all times. Cameras are present in most areas, with the exception of bathrooms and bedrooms. In those areas, procedures have been established to ensure safety. The following areas are assessed: o Generally accepted detention practices: Haven't had any. o Judicial Findings: Haven't had any.

	o Inadequacy from federal investigations: Haven't had any. o Inadequacy from internal or external oversight bodies: Haven't had any. o All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); o Composition of resident population: o The number and placement of supervisory staff: the agency staffing ratios are greater than PREA standards; o Institution programs; o Any applicable state or local laws, regulations, or standards: all are followed o The prevalence of substantiated and unsubstantiated incidents of sexual abuse: in the event of a substantiated sexual abuse incident, staffing levels would be increased. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.313 (b). The agency shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ the facility has not deviated from the staffing plan. The facility operates a staffing plan that meets the PREA ratio standards. The current staffing ratios for the facility are 1:4 during the waking hours and 1:16 during sleeping hours. Interviews: Director– There have been no instances where staffing ratios could not be met. There are additional supervisor level staff on all shifts to assist if needed. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.313 (c). Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 2:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: According to the PAQ, the facility exceeds staffing ratios by maintaining the staffing ratios of a minimum of 1:4 during resident waking hours and 2:16 during resident sleeping hours. As reported, the facility has not deviated from the staff ratios during waking or during resident sleeping hours. The current 2:8 and 2:16 ratios exceed the staffing requirements. In the past 12 months, the number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours: 0. In the past 12 months, the number of times the facility deviated from the staffing ratios of 1:16 during resident sleeping hours: 0. Interviews: Director: The program is required by state law to have a 1:4 day and 1:16 evening staffing ratio. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.313 (d). Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility's deployment of video monitoring systems and other monitoring technologies; and (3) The resources the facility has available to commit to ensure adherence to the staffing plan. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, at least once a year the facility, in collaboration with the agency’s PREA coordinator; reviews the staffing plan to see whether adjustments are needed to:

	o The staffing plan; o Prevailing staffing patterns o The deployment of monitoring technology; or o The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan. · Annual Review of staffing plan (2024). The staffing plan addresses all of the above-mentioned areas. Interviews: PREA Coordinator – The agency does not have a PREA Coordinator, as its responsible for one site. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.313 (e). Each secure facility shall implement a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has a policy and practice in place where intermediate or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. It was further reported that the unannounced rounds covered all shifts. · Policy: PREA Zero Tolerance states that “The facility has intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. This is implemented for night shifts as well as day and evening shifts. The facility prohibits staff from alerting other staff members of an unannounced round. Unannounced rounds are documented and kept in the office of the PREA Compliance Manager” (p. 4). · Unannounced Rounds (Senior Leaderships Rounds): The logs of unannounced rounds offer a 12-month summary of supervisor-level staff conducting rounds across

	all shifts and on various days each month. The recorded rounds were thorough and included detailed analyses. Interviews: · Intermediate or Higher-Level Staff- The interviewed staff reported that unnanounced rounds are conducted to ensure that residents are on schedule and doing what they are supposed to do. The rounds are documented using the supervisor monitor logs. Some of the ways used to ensure staff are not alerting each other when rounds are conducted is to monitor radio conversations and observe interactions. Radios are not consistently used. When conducting rounds, walking through the units, education, or other areas off the facility to see where the staff and residents are located, check on any safety issues or concerns and make sure that everyone is where they are supposed to be, verify ratios, informally talk to residents and staff about safety. Additionally, cameras are reviewed and monitored. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Searches Contraband Cross Gender Viewing (2023) c. Cross Gender Viewing 2. Interviews:

a. Random sample of staff (13)

b. Residents(s) in custody Interview (25)

Findings (By Provision):

115.315 (a). The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the facility does not conduct cross-gender strip or cross gender visual body cavity searches of residents. The facility reported that staff receive the following training: Guidance in Cross Gender and Transgender Pat Searches. In the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents: 0. In the past 12 months, number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: 0.

· Policy: PREA Searches Contraband Cross Gender Viewings, states that “A resident may only be searched with significant cause and with the permission by upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strip, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments” (p. 1).

· Memo: Prohibition of Cross-Gender Searches of Youth, stating that the facility leadership reported that the site does not conduct any type of pat-down search.

Site Review:

· Search Observations:

o The auditor did not observe any searches being conducted during the site review.

· Staff Practices:

o Informal conversations with staff confirmed that they are not permitted to conduct cross-gender strips or pat-down searches. They emphasized that they do not place their hands on residents, and any searches conducted during intake are performed by staff of the same gender as the residents.

· Resident Feedback:

o Residents reported that they have never experienced a search by any staff. They also stated that no staff member has ever conducted a strip or pat-down search on

	them. Staff do not physically touch them. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.315 (b). The agency shall not conduct cross-gender pat-down searches except in exigent circumstances. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that it does not permit cross-gender pat-down searches of residents, absent exigent circumstances. In the past 12 months, the number of cross-gender pat-down searches of residents: 0. In the past 12 months, the number of cross-gender pat-down searches of residents did not involve exigent circumstance(s): 0. · Policy: PREA Searches Contraband Cross Gender Viewings, states that “A resident may only be searched with significant cause and with the permission by upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strip, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments” (p. 1). · Memo: Prohibition of Cross-Gender Searches of Youth, stating that the facility leadership reported that the site does not conduct any type of pat-down search. Interviews: Random Sample of Staff: All of the interviewed staff articulated their understanding that they are restricted from conducting cross-gender pat-down except in exigent circumstances. However, staff were not able to provide an example of a situation that would require them to conduct a cross-gender search. Staff stated they would wait for the same gender to be available and should always have a spotter present Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.315 (c). The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Policy: PREA Searches Contraband Cross Gender Viewings, states that “A resident may only be searched with significant cause and with the permission by upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strips, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments” (p. 1). · Memo: Prohibition of Cross-Gender Searches of Youth, stating that the facility leadership reported that the site does not conduct any type of pat-down search. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.315 (d). The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As indicated in the PAQ, the 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, along with policies and procedures that advise staff. · Policy: PREA Searches Contraband Cross Gender Viewings, states that “At all times, residents are able to shower, perform bodily functions and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia area. Except in emergency circumstances or when such viewing is incidental to routine room checks. If these situations were to occur, the viewing will be clearly documented in an incident report kept in the resident’s file.” Staff of the

	opposite gender must announce their presence when entering an area where residents are likely to be showering, performing bodily functions or changing clothing (p. 1). Site Review: · Observation of Areas Where Residents May Be Undressed: o The auditor inspected all areas where residents might be in a state of undress, such as while showering, using the toilet, or changing clothes. The only location where this occurs is within the housing area, which has a large bathroom containing four shower stalls, separate toilet area, and a laundry area. o Each shower stall has a door and an open space for residents to change, with a separate shower and curtain within the stall. Residents typically change in the shower; however, if requested to change in the room, they have to be the only one in the room and can temporarily shut the door. On the units there is signage indicating expectations and that residents are not allowed in each other’s rooms. o The toilet area is enclosed with stall doors, ensuring residents do not use the toilet in an open area. · Cross-Gender Observation and Privacy: o The auditor assessed whether non-medical staff of the opposite gender could view residents in a state of undress, including from different angles or via mirrors. The facility's design ensures that staff do not have a direct line of sight into areas where residents undress or use the toilet. Mirrors are only present above the sinks in the bathroom. o The auditor also reviewed the electronic surveillance monitoring areas and confirmed that management staff do not have the ability to observe residents in restroom areas where they could be undressed. No mirrors are used in the housing area for surveillance purposes, and the facility does not employ any software or physical mechanisms (e.g., pixelation, post-its, tape) to obscure cross-gender viewing. Observation of the camera system occurred on the PREA Coordinators computer. · Staff and Resident Feedback: o Informal conversations with direct care staff reported that residents shower and change only in the bathroom, with typically only allowing two residents in at a time. If two residents are in the area they cannot use adjacent stalls. Staff emphasized that residents must remain fully dressed at all times. They will utilize every other stall. o Residents reported that staff never see them in a state of undress and that they are expected to be fully clothed at all times. · Opposite Gender Announcements:

	o During the site review, the auditor observed that staff did not make an opposite-gender announcement when entering the housing area or restroom. However, it was noted that no staff is allowed to enter the restroom area when residents were present, and residents had to request permission to enter the restroom. o The auditor also observed that in some instances, opposite-gender staff were already in the housing area before the auditor's entrance. o In informal conversations, staff reported that opposite-gender announcements are not made because there is a sign up those states opposite gender staff on duty. Interviews: Random Sample of Staff: All of the interviewed staff reported that they do not announce themselves when entering the dorms. Female staff mentioned they would call out before entering the shower or bathroom areas to ensure no youth are present. Additionally, staff explained that they have a process of spotters to ensure that areas with blind spots for cameras are monitored by two staff members. Additionally, staff confirmed that staff confirmed that youth in custody can dress, shower, and use the toilet without being observed by staff or members of the opposite gender. Residents(s) in custody Interview Questionnaire: Twenty-five residents were interviewed; representing random and targeted residents. All of the residents reported that the opposite gender staff do not perform a pat down search of their bodies. When probed the residents reported that no one conducts pat down searches of their body. Corrective Actions: Opposite Gender Announcement: While the facility has signage regarding opposite gender on shift at all times, they shall develop a process where opposite gender announcements are made at lease when residents are at a time of dress, shower or changing clothes so that residents are aware. Additionally, opposite gender staff who are not working that assigned area should make an announcement when entering the area. Based on a FAQ, the site cannot post a notice in the housing unit informing residents that they may be subject to cross-gender supervision at all times. The auditor has provided the site with more information on the FAQ. The facility shall develop a protocol for opposite gender announcements. Ø Corrective Action Taken: Staff received additional information and training on cross gender announcements. No further action is required. 115.315 (e.) 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Per the PAQ, the 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. There were no reported searches that were conducted in the last 12 months. · Policy: PREA Searches Contraband Cross Gender Viewings, states that "Transgender or intersex residents are never to be searched for the sole purpose of determining the resident's genital status" (p 1). Interviews: Random Sample of Staff: All of the interviewed staff reported that they are not allowed to search or physically examine a transgender or intersex individual in custody for the purpose of determining the individual in custody's genital status. Transgender/Intersex Residents: There were no residents identified at the facility during the onsite visit that identified as transgender or intersex. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.315 (f). The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility trained zero percent of security-staff on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs as such searches are prohibited. This is because the facility does not train any staff to conduct cross-gender pat down searches on any residents. Interviews Random Sample of Staff: All of the staff interviewed reported that they do not do strip searches. The staff reported that they were trained to do searches to includes transgender and intersex residents however they do not touch the residents. There

	is no opposite gender search allowed, and staff only perform visual inspections. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor utilized a comprehensive triangulation approach to determine compliance with the PREA standards. This included a thorough review of PREA-related facility documentation, agency policies, on-site observations, a detailed site review of facility operations and practices, and interviews with staff, residents, and both local and national advocates. The auditor also reviewed the facility's responses to the online PREA Audit: Pre-Audit Questionnaire. During the initial assessment, the facility was placed in corrective action to address deficiencies related to opposite-gender announcements. Specifically, the facility was not consistently ensuring that staff of the opposite gender were announcing their presence when entering housing units, as required by PREA standards to preserve the privacy and dignity of residents. In response, the facility took several corrective measures to come into compliance. This included updating policy language to clearly require opposite-gender announcements, retraining all staff on this requirement, and instituting supervisory checks and documentation procedures to verify compliance. Visual signage was also posted in housing units as a prompt and reminder for staff to make these announcements. Based on the corrective actions implemented and verified through documentation, observation, and interviews, the auditor determines that the facility has addressed the previous concerns and is now in full compliance with the standard.

115.316	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Pre-Audit Questionnaire (PAQ) a. Policy: PREA Zero Tolerance (2023)

	b. Policy: PREA -Equal Opportunities for Students with Disabilities (2025) c. Vivant Behavioral Health LLC, Translations (How to Submit a Request Poster) d. LSA Translation Languages List e. Vivant Behavior Health LLC “To Schedule an Onsite Interpreter or Scheduled Virtual Session” Poster f. PREA Pamphlet (Spanish) 2. Interviews: a. Random sample of staff (13) b. Disabled and Limited English Proficient Resident (6) 3. Corrective Action: a. Interpreter Services Signage/posting b. Resident Access to Services Findings (By Provision): 115.316 (a). The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech 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. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility, 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.

· Policy: PREA Zero Tolerance, states that “The facility will provide client education in formats accessible to all clients, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as the clients who have limited reading skills” (p. 2).

· Policy: PREA Equal Opportunities for Students with Disabilities Policy provides guidance on the agency response “to ensure that residents with disabilities or who are limited English proficient, receive an equal opportunity to participate in or benefit from all aspects of Woodward Academy’s efforts to prevent, detect and respond to sexual abuse/rape, harassment and retaliation” (p. 1).

· The agency also provides written materials in formats or through methods that ensure effective communication with residents/residents, who have intellectual disabilities, limited reading skills or who are blind or have low vision. The site reported that they are not equipped to access residents with physical disabilities or who are blind or have low vision. However, if there is a reading disability staff are expected to read the information to the youth. The program has an onsite education program and education plans are in place to address any educational needs.

Site Review

· While the facility did not have any residents who were limited English Speaking, the auditor was able to test securing interpretation services.

o The auditor contacted the language line and spoke to the staff on the process of accessing on demand languages. The staff table walked the auditor through the process so the site would not be charged for the use of services. We went through providing the pin and the prompts for various languages. The auditor tested two of the languages (Spanish and Mandarin).

· While the residents would not have to self-identify the facility would have to enter a pin number to access the contracted services. The residents at the facility do not have access to a phone at any given time, therefore accessing such services would be limited to staff requests for services.

· The interpreter services are available 24/7 with staff assistance to access the line.

· Access to the services is coordinated with the director or the PREA Coordinator. Additional language services would be known through the pre-placement interview and file review process.

Additionally:

· During informal and formal conversation with the admissions and medical staff who conduct intake it was reported that if interpreter services were needed, they would coordinate with the facility director to access the services. Staff reported that they did not have to utilize said services.

	Interviews: Agency Head- interviewed agency head reported that each case will be reviewed annually, and the treatment team will develop the appropriate plan. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.316 (b). The agency shall 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, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility 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: PREA Zero Tolerance, states that "The facility will provide client education in formats accessible to all clients, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as the clients who have limited reading skills" (p. 2). · Policy: PREA Equal Opportunities for Students with Disabilities provides guidance on the agency response "to ensure that residents with disabilities or who are limited English proficient, receive an equal opportunity to participate in or benefit from all aspects of Woodward Academy's efforts to prevent, detect and respond to sexual abuse/rape, harassment and retaliation" (p. 1). · Vivant Behavioral Health LLC, Translations (How to Submit a Request Poster): provides documentation of the readily accessible translation services. · LSA Translation Languages List: provides documentation in specific languages so that the facility has readily accessible translation services. · Vivant Behavior Health LLC "To Schedule an Onsite Interpreter or Scheduled Virtual Session" Poster provides documentation of the readily available translation services. · PREA Pamphlet (Spanish): provides evidence of a readily available PREA

pamphlet in the most common second language of Spanish.

· Staff Training: Staff Training is addressed in PREA Standard 115.313.

Interviews:

Residents with disabilities or those who are limited English proficient – Six residents with disabilities were interviewed. All six reported that Woodward Academy provides clear and easily understandable information about sexual abuse and harassment. They also indicated comfort in asking staff to clarify any confusing information. Additionally, the residents noted that they had the opportunity to watch a video during the intake process upon their arrival at the facility, and that staff explained forms to them before they were asked to sign. All six residents mentioned that staff members would assist them in understanding information about sexual abuse or harassment if needed. They also indicated that they felt comfortable asking a staff member for help if they needed to make a report.

Corrective Actions:

N/A. There are no corrective actions.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.316 (c). The agency shall not rely 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 § 115.364, or the investigation of the resident's allegations.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the facility prohibits the use of resident interpreters, readers, or other types of resident assistance and there were zero instances where resident interpreters, readers, or other types of resident assistants were used. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident’s safety, the performance of first-response duties under §115.364, or the investigation of the resident’s allegations: 0.

· Policy: PREA Equal Opportunities for Students with Disabilities states that “Woodward Academy will not rely on resident interpreters, resident readers or other types of resident assistants except in limited circumstances where a delay in obtaining an effective interpreter could compromise the resident's safety or the

	investigation of the resident's allegation" (p. 1). Interviews: Random Sample of Staff: The interviewed staff confirmed that they would not rely on another youth to interpret or assist a disabled or limited English proficiency youth in reporting allegations of sexual abuse or harassment. Six staff stated they would seek assistance from another staff member for interpretation, while three indicated they would contact an external interpretation service. One staff member was unaware of the process for using interpreters, and one stated they would use a youth to interpret. When probed the 13 staff interviewed emphasized that they would ensure proper arrangements and notify a supervisor or program director that youth were in needing interpretation services. Residents with disabilities or those who are limited English proficient – Six residents with disabilities were interviewed. All six reported that Woodward Academy provides clear and easily understandable information about sexual abuse and harassment. They also indicated comfort in asking staff to clarify any confusing information. Additionally, the residents noted that they had the opportunity to watch a video during the intake process upon their arrival at the facility, and that staff explained forms to them before they were asked to sign. All six residents mentioned that staff members would assist them in understanding information about sexual abuse or harassment if needed. They also indicated that they felt comfortable asking a staff member for help if they needed to make a report. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-audit Questionnaire (PAQ)

b. Policy: PREA Employee Background Check Hiring and Promotions (2023)

c. Staff Records

i. Contractor Background check (2)

ii. 5 Year Background Check (68)

iii. Employee Reference Check (0)

iv. Background Checks (77)

v. Child Abuse Check (77)

vi. Pre-employment questionnaire (79)

2. Corrective Action:

a. Self-Disclosure (17)

3. Interviews:

Administrative (Human Resources) Staff

Findings (By Provision):

115.317 (a). The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the 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:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution.

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, of 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: PREA-Employee Background Check Hiring and Promotion states that: The facility 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— (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); The facility will ask all applicants and employees or contractors, who may have contact with residents, directly in interviews for hiring or promotions and in any interviews or written self-evaluations. (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 (p.1). · New Hire Criminal Background Checks (77) · Pre-Employment questionnaire (77) Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.316 (b). 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 residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility, has a policy that 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 the residents. · Policy: PREA-Employee Background Check Hiring and Promotion states that

states that “the facility 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 (p. 1).

Interviews:

Administrative (Human Resources) – The interviewed human resources staff reported that the facility considers prior 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. Additional reference checks are done, and we will correspond with prior institutional employers.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.317 (c). Before hiring new employees who may have contact with residents, the agency shall: (1) Perform a criminal background records check; (2) Consults any child abuse registry maintained by the State or locality in which the employee would work; and (3) 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

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility policies requires that before hiring new employees who may have contact with residents the agency shall: (1) Perform a criminal background records check; and (2) 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. In the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks: 99.

· Policy: PREA-Employee Background Check Hiring and Promotion states that “The facility requires that before hire of any new employees who may have contact with residents, it (a) conducts criminal background record checks, (b) consults any child abuse registry maintained by the State or locality in which the employee would work; and (c) 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” (p.1).

	· Personnel Files New Hire Background Checks (72). Provides information showing the agency's process to complete background checks. Said checks includes a child abuse registry check. · The auditor could not determine where and if prior institutional reference checks were being conducted. Interviews: Administrative (Human Resources)- The interviewed human resources staff reported that the facility performs criminal record background checks or consider pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. The background check process includes local and national checks, child abuse registry checks, and reference checks. Corrective Actions: Prior Institutional Reference Checks: the auditor shall monitor new hires to determine if prior institutional reference checks are being conducted. The auditor will monitor in 60 day increments not exceed 180 days. The facility shall provide documentation of new hire background checks to include prior institutional reference checks. Ø Corrective Action Taken: The facility provided documentation that a prior institutional reference check was conducted. 115.317 (d): The agency shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their response to the PAQ that agency policies require that a criminal background records check is completed before enlisting the services of any contractor who may have contact with residents. Consistent with employee background checks; criminal history background checks, including driver's license checks and fingerprinting, shall be conducted on all volunteers, interns, and persons working in the department on contract who have direct contact with offenders. In the past 12 months, the number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 2. · Policy: PREA-Employee Background Check Hiring and Promotion states that "The facility requires that a criminal background record check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents" (p. 1).

	· Furthermore, the policy states that: o Applicants must complete an application statement and driving record form authorizing the facility to perform background checks. o Background check results will be stored in the employee's personnel file. These checks may include, but are not limited to: § Criminal History unit background check § Social Security Verification § Prior Employment Verification: Confirms applicant's employment with the listed companies, including dates of employment and position held. § Professional and Personal References: Calls will be placed to individuals listed as references by the applicant. § National Sexual Offenders Registry § Office of Inspector General (OIG) § Education verification: Highest level of education claimed will be verified. § Licensure Verification (if applicable): Confirms the applicant's claimed professional/clinical licensure. § Motor Vehicle Records (if applicable): Provides a report on an applicant's driving history in the state requested. § Drug Screening (if applicable) § Fingerprint Scan (if applicable) § Physical Health Screening (if applicable) · Contracted staff background checks were provided (2). The auditor reviewed and checks are consistent with policy and provision requirements. Interviews Administrative (Human Resources) The interviewed human resources staff reported that the facility performs criminal record background checks or consider pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. Corrective actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.317 (e). The agency shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility either conducts criminal background records checks at least every five years of current employees and contractors who may have contact with residents or has in place a system for otherwise capturing such information for current employees. · Policy: PREA-Employee Background Check Hiring and Promotion states that ". The facility requires that criminal background record checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees" (p. 2). · 5 year checks (68):The auditor observed that the facility has a process that consistently conducts 5 year checks on employees. Interviews: Administrative (Human Resources)-The human resources staff interviewed reported that the system the facility presently has in place to conduct criminal record background checks of current employees and contractors who may have contact with residents is a local, national, and child abuse registry check. Additionally, checks are done every five years. Corrective actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115. 317 (f). The agency shall also 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 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. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because:

	· The agency should also 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 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. Interviews: Administrative (Human Resources) – The interviewed human resources staff reported that the facility asks all applicants and contractors who may have contact with residents about previous misconduct described in section (a)* in written applications for hiring or promotions, and in any interviews as part of reviews of current employees. The questions were verbally asked but not in verbal process rather than a written self-evaluation. Corrective Actions: Pre-employment questionnaire: During the pre-audit phase it was determined that the facility would ask newly hired staff about prior misconduct, however, did not have any written self-evaluation. The facility implemented a corrective action plan to implement a process where applicants complete a written self-evaluation. The auditor will monitor new hires in a 60-day incremental period to determine that the new process has been implemented. Ø Corrective Action Taken: The facility provided documentation that new hires completed a disclosure statement. No further action required. N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.317 (g). Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ, the agency's policy states that material omission regarding misconduct, or the provision of materially false information, shall be grounds for termination. · Policy: PRES-Employee Background Check Hiring & Promotions states that "Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination" (p. 2). Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.317 (h). Unless prohibited by law, the agency 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Unless prohibited by law, the agency 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. Interviews: Administrative (Human Resources) – The interviewed human resources staff reported that when a former employee applies for work at another institution, upon request from that institution, the facility provides information on substantiated allegations of sexual abuse or sexual harassment involving the former employee, unless prohibited by law. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor utilized a triangulation approach to assess compliance with PREA standards, drawing on a comprehensive review of facility documentation, agency policies, on-site observations, facility practices, staff and resident interviews, input from local and national advocates, and responses provided in the PREA Audit: Pre-Audit Questionnaire. At the outset, the facility was placed in corrective action to address deficiencies related to conducting prior institutional reference checks and the consistent use of pre-employment questionnaires during the hiring process. These gaps posed a concern in ensuring the facility appropriately screens potential employees for any history of sexual misconduct or abuse in institutional settings, as required under the PREA standards. During the corrective action period, the facility revised its hiring protocols to ensure

	that institutional reference checks are completed for all applicants who have worked in facilities housing vulnerable populations. The pre-employment questionnaire was also updated to align with PREA standards and is now required for all prospective hires prior to final job offers. Training was provided to Human Resources and hiring personnel to reinforce the importance of these steps, and internal tracking systems were implemented to verify and document compliance for each applicant. The auditor reviewed sample personnel files, updated forms, training records, and interview responses confirming these changes are now embedded in hiring practices. Based on the corrective measures taken and verified through documentation and interviews, the auditor finds the facility to be in full compliance with the standard.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Estimate for Camera Work (1/16/2025) 2. Interviews: a. Agency head b. Director Findings (By Provision): 115.317 (a). When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility has not acquired a new facility or made substantial expansions or modifications to the existing facility since the last PREA audit.

	Interviews Agency Head/Director – The interviewed agency head reported that We deploy video monitoring and attempt to identify any areas of concern that could prevent detection of abuse. All of the above are considered in the design of the facility. We will look at the rooms, camera placement and the distance for staff and direct supervision. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.316 (b). When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that they have installed or updated its video monitoring system, electronic surveillance system, and other monitoring technology since August 20, 2012, or since the last PREA audit. · Camera Installation: The facility provided documentation of an estimate on 1/6/2025 to install additional cameras. Interviews: Agency Head/Director: The agency head interviewed reported that we deploy technology (whether video monitoring or advancements that improve supervision) in areas in need of such technology to prevent abuse and protect clients. We conduct an assessment every year. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and

	online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Evidence Protocol, Forensic Medical Examinations (2023) c. Email Correspondence with Police Department d. Qualified Staff clinical license (2) e. Website: UnityPoint Health - Blank Children's STAR Center 2. Interviews: a. Random sample of staff (13) b. PREA coordinator c. Resident who Reported a Sexual Abuse (2) 3. Corrective Action: a. First Responder Training b. Uniform Evidence Protocol c. Advocacy MOU Findings (By Provision): 115.321 (a). To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency/facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The agency/facility is not responsible for conducting criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Woodward Police Department is responsible for conducting criminal sexual abuse investigations. It was further reported that when conducting a sexual abuse investigation, the agency investigators followed a uniform evidence protocol. · Policy: PREA Evidence Protocol Forensic Medical Examinations serves as the uniform evidence protocol. The police had limited information other than the process of having the local police department investigate allegations of sexual abuse. · Email correspondence with the local Police Department indicates that Woodward Police Department would investigate allegations of sexual abuse. Interviews Random Sample of Staff: Staff demonstrated awareness of the agency's protocols but required probing to describe the steps for preserving usable physical evidence. While they could identify key actions such as separating the youth, securing the area, notifying a supervisor, and completing necessary reports, they needed to include critical steps such as preventing the youth from showering and ensuring they receive medical and mental health evaluations. One staff member could not confirm who would conduct the investigations, while ten stated that quality assurance would manage them, and one indicated that outside police would conduct sexual abuse investigations. Corrective Actions: Evidence: The interviewed staff struggled to articulate the process for protecting and preserving evidence. The staff shall receive additional training in the process to protect and preserve evidence. The facility shall provide the auditor with the documentation that staff received additional training. Ø Corrective Action Taken: The facility provided documentation that the staff completed the training. The content of the training was also provided. 115.321(b). The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported by the PAQ, the protocol is developmentally appropriate for youth. 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. · Policy: PREA Evidence Protocol Forensic Medical Examinations serves as the uniform evidence protocol. The policy had limited information other than the process of having the local police department investigate allegations of sexual abuse. Corrective Actions: Uniform Evidence Protocol: the auditor provided the facility with the standard in focus on the uniform evidence protocol process. The facility shall review and enhance their process to ensure it is compliant with the standard. Ø Corrective Action Taken: The facility provided documentation that a uniform evidence protocol was established. No further action is required. 115.321 (c). The agency shall offer all residents who experienced sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire that the facility offers all residents who experience sexual abuse access to forensic medical examinations at an outside facility and that there is no charge for these examinations. The facility responded that forensic medical examinations are offered without financial cost to the victim. It was further reported that when SANEs or SAFEs are not available, they offer a qualified medical practitioner to perform forensic medical examinations. The number of forensic medical exams conducted during the past 12 months: 0. The number of exams performed by SANEs/SAFEs during the past 12 months: 0. The number of exams performed by a qualified medical practitioner during the past 12 months: 1. · Policy: PREA Evidence Protocol Forensic Medical Examinations states that "The facility does not perform forensic examinations. The facility provides access to forensic medical examinations off-site, without financial cost to the residents.

	Forensic medical examinations will only be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). The facility will document these efforts. When SANEs or SAFEs are not available, a qualified medical practitioner will perform the forensic medical evaluation" (p. 1). Interviews · SAFE/SANE - The auditor contacted the STARS program to verify that the program offers forensic medical services. Such services will be provided to a resident that is brought. UnityPoint Health - Blank Children's STAR Center Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.321 (d). The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire that it has made attempts to make available to the victim, a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the facility makes available to provide these services a qualified staff member from a community-based organization, or a qualified facility staff member. However, it was further reported that they do not have an agreement with a crisis center and that law enforcement or DHS refers this and sets it up at the Blanks Children's Hospital in Des Moines. Interviews: PREA Compliance Manager- The facility does not have a PREA compliance manager. Residents who Reported a Sexual Abuse – The interviewed residents reported that

	they were able to speak to family; and one resident who reported sexual abuse stated that he went and received services at the STAR center. Corrective Actions: Victim Advocate: The facility shall provide documentation where it has attempted to make available to the victim a victim advocate from a rape crisis center. The standard requires attempts to be made or an agreement with rape crisis center for services. Ø Corrective Action Taken: The facility has entered into a MOU with a victim advocacy and emotional support center. No further action is required. 115.321 (e). As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their responses to the Pre-Audit Questionnaire that they would provide, if requested by the victim, a victim advocate, a qualified agency staff member, or a qualified community-based organization staff member to accompany and support the victim through the forensic medical examination process and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. · Policy: PREA Evidence Protocol, Forensic Medical Examinations states that "The facility will provide access to a rape crisis center to provide victim advocate services to the resident. If a rape crisis center is not available, the facility will make available a qualified staff member or qualified staff member from a community-based organization. The facility will document these efforts" (pp.1-2). · The facility provided documentation of two of its licensed clinicians to show qualification of an agency staff member to support the victim as a victim advocate. Interviews: PREA Compliance Manager- The facility does not have a PREA compliance manager. Residents who Reported a Sexual Abuse – The interviewed residents reported that they were able to speak to family; and one resident who reported sexual abuse stated that he went and received services at the STAR center. Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.321 (f). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · If the agency is not responsible for investigating administrative or criminal allegations of sexual abuse and relies on another agency to conduct these investigations, the agency has requested that the responsible agency follow the requirements of paragraphs §115.321 (a) through (e) of the standards. · The agency does not have an agreement with the local police department; therefore, the auditor requested additional documentation or correspondence to verify the process. Email correspondence with the local Police Department indicates that Woodward Police Department would investigate allegations of sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.321 (g). The auditor is not required to audit this section. 115.321 (h). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency provided documentation of two licensed Professional Counselors who could serve as qualified staff members if a community-based staff member is not available to assist or serve as the victim advocate during the forensic process. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	Overall Findings: The auditor applied a triangulation approach to assess compliance with PREA standards, drawing from a comprehensive review of facility documentation, agency policies, on-site observations, facility operations and practices, interviews with staff and residents, feedback from local and national advocates, and information provided in the PREA Audit: Pre-Audit Questionnaire. During the initial audit, it was determined that staff lacked sufficient knowledge and understanding of how to properly manage and preserve evidence in the event of a sexual abuse incident. As a result, the auditor directed the facility to implement corrective actions, including providing targeted training to staff, seeking a Memorandum of Understanding (MOU) with a local child advocacy center, and enhancing the agency's uniform evidence protocol. In response, the facility developed and delivered specialized training for all relevant staff on evidence preservation procedures, emphasizing first responder responsibilities, chain of custody, contamination prevention, and compliance with the agency's evidence protocol. Training materials were updated to reflect best practices and aligned with PREA requirements. The facility also successfully initiated a partnership with a local child advocacy center and obtained a formal MOU to support coordinated response efforts and access to forensic services when appropriate. Additionally, the agency revised and enhanced its uniform evidence protocol to clearly define roles, responsibilities, and required actions during and after an incident. Based on the corrective actions taken and verified through documentation, training records, and interviews, the auditor concludes that the facility has effectively addressed the identified concerns and is now in full compliance with the PREA standard regarding evidence management in cases of sexual abuse.

115.322	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Website: PREA-Referral-Investigation.docx d. Email Correspondence with Local Law Enforcement (standard 115.321)

e. Investigations (7) Standard 115.386

2. Interviews:

a. Agency head

b. Investigative staff (1)

3. Corrective Action:

a. Policy Update

Findings (By Provision):

115.322 (a): The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

Compliance Determinations:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. In the past 12 months, the number of allegations of sexual abuse and sexual harassment that were received: 6. In the past 12 months, the number of allegations resulting in an administrative investigation: 6. In the past 12 months, the number of allegations referred for criminal investigation: 0. It was further reported that one of the allegations occurred at another facility.

· Policy: PREA Zero Tolerance outlines the investigation protocol for each incident of reported sexual abuse or sexual assault /rape (pp. 6-7). Upon review it was determined that the language in the policy needs to be extended to explicitly address sexual abuse and sexual harassment.

· The auditor reviewed seven reported incidents. All allegations were administratively investigated.

Interviews

Agency Head: The interviewed agency head stated that the agency ensures that administrative or criminal investigations are completed for all allegations of sexual abuse or sexual harassment. This is determined by the nature of the allegation; however, if the initial investigation does not indicate a need for a criminal investigation the following procedure is followed: the PREA Coordinator will conduct the administrative investigation and criminal investigations is forward to local law enforcement. If staff are involved, we will place them on leave during the duration of the investigation.

Corrective Actions:

	Policy: Upon review it was determined that the language in the policy needs to be extended to explicitly address sexual abuse and sexual harassment. · Corrective Action Implemented: During the pre-audit phase, the facility updated its policy to include specific language regarding sexual harassment. While investigations on sexual harassment were conducted previously, the policy did not explicitly mention sexual harassment. The update to the policy now explicitly addresses sexual harassment. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.322 (b). The agency shall have in place a policy to ensure that allegations of sexual abuse and/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. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. In addition, the facility reported in the PAQ that the agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is not published on the agency website or made publicly available via other means. · Policy: PREA Zero Tolerance outlines the investigation protocol for each incident of reported sexual abuse or sexual assault /rape (pp. 6-7). Upon review it was determined that the language in the policy needs to be extended to explicitly address sexual abuse and sexual harassment. · Email correspondence with local law enforcement (Woodward PD) indicates that the police department will investigate allegations of sexual abuse. Interviews Investigative Staff: The interviewed staff reported that the policy requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. Criminal cases are referred to local law enforcement. Corrective Actions: Policy: Upon review it was determined that the language in the policy needs to be extended to explicitly address sexual abuse and sexual harassment.

	· Corrective Action Implemented: During the pre-audit phase, the facility updated its policy to include specific language regarding sexual harassment. While investigations on sexual harassment were conducted previously, the policy did not explicitly mention sexual harassment. The update to the policy now explicitly addresses sexual harassment. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.322 (c). If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency website has a link from the home page with a link on the agency investigation policy (PREA-Referral-Investigation.docx). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.322 (d). The auditor is not required to audit this provision of the standard. 115. 322 (e). The auditor is not required to audit this provision of the standard. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents:

	a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Training Record (81) d. Training Curriculum e. Refresher Training (78) f. Signed Acknowledgement (14) 2. Interviews: a. Random sample of staff (13) Findings (By Provision): 115.331 (a). The agency shall train all employees who may have contact with residents on:(1) Its zero-tolerance policy for sexual abuse and sexual harassment;(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;(3) Residents' right 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 juvenile facilities;(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;(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;(11) Relevant laws regarding the applicable age of consent. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency trains all employees who may have contact with residents in the following matters: · The agency’s zero-tolerance policy for sexual abuse and sexual harassment; · How staff fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; · Residents right to be free from sexual abuse and sexual harassment; · The right of residents and employees to be free from retaliation for reporting

	sexual abuse and sexual harassment; · The dynamics of sexual abuse and sexual harassment in resident facilities; · The common reactions of sexual abuse and sexual harassment victims; · How to detect and respond to signs of threatened and actual sexual abuse; · How to avoid inappropriate relationships with residents; · How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; · How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.; and · Relevant laws regarding the applicable age of consent. · Policy: The PREA Zero Tolerance Policy states that “All facility staff, contractors and volunteers that have regular contact with clients, must complete initial and annual training for sexual assault/rape prevention, incident response and reporting. At the conclusion of each training session, all trainees must sign that they attended and understood the training. This signature sheet must be kept on file for all initial and annual trainings” (p. 3). · Training Curriculum: The agency training curriculum covers all of the above-mentioned elements. The agency's training curriculum comprehensively covers all necessary topics, including the prevention, detection, reporting, and response to sexual abuse and sexual harassment. This training ensures that staff are well-equipped to uphold the rights of residents and employees to be free from abuse and retaliation. · Sample of Training Record: 79 records were reviewed for new hire staff showing the completion of PREA training. A sample of 79 training records confirmed the completion of PREA training for new hires, and interviews with 13 randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. Interviews Random Sample of Staff – All of the interviewed random sample of staff reported that they have been trained on the agencies zero tolerance policy for sexual abuse or sexual harassment. The 13 staff interviewed confirmed that they received PREA education during basic training and undergo refresher training every six months. This training covers policy updates, employee, and youth rights, recognizing signs of sexual abuse, and reporting and response procedures. They demonstrated knowledge of how to prevent, detect, report, and respond to sexual abuse and harassment, including identifying physical harm, maintaining appropriate boundaries, and recognizing signs such as sadness, bruises, or isolation. Additionally, the staff articulated strategies to prevent inappropriate relationships

	with youth, comply with mandated reporting laws, and understand age of consent regulations. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.331 (b). Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa. Compliance Determination: · The facility reported in the PAQ that training is tailored to meet the unique needs and attributes and gender of the residents at the facility. The facility only houses males. · Training Curriculum: The agency training curriculum covers all the above-mentioned elements. The agency's training curriculum comprehensively covers all necessary topics, including the prevention, detection, reporting, and response to sexual abuse and sexual harassment. This training ensures that staff are well-equipped to uphold the rights of residents and employees to be free from abuse and retaliation. Additionally, the facility included scenarios in the training. · Sample of Training Record: 81 records were reviewed for new hire staff showing the completion of PREA training. A sample of 81 training records confirmed the completion of PREA training for new hires, and interviews with 13 randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.331 (C). 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. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, between trainings the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and harassment. The frequency with which employees who may have contact with residents receive refresher training on PREA requirements: Annually. · Sample of Training Record: 81 records were reviewed for new hire staff showing the completion of PREA training. A sample of 81 training records confirmed the completion of PREA training for new hires, and interviews with 13 randomly selected staff members corroborated their understanding and adherence to the zero-tolerance policy. · Refresher Training: 78 records were reviewed for existing staff show the completion of PREA Refresher Training. Refresher training occurs bi-annually. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.331 (d). The agency shall document, through employee signature or electronic verification, that employees understand the training they have received. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: · The PAQ indicated that the facility requires employees who may have contact with residents to document, via signature, that they understand the training they received. The facility will have the service providers, volunteers, and non-detention juvenile office staff sign an agreement acknowledging the facilities zero tolerance policy for sexual abuse and sexual harassment along with the duty to report. · Training Acknowledgement: The agency ensures that employees who may have contact with residents confirm their understanding of the training received through either a signature or electronic verification. The agency changed the process to electronic and the electronic process does not have an acknowledgement. · Sample of Training Record: 14 (Acknowledgements) Corrective Actions: Training Acknowledgement: The agency ensures that employees who may have contact with residents confirm their understanding of the training received through either a signature or electronic verification. The agency changed the process to

	electronic and the electronic process does not have an acknowledgement. The agency shall include an acknowledgement statement on its electronic training. Ø The facility updated its online training to include an acknowledgement statement. No further action is required. Overall Findings: The auditor used a triangulation approach to assess compliance, drawing from a thorough review of PREA-related facility documentation, agency policies, on-site observations, facility practices, staff and resident interviews, input from local and national advocates, and the completed PREA Audit: Pre-Audit Questionnaire. Initially, the facility was placed in corrective action due to concerns regarding its electronic acknowledgment process. Specifically, the system used to document staff acknowledgment of PREA-related policies and training did not consistently capture or verify that acknowledgments were being completed by the intended staff members in a secure and accountable manner. In response, the facility implemented significant improvements to ensure the integrity and reliability of the electronic acknowledgment process. These improvements included the integration of secure, role-based login protocols; time-stamped confirmations; and tracking features that allow supervisory staff to monitor completion rates. Based on these corrective actions and verification through documentation, observation, and interviews, the auditor finds that the facility has resolved the previous concerns and is now in full compliance with this standard.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Relied Upon in Making the Compliance Determination: Documentation: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Training Curriculum (Same as staff standard 115.331) c. Signed Acknowledgement of PREA Training (4) 2. Interviews:

	a. Volunteers or contractors who have contact with residents (2) 115.332 (a). The agency shall ensure 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · According to the PAQ, all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The number of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 2. · Sample of Volunteer or Contractor Training Record (4). The auditor reviewed four training records, which encompass all contractors for the facility. The record provides acknowledgement of training received. Interviews: Volunteer(s) or Contractor(s) who have Contact with Residents: Two contracted staff were interviewed. Both staff reported that they were trained on the policy on sexual abuse and sexual harassment. The training occurred when they initially began services at the facility. Both reported that the training occurred via a video and that they had to answer questions and sign an acknowledgement. When probed, the contractors reported that they would notify a supervisor immediately and cooperate with any next steps. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.332 (b). The level and type of training provided to volunteers and contractors shall be based on the services they provided and level of contact they have with residents, but all volunteer and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· The facility reported in the PAQ, that all volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. · Volunteer Training Curriculum: (Volunteer Contractor PREA Training Policy): The volunteers take the same training as staff. The curriculum is uploaded in standard 115.331. The curriculum addresses their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. · Sample of Volunteer or Contractor Training Record (4). The auditor reviewed four training records, which encompass all contractors for the facility. The record provides acknowledgement of training received. Interviews: Volunteer(s) or Contractor(s) who have Contact with Residents: Two contracted staff were interviewed. Both staff reported that they were trained on the policy on sexual abuse and sexual harassment. The training occurred when they initially began services at the facility. Both reported that the training occurred via a video and that they had to answer questions and sign an acknowledgement. When probed, the contractors reported that they would notify a supervisor immediately and cooperate with any next steps. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.332 (c). The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains documentation confirming that the volunteers and contractors understand the training they have received. · Sample of Volunteer or Contractor Training Record (4). The auditor reviewed four training records, which encompass all contractors for the facility. The record provides acknowledgement of training received. Corrective Actions: · N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Policy: Equal Opportunities for Students with Disabilities (2025) d. Policy: Basis of Acceptance and Admissions (2023) e. Intake Records PREA Education: Juvenile Confirmation of Receipt of Prison Rape Elimination Act (PREA)/ Resident Orientation Acknowledgement (49) f. Poster: End the Silence (English/Spanish) g. Poster: No Means NO (English/Spanish) h. Posting: Student Grievance Procedure i. Student PREA Orientation Manual j. PREA Training Juvenile Video (https://www.youtube.com/watch?v=TRqJd_tZh1A k. Poster Texas Ombudsman l. Refresher Training Material and Test m. PREA Pamphlet: End the Silence 2. Interviews: a. Intake staff

b. Residents(s) in custody Interview (25)

3. Site Review

4. Corrective Action:

a. Training for Intake Staff

b. Resources for Resident with Reading Disability

c. Updated Handbook

d. Updated PREA Signage

e. Updated Victim Advocacy and emotional Support Signage

f. Sample of Resident Orientation (6)

g. Verification of Enrollment (4)

Findings (By Provision):

115.333 (a). During the intake process, residents shall receive information explaining, in an age-appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The number of residents admitted in the past 12 months who were given this information at intake: 157. It was further reported that the information is provided in an appropriate age fashion.

· Policy: PREA Zero Tolerance states that:

a. “Clients must be supported and encouraged to report sexual assault/rape, attempted sexual assault/rape, and/or sexual harassment and be protected from retaliation. A client that believes that they were the victim of a sexual assault/rape, attempted sexual assault/rape or sexual harassment or believes another client was the victim of sexual assault/rape, attempted sexual assault/rape, or sexual harassment must report this information to a staff member. Clients may also write down their report and turn it into staff or use the PREA grievance process to report. An option must exist for clients to report sexual abuse to someone outside of the facility. The outside reporting option for the facility clients is to place a call to CPS/ DCS, at 1-800-362-2178. This information can be found in the PREA orientation packet or on posters in living units. If a client requests to report outside of the

	facility the following must occur: b. The client may request such action in writing via the grievance procedure. The client may also request to speak with the PREA Compliance Manager and/or Program Representative. The PREA Compliance Manager and our Program Representative will facilitate the call. The call is confidential. The PREA Compliance Manager and/or Program Representative will not listen to the client's report but will keep the client within direct line of sight. Woodward Academy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. A resident grievance alleging sexual abuse will not be referred to the staff member who is the subject of the complaint (p. 4). · Student PREA Orientation Handbook provides guidance to the residents on how to make a report, what is reportable and services available if an incident occurs. The Student PREA Orientation Handbook offers comprehensive guidance to residents on reporting procedures, outlining what can be reported, and detailing the available services if an incident occurs. This handbook is a crucial component in ensuring residents are informed about their rights and the support mechanisms in place, thereby fostering a safer and more responsive environment. · Resident Education Documentation (49): The residents signed acknowledgment of review of the Handbook and review of the PREA video (https://www.youtube.com/watch?v=TRqJd_tZh1A) · Video: The PREA Training Juvenile video was created by Idaho; however, the video addresses how to protect yourself, defining PREA, sexual safety in a juvenile detention center, different ways sexual abuse and sexual harassment in a facility, prohibited behaviors, and to report any knowledge or suspicion. The video is age appropriate. The PREA Training Juvenile video, developed by Idaho, is an essential part of the orientation process. This video provides comprehensive guidance on various aspects of PREA, including methods of self-protection, the definition of PREA, and maintaining sexual safety within a juvenile detention center. It covers the different forms of sexual abuse and sexual harassment that can occur within a facility, outlines prohibited behaviors and emphasizes the importance of reporting any incidents or suspicions of sexual abuse or harassment. The content is designed to be age-appropriate, ensuring that all residents can understand and apply the information effectively. · The facility is required to also provide residents with the Texas Ombudsman reporting number as a requirement of the placement of Texas youth. The facility is also mandated to provide residents with the Texas Ombudsman reporting number, as stipulated by the placement requirements for Texas youth. This ensures that all residents, regardless of their state of origin, have access to the necessary resources to report any incidents or suspicions of sexual abuse or harassment, thereby reinforcing the facility's commitment to upholding the standards set by the PREA. Site Review Intake Process Observation:

	During the site review, the auditor confirmed that the intake process is managed by the admissions and medical staff. The facility pre-approves placement of residents at the facility through a referral, review of placement packets, and interviews. Prior to the resident placement at the facility, they are interviewed. Although there were no new intakes during the audit, a mock intake was conducted by a mental health staff member, revealing the following: An overview of how they introduce themselves, discuss what brought the residents to the site, their average length of stay and several authorizations. Written materials, including the PREA Client Handbook and the Facility Rules Handbook, are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). The PREA brochure is available in both English and Spanish. The handbook is only available in English, however the PREA Coordinator reported that if they had a limited English resident that would have the document placed in the respective language. Since the residents are pre-approved of placement they would know prior to placement if there were any limitations related to language barriers. The facility offers interpreter services when needed, including for Deaf and non-English speaking residents. The intake staff reported that they would coordinate with the facility director to arrange these services if required. Furthermore, it was reported that if they were made aware of a disability that would find out what the disability was and determine what services were needed. During the mock intake, the staff demonstrated how they review the PREA Client Handbook and Facility Rules Handbook with residents, asking follow-up questions to ensure comprehension. They also request residents to provide examples to confirm their understanding. The admissions staff also showed the auditor how they present the PREA video to residents as part of the orientation process. It should also be noted that during intake the residents receive information about mandatory reporting requirements and the limitations to confidentiality. The staff demonstrated that once they go over the documents the residents watch the PREA video and sign acknowledging receipt of information. Informal Conversations: Informal conversations with residents confirmed that upon arrival the admissions staff reviewed the PREA-related information and showed them a video during the intake process. INTERPRETATION SERVICES · While the facility did not have any residents who were limited English Speaking, the auditor was able to assess securing interpretation services. o The auditor contacted the language line and spoke to the staff on the process of accessing on demand languages. The staff table walked the auditor through the

process so the site would not be charged for the use of services. We went through providing the pin and the prompts for various languages. The auditor assessed two of the languages (Spanish and Mandarin).

· While the residents would not have to self-identify the facility would have to enter a pin number to access the contracted services. The residents at the facility do not have access to a phone at any given time, therefore accessing such services would be limited to staff requests for services.

· The interpreter services are available 24/7 with staff assistance to access the line (115.316).

· As described by the admissions staff and the PREA Coordinator, in coordination with the Director the language line services would be accessed, and the use of the interpreter would occur in a closed-door setting.

Additionally:

· During informal and formal conversation with the admissions and medical staff who conduct intake it was reported that if interpreter services were needed, they would coordinate with the facility director to access the services. Staff reported that they did not have to utilize said services.

Interviews

Intake Staff: One staff member was interviewed that performs intake duties. Staff stated that during admission to the facility all youth are provided information regarding agency’s zero tolerance policy for sexual abuse or sexual harassment. During the intake process, we go over rights and responsibilities, HIPAA and PREA information. We verbally discuss the information as well as residents will watch a PREA video. At the end, the residents will sign acknowledgement of receipt of information. The residents will be asked questions about the information to ensure they understand the information. Additionally, it was reported that the PREA education is completed by admissions and the assessments are completed by Nursing staff.

Residents(s) in custody Interview Questionnaire: Twenty-five residents (11 random and 14 targeted) in custody were interviewed. When asked about the timing of when residents received this information all twenty-five residents recalled they were provided with this information on the same day they arrived at the facility during the intake process. Residents reported that they received information upon arrival via the video, handbook and staff going over the information.

Corrective Actions:

Student PREA Orientation Handbook: While the residents receive consistent and reliable PRA education, there were two areas that need improvement. Upon review of the orientation process and interviews with staff and residents, the residents are provided limited information on the PREA policy related to access to victim advocacy and emotional supportive services. Additionally, the residents have

	limited information on how they could make an anonymous or confidential report. The facility shall enhance its PREA Orientation handbook to include additional information related to victim advocacy and emotional supportive services and how to make anonymous and confidential reports. The facility shall provide the enhanced process and documentation of new intakes receipt of the information. The auditor will review in 60-day increments, if compliant does not exceed 180 days. Ø Corrective Action Completed: The facility enhanced the intake to complete victim advocacy and emotional supportive services. A sample intake packet was provided for verification. Training: Intake staff shall be trained in the delivery of information related to victim advocacy and emotional support along with educating residents on ways to report anonymously and confidentially. Ø Corrective Action Completed: Additional training occurred and was documented. No further action is required. 115.333 (b). Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 157 residents that were admitted in the facility during the past 12 months, whose length of stay was for 10 days or more received comprehensive education regarding their right to be free from both sexual abuse/ harassment and retaliation for reporting such incidents and on agency policies and procedures for responding to such incidents. · Resident Education Documentation: The facility tracks resident participation in education sessions through the completion of the Resident Orientation Acknowledgement Form, along with Client Signature Sheet for PREA Video Orientation. During the mock intake process, the auditor observed residents would sign upon completion of review of the video and staff review of the brochure. · The facility ensures that new intakes are provided with comprehensive and age-appropriate education regarding their rights to be free from sexual abuse and harassment, as well as the agency's policies and procedures for responding to such incidents. This is corroborated by the documentation of completed Resident Orientation Acknowledgement forms and Client Signature Sheets for PREA Video Orientation. · The use of the PREA video in conjunction with the provided PREA Brochure and Handbook ensures residents receive the necessary information upon intake. The

	PREA Brochure is available in both English and Spanish, and interpreter services are provided when needed. · The presence of the language line number and the coordination with the PREA Coordinator for necessary services underscore the facility's initiative-taking approach to addressing the needs of all residents. · Upon review of the resident intake date and the date of signature on the PREA education acknowledgment residents consistently receive the information immediately upon arrival of the facility and in very few instances less than 24 hours of arrival. Site Review Although no new intakes occurred during the audit, admissions and medical staff members conducted a mock intake, revealing the following: · Written Materials: The PREA Brochure and Handbook are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). The brochure was readily available in English and Spanish, and the handbook was available in English. Staff reported that the residents are pre-approved for placement and if needed they would obtain the information in the requested language prior to placement at the facility. · Interpreter Services: The facility offers interpreter services when needed, including for Deaf and non-English speaking residents. Admissions staff would coordinate with the PREA Coordinator any services needed. The language line number was posted in the admissions office. · Mock Intake Demonstration: During the mock intake, staff demonstrated how they reviewed the PREA Brochure and Student Orientation Packet with the residents. They ask follow-up questions and request residents to provide examples to ensure comprehension. · PREA Video Presentation: The admissions staff also showed the auditor how they present the PREA video to residents as part of their orientation. · Student Orientation Packet: The auditor confirmed that the Student Orientation packet includes detailed information on the following topics: o Zero Tolerance Policy o PREA Talk About It o Student Signature Sheet for PREA Orientation o Client Signature Sheet for PREA Video Orientation o Free and Reduced-Price Meal Application o Conditions of Admission

	o Informed Consent o Consent and Release o Red Flag Review Request Form Process o Student Rights o Student Advisement o Student Handbook Sign Off o Sanctuary Model o Volunteer Release o Substance Abuse Release o Runaway Plan o Student Internet Acceptable Use and Safety Policy o Clothing Inventory Interviews Intake Staff: One staff member was interviewed that performs intake duties. Staff stated that during admission to the facility all youth are provided information regarding agency's zero tolerance policy for sexual abuse or sexual harassment. During the intake process, the residents are provided information on the policy and procedures, watch a video and verbally discuss before they sign. Usually this will occur on the first day (immediately upon arrival), as intakes are scheduled. We did not see any language barriers but there were barriers with access an interpreter. When probed about how to access the interpreter line, the staff could not readily identify the contact information but stated that the agency had access. Upon review the interpreter line number was posted in the admissions area and the PREA Coordinator showed the interviewed staff where it was located. Residents(s) in custody Interview Questionnaire: Twenty-five residents (11 random and 14 targeted) in custody were interviewed. All the residents reported that upon arrival at the facility they were told about their right not to be sexually abused or sexually harassed, how to report sexual abuse or sexual harassment, and their right not to be punished for reporting sexual abuse or sexual harassment. The information was provided on the first day by staff and the resident was able to describe receiving a handbook and watching the PREA video. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.333 (c). Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, all residents received PREA related education within 10 days of being placed at the facility. Additionally, residents transferred from another facility will receive PREA education upon intake and during orientation. It was further reported that the residents receive PREA education within the date of admission. · Policy: PREA Zero Tolerance states that “Current clients who have not received such education will be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the client’s new facility differ from those of the previous facility” (p. 2). · Resident Education Documentation: The facility tracks resident participation in education sessions through the completion of the Resident Orientation Acknowledgement Form, along with Client Signature Sheet for PREA Video Orientation. As described in provision 115.333 (a/c), PREA education is provided to all residents upon intake. Interviews Intake Staff: One staff member was interviewed that performs intake duties. Staff stated that during admission to the facility all youth are provided information regarding agency’s zero tolerance policy for sexual abuse or sexual harassment. The residents are verbally given the information as well as written handouts. Verbal review occurred with the residents to verify that they understand what was provided. The staff also reported that they will ask the residents if they have any questions. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.333 (d). The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As indicated in the PAQ, resident PREA education is available in formats accessible to all residents, including those that are: limited English proficient (LEP). It was further reported that the clients admitted to this program would not be eligible for admission if there was an identified disability of deaf, visually impaired, or severally cognitively delayed. · Policy: Basis of Acceptance and Admissions provides an overview of exclusionary admissions into the program. “Full-scale IQ below 70. Students possessing learning disabilities are not disqualified. Adolescent males requiring a locked facility. Youth whose Primary Diagnosis consists of: Mental Retardation, Severe Autism Spectrum Disorder, Schizophrenia, Paranoia, Pervasive Development Disorder, organic mental disorders, organic brain syndromes, etc. Youth possessing significant fire setting history. Significant=intentional and imminent harm to others. Youth who require detoxification. Youth who have major medical concerns that are not compliant with medical treatment. When an individual does not meet admission criteria, requiring a different level of care than the Facility provides, Facility personnel will immediately contact the referring agent and inform them of the decision” (p. 2). · Policy: PREA Zero Tolerance states that “The facility will provide client education in formats accessible to all clients, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as the clients who have limited reading skills” (p. 2). · Policy: Equal Opportunities for students with disabilities provide general guidance on staff effectively communicating with residents to ensure their understand the material provided to them and accessing interpreters as needed. · PREA Posters (English/Spanish): The facility has PREA Posters (English/Spanish) that provide information on right to report, how to report, and victim services. How to report includes 1800 outside agency numbers, staff information, and agency information to report allegations of sexual abuse and sexual harassment. · Written Materials: The PREA Student Orientation Handbook are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). These handbooks are available in English and the PREA Coordinator reported that it would be created in Spanish. Due to the pre-placement process the site would know in advance if the resident was LEP. · Interpreter Services: The facility offers interpreter services when needed. The language line offers on demand services 24/7 for nine languages, and additional language services as requested. · PREA Video Presentation: The intake staff also showed the auditor how they

present the PREA video to residents as part of their orientation. The PREA Video covers information about residents right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. The staff demonstrated that once they go over the documents the residents watch the PREA video and sign acknowledging receipt of information. For the immediate, the PREA video is available to residents who have a reading disability as they can audio learn the information. In addition, the staff and residents reported that the mental health staff verbally goes overall documentation and asks to follow up questions for knowledge and understanding. It should be noted that PREA is discussed with the admissions staff and the nursing staff.

Corrective Actions:

· N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.333 (e). The agency shall maintain documentation of resident participation in these education sessions.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the agency maintains documentation of resident participation in the PREA education sessions.

· Resident Education Documentation: The facility tracks resident participation in education sessions through the completion of the Resident Orientation Acknowledgement Form, along with Client Signature Sheet for PREA Video Orientation. During the mock intake process, the auditor observed residents would manually sign both forms upon the completion of intake.

Corrective Actions:

· N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.333 (f). In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

Compliance Determination:

· The facility reported in the PAQ that the agency will ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

	· Material: Poster: End the Silence (English/Spanish), Poster: No Means NO (English/Spanish), Posting: Student Grievance Procedure, Student PREA Orientation Manual. PREA Pamphlet (End The Silence). All of the material provides information on how to report, general information about PREA and what to do if you are abused. · Student PREA Orientation Handbook provides guidance to the residents on how to make a report, what is reportable and services available if an incident occurs. The Student PREA Orientation Handbook offers comprehensive guidance to residents on reporting procedures, outlining what can be reported, and detailing the available services if an incident occurs. This handbook is a crucial component in ensuring residents are informed about their rights and the support mechanisms in place, thereby fostering a safer and more responsive environment. Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level. Signage about emotional and victim advocacy support services was not available nor readily available to staff or residents. PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or harassment. Additionally, the brochure contained information about supportive services at the Blank Center. However, neither direct care staff nor residents could specify how to access these services or what emotional support and advocacy services were available due to a lack of detailed information. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. While the signage is posted in an enclosed case (see attached picture) on the unit, many of the residents and staff were unaware that the information was posted in the casings. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA

	posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of PREA and how to make a report; however, there was inconsistency with staff and residents being aware of where the information is posted. The auditor allowed one resident to show how they would make a report. It was determined that due to the location of the posters, the residents would have to write the number down, ask staff to use the phone and dial the number to make a report over the phone. The residents stated that if they wanted to talk privately, they would have to whisper. Staff reported and showed the auditor that the residents could utilize a cordless phone to have a private conversation, however they would have to seek permission to use the phone. The phone calls are not recorded. Staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has implemented corrective actions to improve awareness and access to these services. Corrective Actions: Postings (Victim Advocacy and Emotional Support): During the site review, the auditor found that residents were not adequately informed about victim advocacy and emotional support services. The postings in the resident housing areas only provided contact information and did not provide material related to what the services offered. The facility provided pictures that the information is placed on the resident housing units. Ø Corrective Action Taken: The facility provided documentation that victim advocacy and emotional support information was posted. No further action is required. Student PREA Orientation Handbook: While the residents receive consistent and reliable PRA education, there were two areas that need improvement. Upon review of the orientation process and interviews with staff and residents, the residents are provided limited information on the PREA policy related to access to victim advocacy and emotional supportive services. Additionally, the residents have limited information on how they could make an anonymous or confidential report. The facility shall enhance its PREA Orientation handbook to include additional information related to victim advocacy and emotional supportive services and how to make anonymous and confidential reports. The facility shall provide the enhanced process and documentation of new intakes receipt of the information. The auditor will review in 60-day increments if compliance does not exceed 180 days. Ø Corrective Action Taken: The requested enhancements to the intake process was

	made. No further action is required. Overall Findings: The auditor utilized a triangulation approach to determine compliance with the PREA standard, incorporating a comprehensive review of facility documentation, agency policies, on-site observations, facility practices, staff and resident interviews, input from local and national advocates, and the PREA Audit: Pre-Audit Questionnaire. The facility was initially placed in corrective action to address the need for additional training for intake staff and residents, as well as improvements to the resident handbook and facility postings to ensure comprehensive PREA education and awareness. In response, the facility implemented a corrective action plan that included enhanced training modules for intake staff focused on PREA protocols and communication strategies, as well as updated orientation procedures for newly admitted residents. The resident handbook was revised to include clearer and more detailed information on residents' rights, reporting mechanisms, and support services. Facility postings were also updated and expanded to ensure visibility and accessibility of PREA-related information in all housing units and common areas. Based on this verification, the auditor concludes that the facility has successfully addressed all identified concerns and is now in full compliance with the standard.

115.334	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Investigations Training (2024) c. Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2) d. Training Curriculum/ Specialized Training: Investigating Sexual Abuse in Confinement Settings | NIC Development Site e. Agency PREA Training (2)-See 115.331 2. Interviews:

a. Investigative staff (1)

Findings (By Provision):

115.334 (a). In addition to the general training provided to all employees pursuant to § 115.331, 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As indicated in the PAQ, the agency has trained investigators as all PREA-related investigations are conducted by an outside entity. The agency does not conduct any sexual abuse investigations. The agency conducts administrative investigations and outside law enforcement conducts criminal investigations.

· Policy: PREA Investigations Training states that “the facility requires that investigators are trained in conducting sexual abuse investigations in confinement settings” (p. 1).

· Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2), demonstrated the completion of the specialized training.

· Training Curriculum: The agency employs the NIC's "Investigating Sexual Abuse in Confinement Settings" training curriculum. This is an online training that can be accessed at: Specialized Training: Investigating Sexual Abuse in Confinement Settings | NIC Development Site.

· Agency PREA Training: the auditor reviewed documentation of staff completion of the agency PREA training.

Interviews

Investigative Staff: The interviewed staff reported that they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings. The training included: techniques for interviewing juvenile 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 or prosecution referral.

Corrective Actions:

· N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.334 (b). Specialized training shall include techniques for interviewing juvenile

	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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2), demonstrated the completion of the specialized training. · Training Curriculum: The agency employs the NIC's "Investigating Sexual Abuse in Confinement Settings" training curriculum. This is an online training that can be accessed at: Specialized Training: Investigating Sexual Abuse in Confinement Settings | NIC Development Site. Interviews Investigative staff: The staff interviewed reported that the training included all of the above. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.334 (c). The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains documentation showing that investigators have completed the required training. The number of investigators currently employed who have completed the required training: 2. · Certificate of Completion PREA: Investigating Sexual Abuse in a Confinement Setting (2), demonstrated the completion of the specialized training. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.334 (d). Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.335	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: · Pre-Audit Questionnaire (PAQ) · Policy: PREA Investigations Training (2024) · Specialized Training PREA 201 for Medical and Mental Health practitioners (11) · Annual PREA Training (9) · Training Curriculum (NIC-PREA 201 Medical and Mental Health Training) · Clinical Staff Annual PREA Training Logs Interviews: Medical and Mental Health Staff (2) Findings (By Provision): 115.335 (a). The agency shall ensure 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 juvenile victims of sexual abuse and sexual harassment; and(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The number of all medical and mental health care practitioners who work regularly at this facility received the training required by agency policy: 12. The percentage of all medical and mental health care practitioners who work regularly at this facility received the training required by agency policy. 83. · Policy: PREA Investigations Training states that “the facility requires medical and mental health practitioners, contractors and volunteers to complete the PREA training in initial orientation and annually” (p. 1). · Specialized Training PREA 201 for Medical and Mental Health practitioners (11) · Training Curriculum: The agency employs the NIC's "PREA 201Medical and Mental Health Training" training curriculum. The training curriculum can be located at: mod_3.pdf Interviews Medical and Mental Health Staff: The interviewed staff reported that they completed the online training on sexual abuse and sexual harassment. The training included: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and whom to report allegations or suspicions of sexual abuse and sexual harassment. The training was taken online. Corrective Action: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.335 (b). If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, medical staff at this facility do not conduct forensic medical exams. · The facility does not conduct forensic examinations. Forensic examinations if needed will be conducted at the local child advocacy center.

	Interviews Medical and Mental Health Staff: The staff interviewed reported that they do not complete forensic medical exams. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.335 (c). The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility maintains training records of the medical and mental health staff. · Specialized Training PREA 201 for Medical and Mental Health practitioners (11) · Clinical Staff Annual PREA Training Logs: provides the staff, date, and title of staff receiving annual PREA training (9) Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.335 (d). Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.331 or for contractors and volunteers under § 115.332, depending upon the practitioner's status at the agency. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Clinical Staff Annual PREA Training Logs: provides the staff, date, and title of staff receiving annual PREA training (9). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.341	**Obtaining information from residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Screening and Use of Information (2023) c. PREA Intake Assessment Form (sample) d. Risk Screening/PREA Intake Assessments Completed (49) e. 90 Day Report/Reassessments (49) f. Sample Intake Packet 2. Interviews: a. Staff responsible for risk screening (1) b. Residents(s) in custody Interview (25) c. PREA coordinator 3. Site Review 4. Corrective Action a. Enhance audit tool sample implementation (5) b. Additional PREA Assessments (44) c. Confidentiality: Access to Assessment Findings (By Provision):

	115.341 (a). Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a process in place of screening and support the residents in care. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The number of residents entering the facility (either through intake of transfer) within the past 12 months whose length of stay in the facility was for 72 hours or more and who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 159. · Policy: The PREA Screening & Use of Information states that “Prior to or upon intake, a resident shall be subjected to a general medical screening, a Bio-Psycho-social (within 72 hours) and a PREA History Report and Medical Safety Screen” (p. 1). While the policy does not require the PREA Screening risk level to be reassessed use the same tool, the facility has service plans that are completed within the first week of placement. The Service plans reviewed quarterly. The service plans are detailed ascertain and addressing the following: o General Information o Overview of Service Plan Conference o Treatment Progress o MAYSI o Service Plan Goals o Individual Child Development and Life Skills o Family and Community Connection Plan o Crisis Intervention and Stabilization Plan o Reintegration Plan o Education Plan o Physical Health o Mental Health and Behavioral Health and Clinical Supports o Medication Management

	· Service Plans are completed in partnership with staff, residents, and family support. · Risk Screening/PREA Intake Assessments Completed (49). The purpose of risk screenings is to ensure the safety and well-being of all residents within the facility. These screenings are designed to identify individuals at risk of sexual victimization or those who may pose a threat to others, thereby creating a safer environment for everyone. Risk screenings are conducted immediately upon a resident’s arrival at the facility, with a thorough and confidential assessment performed by medical staff. This initial screening helps to inform the Service Plans, which are developed within 24 hours and updated periodically to reflect any changes in a resident’s history, treatment, and behavior. Moreover, the screenings support the creation of comprehensive and individualized treatment plans, updated at least every six months. The auditor determined that the screenings were consistently completed immediately or within 24 hours of admission. · Service Plans Reviewed (49): The service plans are completed in 90-day increments serving as the reassessment for youth. The service plans are comprehensive, providing a review of all the above needs related to the residents. Woodward Academy's Service Plan plays a crucial role in ensuring the safety and well-being of its residents by systematically reassessing the risks of sexual victimization and the potential for sexually abusive behavior. This thorough and ongoing evaluation process is designed to create a secure environment for all residents, minimizing risks and enhancing individual care. · Upon a resident's arrival at the facility, a detailed and confidential risk screening is conducted by medical staff. This initial assessment identifies individuals who may be at risk of sexual victimization or those who could pose a threat to others. The data gathered from these screenings inform the development of individualized Service Plans within 24 hours, which are continuously updated to reflect any changes in the resident's history, treatment, and behavior. The auditor has confirmed that these screenings are completed immediately or within 24 hours of admission, ensuring prompt identification and response to potential risks. · Service Plans are essential for reassessing risks and implementing appropriate interventions to safeguard residents. The plans are reviewed and updated every 90 days, serving as a regular reassessment tool for the youth. These comprehensive Service Plans include various aspects of a resident's needs, such as safety, physical health, mental health, behavioral health, education, and medication management. By regularly reassessing these factors, the facility can adapt its care and intervention strategies to address emerging risks and promote a safe and supportive environment. · Medical staff at Woodward Academy are responsible for conducting the PREA (Prison Rape Elimination Act) risk screening in a confidential setting. During the screening, medical staff engage with residents in a respectful and empathetic manner, asking questions individually and checking for understanding. This process helps identify risks and ensures that the assessments are accurate and

comprehensive.

· Furthermore, the policy states that the facility utilized a Sanctuary Safety Plan and a Treatment Plan to reassess the youth throughout placement at the facility. “The facility will create a Sanctuary Safety Plan within 24 hours of a resident ’s admission. The Sanctuary Safety Plan shall be updated periodically throughout the resident ’s treatment to reflect any changes in history, treatment, and behavior. In addition, the resident ’s treatment plan is updated at least every 6 months within addition to any program assessment and placed in the resident ’s file. In utilizing a Sanctuary Safety Plan, the facility provides appropriate controls on the dissemination of the plan within the facility. This will update the residents’ risk level periodically throughout their confinement. In distribution, all staff are notified that the material contained within is sensitive information and is not exploited to the resident ’s detriment by staff or any other resident. This information is to remain confidential by all receiving staff” (p.1).

· Resident interview questions would suggest that staff are not conducting the reassessment; however, upon review the auditor determined that the questions are not asked explicitly as written on the resident interview questionnaire however a reassessment to address the safety and needs of the residents occur in a treatment team/plan every 90 days.

Site Review

PREA Risk Screening

Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process.

· Staff Responsibilities and Process:

o The auditor confirmed that medical staff are responsible for conducting the PREA risk screening.

o The screening takes place in the private office of medical staff, ensuring confidentiality. Only medical staff are present during the screening. When a resident arrives at the facility they are immediately taken to admission. The admissions staff will cover PREA education, facility rules, and additional policy and procedures. Upon completion at admissions, the admissions staff will walk the residents to medical to complete medical and PREA related assessments.

o During the mock demonstration, the medical staff asked each question individually, periodically checking the residents’ understanding and repeating responses to ensure accuracy.

o The staff asked questions in a slow and respectful manner; and reported that they will frequently check in as some of the questions can be uncomfortable for the residents. They also showed how they explained to the residents why they are asking the questions, and that the questions are asked out of all residents.

	o The nursing staff not only ascertained information on the tool based on resident responses but also use subjective determination on the resident's perceived status related to sexual orientation and/or gender identity. It was determined that the specific questions around sexual orientation and/or gender identity were not on the current tool but asked on other medical assessments. o The screening staff uses additional medical assessments to ascertain information on the clients. The additional assessments include: § Admit Checklist § Student Billing and Pharmacy Sheet § Health Screening § Visual Examination § PREA Guidelines to include a duty to report. § Scabies, Head Lice, and Bed Bugs Medical Form § Student Medical Complaint Form § Medical Care Instructions § TB Test § Medical Flow Sheet § Medical Provider's Standing Order § Audiology o Some screenings are documented electronically in a secure client file accessible only to clinical staff and the facility leadership. o The medical staff follow the screening instrument verbatim when asking questions. o Additionally, medical and admissions staff review the client file provided by referral source prior to placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history. o Parents/legal guardians are required to sign off on confidentiality and limitations as well as the residents. Informal Conversations: · With Staff: o The auditor asked how staff manage situations where a resident's information conflicts with the data provided by the referral provider. Staff reported that they

would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments. It was reported that they try to make the residents comfortable as many of the questions are uncomfortable for them.

o After review, it was determined that the location of the PREA Screening in the electronic file was accessible to all staff. The auditor discussed creating a system to limit who had access to the information on the tool.

· With Residents:

o Residents confirmed that they completed the PREA risk screening on their first day, conducted by the medical staff in a private office. They reported being asked specific questions during the process.

Interviews

Staff Responsible for Risk Screening – The interviewed staff responsible for performing screening for risk of victimization and abusiveness reported that all residents are screened for risk of sexual abuse victimization or risk of sexually abusiveness toward other residents The screening occurs immediately upon youth placement at the facility. The information is ascertained through conversations with residents and documentation provided pre-placement. Reassessments are made within 30 days. Medical staff completes the risk screening.

Residents(s) in custody Interview Questionnaire: Of the twenty-five residents interviewed while in custody, twenty had been admitted to the facility within the past year. These residents were asked about their intake experience, including whether they were questioned about past sexual abuse, sexual orientation (gay, lesbian, bisexual, or transgender), disabilities, and their perception of being at risk for sexual abuse. Fifteen residents recalled being asked about any history of sexual abuse, while five stated they were not asked about prior sexual abuse. Additionally, four residents reported that they were not questioned about their sexual orientation, disabilities, or whether they believed they might be at risk for sexual abuse. All but three of twenty residents interviewed stated that these questions were asked during the intake process and have not been asked again since arriving at the academy. The three residents could describe where staff addressed during the treatment team meetings.

Corrective Actions:

· N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.341 (b). Such assessments shall be conducted using an objective screening instrument.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The PAQ indicated that the facility utilizes a risk assessment that is an objective screening instrument. · The auditor reviewed the PREA Intake Assessment Form, and it was determined that the site is not using an objective screening instrument. Objectivity was determined based on the following: o Standardized Criteria: It uses pre-determined, clear, and measurable criteria for evaluating risk. o Consistent Application: The instrument is applied uniformly to all individuals being assessed, ensuring that each person is evaluated using the same criteria and process. o Quantifiable Metrics: The numerical scoring system is not clearly defined by categories to measure risk, reducing reliance on personal judgment. Corrective Actions: Enhance Audit Tool: Upon review there was critical information missing from the audit tool. The auditor recommended that the facility review the audit tool and ensure that the assessment scores are more consistent with areas of vulnerability and risk. While the facility provided documentation of five risk assessments completed with the updated tool, in addition to a list of all new intakes for the review period. The auditor shall monitor in a corrective action period of 60 day increments to determine continued compliance not to exceed 180 days. Ø Corrective action taken: The facility provided documentation showing continuous use of the enhanced audit tool. The facility remains in compliance with the requirements of the provision. No further action needs to be taken. 115.341 (c). At a minimum, the agency shall attempt to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

because:

Upon review of the screening instrument, it was determined that the instrument does not specifically address all questions as defined by the provision of the standard. Critical and mandatory components were missing therefore the facility shall enter corrective action to enhance the tool.

Ø Corrective action taken: The facility provided documentation showing continuous use of the enhanced audit tool. The facility remains in compliance with the requirements of the provision. No further action needs to be taken.

Site Review

PREA Risk Screening

Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process.

· Staff Responsibilities and Process:

o The auditor confirmed that medical staff are responsible for conducting the PREA risk screening.

o The screening takes place in the private office of medical staff, ensuring confidentiality. Only medical staff are present during the screening. When a resident arrives at the facility they are immediately taken to admission. The admissions staff will cover PREA education, facility rules, and additional policy and procedures. Upon completion at admissions, the admissions staff will walk the residents to medical to complete medical and PREA related assessments.

o During the mock demonstration, the medical staff asked each question individually, periodically checking the residents' understanding and repeating responses to ensure accuracy.

o The staff asked questions in a slow and respectful manner; and reported that they will frequently check in as some of the questions can be uncomfortable for the residents. They also showed how they explained to the residents why they are asking the questions, and that the questions are asked out of all residents.

o The nursing staff not only ascertained information on the tool based on resident responses but also use subjective determination on the resident's perceived status related to sexual orientation and/or gender identity. It was determined that the specific questions around sexual orientation and/or gender identity were not on the current tool but asked on other medical assessments.

o The screening staff uses additional medical assessments to ascertain information on the clients. The additional assessments include:

§ Admit Checklist

§ Student Billing and Pharmacy Sheet

§ Health Screening

§ Visual Examination

§ PREA Guidelines to include a duty to report

§ Scabies, Head Lice, and Bed Bugs Medical Form

§ Student Medical Complaint Form

§ Medical Care Instructions

§ TB Test

§ Medical Flow Sheet

§ Medical Provider’s Standing Order

§ Audiology

o Screenings are documented electronically in a secure client file accessible only to clinical staff and the facility leadership.

o The screening staff used an objective instrument that is designed to collect information during the screening process.

o The medical staff follow the screening instrument verbatim when asking questions.

o Additionally, medical and admissions staff review the client file provided by referral source prior to placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history.

o Parents/legal guardians are required to sign off on confidentiality and limitations as well as the residents.

Informal Conversations:

· With Staff:

o The auditor asked how staff manage situations where a resident's information conflicts with the data provided by the referral provider. Staff reported that they would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments. It was reported that they try to make the residents comfortable as many of the questions are uncomfortable for them.

o After review, it was determined that the location of the PREA Screening in the electronic file was accessible to almost all staff. The auditor discussed creating a system to limit who had access to the information on the tool.

	· With Residents: o Residents confirmed that they completed the PREA risk screening on their first day, conducted by the medical staff in a private office. They reported being asked specific questions during the process. Interviews Staff Responsible for Risk Screening – The interviewed staff responsible for risk screening reported that the initial risk screening considers age, mental status, sexual orientation, medical information, prior detention status, and prior sexual victimization. The information is ascertained through interviews and documentation review. Corrective Actions: Enhance Audit Tool: Upon review there was critical information missing from the audit tool. The auditor recommended that the facility review the audit tool and ensure that the assessment scores are more consistent with areas of vulnerability and risk. While the facility provided documentation of five risk assessments completed with the updated tool, in addition to a list of all new intakes for the review period. The auditor shall monitor in a corrective action period of 60 day increments to determine continued compliance not to exceed 180 days. Ø Corrective action taken: The facility provided documentation showing continuous use of the enhanced audit tool. The facility remains in compliance with the requirements of the provision. No further action needs to be taken. 115.341 (d). This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Site Review PREA Risk Screening Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process. · Staff Responsibilities and Process: o The auditor confirmed that medical staff are responsible for conducting the PREA risk screening. o The screening takes place in the private office of medical staff, ensuring

	confidentiality. Only medical staff are present during the screening. When a resident arrives at the facility they are immediately taken to admission. The admissions staff will cover PREA education, facility rules, and additional policy and procedures. Upon completion at admissions, the admissions staff will walk the residents to medical school to complete medical and PREA related assessments. o During the mock demonstration, the medical staff asked each question individually, periodically checking the residents' understanding and repeating responses to ensure accuracy. o The staff asked questions in a slow and respectful manner; and reported that they will frequently check in as some of the questions can be uncomfortable for the residents. They also showed how they explained to the residents why they are asking the questions, and that the questions are asked out of all residents. o The nursing staff not only ascertained information on the tool based on resident responses but also use subjective determination on the resident's perceived status related to sexual orientation and/or gender identity. It was determined that the specific questions around sexual orientation and/or gender identity were not on the current tool but asked on other medical assessments. o The screening staff uses additional medical assessments to ascertain information on the clients. The additional assessments include: § Admit Checklist § Student Billing and Pharmacy Sheet § Health Screening § Visual Examination § PREA Guidelines to include a duty to report § Scabies, Head Lice, and Bed Bugs Medical Form § Student Medical Complaint Form § Medical Care Instructions § TB Test § Medical Flow Sheet § Medical Provider's Standing Order § Audiology o Screenings are documented electronically in a secure client file accessible only to clinical staff and the facility leadership. o The screening staff used an objective instrument that is designed to collect

	information during the screening process. o The medical staff follow the screening instrument verbatim when asking questions. o Additionally, medical and admissions staff review the client file provided by referral source prior to placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history. o Parents/legal guardians are required to sign off on confidentiality and limitations as well as the residents. Informal Conversations: · With Staff: o The auditor asked how staff manage situations where a resident's information conflicts with the data provided by the referral provider. Staff reported that they would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments. It was reported that they try to make the residents comfortable as many of the questions are uncomfortable for them. o After review, it was determined that the location of the PREA Screening in the electronic file was accessible to almost all staff. The auditor discussed creating a system to limit who had access to the information on the tool. · With Residents: o Residents confirmed that they completed the PREA risk screening on their first day, conducted by the medical staff in a private office. They reported being asked specific questions during the process. Interviews Staff Responsible for Risk Screening - The staff interviewed responsible for risk screening reported that the information is ascertained by talking to residents and reviewing their placement packet. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.341 (e). The agency shall implement appropriate controls on the dissemination

	within the facility of responses to questions asked pursuant to this standard to ensure that sensitive information is not exploited to the residents' detriment by staff or other residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Site Review · Risk Screening Process: o The risk screening is conducted and securely stored in an electronic case management system. It was determined that the information was accessible to almost all staff. The site was requested to develop a plan to limit access to only the necessary staff. · Access Control: o Informal conversations with the leadership staff confirmed that access to the case management system, particularly to the assessments, is not limited. Interviews PREA Coordinator – The interviewed PREA Coordinator reported that the nursing staff completes the assessment and puts in the electronic case file. It was further reported they will notify the dorm supervisor and the PREA Coordinator. When probed as to who has access, it was reported that technically all staff have access to the system, but verification is needed of who can access each area. PREA Compliance Manager- The facility does not have a PREA compliance manager. Staff Responsible for Risk Screening - The staff interviewed responsible for risk screening reported that the information is held in an electronic health record and those have limited to who have access. The information is available to the case managers, dorm supervisors and the treatment team. Corrective Actions: Access to Information: During the site review it was determined that all staff that have access to the case management system also have access to the risk assessments completed. The facility shall develop a process to limit access to only the necessary staff. Ø Corrective action taken: The facility provided documentation showing the new process for how has access to risk assessments. No further action shall be taken. Overall Findings: The auditor utilized a triangulation approach to assess compliance, incorporating

	PREA-related facility documentation, agency policies, on-site observations, facility reviews, current practices, staff and resident interviews, feedback from local and national advocates, and the completed PREA Audit: Pre-Audit Questionnaire. At the onset of the audit, the facility entered corrective action to address two key concerns: the consistent utilization of the enhanced risk assessment tool in housing, program, and work placement decisions; and the need to limit and secure access to the risk assessment tool to preserve confidentiality and ensure appropriate use. During the corrective action period, the facility took several steps to come into full compliance. The enhanced risk assessment process was revised to ensure the tool is consistently used to guide informed decisions regarding each resident's housing, education, work, and programming placements. In addition, system access controls were implemented to ensure that only designated personnel have access to the tool and the sensitive data it contains. The auditor confirmed these corrective actions through a review of updated policies, staff training logs, role-based access protocols, and recent risk assessment records. On-site interviews with staff demonstrated a clear understanding of the tool’s purpose and appropriate use. As a result of these improvements and supporting documentation, the facility is now found to be in full compliance with this standard.

115.342	**Placement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance Policy (2023) c. Risk Assessment (49) (Uploaded Standard 115.341) d. Initial Treatment Plans/Treatment Plans (49) (Uploaded Standard 115.341) e. Student on Campus List/Documentation of Placement 2. Interviews: a. PREA Coordinator b. Staff responsible for Risk Screening (1) c. Director

d. Medical and Mental Health Staff (2)

e. Gay/Lesbian (3)

3. Corrective Action:

a. Treatment Plans (8)

Findings (By Provision):

115.342 (a). The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As stated in the PAQ, the facility uses information from risk screening to inform housing, bed, work, education, and facility assignment with the goal of keeping the resident safe and free from sexual abuse.

· Policy: PREA Zero Tolerance, states that “The facility must use all information obtained to make housing, bed, program, education and work assignments for clients with the goal of keeping clients safe and free from sexual abuse” (p. 3).

· The auditor reviewed the Assessment for 49 residents. The assessments were completed to determine the risk of sexual victimization or perpetration. The facility meets as a treatment team to review the pre-placement packet along with the completed risk assessments. Standard 115.34 shows the initial plan and service plans (49) that are completed to conduct determination of bed, housing, programming, education, and work assignments. Residents are only eligible for work assignments based on upward mobility through the behavior-based management system. Work assignments are limited. However, it should be noted that the objectivity of the screening tool, was met with challenges and needs enhancement to effectively assess for risk and vulnerability further accurately determining bed, housing, programming, education and work assignments.

· The facility convenes a treatment team to review the pre-placement packet along with the completed risk assessments upon placement at the facility. An initial plan and 90-day service plan is completed on all residents. Additionally, the auditor reviewed the documentation of placement list to verify resident risks to placement locations.

· The facility's zero-tolerance policy explicitly states that all information obtained from risk screenings must be used to make housing, bed, program, education, and work assignments with the goal of keeping residents safe and free from sexual abuse. Additionally, Standard 115.381 outlines the initial plan and service plans that guide the determination of bed, housing, programming, education, and work

assignments.

· Residents are eligible for work assignments based on upward mobility through the behavior-based management system, and such assignments are limited to ensure safety and compliance with PREA standards.

· The facility is a residential program. The Comprehensive Boys Residential Program serves male residents, ages 12 to 18. The length of stay in this program averages about 4-6 months. Woodward Academy has five separate boys' comprehensive residential dormitories, allowing residents to separate into smaller groups to work more as a therapeutic family. The focus of treatment is to psychiatrically and behaviorally stabilize the residents. The treatment structure facilitates a trauma-informed approach while emphasizing symptom management and personal accountability. Residents develop the ability to navigate conflict, manage difficult emotions, and maintain healthy interpersonal relationships.

· During their stay, residents advance through each of the four program phases, applying the cognitive pieces they are learning. The four phases of the program explore areas of victim empathy, taking responsibility for their actions, learning alternatives to their behaviors, and relapse prevention. The residents also participate in multiple groups throughout the week such as Daily Community Group, Skill Development Sessions, primary counseling, and Life skills groups. Off the dormitories they participate in individual, family, and group therapy and/or specialized clinical services such as Eye Movement Desensitization and Reprocessing (EMDR), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and psychiatric consultations.

· Upon intake the medical staff conducts the assessment and reviews all documentation to determine a resident's vulnerability to victimization and sexually aggressive behaviors. Upon completion of intake, the medical staff sends a message to the PREA Coordinator, Dorm Leader and Treatment Team regarding the risk and vulnerability level to further determine placement (Sample Determine Placement Email).

· There is a treatment team that meets to review all new intakes along with ongoing meetings. An initial treatment plan is created within 72 hours. The plan addresses the following and is used to determine all services for the residents:

o Clinical Medical and Mental Health Information

o Education

o Routine Meals

o Athletics/Intramurals

o Therapy Groups

o Client Risk and Precautions:

§ Medical Concerns

§ Food Allergies

§ Truancy Risk

§ Suicide/Self Harm Risk

§ Homicidal Risk

§ Fire Setting Risk

§ PTSD/Trauma Concerns

o Care Coordination

Interviews

PREA Compliance Manager – The facility does not have a PREA compliance manager.

Staff Responsible for Risk Screening – The interviewed staff reported that the information is shared with the case managers, and they make decisions on placement, programming, and housing.

Corrective Actions:

Utilization of Risk Assessment: Although the agency has a well-established procedure for developing treatment plans and incorporating information from the risk assessment, the efficacy of the risk assessment will be reevaluated during the corrective action period in light of improvements to the tool and its objectivity (115.341). This review aims to ensure that the assessment instrument effectively determines housing, bed assignments, work assignments, education, and programming. The auditor will examine the placement of residents and the completion of risk assessments/reassessments at 60-day intervals, not exceeding a total of 180 days, during the corrective action period.

Ø Corrective Action Taken: The facility provided documentation where residents had a treatment plan showing how programming, housing, placement, end education decisions are made. Eight Documents were reviewed.

115.342 (b). Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As stated in the PAQ, the facility does not have a policy that indicates that the residents at risk of sexual victimization will only be placed in isolation if less restrictive measures are inadequate to keeping them and other residents safe. It was further reported that the facility does not use isolation. The number of residents at risk of sexual victimization who were placed in isolation in the past 12 months: 0. The number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education or special education services in the past 12 months: 0 The average period residents at risk of sexual victimization were held in isolation to protect them from sexual victimization in the past 12 months: 0 · There are no residents placed in isolation therefore there are no documents to review. Informal conversation with the residents and staff further confirmed that the site does not use isolation. Interviews Director: The interviewed director reported that the facility does not use any form of isolation. Medical and Mental Health Staff: The staff interviewed reported that the facility does not have isolation. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (c). Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prohibits placing lesbian, gay, bisexual, or intersex residents in particular housing, bed, or other assignments solely based on such identification status. The PAQ further reiterates that the facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

	· Policy: The PREA Zero Tolerance policy states that: Lesbian, gay, bisexual, transgender, or intersex (LGBTI) clients may not be housed solely on the basis of such identification or status. In addition, the facility must: a. Decide on a case-by-case basis whether to place a transgender or intersex client in a facility for male or female clients. b. Placement decisions are based on whether the placement would ensure the client's health and safety and whether the placement would present management or security problems. The client's own view of his/her gender identity should be considered when determining placement. c. Review placement and programming assignments at least twice each year to assess any threats to safety experienced by the client. Every 30 days when client has been housed separately due to having less restrictive alternatives to keep client safe. d. Allow transgender and intersex clients the opportunity to shower separately from other clients (p. 3). · There auditor reviewed the housing assignment of the identified gay and/or lesbian residents. The housing assignments did not provide any indication that residents were placed in any housing assignments solely based on identification status. Interviews PREA Coordinator - The interviewed PREA Coordinator reported that the facility does not have a special housing unit for lesbian, gay, bisexual, transgender, or intersex residents. PREA Compliance Manager – The facility does not have a PREA compliance manager. Gay, Lesbian, and bisexual resident(s) in custody: Three residents were interviewed that identified as gay and/or bisexual. The residents stated that they have never been separated or isolated in the housing area; or placed in a housing area only for residents that identified as gay, lesbian, bisexual, transgender, or intersex. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (d). In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the

	placement would present management or security problems. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility makes housing and facility assignments for transgender or intersex residents in a facility on a case-by-case basis. · Policy: The PREA Zero Tolerance Policy states that: Lesbian, gay, bisexual, transgender, or intersex (LGBTI) clients may not be housed solely on the basis of such identification or status. In addition, the facility must: e. Decide on a case-by-case basis whether to place a transgender or intersex client in a facility for male or female clients. f. Placement decisions are based on whether the placement would ensure the client's health and safety and whether the placement would present management or security problems. The client's own view of his/her gender identity should be considered when determining placement. g. Review placement and programming assignments at least twice each year to assess any threats to safety experienced by the client. Every 30 days when client has been housed separately due to having less restrictive alternatives to keep client safe. h. Allow transgender and intersex clients the opportunity to shower separately from other clients (p. 3). Interviews PREA Compliance Manager – The facility does not have a PREA compliance manager. Transgender/Intersex Residents: There were no identified transgender or intersex residents during the onsite review. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (e). Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · The facility has shown compliance with this provision by ensuring that placement and programming assignments for transgender or intersex residents are reassessed at least twice a year. Although no transgender or intersex residents were identified during the onsite review, the facility maintains documentation and processes to reassess any potential threats to the residents' safety. The facility has a demonstrated process to reassess all residents in 90-day increments. Interviews PREA Compliance Manager – The facility does not have a PREA compliance manager. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that the nursing staff is not involved in that process; however, the program directors and group leads with address a transgender people view of safety, placement, and programming, with the residents. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (f). Transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility has shown compliance with this provision by ensuring that placement and programming assignments for transgender or intersex residents are reassessed at least twice a year. Although no transgender or intersex residents were identified during the onsite review, the facility maintains documentation and processes to reassess any potential threats to the residents' safety. Interviews PREA Compliance Manager – The facility does not have a PREA compliance manager. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that transgender and intersex are residents’ opportunity to shower separately would be addressed by the group leads and case managers and not the nursing staff.

	Transgender/Intersex Residents: There were no identified transgender or intersex residents during the onsite review. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (g). Transgender and intersex residents shall be given the opportunity to shower separately from other residents. Compliance Determination: · The facility has shown compliance with this provision by ensuring that placement and programming assignments for transgender or intersex residents are reassessed at least twice a year. Although no transgender or intersex residents were identified during the onsite review, the facility maintains documentation and processes to reassess any potential threats to the residents' safety. The auditor assessed that all residents could dress and shower separately from other residents. This is done through a single shower and bathroom stalls. Interviews PREA Compliance Manager – The facility does not have a PREA compliance manager. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community information is documented and forwarded to mental health staff. Additionally, the PREA coordinator is notified to address any related matters. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (h). If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: (1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged. Compliance Determination: · The PAQ indicated that there were zero residents at risk of sexual victimization who were held in isolation in the past 12 months. The facility reported that they do not utilize isolation.

	· There were no residents identified as ever being placed in the “isolation” room and through informal conversation with residents the room has never been occupied during the placement at the facility. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (i). Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population. Compliance Determination: · As reported in a PAQ, if a resident at risk of sexual victimization is held in isolation, the facility does not afford each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population; because the facility does not utilize isolation. Interviews: Staff who Supervise Residents in Isolation: The facility does not utilize isolation. Director: The staff interviewed reported that the facility does not use any form of isolation. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse): There were no residents to interview as the facility does not use any form of isolation. Corrective Actions: · N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor used a triangulation approach—reviewing facility documentation, agency policies, on-site observations, facility practices, and interviews with staff, residents, and advocates, in addition to the Pre-Audit Questionnaire—to assess compliance with the standard. Initially, the facility was found non-compliant due to deficiencies in using the risk assessment to inform housing, bed, work, education, and program assignments, and in the timely completion of reassessments. During the corrective action period, the facility implemented necessary changes to ensure full compliance. Specifically, the facility revised its procedures to

	consistently use risk screening outcomes to guide individualized housing, bed, work, education, and program decisions. The auditor reviewed documentation demonstrating this process is now fully operational and observed the application of these procedures in current resident files.

115.351	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. PREA Pamphlet (English/Spanish) d. Student Orientation Manual e. Testing of Incident/Functions f. Picture (PREA Postings) 2. Interviews: a. Random sample of staff (13) b. Residents(s) in custody Interview (25) c. Resident who Reported a Sexual Abuse (2) 3. Corrective Action a. Grievance Boxes Findings (By Provision): 115.351 (a). The agency shall provide multiple internal ways for residents to privately report sexual abuse and 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

because:

· As reported in the PAQ, the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: • sexual abuse and 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.

· Policy: PREA Zero Tolerance policy states that “Reporting procedures; how to report rape, sexual activity, sexual abuse, or harassment. There are multiple reporting options at the facility to include:

i. Verbally to any staff, counselor, or administrator

ii. Writing to any staff, counselor, or administrator

iii. Writing through the client PREA grievance process

iv. Externally by telephoning Children’s Protective Services (CPS), or

v. Department of Children Services (DCS)

vi. Anonymous and third-party reporting

vii. All reporting procedures must be documented by staff, client, or both.” (pp. 1-2).

· PREA Pamphlet provides additional information on the above methods in which someone could report sexual abuse or sexual harassment.

· The Student PREA Orientation Handbook provides guidance to the residents on how to make a report, who to report to, and what is reportable and services available if an incident occurs.

Site Review:

During the site review, the auditor noted the following:

Signage Clarity and Accessibility:
Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level.
Signage about emotional and victim advocacy support services was not available nor readily available to staff or residents.

PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or

	harassment. Additionally, the brochure contained information about supportive services at the Blank Center. However, neither direct care staff nor residents could specify how to access these services or what emotional support and advocacy services were available due to a lack of detailed information. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. While the signage is posted in an enclosed case see attached picture) on the unit, many of the residents and staff were unaware that the information was posted in the casings. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. Testing Internal Reporting Methods for Confined Persons · Internal Reporting: o The auditor assessed the internal reporting methods by contacting the phone numbers listed on the facility's posters. It was confirmed that residents can call the hotline to make a report, and if an allegation is made, the Child Protective Services will assign to an investigator and will notify the facility to initiate an investigation. o The facility houses residents from various states. The state of Texas has posters End the Silence) also displayed throughout the facility. The auditor called the hotline and spoke to the operator. The operator reported that they will accept all calls and notify the reporting authority of the allegation made. · Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has grievance forms available. It was determined that when the residents complete the grievance forms it is placed in an open area accessible to anyone on the unit. o Informal conversations with residents confirmed that they have access to writing materials, and they can write a grievance.

· Electronic Reporting:

o The facility reported that the residents have access to computers and could make a report on the agency website. However, there is no information in the brochure regarding the agency's website.

· Verbal Reporting:

o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member, and they feel comfortable approaching trusted staff privately.

o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay.

Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom)

· Incoming/Outgoing Mail:

o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows:

§ Residents write a letter, place it in an envelope and it is left in an area retrieved every day.

§ Administrative staff provide the mail to the State Resource Center.

§ The mail is not read or reviewed; however, the staff have a pre-approved mail list.

§ When the residents open their mail, they will open in front of the staff and shake it out to ensure there is no contraband.

Record Storage

· Risk Screening Process:

o The risk screening and other assessment tools (e.g., Assessments, biopsychosocial evaluations, and treatment plans are securely stored in an electronic case management system.

o Additional documentation on the residents in paper files is kept in a locked file cabinet in the medical office, accessible only to medical staff.

o Onsite the facility has a locked records room for current resident files and a separate locked records room for prior residents. Records have been retained for seven years.

o The records room is locked and secured, limited to medical and leadership staff. Cameras are placed in the hallways accessible to the record rooms.

· Access Control:

	o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is not restricted. · Conversations with staff have indicated that access to the case management system, specifically the assessments, is currently unrestricted. Interviews Random Sample of Staff - The interviewed staff reported various ways in which they could privately report sexual abuse or sexual harassment of residents. The staff reported that the youth can privately report by notifying staff, calling the number of the poster, or writing a red flag. Staff reported that youth can call PREA Hotline number however staff would have to dial the number. Residents(s) in custody Interview Questionnaire: Twenty-four of the twenty-five residents interviewed stated that they had a trusted person outside of Woodward Academy to report incidents of sexual abuse or harassment. This included family members, JCOs, probation officers, lawyers, DHS representatives, or therapists. Ten out of the twenty-five residents interviewed were not aware that they could make a report without disclosing their name Corrective Actions: Private Reporting: Upon review of interviews and agency practices the facility has a limited ability for residents to report sexual abuse and sexual harassment confidentially or anonymously. The auditor recommended that the site create a system, such as giving them self-addressed stamped envelopes to outside reporting entities or a confidential grievance box to be able to anonymously report. Ø Corrective Action Taken: The facility provided documentation that confidential grievance boxes were created. No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.351 (b). The agency shall also provide 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 agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides more than one way for residents to report abuse or harassment to a public or private entity that is not part of the

	agency. The PAQ further states that the agency does not detain for civil immigration purposes. · Policy: PREA Zero Tolerance policy states that “Reporting procedures; how to report rape, sexual activity, sexual abuse, or harassment. There are multiple reporting options at the facility to include: viii. Verbally to any staff, counselor, or administrator ix. Writing to any staff, counselor, or administrator x. Writing through the client PREA grievance process xi. Externally by telephoning Children’s Protective Services (CPS), or xii. Department of Children Services (DCS) xiii. Anonymous and third-party reporting xiv. All reporting procedures must be documented by staff, client, or both.” (pp. 1-2). · PREA Pamphlet provides additional information on the above methods in which someone could report sexual abuse or sexual harassment. Both the policy and pamphlet provide contact information to make a report of sexual abuse or sexual harassment to child protective services. · The Student PREA Orientation Handbook provides guidance to the residents on how to make a report, who to report to, and what is reportable and services available if an incident occurs. Site Review During the site review, the auditor noted the following: Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level. Signage about emotional and victim advocacy support services was not available nor readily available to staff or residents. PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or harassment. Additionally, the brochure contained information about supportive services at the Blank Center. However, neither direct care staff nor residents could specify how to access these services or what emotional support and advocacy services were available due to a lack of detailed information.

	The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. While the signage is posted in an enclosed case (see attached picture) on the unit, many of the residents and staff were unaware that the information was posted in the casings. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of PREA and how to make a report; however, there was inconsistency with staff and residents being aware of where the information is posted. The auditor allowed one resident to show how they would make a report. It was determined that due to the location of the posters, the residents would have to write the number down, ask staff to use the phone and dial the number in order to make a report over the phone. The residents stated that if they wanted to talk privately, they would have to whisper. Staff reported and showed the auditor that the residents could utilize a cordless phone to have a private conversation, however they would have to seek permission to use the phone. The phone calls are not recorded. Staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has implemented corrective actions to improve awareness and access to these services. Reporting via Phone: · Phone Access: Residents do not have unrestricted access to a phone. Instead, they must request permission from staff to use the phone for external reporting. · Auditor's Test: The auditor assessed the external reporting method by calling the listed hotline as a resident would. The test confirmed the following:

	The staff phone that residents use to make reports is functional. The phone number on the signage connects directly to the external reporting entity. Reporting does not require the residents to provide their name; however, they must request phone access through staff, typically mental health staff. The hotline number is local/toll-free, answered by a live person, and available 24/7. The external reporting entity is equipped to receive reports of sexual abuse and harassment from residents and promptly forwards reports to agency officials. During the test, the auditor spoke with a representative who confirmed that residents can make reports, and that the facility would be notified if pertinent information is provided. The reporting entity also confirmed that residents can report anonymously upon request. · Phone Call Privacy: While residents can access a phone through staff, informal conversations with staff indicated that when a resident requests to call the hotline, staff allow for confidentiality by stepping away, though they maintain a line of sight for supervision. · Monitoring Other Calls: Calls to parents and individuals on the approved list are monitored. Informal conversations with staff confirmed that phone calls are monitored to ensure compliance with the approved contact list. However, if a resident requests to call the hotline, staff will dial the number and then provide some privacy by stepping away while maintaining visual supervision. Staff reported and the auditor observed that there are cordless phones on each housing unit. Residents, during informal conversations, reported that while calls are generally monitored, they believe they could not have a confidential conversation if needed; unless they whispered while on the phone. Testing Internal Reporting Methods for Confined Persons · Internal Reporting: o The auditor assessed the internal reporting methods by contacting the phone numbers listed on the facility's posters. It was confirmed that residents can call the hotline to make a report, and if an allegation is made, the Child Protective Services will assign to an investigator and will notify the facility to initiate an investigation. o The facility houses residents from various states. The state of Texas has posters End the Silence) also displayed throughout the facility. The auditor called the hotline and spoke to the operator. The operator reported that they will accept all calls and notify the reporting authority of the allegation made. · Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has grievance forms available. It was determined that when the residents complete the grievance forms it is placed in an open area accessible to anyone on the unit.

	o Informal conversations with residents confirmed that they have access to writing materials, and they can write a grievance. · Electronic Reporting: o The facility reported that the residents have access to computers and could make a report on the agency website. However, there is no information in the brochure regarding the agency's website. · Verbal Reporting: o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member, and they feel comfortable approaching trusted staff privately. o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) · Incoming/Outgoing Mail: o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows: § Residents write a letter, place it in an envelope and it is left in an area retrieved every day. § Administrative staff provide the mail to the State Resource Center. § The mail is not read or reviewed; however, the staff have a pre-approved mail list. § When the residents open their mail, they will open in front of the staff and shake it out to ensure there is no contraband. Record Storage · Risk Screening Process: o The risk screening and other assessment tools (e.g., Assessments, biopsychosocial evaluations, and treatment plans are securely stored in an electronic case management system. o Additional documentation on the residents in paper files is kept in a locked file cabinet in the medical office, accessible only to medical staff. o Onsite the facility has a locked records room for current resident files and a separate locked records room for prior residents. Records have been retained for seven years. o The records room is locked and secured, limited to medical and leadership staff.

Cameras are placed in the hallways accessible to the record rooms.

· Access Control:

o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is not restricted.

· Conversations with staff have indicated that access to the case management system, specifically the assessments, is currently unrestricted.

Interviews

PREA Compliance Manager- The facility does not have a PREA compliance manager.

Residents(s) in custody Interview Questionnaire: Twenty-five residents in custody were interviewed. Twenty-two reported that they could report sexual abuse or harassment either in person or in writing. When asked for details, they mentioned options such as having family or friends report on their behalf, submitting a grievance or red flag form, using the PREA Hotline, mailing a letter, or giving a written note to a trusted staff member. Three residents did not recall ways to submit a written report but stated they felt comfortable verbally reporting to staff or informing a family member.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.351 (c). Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· The facility reported in the PAQ, that there is a policy mandating staff to accept reports of sexual abuse or sexual harassment made verbally, in writing, anonymously and from third parties. It further reported that staff are required to document verbal reports within 48 hours.

· Policy: PREA Zero Tolerance policy states that “Reporting procedures; how to report rape, sexual activity, sexual abuse, or harassment. There are multiple reporting options at the facility to include:

xv. Verbally to any staff, counselor, or administrator

xvi. Writing to any staff, counselor, or

	administrator xvii. Writing through the client PREA grievance process xviii. Externally by telephoning Children's Protective Services (CPS), or xix. Department of Children Services (DCS) xx. Anonymous and third-party reporting xxi. All reporting procedures must be documented by staff, client, or both." (pp. 1-2). Interviews Random Sample of Staff - The interviewed staff report that when a resident alleges sexual abuse, they can do so verbally, in writing, anonymously and from third parties. Staff confirmed that youth can report concerns regarding sexual abuse or sexual harassment verbally or in writing. All 13 staff interviewed stated they would immediately notify the supervisor upon receiving a report and follow proper procedures to ensure the allegation is addressed promptly. Residents(s) in custody Interview Questionnaire: Twenty-five residents in custody were interviewed. Twenty-two reported that they could report sexual abuse or harassment either in person or in writing. When asked for details, they mentioned options such as having family or friends report on their behalf, submitting a grievance or red flag form, using the PREA Hotline, mailing a letter, or giving a written note to a trusted staff member. Three residents did not recall ways to submit a written report but stated they felt comfortable verbally reporting to staff or informing a family member. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.351 (d). The facility shall provide residents with access to tools necessary to make a written report. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides residents with access to tools to make written reports of 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. · The facility provides the residence with the necessary tools to write a grievance. There were grievance forms available on every housing unit. Interviews PREA Compliance Manager- The facility does not have a PREA compliance manager. Resident who Reported a Sexual Abuse – Two residents who reported sexual abuse were asked if someone at the facility helped them make a written report. The residents reported that they just made a statement not a written report. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.351 (e). The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility indicated in their response to the Pre-Audit Questionnaire that the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. · It was also reported in the PAQ that staff can report anonymously at the following website: https://vbh.compliancemanager.healthicity.com/report/11311D0-F08. The auditor tested the functionality of making an online report. Interviews Random Sample of Staff: The staff reported if a report needed to be done privately, they still would notify supervisor, PREA hotline, HR or PREA Coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor employed a triangulation approach to determine compliance with the PREA standard, incorporating a thorough review of facility documentation, agency

	policies, on-site observations, operational practices, staff and resident interviews, feedback from local and national advocates, and the PREA Audit: Pre-Audit Questionnaire. During the initial audit, the facility was placed in corrective action to address the need for a clearly defined process and increased staff and resident education regarding the multiple ways reports of sexual abuse and sexual harassment can be made privately. In response, the facility developed and implemented a standardized process outlining all available private reporting methods, including verbal and written reports, third-party reporting, access to external support agencies, and the use of confidential hotlines. The facility also updated training content and conducted additional training sessions for staff to reinforce their responsibilities in receiving and responding to reports. Residents received updated information during intake, and facility postings were revised to clearly communicate private reporting options in accessible language and multiple formats. The auditor verified the effectiveness of these corrective actions through interviews, policy reviews, training records, and observation of signage and informational materials posted throughout the facility. Based on the corrective measures taken and confirmed through documentation, observation, and interviews, the auditor concludes that the facility is now in full compliance with the standard.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Policy: Student & Family Concerns/Grievances (1/27/2025) d. Grievances Reviewed (12 months) e. Grievance Form (English) f. Picture (PREA Postings) g. Testing Incident/Functions

2. Interviews:

a. Resident who Reported a Sexual Abuse (2)

3. Corrective Action:

a. Grievance Box

Findings (By Provision):

115.352 (a). An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the agency does not have an administrative process for dealing with resident grievances regarding sexual abuse and is not exempt from this standard.

· Policy: The PREA Zero Tolerance policy states that “The client may request such action in writing via the grievance procedure. The client may also request to speak with the PREA Compliance Manager and/or Program Representative. The PREA Compliance Manager and our Program Representative will facilitate the call. The call is confidential. The PREA Compliance Manager and/or Program Representative will not listen to the client’s report but will keep the client within direct line of sight. Woodward Academy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. A resident grievance alleging sexual abuse will not be referred to the staff member who is the subject of the complaint” (p. 4).

· Residents can report sexual abuse allegations through the grievance process, but such grievances are automatically referred for investigations instead of following the grievance procedure.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.352 (b). (1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse. (3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an

	alleged incident of sexual abuse. (4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency 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. The PAQ further states that agency 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. · Policy: The PREA Zero Tolerance policy states that “The facility shall not impose a time limit on when a client may submit a grievance regarding an allegation of sexual abuse” (p. 8). · 12-month grievances-the agency reviewed the grievance logbook onsite and determined that there were several allegations that should be reviewed as a PREA investigation. · Blank Grievance Form (English) Corrective Actions: Grievance: the agency shall conduct training with the grievance review team to review the definitions of PREA allegations and what allegations should be immediately reported for investigation. Ø Corrective Action Taken: The additional training was provided. No further action is required. 115.352 (c). The agency shall ensure that (1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The agency reported in the PAQ that the agency's policy and procedure allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. · Policy: The PREA Zero Tolerance policy states that “The facility shall not require a client to use any informal grievance process, or to otherwise attempt to resolve with staff an alleged incident of sexual abuse.” (p. 8).

	· 12-month grievances (reviewed onsite). It was determined that at least two allegations should have been investigated initially as PREA. Corrective Actions: Grievance Forms: The facility has a process for residents to complete a grievance form. Once submitted the form will be turned over to investigations. The system does not allow for anonymity in that the forms are left an open area. The facility shall develop a process where the grievance forms can be submitted in a locked and secure box. Ø Corrective Action Taken: The facility provided documentation that confidential grievance boxes were created. No further action is required. Training: The facility should provide additional training to staff who review Grievances and the Investigators on cases that should be referred as an initial PREA investigation. Such training should include a review of any FAQs and Standards in Focus provided on the PREA Resource center site. Ø Corrective Action Taken: The additional training was provided. No further action is required. 115.352 (d). (1) The agency shall 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. (2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal. (3) The agency may claim an extension of time to respond, up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made. (4) 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, the resident may consider the absence of a response to be a denial at that level. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency's policy and procedures require 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. In the past 12 months, the number of grievances that were filed that alleged sexual abuse: 2. In the past 12 months, the number of grievances alleging sexual abuse reached final decision within 90 days after being filed: 2. In the past 12 months, the number of grievances alleging sexual abuse involved extensions because final decision was not reached within 90 days: 0. The agency always notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made.

	· Policy: The PREA Zero Tolerance policy states that “The facility must issue a final decision (initial decision and appeal decision if appealed) on the merits of a grievance alleging sexual abuse or harassment within 90 calendar days of the initial filing of the grievance. The facility may claim an extension of time to respond up to 70 calendar days if the normal time period for a response is insufficient to decide. The facility must notify the client and the client’s parent/guardian in writing of any such extension and provide a date by which a decision will be made” (p. 8). Interviews: Residents who Reported a Sexual Abuse -The interviewed residents reported that they were not given the conclusion of the investigations. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.352 (e). (1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. (2) If a third party, other than a parent or legal guardian, 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. (3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision. (4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that the aagency 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. The number of the grievances alleging sexual abuse filed by residents in the past 12 months in which the residents declined third-party assistance, containing documentation of the resident's decision to decline: 0. · Policy: The PREA Zero Tolerance policy states that “Third parties, including fellow clients, staff, family, attorneys, and outside advocates may assist a client

	filing grievance relating to allegations of sexual abuse and harassment. If a third party, other than the parent or guardian, files a grievance on the client's behalf, such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf. If the alleged victim declines to have the grievance processed on his behalf, the facility must document the client decision" (p. 8). Site Review: During the site review, the auditor noted the following: Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level. Signage about emotional and victim advocacy support services was not available nor readily available to staff or residents. PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or harassment. Additionally, the brochure contained information about supportive services at the Blank Center. However, neither direct care staff nor residents could specify how to access these services or what emotional support and advocacy services were available due to a lack of detailed information. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. While the signage is posted in an enclosed case (see attached picture) on the unit, many of the residents and staff were unaware that the information was posted in the casings. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. With Staff and Residents: Conversations confirmed that staff and residents are aware of PREA and how to make a report; however, there was inconsistency with staff and residents being aware of where the information is posted.

	The auditor allowed one resident to show how they would make a report. It was determined that due to the location of the posters, the residents would have to write the number down, ask staff to use the phone and dial the number to make a report over the phone. The residents stated that if they wanted to talk privately, they would have to whisper. Staff reported and showed the auditor that the residents could utilize a cordless phone to have a private conversation, however they would have to seek permission to use the phone. The phone calls are not recorded. Staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has implemented corrective actions to improve awareness and access to these services. Testing Third-Party Reporting Testing the Third-Party Reporting Method: The auditor assessed the third-party reporting process using the method publicly available, such as through the agency or facility website. The method for third-party reporting posted on the website was confirmed to be easily accessible and understandable, and it is prominently featured on the agency's PREA site. The auditor submitted a test report, and an immediate response was received from the facility indicating that follow-up contact would be made regarding the report. The auditor received follow-up correspondence from the PREA coordinator confirming that the report had been acknowledged. Evidence was provided via email showing that the report was received by the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.352 (f). 1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · The agency reported in the PAQ that the agency 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. The agency's policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days. The number of emergency grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months:0. The number of those grievances in 115.352(f)-3, that had an initial response within 48 hours: 0. The number of the grievances alleging substantial risk of imminent sexual abuse filed in the past 12 months that reached final decisions within 5 days: 0. · Policy: Student & Family Concerns/Grievance states that “A student may file an emergency grievance alleging that they are at a substantial risk of imminent sexual abuse. After receiving an emergency grievance alleging a student is subject to a substantial risk of imminent sexual abuse, staff will immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to the Executive Director (or designee) so that immediate corrective action may be taken. The Executive Director will provide an initial response within 48 hours and will issue a final decision within 5 calendar days. Both the initial response and final decision will state our determination whether the student is at substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. After an agency’s decision is made, a copy of the emergency grievance and all responses will be forwarded to the PREA Coordinator” (p. 3). · The above-mentioned policy was updated during the pre-onsite phase to explicitly stated that “If a PREA complaint comes in through the grievance process, it will be immediately investigated rather than go through the typical grievance process. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.352 (g). The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where

	the agency demonstrates that the resident filed the grievance in bad faith. In the past 12 months, the number of residents alleging sexual abuse resulted in disciplinary action by the agency against the residents for having filed the grievance in bad faith: 0. · Policy: The PREA Zero Tolerance policy states that “The facility prohibits disciplinary actions 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” (p. 2). · Documentation of Disciplinary Action: There was no documented disciplinary sanctions to residents. Corrective Actions: · N/A. There are no corrective actions for this provision. Overall Findings: The auditor used a triangulation approach to assess compliance with the PREA standards, drawing from a comprehensive review of facility documentation, agency policies, on-site observations, site review of practices, staff and resident interviews, input from local and national advocates, and the online PREA Audit: Pre-Audit Questionnaire. Based on this analysis, the facility was initially placed in corrective action to address concerns with the process for submitting and reviewing grievances related to sexual abuse and sexual harassment. Specifically, the existing procedures lacked clarity and consistency in how residents could file grievances privately and without retaliation, and how those grievances were reviewed and responded to in a timely manner. In response, the facility updated its grievance policy to ensure it aligns with PREA standards. Changes included clearly outlining procedures for submitting emergency and non-emergency grievances, removing any requirement for residents to attempt informal resolution prior to filing, and establishing prompt response timelines. The facility also provided additional training to staff responsible for receiving and processing grievances to ensure proper handling and documentation. As a result of the corrective actions taken and verified through documentation, interviews, and observation, the auditor finds the facility is now in full compliance with the PREA standard governing grievance procedures.

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: The PREA Zero Tolerance (2023) c. PREA Pamphlet End the Silence (English/Spanish) d. Website: UnityPoint Health - Blank Children's STAR Center e. Website: STAR Center Overview Brochure_V03.pdf 2. Interviews: a. Residents(s) in custody Interview (25) b. Resident who Reported a Sexual Abuse (2) c. Director 3. Corrective Action: a. Posting on Victim Advocacy and Emotional Support b. Staff Training c. Advocacy MOU d. Resident Education Findings (By Provision): 115.353 (a). The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides residents with access to an outside victim advocate for emotional supportive services related to sexual abuse. It further reports that the facility provides residents with access to such services by giving

	residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, State, or national victim advocacy or rape crisis organizations. The resident handbook has specific information for the residents to contact an outside advocate. The facility provides residents with access to such services by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. The facility does not provide residents with access to such services by giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for immigrant services agencies for persons detained solely for civil immigration purposes; as they do not detain for civil immigration. · Pamphlet (End the Silence) On the PREA Pamphlet information is provided on support services if you are abused the information provided is the local and toll-free number to Access Assault Care Center and Blank Children's STAR Center. However, the pamphlet does not provide any information on what Victim Advocacy and Emotional Support Services entails. · A review of the Blank Children's Hospital found that the entity provides a coordinated response if a child has been abused, forensic interviews, medical examinations, family advocacy, and mental health therapy. Website: UnityPoint Health - Blank Children's STAR Center. Website: STAR Center Overview Brochure_V03.pdf Site Review: During the site review, the auditor noted the following: Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level. Signage about emotional and victim advocacy support services was not available nor readily available to staff or residents. PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or harassment. Additionally, the brochure contained information about supportive services at the Blank Center. However, neither direct care staff nor residents could specify how to access these services or what emotional support and advocacy services were available due to a lack of detailed information. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. While the signage is posted in an enclosed case (see attached picture) on the unit, many of the residents and staff were unaware that the information was posted in the casings. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency:

	The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of PREA and how to make a report; however, there was inconsistency with staff and residents being aware of where the information is posted. The auditor allowed one resident to show how they would make a report. It was determined that due to the location of the posters, the residents would have to write the number down, ask staff to use the phone and dial the number to make a report over the phone. The residents stated that if they wanted to talk privately, they would have to whisper. Staff reported and showed the auditor that the residents could utilize a cordless phone to have a private conversation, however they would have to seek permission to use the phone. The phone calls are not recorded. Staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has implemented corrective actions to improve awareness and access to these services. TESTING ACCESS TO OUTSIDE EMOTIONAL SUPPORT SERVICES Outside Emotional Support via Phone · Current Status: o During the site review, it was noted that there was insufficient information readily available on emotional support and victim advocacy services. · Findings: o Informal conversations with staff and residents revealed a lack of direct knowledge or information regarding victim advocacy and emotional support services. Outside Emotional Support via Mail Processes for Sending and Receiving Mail · Outgoing Mail:

o Residents have easy access to paper and pencils for writing letters. The process for outgoing mail is as follows:

§ Residents write their letters and place them in envelopes provided by mental health staff.

§ Staff deliver these envelopes to administrative staff.

§ Administrative staff verify that the letters are addressed to approved recipients.

§ Residents are provided stamps and envelopes.

· The administrative staff confirmed that resident mail is not read.

· Informal Conversations:

o Informal discussions with the mail clerk confirmed that while residents are given envelopes and the mail clerk applies stamps, no resident mail is read. The mailing is not logged.

o Informal conversation with two residents stated that they do not believe the mail is read.

· Contacting outside emotional support and victim advocacy services: the auditor called the general phone number and was notified by the staff at the Blank Children's Star Center that anyone brought to the site would be offered the following services:

o Family advocacy services

o Mental health services

o Forensic Medical Examination

o Child Advocacy Services.

It was further confirmed that such services are at no cost to the client.

Interviews

Resident in Custody Interview Questionnaire – The interviewed residents represented a sample of targeted and random residents. Twenty-five residents were interviewed however two residents reported sexual harassment at the facility therefore they were not asked the proceeding questions. Of the twenty-three residents asked about their awareness of victim advocacy and emotional support services, fourteen were aware of services outside the facility that specifically address issues related to sexual abuse. These residents mentioned various community resources available to them for support and assistance. Residents mentioned services such as DHS, Boy Towns, Orchard Place, Aftercare, and outside therapists. However, they indicated that to access these services, they would need to ask staff for assistance. Residents are not allowed to dial the numbers

	themselves, and staff are required to be present while they are on the phone. When asked if the facility provided mailing addresses and phone numbers for external services, residents recalled seeing information displayed on boards throughout the facility, including addresses and phone numbers. However, they could not specifically recall the services listed on the posters. Residents believed the calls would be free but still required staff to dial the number for them, meaning staff would know who they were speaking with. When asked if they had ever contacted these external services, all residents stated they had never encountered a situation that required such services. All residents stated that if they asked a staff member for assistance, the staff would immediately help them access the services they requested. They expressed confidence that staff would be responsive and supportive in facilitating their needs. When residents were asked, do you know if what you say to people from these services remain private, the residents all but two of the interviewed residents reported that they believe the conversation would remain private. Resident who Reported a Sexual Abuse – Two residents onsite were interviewed. One resident reported sexual harassment and one reported sexual abuse. When asked did the facility gave you mailing addresses and telephone numbers for outside services the residents reported that no information was provided. One resident stated that they did receive services at STAR child advocacy center. The residents indicated if asked of staff they probably could contact services; but overall unsure. Furthermore, the residents said that staff monitors all calls. Corrective Actions: Advocacy and Emotional Support Services: During the site review, the auditor found that residents were not adequately informed about victim advocacy and emotional support services. Although there was phone numbers posted, residents were unaware of the services available and how to access them. The facility will develop a plan to incorporate information about advocacy and emotional support services into the intake process and conduct a group session with current residents to educate them on these services. Additionally, the facility must provide documentation confirming that the group session occurred and that these services were integrated into the intake process. Ø Corrective Action Taken: The facility provided the requested documentation via the training material, list of resident participants, and a sample group case note. No further action is required. Postings: The facility shall make available to the residents' postings of the victim advocacy and emotional support services information. Such information should be posted on the residents' units. The facility shall provide documentation that the information is posted on the residential housing units. Ø Corrective Action Taken: The facility provided documentation that victim advocacy and emotional support information was posted. No further action is required.

	Confidential: The facility develop a process and educate residents and staff on a process where residents can communicate with outside victim advocacy and emotional supportive services in a confidential manner. Ø Corrective Action Taken: The facility incorporated information into the intake packet and postings on the wall to better educate residents on victim advocacy and emotional support. No further action is required. 115.353 (b). The facility shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility informs residents prior to giving them access to outside support services, the extent to which such communications will be monitored. It was also reported that 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. Such information can be found in the resident handbook. · Policy: The PREA Zero Tolerance policy states that “If a client requests to report outside of the facility the following must occur: The client may request such action in writing via the grievance procedure. The client may also request to speak with the PREA Compliance Manager and/or Program Representative. The PREA Compliance Manager and or Program Representative will facilitate the call. The call is confidential. The PREA Compliance Manager and/or Program Representative will not listen to the client’s report but will keep the client within direct line of sight” (p. 4). · The auditor observed that during the intake process the resident and the guardian are notified of mandatory reporting requirements. Interviews Resident in Custody Interview Questionnaire – All of the interviewed residents expressed concern that that staff could listen to their calls because staff were required to dial the telephone number. Some residents expressed that they have a court order condition that requires all their calls to be monitored and on speakerphone, meaning staff will be able to listen to the conversation. Residents who Reported a Sexual Abuse – Two residents were interviewed. One who reported sexual harassment and one who reported sexual abuse. One resident reported that the conversation with outside services would remain private, however

	when probed they could not express how that would occur. Another resident stated that they were unsure if the information would have to be shared with law enforcement or the probation staff. Corrective Actions: During the site review, the auditor found that residents were not adequately informed about victim advocacy and emotional support services. Although there were posters on the walls, residents were unaware of the services available and how to access them. The signage informs residents that there are limitations to confidentiality based on mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to the outside victim advocates. The facility should educate the residents about the limitation of confidentiality when calling the outside victim advocacy and emotional supportive services. The facility shall provide documentation of how this is addressed at intake and that current residents are educated on the process. Ø Corrective Action Taken: The facility provided the requested documentation via the training material, list of resident participants, and a sample group case note. No further action is required. Confidential Communication: While the nursing staff covers limitation of confidentiality, the auditor recommends that the facility re-educate the residents and add said information to the resident handbook and that the admissions staff cover with the residents when educating the residents on outside emotional support and advocacy services. The facility shall provide documentation that the current residents and the admissions staff were educated on limitations of confidentiality and that the process was added to the resident intake education process. Ø Corrective Action Taken: The facility provided the requested documentation. No further action is required. 115.353 (c). The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility does not maintain memoranda of understandings or other agency agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. Corrective Actions:

	MOU: The facility shall provide documentation that maintains a memorandum of understanding or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse and/or documentation of the attempts made to enter into an MOU or other agreements. Ø Corrective Action Taken: The facility provided documentation where it has entered into a MOU with a child advocacy center. No further action is required. 115.353 (d). The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides residents with reasonable and confidential access to their attorneys or other legal representation, and parents or legal guardians. · The Student and Guardian Handbook provides guidelines on visitors' rights and public access. It states that students have the right to receive visitors from their immediate family and that youths can communicate with their families, public officials, the courts, referring workers, and attorneys. Additionally, the handbook mentions that mail is not censored unless there is a safety and security threat, in which case it would be documented. Interviews Director: The residents are provided meaningful and confidential access to their attorneys and other legal representation/parents/guardians. The attorneys and parents can visit the residents onsite. The residents can have telephone communication with relatives that are on the approved list. The probation officer approves the list. PREA Compliance Manager- The facility does not have a PREA compliance manager. Resident in Custody Interview Questionnaire – Twenty-three of the interviewed residents were asked if they could privately speak to their lawyer. Twenty-one residents asked this question confirmed that they are allowed confidential access to their attorneys and other legal representatives. However, two residents stated that they believe calls from attorneys and legal representatives are still monitored. However, when probed the residents could not articulate how a private call would occur. When asked about their ability to see or talk to their parents the residents overwhelmingly reported that they can speak to their residents if they wish. Due to distance, visitation is limited, but they can earn home passes to visit family. When speaking to family members, staff are required to dial the number and remain with the resident during the call. Additionally, some residents have court conditions that require all their calls to be monitored and on speakerphone, allowing staff to listen

	in on the conversation. Three residents stated they have no contact with family members. Resident who Reported a Sexual Abuse (15.16) – One resident who reported sexual abuse and one resident who reported sexual harassment were asked if they could privately talk to their lawyer, parents or guardian or someone else. The residents reported that they could; however, they do not have a lawyer. One resident stated that they did not inform their family of the incident. Corrective Actions: Calls to Attorneys: The facility should develop a process and educate the staff and residents how a resident could conduct a private call with their attorney. The facility shall provide the auditor with documentation of the process and documentation of education and training conducted with staff and residents. The education of residents shall be included in the intake process for ongoing and immediate education to new residents. Ø Corrective Action Taken: The facility provided documentation that the staff completed the training. The content of the training was also provided. Overall Findings: The auditor utilized a triangulation approach to determine compliance with the PREA standards, drawing from a comprehensive analysis of facility documentation, agency policies, on-site observations, operational practices, staff and resident interviews, feedback from local and national advocates, and the online PREA Audit: Pre-Audit Questionnaire. Based on this analysis, the facility was placed in corrective action to address several deficiencies under the provision related to access to victim advocacy and emotional supportive services, specifically focusing on the need to improve confidential access for residents and staff awareness of available resources. The initial audit identified the following areas of concern: Inconsistent or unclear access for residents to outside victim advocacy and emotional support services. Lack of confidentiality when accessing such services, including unclear signage and limitations with phone access. Gaps in staff knowledge regarding their responsibilities in facilitating access to these services and maintaining confidentiality. To address these concerns, the facility committed to the following corrective actions: Establishing formal agreements (e.g., MOUs) with outside victim advocacy organizations to ensure timely and confidential access to emotional support services.

	Enhancing communication to residents by updating and clearly posting information about how to access victim advocacy and support services confidentially. Improving phone systems and ensuring private access to designated phones for support services. Conducting targeted staff training to increase awareness of available services and reinforce staff responsibilities in supporting resident access and confidentiality. The goal of this corrective action plan is to ensure that all residents are provided with confidential, informed, and meaningful access to victim advocacy and emotional support services and that all staff are fully aware of their role in supporting and protecting that access, in alignment with PREA standards. The facility has completed all requirements of the corrective action plan. The facility is in full compliance with the standard.

115.354	**Third-party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: · Website: https://www.wwacademy.com · Testing of Incident/Functions · Picture (PREA Postings) Findings (By Provision): 115.354 (a). The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment, and the agency/facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents.

	· Website: https://www.wwacademy.com, provides information on how to call or write a letter to the Woodward Academy PREA Compliance Officer. Additionally, the site provides information to the outside Sexual Assault Centers. · Test Functionality: The auditor has completed the electronic third-party reporting form. The facility has uploaded a copy of the test functions along with the third-party test report they received. Site Review: During the site review, the auditor noted the following: Upon review, the auditor determined that the signage is on a high school reading level; according to the Flesh-Kincaid reading level. Signage about emotional and victim advocacy support services was not available nor readily available to staff or residents. PREA brochures and posters were available in both English and Spanish. These materials provide information on the right to report, actions to take if one is abused, zero tolerance policies, and contact details for reporting sexual abuse or harassment. Additionally, the brochure contained information about supportive services at the Blank Center. However, neither direct care staff nor residents could specify how to access these services or what emotional support and advocacy services were available due to a lack of detailed information. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. While the signage is posted in an enclosed case (see attached picture) on the unit, many of the residents and staff were unaware that the information was posted in the casings. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Other PREA Signage: In addition to signage being placed in areas typically utilized by residents, PREA posters on how to report were placed in staffing areas. The signage was posted on the staff boards in the administrative area. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of PREA and how to make a report; however, there was inconsistency with staff and residents being aware of where the information is posted.

	The auditor allowed one resident to show how they would make a report. It was determined that due to the location of the posters, the residents would have to write the number down, ask staff to use the phone and dial the number to make a report over the phone. The residents stated that if they wanted to talk privately, they would have to whisper. Staff reported and showed the auditor that the residents could utilize a cordless phone to have a private conversation, however they would have to seek permission to use the phone. The phone calls are not recorded. Staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has implemented corrective actions to improve awareness and access to these services. TESTING THIRD-PARTY REPORTING Testing the Third-Party Reporting Method: The auditor assessed the third-party reporting process using the method publicly available, such as through the agency or facility website. The method for third-party reporting posted on the website was confirmed to be easily accessible and understandable, and it is prominently featured on the agency's PREA site. The auditor submitted a test report, and an immediate response was received from the facility indicating that follow-up contact would be made regarding the report. The auditor received follow-up correspondence from the PREA coordinator confirming that the report had been acknowledged. Evidence was provided via email showing that the report was received by the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.361	**Staff and agency reporting duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Investigations (7) 2. Interviews: a. Random sample of staff (13) b. Medical and mental health staff (2) c. Director Findings (By Provision): 115.361 (a). The agency shall require all staff to report immediately and according to agency 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 agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether it is part of the agency. The agency requires all staff to report immediately and according to agency policy to make any retaliation against residents or staff who reported such an incident. The agency requires all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. · Policy: The PREA Zero Tolerance Policy states that: o Staff must report immediately any knowledge, suspicion, or information that they receive regarding: an incident of sexual abuse or sexual harassment that occurred at the facility, retaliation against clients or staff that reported such an incident; and/ or, any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation. o Staff receiving a report of a sexual assault/rape or attempted sexual assault/ rape, or staff that become aware of sexual activity between clients or between a

	client and a staff, contractor, visitor, or volunteer must immediately report this event to the program director. The program director must immediately relay the report to the PREA Compliance Manager. The PREA Compliance Manager will notify the Group Living Director and Executive Director/Designee. The Executive Director, or designee is responsible for notifying Licensure, any state entity notifications, and appropriate Sequel Administration. (p. 5) Interviews: Random Sample of Staff - The interviewed staff report that the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that have contributed to an incident or retaliation. It was further reported that such information would be reported to the Director, Supervisor, or PREA Coordinator. Reports are made immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (b). The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws. Compliance Determination: The facility has demonstrated compliance with the provision of the standard because: · As reported in the PAQ, the facility requires that all staff comply with any applicable mandatory child abuse reporting laws. · Policy: The PREA Zero Tolerance policy states that “The facility has a zero-tolerance policy related to sexual abuse or sexual harassment of a client and will cooperate in the investigation and prosecution of anyone involved in a sexual abuse and/or sexual harassment of a client. The facility staff will implement and understand the approach to take when preventing, detecting, and responding to sexual abuse and sexual harassment. The primary responsibility of all facility employees is client safety. This policy shall be followed in conjunction with all Federal and State mandatory reporting requirements” (p. 1). Interviews The 12 staff interviewed confirmed that they received PREA education during basic training and undergo refresher training every six months. This training covers policy updates, employee, and youth rights, recognizing signs of sexual abuse, and reporting and response procedures. They demonstrated knowledge of how to

	prevent, detect, report, and respond to sexual abuse and harassment, including identifying physical harm, maintaining appropriate boundaries, and recognizing signs such as sadness, bruises, or isolation. Additionally, the staff articulated strategies to prevent inappropriate relationships with youth, comply with mandated reporting laws, and understand age of consent regulations. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (c). Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, apart from reporting to the designated supervisors or officials and designated State or local service agencies, agency 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. · Policy: PREA Zero Tolerance Policy: During the PREA audit phase the facility updated its policy to include the above referenced language. Interviews Random Sample of Staff: Staff indicated a clear understanding of the duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurs. The various ways staff indicated that they would report included, but was not limited to: · Report to supervisor · PREA Coordinator · Email to Program Director · Text message · Contact Police Corrective Actions:

	Policy: Policy was updated to include the above referenced language. No further action is needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (d). Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws. (2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Incidents/investigation report: The auditor reviewed allegations made of sexual abuse or sexual harassment. Said allegations were reported. Interviews Medical and Mental Health Staff: The staff members interviewed indicated that they are required to disclose the limitations of confidentiality and their duty to report at the initiation of services. They must also report any knowledge, suspicion, or information regarding incidents of sexual abuse or harassment to a designated supervisor or official immediately upon becoming aware of it. Furthermore, staff reported that the limitations of confidentiality and mandatory reporting are communicated to residents during intake, and parents are also notified accordingly. Staff confirmed their awareness of past incidents, whether occurring onsite or elsewhere, and stated that such incidents were promptly reported. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (e). Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's case worker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Incidents/investigation report: The auditor reviewed allegations made of sexual abuse or sexual harassment. Said allegations were reported. Additionally, the form documents to whom all it has been reported. Interviews PREA Compliance Manager- The facility does not have a PREA compliance manager. Director – When the facility receives an allegation of sexual abuse the response would be to report to DHS, local Law Enforcement, and the Probation Officer. From there the alleged victims and perpetrators, parent/guardian and probation officer will be notified. If the victim is in the child welfare system, the caseworker would be notified. Notifications are made at the time of the report. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (f). The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Incidents/investigation reports: The auditor reviewed allegations made of sexual abuse or sexual harassment. Said allegations were reported. Additionally, the form documents to whom all it has been reported. Interviews Director: All allegations of sexual abuse and sexual harassment are reported to agency PREA Coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings:

	The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.362	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Policy: Protection Against Retaliation 2. Interviews: a. Agency head b. Director c. Random sample of staff (13) Findings (By Provision): 115.362 (a). When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. In the past 12 months, the number of times the agency or facility has determined that a resident was subject to a substantial risk of imminent sexual abuse: 0. · Policy: The Protection Against Retaliation policy includes the above-mentioned language. “To ensure that residents at the facility are protected from retaliation due to a report of sexual abuse/rape or harassment. When a resident is subject to a

	substantial risk of imminent sexual abuse, the facility will take immediate action to protect the resident" (p. 1). Interviews Agency Head/Director: The interviewed agency head reported that when they learn that residents are subject to a substantial risk of imminent sexual abuse, immediate protective actions are taken by the facility. A safety plan will be developed immediately, and the parents and case worker will be notified. All staff are expected to report immediately. Random Sample of Staff - The 13 interviewed staff stated that if it is determined that a youth is at imminent risk of sexual abuse, they would promptly separate the individual from others, notify their supervisor, and initiate these actions immediately. Staff articulated that they would immediately take action to keep youth safe from harm of sexual abuse or sexual harassment. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.363	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Tolerance (2023) c. Investigation/Incident Report (7)-standard 115.386 d. Follow up communication with external source-reported to another facility

	2. Interviews: a. Agency head b. Director 115.363 (a). Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ the agency 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, the number of allegations the facility received that a resident was abused while confined at another facility: 1. · Policy: The PREA Zero Tolerance Policy states that “If a report is received of sexual abuse from another agency, the Executive Director must report Director-to-Director to the other facility within 72 hours. NOTE: All other applicable reporting requirement still apply” (p. 6). · Investigation (1): the facility documented on an investigation report that an allegation was made to another facility and that the call was made verbally not via email. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.363 (b). Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

	· Policy: The PREA Zero Tolerance Policy states that “If a report is received of sexual abuse from another agency, the Executive Director must report Director-to-Director to the other facility within 72 hours. NOTE: All other applicable reporting requirement still apply” (p. 6). · Investigation (1): the facility documented on an investigation report that an allegation was made to another facility and that the call was made verbally not via email. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.363 (c). The agency shall document that it has provided such notification. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. · Investigation (1): the facility documented on an investigation report that an allegation was made to another facility and that the call was made verbally not via email. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.363 (d). The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency or facility requires that all allegations received from other agencies or facilities are investigated in accordance with the PREA standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: 1. · Policy: The PREA Zero Tolerance policy was updated to state “Allegations received from other facilities are investigated in accordance with PREA standards”

	(p. 6). · Incident Report: Upon review of the incident reports/investigations it was determined that one allegation was reported from another agency. The facility immediately investigated the allegation. Interviews Agency Head/Director: The interviewed staff reported that if another agency or facility within your agency refers allegations of sexual abuse or sexual harassment that occurred within one of the facilities the head of the agency where the alleged abuse occurred will be notified asap AND appropriate investigative agency will be notified. The agency head reported that there may have been one instance where this occurred, and it was investigated. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Institutional Plan (2023) c. Investigations/Incident Reports (7) 2. Interviews: a. Random sample of staff/Security Staff First Responders (14) b. Residents who Reported a Sexual Abuse (2) 3. Corrective Action: a. Staff Training 115.364. (a). Upon learning of an allegation that a resident was sexually abused, the

	first 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a first responder policy for allegations of sexual abuse. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report separate the alleged victim and abuser. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. policy requires that, if the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report 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. The policy requires that, if the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report 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. In the past 12 months, the number of allegations that a resident was sexually abused: 6. Of these allegations, the number of times the first security staff member responded to the report separated the alleged victim and abuser: 0. In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report preserved and protected any crime scene until appropriate steps could be taken to collect any evidence: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report requested 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: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report ensured 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: 0.

· Policy: The PREA Institutional Response Plan outlines a comprehensive protocol or process for the agency to respond to allegations of sexual abuse.

· Investigation Report: The auditor reviewed all allegations of sexual abuse and harassment. There were no allegations where evidence was collected.

Interviews

Random Sample of Staff/ Security Staff and Non-Security Staff First Responders: All interviewed staff confirmed that if they were the first to be notified of alleged sexual abuse, they would immediately inform their group leader and wait for further instructions. They also stated that they would not share the information with other youth or staff who were not directly involved in managing the incident. The one staff interviewed who was considered non-security, could fluently articulate the first responder protocol.

Residents who Reported a Sexual Abuse: Two residents in custody were interviewed regarding a reported sexual abuse incident. Upon further review, it was determined that one resident's account described sexual harassment rather than sexual abuse. When asked if he had ever reported a sexual abuse incident, he stated that he had not. The other youth mentioned that once staff were informed, they promptly relocated the youth from the housing area. The resident interviewed stated that the sexual abuse incident was reported to staff immediately after it occurred, and the youth involved were promptly separated from one another. One resident reported the incident to staff, who promptly separated them from the other residents. They were then seen by the Star Center (CACGA), and the police were contacted.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.364 (b). If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ all staff members are not considered first responders. Of the allegations that a resident was sexually abused in the past 12 months, the number of times a non-security staff member was the first responder: 0. However after further review it was reported that all staff are trained the same. · Investigation Report: The auditor reviewed four allegations of sexual abuse. One allegation was reported by an outside entity for an allegation that occurred several years ago. The actions immediately taken for the three allegations of sexual abuse were documented in the report. Interviews Random Sample of Staff/ Security Staff and Non-Security Staff First Responders – All interviewed staff confirmed that if they were the first to be notified of alleged sexual abuse, they would immediately inform their group leader and wait for further instructions. They also stated that they would not share the information with other youth or staff who were not directly involved in managing the incident. Corrective Actions: Training: Staff demonstrated a general understanding of their first responder duties, however without extra prompting they struggled to have a full understanding on protecting and preserving the crime scene. The auditor is recommended additional training to the direct care staff. The facility shall provide the auditor with the additional training material and signed acknowledgement of participation in the training. Ø Corrective Action Taken: The facility provided documentation that the staff completed the training. The content of the training was also provided. Overall Findings: The auditor employed a triangulation approach to assess compliance with the PREA standards, incorporating a thorough review of facility documentation, agency policies, on-site observations, site reviews, interviews with staff and residents, input from local and national advocates, and the online PREA Audit: Pre-Audit Questionnaire. Based on this comprehensive analysis, the facility was initially placed in corrective action to address deficiencies in staff training related to the first responder protocol. The initial review identified inconsistent staff understanding of their responsibilities in the event of a report or discovery of sexual abuse, particularly concerning evidence preservation, resident safety, and immediate notification procedures. In response, the facility implemented targeted corrective measures, including the revision of training materials to emphasize the first responder duties for both security and non-security staff. All staff received refresher training that outlined the specific steps to take upon receiving a report of sexual abuse or witnessing an incident, with a focus on securing the scene, separating the victim and alleged abuser, preserving evidence, and making the appropriate notifications without

	delay. The auditor verified the effectiveness of these corrective actions through staff interviews, review of training logs and materials, and observation of facility practices during the on-site visit. Staff demonstrated a clear understanding of the first responder protocol and their role in protecting residents and preserving the integrity of an investigation. Based on the corrective actions taken and confirmed through multiple sources, the auditor concludes that the facility is now in full compliance with the PREA standard concerning first responder responsibilities.

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Institutional Response Plan (2023) 2. Interviews: a. Director Findings (By Provision): 115.365 (a). The facility shall develop 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. · Policy: The PREA Institutional Response Plan outlines a comprehensive protocol or process for the agency to respond to allegations of sexual abuse. Interviews

	Director: All levels of staffing are provided training on how to respond to incidents of sexual abuse or sexual harassment. We have a care coordinated team who meet weekly, and we would review all the allegations. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) 2. Interviews: a. Agency head Findings (By Provision): 115.366 (a). Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	N/A-As reported in the PAQ, the agency, facility, or any other government 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. Interviews Agency Head – The interviewed agency head reported that the agency is not responsible for collective bargaining. Corrective Actions: N/A. There are no corrective actions for this provision. 115.366 (b). Auditor is not required to audit this provision. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.366 (b). Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Protection Against Retaliation (2023) 2. Interviews: a. Agency head

b. Director

c. Designated staff member charged with monitoring retaliation

d. Residents who Reported a Sexual Abuse (2)

3. Corrective Action:

a. Training Material and Roster (also in standard 115.371)

Findings (By Provision):

115.367 (a). The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, 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 agency has a designated staff charged with monitoring for retaliation.

· Policy: The PREA Protection Against Retaliation policy states that “The facility will take appropriate measures to protect any individual who cooperates with an investigation who expresses fear of retaliation” and “The facility will protect all employees that have fear of retaliation due to the participation in an investigation. Woodward Academy has a core protection against retaliation policy” (p. 2).

Corrective Actions:

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.367 (b). 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· The facility reported in the PAQ, that zero residents that were placed on

segregated housing after reporting sexual abuse or sexual harassment.

· Four Incident Reports of Sexual Abuse were reported and reviewed. One incident was an allegation reported years after the alleged event. Of the three incidents, the staff immediately took protective measures, and it was documented in the incident report; however, monitoring for retaliation did not occur at the onset of the allegations.

Interviews

Agency Head/Director: The interviewed agency head reported that there is a designated staff member who monitors such retaliation. We will separate the parties involved. If staff are involved, they will be put on leave. A safety plan will be put in place. We will involve all disciplines to produce the best course of action.

Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported part of their responsibility is to ensure that clients and staff do not retaliate against reporters of sexual abuse and sexual harassment. Monitoring would occur by ensuring clients nor staff retaliate against reports of sexual abuse and sexual harassment. This is done by monitoring the day-to-day interactions with staff and clients, review of consequences given to clients or disciplinary actions by supervisor to staff, and regular interactions with clients/staff. If retaliation is suspected, clients can be moved to another housing unit, and staff would be addressed. The monitoring would begin as soon as the residents are notified of the outcome of the investigation.

Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – During the site review there were no residents identified that were placed in isolation. It was further determined that the facility does not use isolation.

Residents who Reported a Sexual Abuse – The interviewed residents stated that they do not feel that staff or other residents have attempted to retaliate against them for reporting. Overall, they feel safe and protected at the program.

Corrective Actions:

Monitoring for Retaliation: Upon review it was determined that the facility has a process where monitoring for retaliation occurred at the end of the investigation. The facility shall develop a written process and retrain staff that conduct monitoring for retaliation on requirement to start the process at the onset of the allegation being made. The facility shall provide the auditor with the training material covered and documentation of the training and enhanced process. Additionally, the auditor recommends that the PREA Standard in Focus is included in the training.

Ø Corrective Action Taken: The additional training was provided. No further action is required.

115.367 (c). For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the agency/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. It was further reported that the agency/ facility acts promptly to remedy any such retaliation; and the agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The number of times an incident of retaliation occurred in the past 12 months: 2.

· Policy: The PREA Zero Tolerance Policy states that “A designated employee must monitor staff and client to prevent retaliation for a minimum of 90 days after a sexual abuse report is made” (p. 6).

1. Four Incident Reports of Sexual Abuse were reported and reviewed. One incident was an allegation reported years after the alleged event. Of the three incidents, the staff immediately took protective measures, and it was documented in the incident report; however, monitoring for retaliation did not occur at the onset of the allegations.

Interviews

Director: The interviewed staff reported that when a client alleges sexual abuse or sexual harassment by a staff member, the staff member is not permitted to return to work until the investigation has cleared them of wrongdoing or they are terminated due to the findings of the investigation. If the allegation involves another client, the clients are immediately separated due to the findings of the investigation.

Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported that when monitoring some of the things that would be looked at when it comes to detecting retaliation is aggressive behaviors, threats, fights, or arguments. Monitor would also review if there were excessive write ups, room changes, improper treatment, change of behavior and is the youth are being treated fairly. Monitoring would occur for as long as needed and would be initiated as soon as the youth are notified of the results of the investigation. While the policy says 90 days if we have to monitor longer we would.

Corrective Actions:

	Monitoring for Retaliation: Upon review it was determined that the facility has a process where monitoring for retaliation occurred at the end of the investigation. The facility shall develop a written process and retrain staff that conduct monitoring for retaliation on requirement to start the process at the onset of the allegation being made. The facility shall provide the auditor with the training material covered and documentation of the training and enhanced process. Additionally, the auditor recommends that the PREA Standard in Focus is included in the training. Ø Corrective Action Taken: The additional training was provided. No further action is required. 115.367 (d). In the case of residents, such monitoring shall also include periodic status checks. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Four Incident Reports of Sexual Abuse were reported and reviewed. One incident was an allegation reported years after the alleged event. Of the three incidents, the staff immediately took protective measures, and it was documented in the incident report; however, monitoring for retaliation did not occur at the onset of the allegations. Interviews Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported that when monitoring some of the things that would be looked at when it comes to detecting retaliation is change of behaviors, threats, fights, or a youth reporting they feel unsafe. The monitor would also review if there were excessive write ups, room changes, improper treatment, housing changes, change of behavior and if the youth are being treated fairly. Corrective Actions: Monitoring for Retaliation: Upon review it was determined that the facility has a process where monitoring for retaliation occurred at the end of the investigation. The facility shall develop a written process and retrain staff that conduct monitoring for retaliation on requirement to start the process at the onset of the allegation being made. The facility shall provide the auditor with the training material covered and documentation of the training and enhanced process. Additionally, the auditor recommends that the PREA Standard in Focus is included in the training. Ø Corrective Action Taken: The additional training was provided. No further action is required. 115.367 (e). 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Four Incident Reports of Sexual Abuse were reported and reviewed. One incident was an allegation reported years after the alleged event. Of the three incidents, the staff immediately took protective measures, and it was documented in the incident report; however, monitoring for retaliation did not occur at the onset of the allegations. Interviews Agency Head/Director: The interviewed agency head reported that there is a designated staff member who monitors such retaliation. We will separate the parties involved. If staff are involved, they will be put on leave. A safety plan will be put in place. We will involve all disciplines to produce the best course of action. Corrective Actions: Monitoring for Retaliation: Upon review it was determined that the facility has a process where monitoring for retaliation occurred at the end of the investigation. The facility shall develop a written process and retrain staff that conduct monitoring for retaliation on requirement to start the process at the onset of the allegation being made. The facility shall provide the auditor with the training material covered and documentation of the training and enhanced process. Additionally, the auditor recommends that the PREA Standard in Focus is included in the training. Ø Corrective Action Taken: The additional training was provided. No further action is required. 115.367 (f). The auditor is not required to audit this provision. Overall Findings: The auditor employed a comprehensive triangulation approach to assess the facility's compliance with the Prison Rape Elimination Act (PREA) standards. This approach included a thorough review of facility documentation, agency policies, on-site observations, site reviews, facility practices, interviews with staff and residents, consultation with local and national advocacy organizations, and analysis of the PREA Audit: Pre-Audit Questionnaire. The facility was placed into corrective action to address identified deficiencies related to the monitoring of residents and staff for potential retaliation following reports of sexual abuse or harassment. During the corrective action period, the facility took substantial and verifiable steps to bring its practices into full compliance with PREA requirements. Through these corrective measures, the facility demonstrated a strong commitment to ensuring the safety and protection of individuals who report sexual abuse or

	harassment, as well as those who assist in such reporting. As a result, the facility has successfully remedied the identified deficiencies and is determined to be in compliance with the standard pertaining to monitoring for retaliation.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) 2. Interviews: a. Director b. Medical and mental health staff (2) Findings (By Provision): 115.368 (a). Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility does not have a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. It was further reported that the facility policy does not require that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. · The number of residents who alleged to have suffered sexual abuse who were placed in isolation in the past 12 months: 0. The number of residents who allege to have suffered sexual abuse who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education or special education services in the past 12 months: 0.The average period of time residents who alleged to have suffered sexual abuse were held in isolation to protect them

	from sexual victimization in the past 12 months: 0. From a review of case files of residents at risk of sexual victimization who were held in isolation in the past 12 months, the number of case files that include BOTH: • A statement of the basis for facility's concern for the resident's safety, and • The reason or reasons why alternative means of separation cannot be arranged: 0. · The facility does not utilize isolation. Interviews Director: The interviewed director reported that the facility does not utilize isolation. Medical and Mental Health Staff: The staff interviewed reported that the site does not have isolation. Staff who Supervise Residents in Isolation – The facility does not have staff who supervise residents in isolation. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – During the onsite audit and upon file review there were no residents held in isolation. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.371	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Investigations Training (2023)

c. Policy: PREA Referral for Investigation (2023)

d. Policy: PREA Zero Tolerance (2023)

e. Investigations (7)

2. Interviews:

a. Investigative staff (1)

b. Director

c. PREA coordinator

d. Residents who Reported a Sexual Abuse (2)

3. Corrective Action:

a. Retrain Investigation Staff Material and Roster (5)

b. Investigative Report

Findings (By Provision):

115.371 (a). When the agency 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the agency/facility has a policy related to criminal and administrative agency investigations.

· Policy: PREA Investigation Training states that “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 will only use trained investigators who have received training in sexual abuse investigations involving juvenile victims” (p. 2).

· Investigation Reports: Seven allegations reported were reviewed. The auditor could determine that all the allegations, no matter the source, were investigated immediately.

Interviews

Investigative Staff: The interviewed staff reported that when an allegation of sexual abuse or sexual harassment is received the investigation are conducted immediately. Anonymous and third-party reports of sexual abuse are managed the same.

	Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (b). Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334. Compliance Determination: · The agency has two administrative investigations. As reported in standard 115.334, the agency investigators have completed the required specialized training for investigating allegations of sexual abuse in a confinement setting. Interviews Investigative Staff: The interviewed staff reported that they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings. The training was completed online; the PREA Resource Investigative training. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Reports: Seven allegations reported and were reviewed. The facility does not have a process where it gathers statements. The investigation report discusses talking to involved parties and reviewing camera footage, but gathering statements is not included in the process. Interviews Investigative Staff: The interviewed staff reported that the first steps in initiating an investigation include immediately ensuring that 1st responders do what they are

	supposed to do; get with the victim and perpetrator and gather statements, gather staff statements, and review video footage. If medical or mental health services are needed, it would immediately be addressed. Criminal investigations are reported immediately to the local authorities, Department of Human Resources, and the Department of Youth Services. Administrative Investigations involve gathering statements from all parties involved and collecting any other pertinent information. Direct or circumstantial evidence is managed in the following manner: statements from staff/clients and video monitoring footage would be collected. Any physical/ DNA evidence would be collected by the Local Law Enforcement Agency. Corrective Actions: Training Enhancement: Develop and implement a detailed training program for investigative staff that includes procedures for gathering statements from all involved parties. This training should emphasize the importance of documenting statements to support thorough investigations. The facility shall provide documentation of the PREA training along with the training material. The auditor recommends that the facility utilizes resources provided on the PREA Resource Center website to conduct the training. Ø Corrective Action Taken: The additional training was provided. No further action is required. Monitoring PREA Allegations: The auditor will review any new allegations, and monitoring will occur in 60 days increments to determine compliance, not to exceed 180 days. The facility shall provide documentation of all allegations and its subsequent incident report/investigation. Ø Corrective Action Taken: An allegation that occurred during the corrective action period was reviewed to show that the facility has conducted a thorough investigation and said investigation was documented. Standard Operating Procedures: Update the facility's investigation procedures to explicitly include the gathering of statements from victims, perpetrators, witnesses, and staff members. Ensure these procedures are documented and accessible to all investigative personnel. The facility shall provide documentation on the enhanced operating procedures. Ø Corrective Action Taken: The additional training was provided. No further action is required. Ø Corrective Action Taken: An allegation that occurred during the corrective action period was reviewed to show that the facility has conducted a thorough investigation and said investigation was documented. 115.371 (d). The agency shall not terminate an investigation solely because the source of the allegation recants the allegation. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ the facility does not terminate an investigation solely because the source of the allegation recants the allegation. · Policy: The PREA Referral for Investigation policy states that “The facility will not terminate an internal investigation based solely on the allegation being recanted, or employment being terminated. If during the course of an internal investigation, criminal activity is established, the Executive Director will immediately contact local authorities for further investigation. The facility will cooperate with any investigation conducted by an outside authority. Upon completion of an external investigation, the facility will request the findings from the appropriate agency in order to inform the resident” (p. 2). Interviews Investigative Staff: The staff interviewed reported that an investigation would not terminate if the source of the allegation recants their allegation. An investigation will follow, and evidence and statements will be gathered to determine if the original allegations are true. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (e). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Report: After reviewing the PREA-related allegations, no allegations were found to warrant criminal prosecution. Interviews: Investigative Staff: The staff interviewed reported that any incident that is potentially criminal in nature would not be investigated administratively. NO interviews would be done by Administrative Staff, this would be left to local law enforcement. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (f). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff: The interviewed investigator reported the credibility is based on history of honesty/dishonesty and motivation for the involvement in the incident. Residents are not subject to a polygraph test. Resident who Reported Sexual Abuse – The interviewed residents were asked if they were subjected to a polygraph test. The residents reported that they were not subjected to a polygraph test. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (g). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Reports: Seven allegations reported and were reviewed. The facility does not have a process where it gathers statements. The investigation report discusses talking to involved parties and reviewing camera footage, but gathering statements is not included in the process. Site Review:

RECORD STORAGE
During the site review, the auditor must:

· Risk Screening Process:

o The risk screening and other assessment tools (e.g., Assessments, biopsychosocial evaluations, and treatment plans are securely stored in an electronic case management system.

o Additional documentation on the residents in paper files is kept in a locked file cabinet in the medical office, accessible only to medical staff.

o Onsite the facility has a locked records room for current resident files and a separate locked records room for prior residents. Records have been retained for seven years.

o The records room is locked and secured, limited to medical and leadership staff. Cameras are placed in the hallways accessible to the record rooms.

· Investigation Files:

o Investigation files are stored in an electronic database limited to the facility investigators and the facility director. The system is called Healthicity.

· Access Control:

o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is not restricted.

· Conversations with staff have indicated that access to the case management system, specifically the assessments, is currently unrestricted.

Interviews

Investigative Staff: The interviewed investigator reported that interviews are conducted with staff to determine what actions were taken, video footage is reviewed. Based on this information many actions can be taken including disciplinary action and implemented corrective action plan implemented. Administrative investigations are documented. Information in the report includes if there is a need for policy change, physical barriers, and technology.

Corrective Actions:

Training Enhancement: Develop and implement a detailed training program for investigative staff that includes procedures for gathering statements from all involved parties. This training should emphasize the importance of documenting statements to support thorough investigations. The facility shall provide documentation of the PREA training along with the training material. The auditor recommends that the facility utilizes resources provided on the PREA Resource Center website to conduct the training.

	Ø Corrective Action Taken: The additional training was provided. No further action is required. Monitoring PREA Allegations: The auditor will review any new allegations, and monitoring will occur in 60 days increments to determine compliance, not to exceed 180 days. The facility shall provide documentation of all allegations and its subsequent incident report/investigation. Ø Corrective Action Taken: The auditor reviewed the allegation and incident report to verify a thorough and complete investigation. Standard Operating Procedures: Update the facility's investigation procedures to explicitly include the gathering of statements from victims, perpetrators, witnesses, and staff members. Ensure these procedures are documented and accessible to all investigative personnel. The facility shall provide documentation on the enhanced operating procedures. Ø Corrective Action Taken: The additional documentation was provided. No further action is required. 115.371 (h). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Investigation Report: After reviewing the PREA-related allegations, no allegations were found to warrant criminal prosecution. Interviews Investigative Staff: Criminal investigations referred to law enforcement to investigate. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (i). Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, there were zero substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20,2012, or since the last PREA audit. · The number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012, or since the last PREA audit, whichever is later: 0. · Policy: The PREA Referral for Investigation policy states that “An internal investigation will begin immediately, however in case of alleged sexual abuse this investigation will be referred to be administered by the proper authorities (i.e., state licensing, CPS/DCS, local law enforcement). The facility is responsible for the administrative investigation. Local law enforcement and CPS/DCS will be responsible for conducting the criminal investigation. The facility documents all referrals or allegations of sexual abuse or sexual harassment for criminal investigation” (p. 1). Interviews Investigative Staff: The interviewed staff reported that cases are referred to prosecution when an investigation reveals the incident may be criminal in nature. This process would occur via local law enforcement investigation and referral. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (j). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ the agency retains all written reports pertaining to administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. · Policy: The PREA Referral for Investigation policy states that “The facility shall make an administrative determination based on the preponderance of evidence gathered during the course of the investigation. This documentation will be retained for as long as the alleged abuser is a resident or employee of the facility, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention” (p. 1). · Investigation Reports: All reported allegations were investigated. There were

	no allegations involving a staff member who departed the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (k). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff: If a staff member alleges to have committed sexual abuse or sexual harassment terminates employes the investigation continues regardless of if her or she is still employed. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (l). Auditor is not required to audit this provision. 115.371 (m). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Director: When an outside agency is investigated, the facility will stay informed by staying in contact with the investigator. We would contact regularly for updates. PREA Coordinator - The interviewed PREA Coordinator reported that we would follow up and stay in touch with the law enforcement investigator. PREA Compliance Manager- The facility does not have a PREA compliance manager. Investigative Staff: If an outside agency investigates, the investigator and the PREA

	Coordinator will maintain regular contact with the outside agency to ensure updated information is provided and to keep the victim updated as well. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor utilized a triangulation approach to assess compliance with the PREA standards, drawing from a comprehensive review of facility documentation, agency policies, on-site observations, facility practices, interviews with staff and residents, feedback from local and national advocates, and information provided in the PREA Audit: Pre-Audit Questionnaire. Based on this analysis, the facility was placed in corrective action to address concerns related to the investigative process. Specifically, the auditor identified areas requiring improvement, including the timeliness, thoroughness, and documentation of investigations into allegations of sexual abuse and sexual harassment, as well as the consistency in applying investigative protocols in accordance with PREA standards. To address these concerns, the facility implemented a corrective action plan that included enhanced training for investigators focused on trauma-informed practices, evidence collection, and documentation requirements. Investigation protocols were updated to reflect PREA-compliant standards, and supervisory oversight mechanisms were introduced to ensure quality control and accountability throughout the investigative process. The auditor monitored progress throughout the corrective action period, reviewing updated policies and training records, sampling investigation files, and conducting follow-up interviews with investigative staff and supervisors. Based on the corrective measures taken and verified through documentation, observations, and interviews, the auditor finds that the facility has made the necessary improvements and is now in full compliance with the PREA standards governing the investigative process.

115.372	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy: PREA Referral Investigations (2023)

c. Investigations (7)

2. Interviews:

a. Investigative staff (1)

3. Corrective Action:

a. Retrain Investigative Staff Material and Roster

Findings (By Provision):

115.372 (a). The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· The facility reported in the PAQ, that the agency imposes a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated.

· Policy: The PREA Referral for Investigation policy states that “The facility shall make an administrative determination based on the preponderance of evidence gathered during the course of the investigation. This documentation will be retained for as long as the alleged abuser is a resident or employee of the facility, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention” (p. 2).

· Investigations: documentation of administrative findings was reviewed for proper standard of proof. The internal investigation report description of how findings were determined was descriptive.

Interviews

Investigative Staff: In general, the standard of evidence require substantiate allegations of sexual abuse or sexual harassment, is that no greater than a preponderance of evidence or clear and concise evidence.

Corrective Actions:

Training Enhancement: Develop and implement a detailed training program for investigative staff that includes procedures for gathering statements from all

	involved parties. This training should emphasize the importance of documenting statements to support thorough investigations. The facility shall provide documentation of the PREA training along with the training material. The auditor recommends that the facility utilizes resources provided on the PREA Resource Center website to conduct the training. Ø Corrective Action Taken: The additional training was provided. No further action is required. Monitoring PREA Allegations: The auditor will review any new allegations, and monitoring will occur in 60 days increments to determine compliance, not to exceed 180 days. The facility shall provide documentation of all allegations and its subsequent incident report/investigation. Ø Corrective Action Taken: The additional documentation was provided. No further action is required. Standard Operating Procedures: Update the facility's investigation procedures to explicitly include the gathering of statements from victims, perpetrators, witnesses, and staff members. Ensure these procedures are documented and accessible to all investigative personnel. The facility shall provide documentation on the enhanced operating procedures. Ø Corrective Action Taken: The additional documentation was provided. No further action is required. Overall Findings: The auditor utilized a triangulation approach to assess compliance with PREA standards, incorporating a thorough review of facility documentation, agency policies, on-site observations, site review of facility practices, interviews with staff and residents, input from local and national advocates, and the online PREA Audit: Pre-Audit Questionnaire. During the audit, the facility was placed in corrective action to address the need for additional training for staff responsible for conducting PREA investigations. The initial review identified gaps in the consistency and completeness of investigations, highlighting the need for enhanced instruction on investigative protocols, documentation, and compliance with PREA requirements. In response, the facility developed and delivered targeted training for all designated investigators. This training focused on proper investigative procedures, trauma-informed practices, timelines for completing investigations, and clear documentation of findings. Supervisory oversight was also implemented to ensure the quality and consistency of investigative outcomes. Based on the corrective actions taken and verified through observation, documentation, and interviews, the auditor finds that the facility has successfully addressed the identified deficiencies and is now in full compliance with the PREA standard related to investigations.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Referral Investigations (2023) c. Investigations (7) 2. Interviews: a. Director b. Investigative staff (1) c. Resident who Reported a Sexual Abuse (2) 3. Corrective Action: a. Retrain Investigative Staff Material and Roster Findings (By Provision): 115.373 (a). Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency 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 agency. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility in the past 12 months: 6. Of the alleged sexual abuse investigations that were completed in the past 12 months, the number of residents who were notified, verbally or in writing, of the results of the investigation: 5. · Policy: The PREA-Referral for Investigation policy states that “Upon completion of an internal investigation into a resident’s allegation of sexual abuse/harassment, the PREA Compliance Manager or designee will inform the resident as to whether

	the allegation has been determined to be substantiated, unsubstantiated, or unfounded (by way of the PREA Compliance Manager's administrative report)" (p. 2). · While the investigation file indicated that notification was completed on the sexual abuse allegations. The investigator placed a note, however, did not have the resident sign that they received notification. The document has a signature line for the residents and staff who are conducting the notification. Interviews Director: Upon completion of the investigation, the PREA Coordinator is responsible for staying informed of the results of the investigation. Investigative Staff: The interviewed investigator reported that residents are notified of the results of the investigation. The practice is to document that the resident is notified. This would occur if the resident was still in custody. Corrective Actions: Training: Retrain Investigation staff on completing the notification form in entirety. Residents shall sign that they receive notification. The facility shall provide documentation of the training completed along with the subsequent training material. Ø Corrective Action Taken: The additional training was provided. No further action is required. Notification: The auditor shall review allegations reported during the corrective action period to determine compliance. Ø Corrective Action Taken: The auditor reviewed an attempt of notification, where a resident was released prior to the completion of the investigation. No further action is required. 115.373 (b). If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the residents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the residents of the outcome of the investigation. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months: 0. Of the outside agency investigations of alleged sexual abuse that were completed in the past 12 months, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: 0.

	· Investigation Reports: Upon review of investigation reports there were no outside agency investigations. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.373 (c). Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: (1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency 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 agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or • The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. There have been zero substantiated or unsubstantiated complaints (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in an agency facility in the past 12 months. While there were zero reported allegations of sexual abuse, the facility has a form (PREA Post Investigation Resident Notification) to notify residents of the results of the sexual abuse allegation. · Policy: The PREA Referral for Investigations policy states that "Following a resident's allegation of sexual abuse by an employee, unless unfounded, the resident shall subsequently be informed verbally and by written documentation: 1. The staff member is no longer assigned to the resident's unit, 2. The staff are no longer employed at the facility 3. The facility learns that the employee has been indicted or convicted on a charge related to sexual abuse at the facility (p. 2). · Investigations/Incident Reports (6): Six incident reports were reviewed. One allegation involved current residents and staff. The incident was found unfounded.

	Interviews: Residents who Reported a Sexual Abuse – The interviewed residents' allegations did not involve staff members. Corrective Actions: Training: Retrain Investigation staff on completing the notification form in entirety. Residents shall sign that they receive notification. The facility shall provide documentation of the training completed along with the subsequent training material. Ø Corrective Action Taken: The additional training was provided. No further action is required. Notification: The auditor shall review allegations reported during the corrective action period to determine compliance. Ø Corrective Action Taken: The auditor reviewed an attempt of notification, where a resident was released prior to the completion of the investigation. No further action is required. 115.373 (d). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: • The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or • The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. There were no reported allegations of sexual abuse. · Policy: The PREA Referral for Investigation policy states that "Following a resident's allegation is of sexual abuse by another resident, the resident shall be informed whenever: 1. The facility learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse at the facility. 2. The facility is responsible for the publication of criminal investigations.

	3. The facility attaches copies of all documentary evidence where feasible. This information is kept in the PREA Compliance Manager's Office with the investigation findings (p. 2). · Notifications: There were two allegations of sexual abuse involving youth on youth. The facility reported notification occurred however the resident did not sign the agency form. Interviews: Residents who Reported a Sexual Abuse - The interviewed residents stated that they were not given any information about the other individual involved in the sexual abuse incident but noted that they were aware the individual was no longer on campus. Corrective Actions: Training: Retrain Investigation staff on completing the notification form in entirety. Residents shall sign that they receive notification. The facility shall provide documentation of the training completed along with the subsequent training material. Ø Corrective Action Taken: The additional training was provided. No further action is required. Notification: The auditor shall review allegations reported during the corrective action period to determine compliance. Ø Corrective Action Taken: The auditor reviewed an attempt of notification, where a resident was released prior to the completion of the investigation. No further action is required. 115.373 (e). All such notifications or attempted notifications shall be documented. Compliance Determination: The facility has demonstrated compliance with the provision of this standard because: · As reported in the PAQ, the facility has a policy that all notifications to residents described under this standard are documented. In the past 12 months, the number of notifications to residents that were provided pursuant to this standard: 0. Of those notifications made in the past 12 months, the number that was documented: 5. · Policy: PREA Referral Investigations states that "Following a resident's allegation of sexual abuse by an employee, unless unfounded, the resident shall subsequently be informed verbally and by written documentation: o The staff member is no longer assigned to the resident's unit,

	o The staff is no longer employed at the facility o The facility learns that the employee has been indicted or convicted on a charge related to sexual abuse at the facility. Following a resident's allegation of sexual abuse by another resident, the resident shall be informed whenever: o The facility learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse at the facility. o The facility is responsible for the publication of criminal investigations. o The facility attaches copies of all documentary evidence where feasible. This information is kept in the PREA Compliance Manager's Office with the investigation findings. · Notifications were not documented. Corrective Actions: Training: Retrain Investigation staff on completing the notification form in entirety. Residents shall sign that they receive notification. The facility shall provide documentation of the training completed along with the subsequent training material. Ø Corrective Action Taken: The additional training was provided. No further action is required. Notification: The auditor shall review allegations reported during the corrective action period to determine compliance. Ø Corrective Action Taken: The auditor reviewed an attempt of notification, where a resident was released prior to the completion of the investigation. No further action is required. 115.373 (f). The auditor is not required to audit this provision. Overall Findings: The auditor utilized a comprehensive triangulation approach to assess compliance with the PREA standards, drawing upon a thorough review of facility documentation, agency policies, on-site observations, site reviews, facility practices, interviews with staff and residents, input from local and national advocates, and responses provided in the PREA Audit: Pre-Audit Questionnaire. During the initial audit, the facility was placed in corrective action to address the need for additional training for investigators and staff responsible for administering notifications to residents at the conclusion of a PREA investigation. This requirement ensures residents are properly informed of the outcome of investigations in accordance with the PREA standard.

	In response, the facility implemented a corrective action plan that included enhanced, scenario-based training for investigators and designated staff. The training focused on the required elements of post-investigation notifications, appropriate documentation procedures, and strategies for delivering notifications in a trauma-informed and respectful manner. Refresher sessions and supervisory oversight were also introduced to ensure consistent application. Based on these corrective measures and verification through documentation and interviews, the auditor concludes that the facility has successfully addressed the identified deficiency and is now in full compliance with the standard.

115.376	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Zero Disciplinary Sanctions for Staff (2023) c. Policy Protection Against Retaliation (2023) d. Incident Reports/Investigations (7) Findings (By Provision): 115.376 (a). Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies. · Policy: The PREA Disciplinary Sanctions for Staff policy outlines the disciplinary steps that can be taken against tan employee based on the result of an allegation of sexual abuse and/or sexual harassment. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.376 (b). Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. In the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0. In the past 12 months, the number of staff from the facility who have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: 0. · Policy: The PREA Disciplinary Sanctions for Staff policy states that “Step 1: Administrative Leave without Pay: · In the event of a resident allegation of sexual assault/harassment against an employee of the facility, the employee will be placed on Administrative Leave without pay pending an investigation of the allegation. · This leave will be administered by the Human Resources Director (or Executive Director if HR is not available). Contact between the Human Resources Director and the employee will occur on a weekly basis. · Upon completion of the investigation; exoneration, disciplinary action or termination will be determined. · Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. · In the event of exoneration, the employee will be returned to work as soon as possible and will be paid for the time they were on Administrative Leave (p. 1). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.376 (c). 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· According to the PAQ, the disciplinary sanctions for violations of agency 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. In the past 12 months, the number of staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse): 0.

· Policy: The Protection Against Retaliation Policy states that “Disciplinary sanctions for violations of agency polices relating to sexual abuse or sexual harassment shall be commensurate with the nature and circumstances or the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories” (p. 1).

· Upon review of the Incident Reports/Investigations there was no staff disciplinary action required to be taken.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.376 (d). 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· According to the PAQ, 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, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: 0.

· Policy: The PREA Disciplinary Sanctions for Staff policy states that “Step 3:

	Recommendation for Termination of Employment: · If upon completion of an investigation, whether internal or external, the conclusion recommends termination of employment, the employee will be contacted by the Human Resources Director (or Executive Director in the absence of HR) to discuss the findings of the investigation and notify the employee of employment termination to be effective immediately. · When possible, the employee will meet with HR and PREA Compliance Manager in person to discuss the findings and sign termination paperwork. · If, upon completion of an investigation, a determination of criminal conduct is concluded, the proper law enforcement authorities will be contacted by the Executive Director" (p. 2) · Report to Law Enforcement: Upon review of the investigations/incident reports there were no reports to outside law enforcement. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard

115.377	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Corrective Action Contractors, Interns, Volunteers (2023) c. Incident Reports/Investigations (7)-standard 115.386

2. Interviews:

a. Director

Findings (By Provision):

115.377 (a). Any contractor or volunteer who engages in sexual abuse shall be 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, there have been zero volunteers or contractors who have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents in the past 12 months; nor any incidents/ persons reported to law enforcement for engaging in sexual abuse of residents. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, the number of contractors or volunteers reported to law enforcement for engaging in sexual abuse of residents: 0.

· Policy: The PREA Corrective Action for Contractors, Interns, and Volunteers policy states that “The facility takes appropriate remedial measures and considers 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. These efforts will be documented by the Human Resources Director or designee and placed in contracted employee, intern, or volunteer files” (p. 1).

· Upon review of the PREA Allegations there were no identified allegations involving interns, volunteers, or contractors.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.377 (b). 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ the facility takes appropriate remedial measures and considers 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: The PREA Corrective Action for Contractors, Interns, and Volunteers policy states that “The facility takes appropriate remedial measures and considers 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. These efforts will be documented by the Human Resources Director or designee and placed in contracted employee, intern, or volunteer files” (p. 1). · Upon review of the PREA Allegations there were no identified allegations involving interns, volunteers, or contractors. Interviews Director: Contractors or volunteers would not be allowed on the premises if they violated the agency sexual abuse or sexual harassment policy. There have been no circumstances for volunteer or contractors violating the agency PREA policy. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Disciplinary Sanctions for Residents (2023)

c. Incident Reports/Investigations (7)

2. Interviews:

a. Director

b. Medical and mental health staff (2)

Findings (By Provision):

115.378 (a). A resident may be 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, there were no reported residents subject to disciplinary sanctions following an administrative finding that the resident engaged in resident-on-resident sexual abuse, following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months, the number of administrative findings of resident-on-resident sexual abuse have occurred at the facility: 0. In the past 12 months, the number of criminal findings guilty of resident-on-resident sexual abuse that have occurred at the facility: 0.

· Policy: The PREA Disciplinary Sanctions for Residents policy states that “Disciplinary action may be administered only upon an administrative or criminal finding that the resident engaged in resident-on-resident sexual abuse” (p. 1).

· Incident Reports/Investigations: The auditor reviewed incident reports/ investigations and any actions taken to immediately address matters were documented on the incident report. It should be noted that no actions were found substantiated.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.378 (b). Per the PAQ, the facility does not utilize isolation.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· In the past 12 months, the number of residents placed in isolation as a

	disciplinary sanction for resident-on-resident sexual abuse: 0. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: 0. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied access to other programs and work opportunities: 0. · The auditor found that the site documents disciplinary actions on the incident reports. Interviews Director: The staff interviewed reported that any criminal findings of abuse would probably result in discharge from the program. All substantiated allegations and the disciplinary actions would be reviewed and assessed by the treatment team. The team would determine the best course of action. The Juvenile Court officer would also be consulted to determine what next steps we should take. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.378 (c). 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. The facility has demonstrated compliance with this provision of the standard because: · Policy: The PREA Disciplinary Sanctions for Residents policy states that “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 discipline, if any, should be imposed” (p. 1). · Disciplinary actions are documented on the incident report. Furthermore, the facility has a location on the report that indicates harm scale (impact to resident). Interviews Director: The staff interviewed reported that any criminal findings of abuse would probably result in discharge from the program. All substantiated allegations and the disciplinary actions would be reviewed and assessed by the treatment team. The team would determine the best course of action. The Juvenile Court officer would also be consulted to determine what next steps we should take. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.378 (d). 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 offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access general programming or education. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. It was further reported that if the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for the abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions. · Policy: The Disciplinary Sanctions for Residents policy states that “The facility offers therapy, counseling, or other interventions (Trauma Focused Care) designed to address and correct the underlying reasons or motivations for abuse. The facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or behavior-based incentives. These efforts must be documented by the assigned Therapist or designee” (p. 1). · It should also be noted that the program offers a Problematic Sexualized Behavior program for males aged 12-18 years old. Interviews Medical Staff: The staff interviewed reported that if needed individual services would be provided. Services are on a voluntary basis. The clients can choose not to participate; however, the program does not utilize isolation. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility are fully compliant with this provision. 115.378 (e). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility disciplines resident sexual contact with staff only upon finding that the staff member did not consent to such contact. · Policy: The PREA Disciplinary Sanctions for Residents policy states that "Disciplinary action will only be considered for resident sexual contact with a staff member if there is an administrative or criminal finding that the staff member did not consent to such contact" (p. 1). · Investigation Report: Upon review of the investigation report there were no allegations involving residents and disciplinary actions for sexual conduct with staff. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.378 (f). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 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 sufficient evidence to substantiate the allegation. · Policy: The PREA Disciplinary Sanctions for Residents policy states that "The facility prohibits disciplinary actions 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" (p. 2). Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.378 (g). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility prohibits sexual activity between residents. In addition, the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. · Policy: The PREA Disciplinary Sanctions for Residents policy states that “The facility will, in its discretion, prohibit all sexual activity between resident’s 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” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.381	**Medical and mental health screenings; history of sexual abuse**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy: Emergency Medical and Mental Services (2023)

c. Client Forms

d. Service Plans/Initial Treatment Plan

i. Reported prior victimization (21)

ii. Reported prior perpetration (23)

2. Interviews:

a. Staff responsible for risk screening - 2

b. Medical and Mental Health staff (2)

c. Residents who Disclosed Prior Victimization During Risk Screening (3)

3. Corrective Action:

a. Access to medical and mental health documentation

Findings (By Provision):

115.381 (a). If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

Compliance Determination:

The facility had demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, residents at the facility who disclosed any prior sexual victimization during a screening pursuant to 115.341 are offered a follow-up meeting with a medical or mental health practitioner. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above-mentioned services. In the past 12 months, the percentage of residents who disclosed prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner: 100.

· Policy: The PREA Emergency Medical and Mental Health Services policy states that “(a) If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting

	or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening" (p. 1). · Follow Up with Medical and Mental Health is documented on the residential initial plan/service plan. Twenty-one resident files were reviewed for compliance determination. Interviews Staff Responsible for Risk Screening: The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, the therapist will discuss with them immediately. This would also be reported to the PREA Coordinator. Medical would address any medical needs based on the timing of the incident. Residents(s) in custody who Disclose Sexual Victimization at Risk Screening: Three residents in custody disclosed past sexual victimization during the audit period. Each of them confirmed that the intake staff offered to connect them with medical or mental health staff after their disclosure. All three residents also reported attending weekly therapy sessions. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.381 (b). If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As indicated in the PAQ, all residents who have previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. In the past 12 months, the percentage of residents who previously perpetuated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: 100. · Policy: The PREA Emergency Medical and Mental Health Services policy states that If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a

	mental health practitioner within 14 days of the intake screening” (p. 2). · Follow Up with Medical and Mental Health is documented on the residential initial plan/service plan. Twenty-three resident files were reviewed for compliance determination. · The facility offers specialized treatment for residents who have exhibited Problematic Sexualized Behaviors. The program description indicates: · At Woodward Academy, our Problematic Sexualized Behaviors treatment program accepts adjudicated and non-adjudicated youth from 12-18 years old. Since 1996, the program has addressed problematic sexualized behaviors through a combination of evidence-based practices and skill development in a high-intensity treatment setting. Residents should expect to receive trauma-informed clinical interventions and high staff-to-resident supervision ratios that result in compassionate care and healing. · Treatment focuses on cognitive behavioral modification. Through our treatment, the residents target different sexual arousal patterns, approaches to restructure belief systems, self-regulation strategies, techniques to eliminate/ replace criminal thinking errors, victim empathy, healthy relationships, identifying and recognizing triggers, and relapse prevention. Residents are prepared for victim reunification when appropriate. Specific emphasis includes identification of the offender’s sexual offenses and cycle, reducing denial, taking full responsibility for offenses, recognizing impact on victims, and the identification of techniques to interrupt the resident’s offense cycle. · Assessment tools used by Woodward Academy include polygraph testing, the JSSOTR (Juvenile Structured Sex Offender Treatment Review) and the JSOAP (Juvenile Sex Offender Assessment Protocol). The residents also participate in multiple groups throughout the week such as Daily Communication Group, Skill Development Sessions, Sex Offender Group, primary counseling, and Life skills groups. Off the dormitories they participate in individual, family, and group therapy and/or specialized clinical services such as EMDR and Trauma-Focused CBT or psychiatric consultations. Interviews Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has previously perpetrated sexual abuse, whether in an institutional setting or in the community, the facility will call the jail nurse immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.381 (c). Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As reported in the PAQ, information related to sexual victimization or abusiveness that occurred in an institutional setting is not strictly limited to medical and mental health practitioners. · Policy: The PREA Emergency Medical and Mental health Services policy states that “) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law” (p. 1). Site Review: RECORD STORAGE · Risk Screening Process: o The risk screening and other assessment tools (e.g., Assessments, biopsychosocial evaluations, and treatment plans are securely stored in an electronic case management system. o Additional documentation on the residents in paper files is kept in a locked file cabinet in the medical office, accessible only to medical staff. o Onsite the facility has a locked records room for current resident files and a separate locked records room for prior residents. Records have been retained for seven years. o The records room is locked and secured, limited to medical and leadership staff. Cameras are placed in the hallways accessible to the record rooms. · Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is not restricted. · Conversations with staff have indicated that access to the case management system, specifically the assessments, is currently unrestricted. Corrective Actions:

	Restrictions: The facility shall develop a process that strictly limits information related to sexual victimization and abusiveness to medical and mental health practitioners and to other staff as necessary. Ø Corrective Action Taken: As described in 115.341 the facility implemented a practice to limit information to the necessary staff. No further action is required. 115.381 (d). Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting unless the resident is under the age of 18. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As reported in the PAQ, this is not applicable as all residents are under the age of 18. · Policy: The PREA Emergency Medical and Mental Health Servies policy states that “Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18” (p. 1). Interviews Medical Staff: The interviewed staff reported that the residents are given information in reference to informed consent and notified of staff reporting requirements. We would also reach out to the referral source and the parent. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor employed a triangulation approach to assess compliance with the PREA standards, drawing from a thorough review of facility documentation, agency policies, on-site observations, operational practices, interviews with staff and residents, input from local and national advocates, and the online PREA Audit: Pre-Audit Questionnaire. During the initial audit, the facility was placed in corrective action to address the lack of a formalized process for restricting access to sensitive information related to residents’ histories of sexual victimization and perpetration. Ensuring this information is safeguarded and accessible only to designated staff with a need-to-know is essential to maintaining resident privacy and safety, in alignment with PREA requirements.

	In response, the agency developed and implemented a comprehensive process to restrict access to this information. This included updating policy to define who has authorized access, establishing role-based security controls within electronic record systems, and implementing procedures for documenting and monitoring access to these records. Staff received training on confidentiality protocols, with an emphasis on appropriate handling of sensitive information and the consequences of unauthorized disclosure. Based on the corrective action taken and verified through documentation, interviews, and system observation, the auditor concludes that the facility is in full compliance with the PREA standard regarding the protection of information related to sexual victimization and perpetration.

115.382	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Emergency Medical and Mental Services (2023) 2. Interviews: a. Medical and mental health staff (2) b. Security staff and non-security staff first responders (14) c. Resident who Reported Sexual Abuse (2) 3. Corrective Action: a. Follow Up with Medical and Mental Health Training Findings (By Provision): 115.382 (a). 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. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. It further stated that the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgement. 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. · Policy: PREA Emergency Medical and Mental Health Services policy states 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 (p. 1). · There was one documented allegation of sexual abuse whereas a resident was taking to be seen by outside medical and mental health services; however the facility had no documentation that the resident was seen by an outside provider. Interviews Medical and Mental Health Staff: If a resident reports sexual abuse they receive timely and unimpeded access to emergency medical treatment and/or crisis intervention services. This is done immediately, and the staff will notify the supervisor immediately. The nature and scope of such services are determined according to professional judgment. Resident who Reported Sexual Abuse: Two residents were interviewed who reported sexual abuse and or sexual harassment. Upon further review one of the residents reported sexual harassment. The resident who reported sexual abuse stated that they did have follow up services with medical and mental health, however they were uncertain with how much time elapsed between when they reported and when services were rendered. Corrective Actions: Outside services: During the corrective action period the auditor will review any allegations of sexual abuse made and the follow-up services provided. Ø Corrective Action Taken: The auditor reviewed documentation where follow-up with medical and mental health services were provided. No further action needed. 115.382 (b). If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the

	appropriate medical and mental health practitioners. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · Policy: PREA Emergency Medical and Mental Health Services policy states that "If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners" (p. 1). Documentation demonstrating immediate notification of the appropriate medical and mental health practitioners was not provided. Interviews Random Sample of Staff: All 13 staff confirmed that if they were the first to be notified of alleged sexual abuse, they would immediately inform their group leader and wait for further instructions. They also stated that they would not share the information with other youth or staff who were not directly involved in managing the incident. Corrective Actions: Documentation of Referral to Medical and Mental Health: Documentation was not provided therefore the auditor will review all allegations of sexual abuse during the corrective action period. Ø Corrective Action Taken: The auditor reviewed documentation where follow-up with medical and mental health services were provided. No further action needed. Training: The medical and mental health staff shall be trained on their requirements to document services. Ø Corrective Action Taken: The auditor reviewed documentation where training occurred with medical and mental health staff was provided. No further action needed. 115.382 (c). 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. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 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. I interviewed medical and mental health staff reported that such services are addressed immediately. · Policy: PREA Emergency Medical and Mental Health Services policy states 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" (p. 1). · There was one documented allegation of sexual abuse whereas a resident was taking to be seen by outside medical and mental health services; however the facility had no documentation that the resident was seen by an outside provider. Interviews Medical and Mental Health Staff: The interviewed staff reported that victims of sexual abuse are offered timely information about access to emergency contraception and sexual transmitted infection prophylaxis. This is done offsite at the Blank Center. Residents who Reported a Sexual Abuse: Two residents were interviewed, and it was determined that one resident reported sexual harassment and one reported sexual abuse. The resident that reported sexual abuse stated that, they do not recall being approached by medical or mental health professionals regarding services but do remember police officers and staff at the Star Center mentioning some services. They also mentioned that if any services were needed, they would rely on a family member for assistance. Corrective Actions: Outside services: During the corrective action period the auditor will review any allegations of sexual abuse made and the follow-up services provided. Ø Corrective Action Taken: There was no additional sexual abuse allegations during the corrective action process. 115.382 (d). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the treatment services provided to every victim are without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out the incident. · Policy: PREA Emergency Medical and Mental Health Services policy states 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” (p. 2). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor utilized a triangulation approach to assess compliance with the standard, incorporating a comprehensive review of PREA facility documentation, agency policies, on-site observations, site review of facility operations, facility practices, interviews with staff and residents, input from local and national advocates, and information obtained through the PREA Audit: Pre-Audit Questionnaire. Following the initial assessment, the facility was placed in corrective action to address deficiencies related to the referral and documentation of follow-up medical and mental health services for residents following a report of sexual abuse. As part of the corrective action process, the facility submitted documentation demonstrating the implementation of procedures ensuring timely referrals and accurate documentation of follow-up care provided by qualified medical and mental health practitioners. Upon verification of the submitted materials and confirmation through interviews and observations, the auditor has determined that the facility has successfully addressed the findings. The facility is now in full compliance with the requirements of the standard.

115.383	**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 compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ)

b. Policy: PREA Emergency Medical and Mental Services (2023)

2. Interviews:

a. Medical and Mental Health staff (2)

b. Resident who Reported a Sexual Abuse (2)

3. Corrective Action:

a. Follow Up with Medical and Mental Health

Findings (By Provision):

115.383 (a). The facility offers 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the facility offers 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.

· Policy: PREA Emergency Medical and Mental Health Services policy states that “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” (p. 2).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

185.383 (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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· Policy: PREA Emergency Medical and Mental Health Services policy states 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" (p. 2).

Interviews

Medical and Mental Health Staff: The interviewed personnel indicated that the evaluation and treatment of residents who have been victimized involves a team assessment to determine the most appropriate course of action. Medical staff reported that they would perform an initial screening, with more comprehensive services provided offsite at the Blank Center. Mental Health staff stated that they would offer trauma services and, if necessary, coordinate with additional external advocacy and emotional support services.

Resident who Reported a Sexual Abuse – During the interview process it was determined that one of the two residents who reported sexual abuse, reported sexual harassment. The one who reported sexual abuse stated that they do not recall being approached by medical or mental health professionals regarding services but do remember police officers and staff at the Star Center mentioning some services. They also mentioned that if any services were needed, they would rely on a family member for assistance.

Corrective Actions:

Documentation of Follow Up Services: The facility shall provide documentation where the resident who reported sexual abuse at the facility was provided follow up services (medical/victim advocacy) and appropriate treatment plans.

Ø Corrective Action Taken: The auditor reviewed documentation where follow-up with medical and mental health services were provided. No further action needed.

115.383 (c). The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· Policy: PREA Emergency Medical and Mental Health Services policy states that "The facility shall provide such victims with medical and mental health services consistent with the community level of care" (p. 2).

· As reported by the interviewed medical and mental health staff, the treatment and services provided are consistent with the community level of care.

Interviews

Medical and Mental Health Staff: The staff interviewed reported that medical treatment and services is consistent with the community level of care.

Corrective Actions:

	Documentation of Follow Up Services: The facility shall provide documentation where the resident who reported sexual abuse at the facility was provided follow up services (medical/victim advocacy) and appropriate treatment plans. Ø Corrective Action Taken: The auditor reviewed documentation where follow-up with medical and mental health services were provided. No further action needed. 115.383 (d). Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The site does not house female residents. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.383 (e). Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: · The site does not house female residents. Interviews Medical and Mental Health Staff: There are no female residents. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.383 (f). Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because:

	· As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. · Policy: PREA Emergency Medical and Mental Health Services policy states that "Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate" (p. 2). Interviews Residents who reported a sexual abuse – The one interviewed resident who reported sexual abuse stated that he was offered testing for STI's and STD weeks after the incident. Corrective Actions: Documentation of Follow Up Services: The facility shall provide documentation where the resident who reported sexual abuse at the facility was provided follow up services (medical/victim advocacy) and appropriate treatment plans. Ø Corrective Action Taken: The auditor reviewed documentation where follow-up with medical and mental health services were provided. No further action needed. 115.383 (g). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 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. · Policy: PREA Emergency Medical and Mental Health Services policy states 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" (p. 2). Interviews Residents who reported a sexual abuse – The one interviewed resident who reported sexual abuse stated that he was unsure if they would be responsible for any costs related to treatment or testing but mentioned that they did not believe so, as they were the victim. Corrective Actions: N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.383 (h). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. Upon admission all juveniles will receive a mental health assessment by a professional mental health provider for the purpose of identifying suicidal tendencies, sexual abuse victimization and predatory risk to other residents. · Policy: PREA Emergency Medical and Mental Health Services policy states that "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" (p. 2). · As deemed appropriate and documented in 115.381 (b). Interviews Medical and Mental Health Staff: Yes, we would look at clinical intervention at intake. The program currently serves and is designed to provide services youth who have committed acts of sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor utilized a triangulation approach to assess compliance with the PREA standards, incorporating a comprehensive review of facility documentation, agency policies, on-site observations, facility operations and practices, staff and resident interviews, input from local and national advocates, and responses to the online PREA Audit: Pre-Audit Questionnaire. Based on this analysis, the facility was initially placed in corrective action to address deficiencies in the follow-up and documentation of medical and mental health services provided to victims of sexual abuse. Specifically, the auditor found inconsistencies in how services were documented, as well as gaps in tracking and

	ensuring timely, trauma-informed follow-up care. In response, the facility implemented a corrective action plan that included updating procedures for documenting all medical and mental health encounters related to incidents of sexual abuse. Medical and behavioral health staff were trained on the revised protocols, which emphasize timely follow-up care, continuity of services, confidentiality, and proper recordkeeping. Additionally, the facility introduced a monitoring mechanism to ensure all services offered or provided are accurately and consistently documented in residents' health records. As a result of these corrective actions and confirmed evidence of sustained implementation, the auditor finds the facility in full compliance with the standard regarding the follow-up and documentation of medical and mental health services for victims of sexual abuse.

115.386	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Sexual Abuse Incident Reviews (2023) c. Incident Reviews (3) d. Incidents (7) 2. Interviews: a. Director b. PREA coordinator c. Incident review team Findings (By Provision): 115.386 (a). The facility shall 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 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. The facility provided a document that shows how an incident review debriefing would be documented. · In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: 3. · Policy: PREA Sexual Abuse Incident Reviews states that “The facility will 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” (p. 1). · The auditor reviewed seven reported incidents. There were five incidents of sexual abuse. Three of the incidents of sexual abuse were unsubstantiated and two unfounded. The incident review occurred for the two allegations that were unsubstantiated. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.386 (b). Such a review shall ordinarily occur within 30 days of the conclusion of the investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility were followed by a sexual abuse incident review within 30 days, excluding only "unfounded" incidents: 3. · The PREA Sexual Abuse Incident Review policy states that “The facility incident review team, along with members of the facility management team, will conduct a sexual abuse incident review within 30 days of the conclusion of the investigation. The sexual abuse incident reporting form will be utilized during this meeting” (p. 1). · The auditor reviewed seven reported incidents. There were five incidents of

	sexual abuse. Three of the incidents of sexual abuse were unsubstantiated and two unfounded. The incident review occurred for the two allegations that were unsubstantiated. Interviews PREA Compliance Manager- The facility does not have a PREA compliance manager. Incident Review Team: The interviewed staff on the incident review team reported that the team will 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 was motivated or otherwise caused by other group dynamics at the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.386 (c). The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 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. · Policy: PREA Sexual Abuse Incident Review policy states that “The review team will include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners” (p. 1). · The auditor reviewed seven reported incidents. There were five incidents of sexual abuse. Three of the incidents of sexual abuse were unsubstantiated and two unfounded. The incident review occurred for the two allegations that were unsubstantiated. · The top review form outlines staff participation in the review. Interviews: Director: The facility has a sexual abuse incident review team; which includes upper-level management and the treatment team. We would have a department team lead meeting and assess what change or corrective actions should take place. This may include staffing levels, policy, and/or additional staff training.

	Corrective Actions: N/A. There are no corrective actions for this provision Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.386 (d). 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 compliance manager. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, 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 Compliance Manager. · The auditor reviewed seven reported incidents. One incident was misreported at the facility but occurred elsewhere. Three incidents involved allegations of sexual abuse. All incidents were investigated with corresponding reviews. The incident review form contains all of the above-mentioned areas, and the facility provided responses to all areas. It is recommended that there is more detail in areas. For example, instead of saying that the facility met staffing ratios, be more specific on how it met ratios. Interviews: Director: The facility has a sexual abuse incident review team, which includes upper-level management. The team consists of the program leads to include the PREA Coordinator. PREA Compliance Manager- The facility does not have a PREA compliance manager. Incident Review Team: The interviewed staff on the incident review team reported

	that the team will 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 was motivated or otherwise caused by other group dynamics at the facility. When reviewing the team will examine all areas of the facility where abuse was reported and look for any physical barriers that might enable abuse. Staffing levels will be reviewed to make sure they are in ratio. When looking at monitoring technology the team will assess if additional cameras are needed or if they are positioned appropriately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.386 (e). The facility shall implement the recommendations for improvement or shall document its reasons for not doing so. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that the facility implements the recommendations for improvement or documents its reasons for not doing so. · The auditor reviewed seven reported incidents. There were five incidents of sexual abuse. Three of the incidents of sexual abuse were unsubstantiated and two unfounded. The incident review occurred for the two allegations that were unsubstantiated. Recommendations of improvement were documented on the form. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.387	**Data collection**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Data Collection (2023) c. Policy: PREA Zero Tolerance (2023) d. Data Collection Instrument (7 investigations) e. SSV 2023) Findings (By Provision): 115.387 (a). The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. · Policy: The PREA Data Collection policy states that “To ensure a process where accurate, uniform data is collected for every allegation of sexual abuse and will abide by the definitions set forth in the PREA standard” (p. 1). · The data collection instrument completed on the investigations is a tool utilized to collect uniform data on allegations. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.387 (b). The agency shall aggregate the incident-based sexual abuse data at least annually. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

because:

· As reported in the PAQ, the agency aggregates incident-based sexual abuse data annually.

· The data collection instrument completed on the investigations is a tool utilized to collect uniform data on allegations.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.387 (c). 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the facility uses a standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice.

· Policy: The PREA Zero Tolerance policy states that “The facility must collect accurate, uniform data for every allegation of sexual abuse. At a minimum, the data must be sufficient to answer all questions on the annually required Survey of Sexual Victimization. Aggregated data must be:

a. Reviewed in order to assess and improve sexual abuse prevention, detection, and response practices.

Made available to the public through a public website or some other means at least annually, NOTE: Personal identifiers must be removed “(p. 8).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.387 (d). 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.

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. · Policy: PREA Data Collection policy states that “The facility will maintain, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews” (p. 1). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.387 (e.) N/A the agency does not contract for the confinement of its residents and skips to 115.387 (f).). It was further reported that the data from private facilities complies with SSV reporting regarding content. 115.387 (f). Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency has been required to provide the Department of Justice (DOJ) with data from the previous calendar year. · SSV Report: The auditor reviewed the last required SSV report (2023). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Website: https://www.wwacademy.com/prea/ c. PREA Annual Report 2. Interviews: a. Agency head b. PREA coordinator 3. Corrective Action: a. Annual Report (2024) Findings (By Provision): 115.388 (a). The agency shall review data collected and aggregated pursuant to § 115.387 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency reviews data collected and aggregated pursuant 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: · Identified problem areas; · Taking corrective action on an ongoing basis; and · Preparing an annual report of its findings from its data review and corrective actions for each facility, as well as the agency as a whole. · Annual Report (2023): the last completed annual report was reviewed and addressed all requirements of the provision.

	Interviews Agency Head: The interviewed agency head reported that incident based sexual abuse data is used to assess and improve problem areas or other issues are identified and corrective action is taken as needed. After every allegation, problem areas or other issues are identified, and corrective action is taken if needed. PREA Coordinator: The interviewed PREA Coordinator reported that all data is completed. All data is reviewed and if there are any areas of concern it will be addressed in a corrective action plan. If there are any issues, we will create a plan of action to address the problem. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.388 (b). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the annual report indicates a comparison of the current year’s data and corrective actions to those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. · Annual Report (2023): the last completed annual report was reviewed and addressed all requirements of the provision. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.388 (c). The agency's report shall be 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency makes its annual report readily available to

	the public, at least annually, through its website. The agency PREA reports are found at: Website: https://www.wwacademy.com/prea/ Interviews Agency Head: The agency head interviewed reported that they approve the agency annual reports. Annual reports are reviewed annually. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.388 (d). The agency may 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, the agency 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. In addition, the agency indicates the nature of redacted material. Interviews PREA Coordinator: The interviewed PREA Coordinator reported that all data is completed. All data is reviewed and if there are any areas of concern it will be addressed in a corrective action plan. If there are any issues, we will create a plan of action to address the problem. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: PREA Data Collection (2023) c. Website: https://www.wwacademy.com/prea/ 2. Interviews: a. PREA coordinator 3. Site Review Findings (By Provision): 115.389 (a). The agency shall ensure that data collected pursuant to § 115.387 are securely retained. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility reported in the PAQ that incident-based and aggregated data is securely retained. · Policy: The PREA Data Collection policy states that “All data collected will be retained for at least 10 years after the date of the data’s initial collection on a secured electronic database as well as a hard copy in a secured location, accessible only by the management team” (p. 2). Site Review: RECORD STORAGE · Risk Screening Process: o The risk screening and other assessment tools (e.g., Assessments, biopsychosocial evaluations, and treatment plans are securely stored in an electronic case management system. o Additional documentation on the residents in paper files is kept in a locked file

	cabinet in the medical office, accessible only to medical staff. o Onsite the facility has a locked records room for current resident files and a separate locked records room for prior residents. Records have been retained for seven years. o The records room is locked and secured, limited to medical and leadership staff. Cameras are placed in the hallways accessible to the record rooms. · Investigation: o Investigation records are stored in an electronic database called Healthicity. The database is limited to the facility investigators and the facility director. · Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is not restricted. · Conversations with staff have indicated that access to the case management system, specifically the assessments, is currently unrestricted. Interviews PREA Coordinator: The interviewed PREA Coordinator reported that all data is filed in the office of the PREA Coordinator. The data is collected in the case management system, and essentially multiple staff have access to individual data. Upon review of each PREA related incident, any identified areas of concern are addressed through corrective action. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.389 (b). The agency shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · As reported in the PAQ, agency policy requires aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website. · Policy: The PREA Data Collection report states that “The facility will redact any

identifying information from the above-mentioned report if it poses a clear and specific threat to the safety and security of the facility or its residents. The nature of the redacted material will be indicated with the published report. The facility will not publish any personal identifiers of publicly available sexual abuse data" (p. 2).

· Website: https://www.wwacademy.com/prea/: Provides a copy of the annual report.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.389 (c). Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

· A review of the agency website did not have any personal identifiers. All personal identifiers were removed from the Annual report. Website: https://www.wwacademy.com/prea/

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.389 (d). The agency shall maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the agency maintains sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. The agency complies with this provision by maintaining at least 10 years of initial data collection.

· Policy: The PREA Data Collection policy states that "All data collected will be

	retained for at least 10 years after the date of the data's initial collection on a secured electronic database as well as a hard copy in a secured location, accessible only by the management team" (p. 2). · Website: Website: https://www.wwacademy.com/prea/ Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: · Website: https://www.wwacademy.com/ Findings (By Provision): 115.401 (a). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · A review of the agency's website provided PREA audit reports according to cycles. · The facility PREA reports are included on the agency website.

	· Residential Facility Audit · The Joint Commission Report · HHS Reports Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (b). As reported by the PREA coordinator, the FACILITY is operated by a private entity (Vivant Behavioral Health, LLC.), a contractor for multiple youth services entities. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: A review of the agency's website provided PREA audit reports according to cycles. The facility PREA reports are included on the agency website. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the facility by the Director. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to observe freely, with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: On the first day of the audit after the entrance conference, the auditor conducted a comprehensive tour of the facility. It was requested that when the auditor pauses to speak to a resident or staff, that staff on the tour please step away so the conversation might remain private. This request was well respected. During the site review the auditor made numerous observations, including the posting of Notices of PREA Audits, PREA Related Posters, notices advising resident

	that female staff routinely work in the facility, locations of showers and privacy issues, bathrooms, configuration of living units, capacities of dorm/bed rooms, observations of blind spots, camera deployment, the use of mirrors to mitigate blind spots, staffing levels, supervision of resident, accessibility to telephones and instructions for using the phones to report sexual abuse, main control room, dayroom, classrooms, etc.. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (i). During the on-site visit, the auditor was provided access to any and all documents requested. All documents requested were received to include, but not limited to employee and resident files, sensitive documents, and investigation reports. Based on review of documentation the facility is compliant with the intent of the provision. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The auditor provided the facility with a documentation checklist. The checklist is organized by standards to help the facility through the pre-audit, onsite and post audit phase and to provide the requested documentation by an auditor. The PREA coordinator/compliance manager provided the auditor with all relevant documents as requested. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (m). The auditor provided private rooms throughout the facility to conduct resident interviews. The staff staged the residents in a fashion that the auditor did not have to wait between interviews. The rooms provided for resident interviews were soundproof and somewhat visually confidential from other residents who were judged to have provided an environment in which the offenders felt comfortable to openly share PREA-related content during interviews. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	· During the pre-audit period, the facility received instructions to post the required PREA Audit Notice of the upcoming audit prior to the on-site visit for confidential communications. The facility posted the notices in English and Spanish. The auditor received email and pictures confirming the posted notices and observed the posted notices on-site. · As of March 28, 2025, there was no communication from a resident or staff. Staff interviews indicated that Residents are permitted to send confidential information or correspondence in the same manner as if they were communicating with legal counsel. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (n). Residents were able to submit confidential information via written letters to the auditor PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the residents of the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The auditor reached out to the following organizations: o Child Protective Services o PREA Coordinator o Texas Ombudsman o Website Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: a. Website: Website: https://www.wwacademy.com/prea/ Findings (By Provision): 115.403 (f). The agency shall ensure that the auditor's final report is published on the agency's website if it has one or is otherwise made readily available to the public. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility's final PREA reports are published on the agency website. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

Appendix: Provision Findings		
115.311 (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
115.311 (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 facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	na
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	na
115.312 (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
115.312 (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 OR the response to 115.312(a)-1 is "NO".)	na
115.313 (a)	**Supervision and monitoring**	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes
115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	na
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes

	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, 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, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, 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, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational	yes

	functions of the facility? (N/A for non-secure facilities)	
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes
115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical 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 a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, 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? (N/A for facilities with discrete housing units)	yes
115.315 (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 a resident’s genital status is unknown, does the facility	yes

	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?	
115.315 (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
115.316 (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:	yes

	Residents who have speech disabilities?	
	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 with residents with disabilities including residents who: Have intellectual disabilities?	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: 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
115.316 (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
115.316 (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	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
115.317 (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 bullet immediately above?	yes
	Does the agency prohibit the enlistment of 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 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 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 bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency 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 residents?	yes
115.317	**Hiring and promotion decisions**	

(c)		
	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: Consult any child abuse registry maintained by the State or locality in which the employee would work?	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
115.317 (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
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (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
115.317 (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	yes

	employees?	
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (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
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, 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
115.318 (a)	**Upgrades to facilities and technologies**	
	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
115.318 (b)	**Upgrades to facilities and technologies**	
	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 a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.321 (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
115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A 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? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all residents who experience 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
115.321 (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
115.321 (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
115.321 (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 entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is responsible for investigating allegations of sexual abuse.)	yes
115.321 (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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	na
115.322 (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

115.322 (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
115.322 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
115.331 (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 juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	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 and how to distinguish between consensual sexual contact and sexual abuse between residents?	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
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes
115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	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
115.331 (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

115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (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
115.332 (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
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (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
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**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?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**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
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(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 administrative or criminal sexual abuse investigations. See 115.321(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 administrative or criminal sexual abuse investigations. See 115.321(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 administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (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 administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.335 (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 juvenile 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
115.335 (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 medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na
115.335 (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

115.335 (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 §115.331? (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
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	yes
115.341 (a)	**Obtaining information from residents**	
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does	yes

	the agency attempt to ascertain information about: Age?	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident’s own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes
115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident’s files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
115.342 (a)	**Placement of residents**	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes
115.342 (b)	**Placement of residents**	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c)	**Placement of residents**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes
115.342 (d)	**Placement of residents**	
	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
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when	yes

	making facility and housing placement decisions and programming assignments?	
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	na
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	na
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes
115.351 (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: 2. 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
115.351 (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	yes

	entity or office that is not part of the agency?	
	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
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	yes
115.351 (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
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (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
115.352 (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.)	yes
	Does the agency always refrain from requiring an 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.)	yes
115.352 (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.)	yes
	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.)	yes
115.352 (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.)	yes
	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 of time to respond is 70 days per 115.352(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.)	yes
	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.)	yes
115.352 (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.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, 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.)	yes
	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.)	yes
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	yes
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	yes
115.352 (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.)	yes
	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.)	yes
	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.)	yes

	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.)	yes
	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.)	yes
	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.)	yes
	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.)	yes
115.352 (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.)	yes
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible 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 provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	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
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (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
115.361 (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 they receive 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 they receive 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	yes

	information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited 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
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.361 (e)	**Staff and agency reporting duties**	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim’s parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim’s caseworker instead of	yes

	the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**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
115.362 (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
115.363 (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
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (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
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in	yes

	accordance with these standards?	
115.364 (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
115.364 (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
115.365 (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
115.366 (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?	yes
115.367 (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
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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?	yes
115.367 (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	yes

	of sexual abuse, does the agency: Act promptly to remedy any such 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: 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: 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: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (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
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes

115.371 (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 does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
115.371 (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 involving juvenile victims as required by 115.334?	yes
115.371 (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
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**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
115.371	**Criminal and administrative agency investigations**	

(f)		
	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
115.371 (g)	**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
115.371 (h)	**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
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes
115.371 (k)	**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	yes

	does not provide a basis for terminating an investigation?	
115.371 (m)	**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 administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.372 (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
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (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
115.373 (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	yes

	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?	
	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
115.373 (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
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.376 (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

115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (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
115.376 (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
115.377 (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
115.377 (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

115.378 (a)	**Interventions and 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, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes
115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary 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
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and 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
115.378 (d)	**Interventions and 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 offer the offending resident participation in such interventions?	yes

	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and 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
115.378 (f)	**Interventions and 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
115.378 (g)	**Interventions and 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
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes
115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	

	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?	yes
115.382 (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
115.382 (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 staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (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
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
115.383 (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
115.383 (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
115.383 (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
115.383 (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.)	na
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(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.)	na
115.383 (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
115.383 (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	yes

	cooperates with any investigation arising out of the incident?	
115.383 (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
115.386 (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
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (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
115.386 (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 §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (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
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.387 (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
115.387 (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
115.387 (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	na

	the confinement of its residents.)	
115.387 (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.)	yes
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 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 § 115.387 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 § 115.387 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
115.388 (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
115.388 (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
115.388 (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	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (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
115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 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 inmates, residents, and detainees?	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