PREA AUDIT REPORT ☐INTERIM ☒FINAL

JUVENILE FACILITIES

Date of report: November 13, 2017

Auditor Information			
Auditor name: Susan Heck			
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Email: susanheckva@gmail.com			
Telephone number: 757-784-1675			
Date of facility visit: April 26-27, 2017; July 27, 2017; October 30, 2017			
Facility Information			
Facility name: Aurora House Girls' Group Home			
Facility physical address: 420 South Maple Street, Falls Church, VA 22046			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 703-237-6622			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☒Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒Other
Name of facility's Chief Executive Officer: Rachel Kindell			
Number of staff assigned to the facility in the last 12 months: 17			
Designed facility capacity: 12			
Current population of facility: 8			
Facility security levels/inmate custody levels: Low-moderate risk			
Age range of the population: 13-17			
Name of PREA Compliance Manager: Rachel Kindell		**Title:** Group Home Manager	
Email address: rkindell@fallschurchva.gov		**Telephone number:** 703-237-6622	
Agency Information			
Name of agency: Department of Housing and Human Services			
Governing authority or parent agency: *(if applicable)* Arlington County Court Services Unit			
Physical address: 300 Park Avenue, Falls Church, VA 22046			
Mailing address: *(if different from above)* 300 Park Avenue, G-04, Falls Church, VA 22046			
Telephone number: 703-248-5005			
Agency Chief Executive Officer			
Name: Nancy Vincent		**Title:** Director, Dept. Housing and Human Services	
Email address: nvincent@fallschurchva.gov		**Telephone number:** 703-248-5191	
Agency-Wide PREA Coordinator			
Name: Rick Strobach		**Title:** CSU Residential	
Email address: Rstrobach@arlingtonva.us		**Telephone number:** Click here to enter text.	

AUDIT FINDINGS

NARRATIVE

Aurora House Girls' Group Home (AH) is a 12 bed, female-only group home located in the City of Falls Church, Virginia. It primarily serves the City of Falls Church and Arlington County, and will also accept referrals and placements from the City of Alexandria and Fairfax County as needed and if space is available. Funding of the group home comes from both the City of Falls Church and Arlington County; the facility is a line item in the City of Falls Church so the facility is within the City's Department of Housing and Human Services for overall supervision and accounting purposes. The facility also has a supervision relationship with the 17th Judicial Circuit's Court Services Unit in Arlington County which refers a majority of the facility's residents. During the process of this PREA audit, the two localities agreed that for purposes of PREA, this facility will fall under the Arlington County Court Services Unit (CSU). The CSU has another group home under its supervision, Arlington House, which is a male-only facility serving roughly the same localities.

The on-site portion of the AH audit started on April 26, 2017 and concluded on April 27, 2017. This auditor met with the PREA Coordinator/PREA Compliance Manager on the first morning of the audit to finalize staff schedules and interviews and to review the facility's current population numbers. The facility tour was conducted and included the PREA Coordiantor and the residential manager for the facility. All areas of the facility were toured; a detailed description of the tour is below under "Description of Facility Characteristics". The facility has a resident capacity of 12.

On the day of the tour, seven residents were counted in population; one resident was in a short-term mental health placement and was not on-site. Six residents were interviewed during the course of the audit. No residents in current population reported abuse while at the facility; one resident identifying as LBGTI is in population and was interviewed.

The facility reports having 12 staff with resident supervision as their primary responsibility; of these, four are full-time and eight are relief counselors. In addition, the group home manager and residential manager help with supervision as needed. Six random staff interviews were conducted, including staff from all shifts (this number includes both full and relief staff). Since this is a small facility without designated staff for intake, several staff took part in multiple interviews based on their areas of responsibility. Additional interviews included: agency head; superintendent; incident review team representative; staff with human resources responsibility; mental health provider interview; staff designated to monitor retaliation of residents and staff; a volunteer for the facility; four interviews with staff who do intake interviews, three interviews with staff who do vulnerable population assessments. In total, 20 distinct staff interviews were conducted.

Facility policy states that all allegations of sexual abuse and sexual harassment are intestigated; the facility has an MOU with the City of Falls Church Police Department that designates that agency as the investigator for all instances of sexual abuse and sexual harassment. In addition, the facility has a MOU in place with Doorways for Women and Families (Doorways) to provide response and victim advocacy for any resident reporting sexual abuse while at Aurora House, including hospital accompainiment.

This auditor issued an Interim Report on May 20, 2017. The facility's policies and procedures included all needed components to meet the standards, staff and resident education pieces included all required elements, and most practices reflected corresponding policy. The effort to become PREA compliant was started by the facility's residentual director, Rachael Kindell in late fall, 2016. After a new Group Home Manager was selected, this responsibility shifted to the new group home manager. At the time of the on-site audit (which was rescheduled from February to April because the new group home manager felt she needed more time), the process for conducting vulnerability assessments on all incoming residents was brand new, having been implemented in late March. This auditor did not feel there was sufficient time to determine if the facility's practice mirrored its policies and procedures, so an Interim Report was issued and all agreed to a follow-up visit in November to determine if facility practice followed its procedure.

On July 7, 2017, this auditor received an email from the facility's Resident Director, Rachael Kindell, stating that the Group Home Manager had resigned unexpectedly and was no longer with the facility. She stated that very little information about where the audit process had been left and that there had been very few intakes. This auditor talked at length with her on the telephone discussing at length where everything had been left. On July 26 this auditor made a second visit to the facility and met with Ms. Kindell, who was acting Group Home Manager at this time. We did a cross walk between the forms and files she had, ensuring that she had all the revised forms from the time of the on-site audit, and was continuing to do everything that had been put in place. We also had a conference call with Rick Strobach, PREA Coordinator for both Aurora House and Argus House, and Earl Conklin, Director of the Arlington County Court Services Unit, to talk over where they were in the process and make sure everyone was fully aware of the current goals.

Another problem for the facility surfaced in late June and early July. Referrals to the program had been handled exclusively by the Group Home Manager, and a number of these referrals had not resulted in placements because too much time elapsed between the time the referral was made and a response by the facility. Referrals during July and August were very low which hampered the facility's ability to demonstrate that its practice mirrored the procedures in place to comply with PREA (specifically, compliance with Standard 115.333 Resident Education and Standard 115.341 Obtaining information from residents).

Ms. Kindell became the new Group Home Manager in October. She has continued to monitor her facility's PREA compliance and has

provided additional training to her staff, has taken additional training herself (advanced investigator training, for example), had implemented more training for residents, and has maintained the compliance strategies she and her predecessor started in the fall of 2016. Referrals to the program are up and relationships with referring agencies have been reestablished and strengthened.

This auditor returned for another visit to the facility on October 30, 2017. At this time, the files of all new intakes to the facilty were reviewed for compliance with resident education, vulnerability assessments and referrals for any resident who disclosed sexual abuse or prior sexual preditor behavior. All files were in compliance with the standards. Ms. Kindell has done an excellent job of continuing under difficult circumstances and the facility's PREA compliance efforts have strengthened during her time as interim director and now as Group Home Manager.

Additionally, the City of Falls Church and Arlington County reached an agreement about the supervision of the PREA efforts of the group homes each locality uses. Aurora House gets funding from both the City of Falls Church and the Arlington County (in terms of payment for bed space). Aurora House is on the budget of the City of Falls Church. In a memorandum between the City of Falls Chuch and Arlington County dated August 3, 2017, the City of Falls Church requests supervision by the Arlington County Court Services Unit's PREA Coordinator. Aurrora House has a PREA Compliance Manager (who also serves as the Group Home Manager). For the purposes of PREA, Arlington County has two group homes, Aurora House (houses females) and Argus House (houses males).

DESCRIPTION OF FACILITY CHARACTERISTICS

Aurora House (AH) is a two story building located in the City of Falls Church, VA, a highly urban area outside Washington, DC. The facility is in a neighborhood of both residential and office/commercial use just off a main road. The building has the appearance of a large house from the outside. This facility is a non-secure group home and has the ability to screen residents for appropriateness of placement prior to admission.

The facility opened in 1991 and is well designed and well-lit. Visability throughout the building is good, with many windows to the outside and several windows in internal walls providing additional line of sight supervision. The entrance is covered with a camera and has a ringer to gain admittance. A Notice of Intent to Audit (Notice) was posted on the front door and plainly visible.

The entrance opens into a foyer and then into an open reception area with windows on two sides. The reception desk is just inside the entrance and has a view of this entire open area. There are chairs around the large window facing the front of the building and parking lot for residents to wait before going out to the bus. There is camera coverage in this area with another Notice and posters in both English and Spanish. Brochures (English and Spanish) are available on the reception desk counter.

Just inside the entrance and to the left of the reception area is a hallway with two staff offices, a copy/file room and a large conference room. Residents are only in this area of the building for specific meetings (treatment team, meetings with probation officers, etc.) and not without supervison. Posters were visible in this area and the Notice was on the doorway to this area and in the conference room. The grievance policy/information was also posted in this room.

Directly across from the front entrance is a wall of windows and a double door to the outside pation/recreation area. This area has a patio with several tables and chairs and a large, well-shaded yard for outdoor activities. The property backs to a park. There is a locked storage shed in the back yard holding bikes and various equipment. The back yard is covered with a camera.

The dining room and kitchen are to the right and behind the reception area. The dining room has four large windows with a view of the yard. Cameras cover this area on opposite sides providing good views of the area and into the kitchen. There are posters in the dining room and information about available resources. There are storage areas with locked doors in the dining room; these doors were locked on the day of the facility tour. The door to the kitchen and serving window/counter separate the kitchen and dining rooms.

The kitchen has camera coverage and a door to the outside (to reach the dumpster). This door remains locked. There is a storage area here and it was locked on the day of the audit. Residents are not allowed in the kitchen area without supervision.

In front and across the room from the reception desk is a small area leading to two other offices and to the stairwell as well as a hallway to the left. This hallway leads to a family counseling and group room, an observation room and a large multi-purpose room at the end of the hallway. The multi-purpose room is quite large and has couches for seating, a large television, recreation equipment, large double doors leading to the patio area and storage areas with keyed locks. Cameras provide provide good coverage of the entire area. It is well lit with no discernable blind spots. PREA posters are visible on the walls along with the Notice.

Next to the multi-purpose room is an observation room with a window in the door and an internal window between it and the family counseling and group room which is next to it. The family counseling and group room has a window in the door, the internal window between it and the observation room mentioned before, and an internal windown to the small hall leading to the staircase and offices. There is a camera in this area and PREA posters and the notice are on the walls/doorway. This room has blinds on the windows and this auditor talked with the PREA coordinator and the residential program manager about the need to be mindful of when blinds are closed.

The entrance to the stairwell leading to the upstairs sleeping and living areas is across from the reception desk. To the right of the stairwell entrance is an area with two offices and a handicapped bathroom. Both offices have windows in the doors and there is camera coverage in this area. The Notice is posted in this area.

The stairwell is covered with two cameras, one facing up and one down, and a large convex mirror covers the area under the stairs by the residents' lockers, eliminating a potential blind spot. PREA posters are in the stairwell and it is well lit.

The second floor contains six, double occupancy bedrooms, three bathrooms, a living area, one counselor's office (with camera coverage in this office), and a laundry room. Two bedrooms share one bathroom; residents use the bathroom areas one resident at a time for privacy during bathing, toileting and while changing clothes. The bedrooms each have nice windows and surround the living area on three sides. There is good camera coverage in the living area; cameras do not have views of bathrooms or inside bedrooms. There is one small blind spot in the living area and the staff are looking at using a mirror to correct this.

The laundry room has an internal window allowing supervision and viewing by staff as residents do their laundry as well as a convex mirror to enhance supervision. There is also a storage closet; this door is secured with a keyed lock. The furniture is placed in a way that does not impede line of sight supervision. There is a wall of windows to the outside which are covered with blinds for privacy from the apartment building built beside AH. Posters (English and Spanish) and the Notice are visible. This auditor suggested varying the posters

periodically to maintain interest.

The counselor's office has a window in the door and camera coverage. The camera system is housed in this office and this auditor reviewed the camera coverage and camera placement.

The facility provides a telephone with direct access to the Doorways for Women and Families program for outside reporting of sexual abuse and sexual harassment and this telephone is located in the upstairs living area.

Overall the facility has good visual sight lines and care has been taken with the camera system and camera placement. Staffing ratios are predicated on the 1:8 required by PREA standards. Staff verbalize commitment to compliance with the standards.

SUMMARY OF AUDIT FINDINGS

The on-site audit of Aurora House Girls' Group Home was completed on April 27, 2017. Follow up visits to the facility were made on July 27 and October 30.

Compliance with the PREA standards and a true commitment to keeping residents in their care safe and free from sexual abuse and sexual harassment is evident at Aurora House. All staff interviewed articulated this commitment.

Sincere thanks to Rachael Kindell, Group Home Manager and PREA Compliance Manager for her dedication to having Aurora House achieve compliance with the PREA standards. She began the work to have the facility become PREA compliant, then took over the effort again after the sudden departure of the prior Executive Director. The work to become a PREA Compliant facility is difficult, and she has done an excellent job overcoming extra obstacles.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 4

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
Aurora House Girls' Group Home Prison Rape Elimination Act Policy*, 1.4.1. Zero Tolerance Policy
Review of job description of Group Home Manager/Director, PREA Compliance Manager of Aurora House Girls' Youth Home
Interview with PREA Compliance Manager/PREA Coordinator

*Aurora House Girls'Group Home Prison Rape Elimination Act Policy hereafter referred to as "PREA Policy" in this document.

The PREA Policy has excellent an description of the plan to prevent, detect and respond to prison rape. Very thorough descriptions of the measures taken to prevent sexual assault and sexual harassment with references to specific standards are included. While the organizational chart shows that PREA Coordinator/Group Home Manager reports directly to the 17th Judicial District's Court Service (CSU) Director, the position is also supervised by the director of the Department of Housing and Human Services in the City of Falls Church which maintains Aurora House on its city budget.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard does not apply to this facility. Aurora House does not contract with other agencies for the confinement of its residents; PREA Policy 1.4.3.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.4.4 Supervision and Monitoring of Residents, pp. 6-7
PREA 115.313/Staffing Plan, pp. 1-6

PREA Policy clearly articulates staffing plan, includes all components of the standard in developing the plan, and details the process for documenting any non-compliance with the plan. The PREA Policy articulates the staffing plan well and includes all elements in developing the plan. Although this facility reviews its staffing needs on a regular basis, incorporating all the elements of the standard into this review is a new practice.

The annual review of the staffing plan had not been done at the time of the on-site audit; it was completed during the corrective action period and includes all elements required in the standard.

The facility's staffing plan procedure describes in detail how staffing is to be deployed and how staff are to be utilized (for example, ensuring that staff may not work more than six consecutive days without a "rest" day).

This facility has moved to a a 1:8 staffing ratio ahead of the October, 2017 timeframe.

The Program Manager/PREA Coordinator is the staff responsible for unannounced rounds and conducts them on each shift. PREA Policy states that staff are not to alert other staff. The facility maintains an "Unannounced Rounds" log which was reviewed by this auditor. The log is excellent, prompting the person making the rounds to observe a specific list of things, thereby ensuring that compliance with the PREA standards are the focus of this observation. The form also has a place for each shift to help ensure they are all covered.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.4.5 Limits to Cross-Gender Viewing and Searches, p. 7
Interviews with residents
Interviews with staff
Interview with transgender resident

This facility does not do pat-down searches of any type. If there are concerns about contraband or safety, local PD are called and respond. All interviews with residents and staff are consistent with no pat-downs. Transgender resident interview also consistent with no pat-down searches of any type for any reason. Residents are asked to turn out their pockets and show their socks; metal detecting wand is sometimes used. Per email response from PRC on question from this auditor (prior audit), this does not apply if the facility does not do any type of pat-down search for any reason. Facility PREA Policy wording prohibits pat-down searches and goes further to be consistent with standard's wording.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.4.6 Residents with disability and who are limited English proficient, p.7-8
City of Falls Church Assisted Listening Technology for deaf or hard of hearing
Federal Information Relay Service for blind or visually impaired
Interview with agency head
Interview with Spanish speaking resident
Posters in Spanish throughout facility
Brochures translated into Spanish

Written material (posters and brochure) available in Spanish. Interview with Spanish-speaking resident confirmed that information and education about PREA available to her in Spanish or is translated by Spanish-speaking staff. Residents do not interpret for other residents per policy and this was confirmed in resident and staff interviews. PREA policy mirrors standard. Facility accesses Assisted Listening Technology for deaf or hard of hearing and Federal Information Relay Service for blind or visually impared.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.4.7 Hiring and promotion decisions, pp. 8-9
Review of HR forms for City of Falls Church and Aurora House
Interview with Hiring Manager at AH
Review of facility personnel files (all staff interviewed during on-site audit)

The facility's PREA Policy is consistent with all elements of the standard. Applicants complete "PREA Acknowledgement Form for Applicants New Hire and Promotion". Statements mirror the standard and there is a place on the form for the applicant to initial. Includes material ommissions about misconduct and false information as grounds for termination. Similar form used for current employees during annual evaluations and also mirrors standard. Facility seeks information from other facilities and provides information to prospective employers on past employees.

All but one 5 year background check was in personnel file for employees. The last one had been submitted, but not yet returned. At the time of the October visit, all five year backgrounds had been completed. All required backgrounds were in personnel records. Reviewed all personnel records for staff interviewed during on-site audit.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.4.8 Upgrades to Facilities and Technology, p. 9
Interview with superintendent (program manager)
Interview with agency head
Review of camera system monitors showing feed from all cameras

The camera system provides good coverage of facility. The camera monitoring system was reviewed to ensure camera viewing area did not show residents while bathing, toileting or dressing. There have been no upgrades to facility; new cameras installed. Camera system is not actively monitored but can be specifically or randomly pulled for review or for investigative purposes.

PREA Policy mirrors standard.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.4.9 Evidence Protocol and Forensic Medical Examinations, pp. 9-10
MOU with City of Falls Church Police Department
MOU with Doorways for Women and Families
Interviews with staff
Interview with PREA Coordinator/Compliance Manager

Facility PREA Policy mirrors standard. This facility does not do criminal or administrative sexual abuse or sexual harassment investigations. All allegations are referred to FCPD; MOU in place which does an excellent job of clarifying expectations of FCPD to follow PREA standard. . A MOU is in place with Doorways for Women and Families to provide victim advocacy and support services and

specifically addresses accompanying an alleged victim to the hospital, ongoing support and help through any criminal investigative process. A telephone with direct dial to Doorways is available to residents 24/7 and posters and brochures reinforce this information and service. Alleged victims are transported to Inova Fairfax Hospital for forensic exams at no cost to resident; SAFE/SANE staff available 24/7 at this hospital.

There have been no allegations of sexual abuse in the past 12 months. No residents who reported sexual abuse while at the facility were available in current population.

No forensic exams are conducted at this facility.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.4.10 Ensuring referrals of allegations for investigations, pp. 10-11
MOU between Aurora House and City of Falls Church Police Department
MOU between Aurora House and City of Falls Church Department of Human Services, Arlington County Court Service Unit, and Doorways for Women and Families
Interview with Agency Head

Facility policy mirrors standard. Agency does not do administrative or criminal investigations. MOU with FCPD is very thorough and details responsibilities including attached PREA standards relating to investigations. FCPD has legal authority to conduct such investigations. Facility has had no allegations; no reports/processes to review.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.5.1 Employee, Volunteer, and Contractor Training, pp. 11-12
"Aurora House Staff Guide to Prevention Detection and Responding to: Sexual Assault, Sexual Abuse and Sexual Harassment"
"PREA: Your Role Responding to Sexual Abuse"
Review of training records of all interviewed staff

PREA Policy mirrors standard. Staff have PREA Handbook entitled, "Aurora House Staff Guide to Prevention Detection and Responding to: Sexual Assault, Sexual Abuse and Sexual Harassment". Facility also requires staff to view on-line course, "PREA: Your Role Responding to Sexual Abuse". Additional information on identifying the common reactions of female victims recently added to curriculum to tailor training to all female population.

Training records and interviews with staff members indicate that they have required PREA knowledge.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.5.1Employee, Volunteer, and Contractor Training, pp. 11-12
"Aurora House Staff Guide to Prevention Detection and Responding to: Sexual Assault, Sexual Abuse and Sexual Harassment"
"PREA: Your Role Responding to Sexual Abuse"
Reviewed "Aurora House Contractor Guidelines: Your Responsibilities to Prevent, Detect and Respond to Sexual Abuse and Sexual Harassment" form
Reviewed "Aurora House Volunteer Guidelines: Your Responsibilities to Prevent, Detect and Respond to Sexual Abuse and Sexual Harassment" form

PREA Policy mirrors standard. Volunteers and contractors have PREA Handbook entitled, "Aurora House Staff Guide to Prevention Detection and Responding to: Sexual Assault, Sexual Abuse and Sexual Harassment". Facility also requires staff to view on-line course, "PREA: Your Role Responding to Sexual Abuse". Additional information on identifying the common reactions of female victims recently added to curriculum to tailor training to all female population. All contractors and volunteers sign, "Aurora House Volunteer Guidelines: Your Responsibilities to Prevent, Detect and Respond to Sexual Abuse and Sexual Harassment" form which details zero tolerance policy and prohibited behaviors.

Training record of volunteer reviewed and included appropriate training. Interview with facility volunteer indicated knowledge of PREA standards and facility's zero tolerance of sexual abuse and sexual harassment.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence:
PREA Policy 1.5.2 Resident Training
Reviewed brochure, "End the Silence"
Reviewed PowerPoint presentation for Resident Education
Reviewed form "Aurora House Prevention, Detection, and Respnse to Sexual Abuse and Assault"

PREA Policy mirrors standard. All resident training materials were reviewed at the time of audit and all residents were interviewed. All indicated that they had received training, but all stated that the training had occurred within the last two weeks. This auditor returned to the facility on October 30 and reviewed files for all intakes since the time of the initial on-site audit. All residents had received the required training within the timeframe indicated in the standard. In addition, residents now view the PREA DVD each Saturday to ensure information is continually available to residents.

Posters were located throughout the facility. This auditor suggested having a larger variety of posters and changing things periodically to help the information stay fresh and catch the attention of residents.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
This standard does not apply to this facility. They do not conduct administrative or criminal investigations.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.5.4 Specialized Training: Medical and Mental Health care, pp. 13
Certificate of training: "PREA: Medical Care for Sexual Assault Victims in a Confinement Setting."

Interview with mental health staff

PREA Policy mirrors standard. No forensic exams are performed at the facility. Mental health practitioner took training from NIC curriculum. Mental health staff also received general PREA training for all staff. Mental health staff indicated that her services are more supportive in nature and not therapy. Residents have outside providers for therapy and most have providers when they come to AH which they continue to see.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.6.1 Obtaining information from residents, pp. 14-15
Aurora House PREA Intake Screening Form, Vulnerability Assessment Instrument
Interviews with staff who conduct vulnerability assessments

PREA Policy mirrors standard. Excellent description of controls in place to protect residents from dissemination of sensitive information. This facility began its implementation of the PREA standards in November, 2016. Most of the required elements required by the standard were available, but located in several different screening instruments and not easy to find. Facility incorporated all information into one tool which it began using just before the on-site audit. Given how recently this tool was put into place, it was not possible to determine practice at the time of the on-site visit in April, 2017.

Auditor made a return visit to the facility on October 30, 2017. All intakes since the date of the on-site audit had been screened with the new tool and this screening had taken place within the timeframe required by the standard. Facility will futher refine the tool to ensure residents who disclose prior sexual abuse or having previously perpetrated sexual abuse are offered follow up meetings with mental health or medical practitioners. (In all files reviewed, appropriate referrals had been made within the timeframe required; facility is modifying as additional safeguard.)

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.6.2 Placement of residents in housing, bed, program, education, and work assignments, pp. 15
Interviews with staff who conduct risk screening
Interview with residents
Interview with PREA Coordinator/PREA Compliance Manager

PREA Policy mirrors standard. Isolation is not used in this facility. Staff who conduct risk assessments indicate that housing, etc., is determined on a case-by-case basis. One housing unit in this facility, so choice is limited to single or double room. Residents often given single rooms. All residents participate in all activities together-meals, recreation, going out to school, etc. All residents shower, toilet, dress separately.

At the time of the on-site audit, the facility's use of an integrated risk/vulnerable population tool was a new practice and the tool's use to determine placements was limited.

This auditor visited the facility again on October 30, 2017. A review of all intakes since the time of the on-site audit in April was conducted and the screening tool is being used to make placement decisions. This facility only houses 12 female residents, and carefully screens each potential intake for placement appropriateness.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.7.1 Resident Reporting of Sexual Abuse or Sexual Harassment, p. 15-16
Resident handbook
"End the Silence" brochure
Resident interviews
Staff interviews
Interview with PREA coordinator

Facility policy mirrors standard. All staff interviewed knew to accept verbal reports, all reported that verbal reports would be documented and said the documentation would happen "immediately". Staff and residents gave multiple examples of ways to report including reporting using the phone connected to Doorways for Women and Families. Tools for making reports are available 24 hours a day and all residents said they had access to these tools whenever they wanted them.
Staff are also allowed to privately report to Doorways for Women and Children.

This facility does not detain residents solely for civil immigration purposes.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:

PREA Policy, 1.7.2 Administrative Remedies, pg. 16
Resident interviews

Facility is exempt from this standard. Since residents are aware of the use of "grievances", facility policy acknowledges this and educates residents that any written allegation is forwarded at once to the PREA Coordinator so that it can be referred to the FCPD for investigation and follow-up. Interviewed residents were aware that FCPD investigate any allegation of sexual abuse or sexual harassment. PREA Policy puts no time-frame on making such an allegation.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.7.3 Resident access to outside support services and legal representatives, pp. 16-17
Reviewed MOU with Doorways for Women and Families
Interviews with residents
Interview with PREA Coordinator/PREA Compliance Manager
"End the Silence" brochure

Residents were not uniformly aware of services available to sexual abuse victims in the community. Information is listed in the brochure provided at the facility, but interviewed residents struggled to remember until prompted. This auditor recommended regular "in-service" training to help with recall. During a follow-up visit in October, the Group Home Manager noted that residents now watch a PREA DVD each Saturday and talk about resources.

Facility's MOU with Doorways for Women and Families is very thorough and covers all elements of the standard relating to the provision of confidential support services.

All residents and staff interviewed stated that residents are allowed confidential time with their legal representatives and with their families.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.7.4 Third Party Reporting of Sexual Abuse or Sexual Harassment, p. 17
Review of facility website, http://www.fallschurchva.gov/514/Aurora-House under PREA

PREA Policy mirrors standard. Brochures and website provide information on making a third party report and provides multiple ways to make reports. Instructions on making reports is in the brochure and on the website.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.8.2 Staff Reporting of Sexual Abuse or Sexual Harassment, pp. 17-18
Interviews with staff
Interview with superintendent
Interview with PREA Coordinator/PREA Compliance Manager

PREA Policy mirrors standard. Interview with program manger (superintendent) was consistent with policy in having FCPD investigate all allegations. Staff indicated knowledge of duty to report and that they could report outside facility. Notifications made to placing entity (juvenile court/dss/parent/guardian); notification made immediately. Mental health practitioner aware of duty to report.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.8.2 Staff Reporting of Sexual Abuse or Sexual Harassment, p. 18

Interviews with staff
Interview with agency head
Interview with superintendent

PREA Policy mirrors standard. Interviews with agency head, superintendent and staff members consistent on providing safety for resident and acting immediately on any threat. The facility has had no incidents in the past 12 months.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.8.3 Reporting to Other Facilities, p. 18
Interviews with staff
Interview with Agency Head

PREA Policy mirrors standard. Interviews indicated that reports would be made to other facility and any report received from another facility would be investigated thoroughly by FCPD. There have been no allegations of this nature in the past 12 months.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy, 1.8.4 First Responder Duties, pp. 18-19
Staff interviews
Reviewed "Aurora House Sexual Abuse Immediate Response Protocol"
Reviewed "Aurora House Non-Emergency Sexual Abuse Reponse Protocol"

For this group home facility, all staff are trained to follow the same protocol regardless of their job description within the facility. PREA Policy mirrors standard. There have been no allegations of sexual abuse at this facility. All staff are trained as First Responders and all staff interviewed were asked about first responder duties. All articulated their responsibilities appropriately. The Response Protocols do a good job of detailing responsibilities of first responders. First responder information is posted throughout facility.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.8.3 Coordinated Response, 19-20
Reviewed "Aurora House Sexual Abuse Immediate Response Protocol"
Reviewed "Aurora House Non-Emergency Sexual Abuse Reponse Protocol"

The facility's coordinated plan is to follow all instructions in PREA Policy 1.8.2 and to provide emergency services as required. In addition,"Aurora House Sexual Abuse Immediate Response Protocol" and "Aurora House Non-Emergency Sexual Abuse Response Protocol" provide additional information for everyone involved in responding to an incident of sexual assault. These are posted throughout the facility. The protocol is facility specific.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
This standard is NA in the Commonwealth of Virginia

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence:
PREA Policy 1.8.7 Protection from Retaliation, pp. 20-22
Interview with agency head
Interview with PREA Coordinator/PREA Compliance Manager tasked with monitoring retaliation against staff or residents
Reviewed ""Aurora House Protection Against Retaliation" form

Facility's policy provides excellent description of services to be provided to any resident or staff who suffers retaliation for reporting sexual abuse or sexual harassment, including the use of a neutral party to monitor retaliation. PREA Policy mirrors standard. Interviews with agency head and superintendent support zero tolerance for instances of retaliation by staff or residents. Excellent form for use in monitoring retaliation will ensure careful attention to any signs of retaliation. Both indicated that monitoring would continue until there was no need. There have been no allegations and no instances of retaliation.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.8.8 Post allegation protective custody, p. 22
Interviews with staff

This facility does not use isolation in any form for any reason. An emergency court order could move the resident to another facility, but no isolation at AH. The facility does not have an area that would even allow segregated housing. Interviews with staff confirm no isolation use.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 1.9.1 Criminal and administrative investigations, pp. 22
Review of MOU with Falls Church Police Department

Review of MOU with Department of Housing and Human Services/CPS
Interview with PREA Coordinator/PREA Compliance Manager

MOU with Falls Church Police Department details their investigation of all allegations of sexual abuse or sexual harassment and outlines the PREA Standards in regards to the conduct of such investigations. This facility does not do administrative or criminal investigations. Their policy states their commitment to support the work of the FCPD and to provide any materials or help requested.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

Evidence:
PREA Policy 1.9.2 Evidentiary standard for administrative investigations, p.22
Review of MOU with FCPD

Facility conducts no investigations, administrative or criminal. MOU with FCPD mirrors the PREA standard and includes information re evidentiary standard. Facility has had no allegations.

Standard 115.373 Reporting to residents

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

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

Evidence:
PREA Policy, 1.9.3 Reporting Investigative Outcomes to Residents, p. 22-23
Interview with Agency Head

PREA Policy mirrors standard with respect to the facility staying in touch with investigating agency and providing feedback to residents. Policy states requirement to let resident know outcome of investigation and what has happened to alleged perpetrator. No allegations at this facility, no investigations to review. MOU with FCPD states that facility will ask for updates to inform resident of case outcomes.

Standard 115.376 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.1 Disciplinary Sanctions for Staff, pp. 23

Facility policy mirrors standard. No terminations of this nature at this facility; no files or records to review.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Click here to enter text.
PREA Policy 2.2 Corrective Action for Contractors and Volunteers, pg. 24
Interview with superintendent

Facility policy mirrors standard. No incidents of this nature have happened at this facility; no incidents with contractors or volunteers.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.3 Disciplinary Sanctions for Residents, pp. 24
Interview with superintendent
Interview with mental health practitioner
Review of resident manual

Facility policy mirrors standard. All sexual contact between residents is prohibited at this facility. AH does not use isolation for any reason. The mental health practitioner at this facility does not provide therapeutic services although residents are expected to take part in groups, etc. General programming and education are not withheld if residents don't participate in these groups (note: groups are not related to sexual abuse or sexual harassment). No incidents of this nature at this facility; no discipline records to review.

Standard 115.381 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.2.1 Medical and mental health screenings; history of sexual abuse, pp. 24-25
Interviews with staff who screen for risk of victimization
Interview with mental health practitioner

Facility policy mirrors standard. Interviews with intake staff confirm policy as practice; any resident who disclosed prior sexual abuse is referred to outside mental health provider right away (most residents are already working with a provider from the community when they come into population, so this information would be relayed to provider). All sensitive information is handled in the most confidential way possible with clear limits on staff who have this information.

The referral aspect of the facility's risk screening tool was new at the time of the on-site audit. The files of all new residents were reviewed on October 30, 2017 and all had the required referrals. The facility is putting an additional safeguard into place to further ensure that referrals are made.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
2.2.2 Access to Emergency Medical and Mental Health Services, p. 25
Interviews with staff
Interview with mental health practitioner

PREA policy mirrors standard. All staff interviewed knew the first responder steps and to protect the victim and secure medical/mental health care for victim. No incidents of sexual abuse have been reported at this facility. No on-site medical staff.

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.2.3 Ongoing Medical and Mental Health Care for Sexual ABuse Victims and Abusers, pp. 25-26
Interview with mental health practitioner

Facility policy mirrors standard. Residents at this facility receive all medical treatment, emergency and ongoing, in the community, so all treatment is consistent with community level of care. There is no medical staff or medical unit on-site. Ongoing mental health needs met in the community with community providers; mental health practitioner does not provide therapy. Resident victims would be provided care without cost. There have been no incidents at this facility.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.3.2 Sexual Abuse Incident Reviews, pp. 26-27
Interview with incident review team member
Interview with PREA Coordinator/PREA Compliance Manager
Interview with superintendent

Facility policy mirrors standard. Interviewed staff were knowledgeable about what elements of an incident review would be critical to help ensure any problems were corrected and to improve any staffing levels, etc. There have been no incidents at this facility so no incident review reports to review.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.3.3 Data Collection, pp 27

Facility policy mirrors standard. There have been no incidents to report.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.3.3 Data Review for Corrective Action, pp .27-28
Interview with agency head
Interview with PREA Coordinator/PREA Compliance Manager

Facility policy mirrors standard. Interviews with PREA Coordinator/PREA Compliance Manager indicate understanding of how data review helps facilities improve. Annual report is on website. There have been no allegations at this facility.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence:
PREA Policy 2.3.4 Data Storage, Publication and Destruction, p. 28

Facility policy mirrors standard. Information on website. There have been no incidents of sexual abuse at this facility.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Susan Heck November 13, 2017

Auditor Signature Date