Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report September 6, 2018

Auditor Information

Name: Marlean Ames	**Email:** marames328@yahoo.com
Company Name: TrueCore Behavioral Solutions, LLC	
Mailing Address: 66 Portside Circle	**City, State, Zip:** Akron, Ohio 44319
Telephone: 330-327-5715	**Date of Facility Visit:** June 25, 2018

Agency Information

Name of Agency North Carolina Department of Public Safety		**Governing Authority or Parent Agency** *(If Applicable)*	
Physical Address: 512 N. Salisbury Street		**City, State, Zip:** Raleigh, North Carolina 27604	
Mailing Address: Same as Above		**City, State, Zip:**	
Telephone: 918-825-2754		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency mission: The overall mission of the Department of Public Safety is to improve the quality of life for North Carolinians by reducing crime and enhancing public safety.

Agency Website with PREA Information: https://www.ncdps.gov

Agency Chief Executive Officer

Name: Erik A. Hooks	**Title:** NCDPS Secretary
Email: erik.hooks@ncdps.gov	**Telephone:** 919-733-2126

Agency-Wide PREA Coordinator

Name: Charlotte Jordan-Williams	**Title:** PREA Director

Email: charlotte.williams@ncdps.gov	**Telephone:** 919-825-2754
PREA Coordinator Reports to: Jane Ammons Gilchrist, General Counsel, NCDPS	**Number of Compliance Managers who report to the PREA Coordinator** 140

Facility Information

Name of Facility: Cabarrus Juvenile Detention Center				
Physical Address: 822 McWhorter Road Concord, NC 28027				
Mailing Address (if different than above):				
Telephone Number: 704-720-0807				
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☒ State	☐ Federal	
Facility Type:	☒ Detention	☐ Correction	☐ Intake	☐ Other:

Facility Mission: To provide a provisional, safe, protected, precise, benevolent environment for juveniles awaiting court or pending placement. To provide services that will help reduce and avoid juvenile delinquency by efficiently intervening, educating, and treating residents.

Facility Website with PREA Information: https://www.ncdps.gov

Is this facility accredited by any other organization? ☐ Yes ☒ No

Facility Administrator/Director

Name: Angela D. Wilson	**Title:** Detention Director
Email: angela.d.wilson@ncdps.gov	**Telephone:** 704-720-0807

Facility PREA Compliance Manager

Name: Roderick Abrams	**Title:** Youth Center Shift Supervisor
Email: roderick.abrams@ncdps.gov	**Telephone:** 704-720-0807

Facility Health Service Administrator

Name: Jeff Paysour	**Title:** Contract Registered Nurse
Email: jeff.paysour@ncdps.gov	**Telephone:** 980-429-6059

Facility Characteristics

Designated Facility Capacity: 30		**Current Population of Facility:** 31	
Number of residents admitted to facility during the past 12 months			741
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:			322
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			562
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	12-19		
Average length of stay or time under supervision:			14.60 days
Facility Security Level:			Maximum
Resident Custody Levels:			Maximum
Number of staff currently employed by the facility who may have contact with residents:			31
Number of staff hired by the facility during the past 12 months who may have contact with residents:			13
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			6

Physical Plant

Number of Buildings: 1		**Number of Single Cell Housing Units:** 2	
Number of Multiple Occupancy Cell Housing Units:			0
Number of Open Bay/Dorm Housing Units:			0
Number of Segregation Cells (Administrative and Disciplinary:			0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):
Cameras are placed throughout the facility and yard to provide more than adequate monitoring. Retention is approximately 3 to 4 weeks.

Medical

Type of Medical Facility:	The medical clinic is comprised of an exam room, storage closet and office area. Designed only for minor issues and examinations.
Forensic sexual assault medical exams are conducted at:	Acute Carolinas Medical Center NE Emergency Room/Non-acute Jeff Gordon's Children's Hospital Child Advocacy Center

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	7
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	5

Audit Findings

Audit Narrative

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

The Prison Rape Elimination Act (PREA) onsite audit of the Cabarrus Juvenile Detention Center (Cabarrus JDC), located in Concord, North Carolina was conducted on June 24, 2018, by Marlean Ames, and assisted by BJA Certified PREA Auditor Flora Boyd, subcontracted by TrueCore Behavioral Solutions, LLC. The detention facility's physical plant is a single story building within a fenced secure area and an outdoor recreation area. Cabarrus JDC has a secured main entrance with an administrative area with several offices and a conference room, two classrooms, intake area with several secure rooms, and two separate living quarters referred to as A-Wing and B-Wing. Each wing has fifteen single bedrooms with individual sinks and toilets with one bedroom in each wing being handicap accessible.

The facility is under the jurisdiction of the North Carolina Department of Public Safety located in Raleigh, North Carolina. The post-adjudication facility is a 30 bed secure facility located in Concord North Carolina. The facility serves adolescent boys and girls aged 12 years to 19 years old. Residents attend school daily Monday – Friday directed by teachers providing educational services licensed by the N.C. Department of Public Instruction. The detention facility provides an educational program during the week in order for residents to maintain their grades and the continuity of care upon return to their community schools. The program is designed for residents to have the opportunity to learn at the highest level possible. The instructional program encourages the residents to explore their abilities to learn, understand their cultural backgrounds, and enhance their future. Residents receive instruction in life skills, English, mathematics, social studies and science. Required special education services are also provided for residents. The facility currently employs 31 full time staff. The facility population the day of the audit was 31 residents. Twenty-eight (28) males and three (3) females. The facility had its last PREA audit on August 22nd and 23rd 2016 receiving full compliance on their final report.

<u>Pre-Onsite Audit Phase</u>

Prior to the onsite portion of the audit, there were initial telephone conference and subsequent follow-up telephone conferences, as needed, with the facility PREA Compliance Manager and state wide PREA Coordinator. The communication ensured synchronized schedules, dissemination of information, progression of the audit preparation process, and provided the itinerary for the site visit. Correspondence was exchanged and shared. The primary facility management staff and some direct care staff previously experienced the PREA audit process in 2016 and worked in the facility during the initial implementation of the PREA standards. The facility staff has also experienced mock PREA audits with the most recent once conducted in August 2017, facilitated by the NCDPS PREA Office, that serve to monitor and review the established practices and review policies and procedures, as well as assist in the preparation of the PREA audit. Through the interactions of the facility Director, PREA Compliance Manager, mock audits;

and documented training, it was determined that the staff remains aware of the audit process, role of the Auditor, and the meaning and purpose of corrective actions.

The completed PREA Pre-Audit Questionnaire, policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the original auditor at TrueCore May 15, 2018 and later forwarded to current auditor approximately two weeks prior to scheduled audit date. The completion date of the Pre-Audit Questionnaire was May 17, 2018. After an assessment of the information provided, a written review was provided to the facility Director and PREA Compliance Manager via email. Numerous phone calls were place to the facility Director.

Clarifications on policy and practice were requested and received prior to the onsite visit. The additional information was provided by the PREA Compliance Manager and facility Director during the onsite visit. A requested list of direct care staff and their shift assignments and a resident population roster. Additionally, the request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, lesbian, bisexual and/or transgender residents; and residents housed in isolation. The Auditor conferred with the PREA Compliance Manager to confirm schedules and to clarify specialized PREA roles. As a result of the information received, the Auditor developed an interview schedule of specialized and random staff.

Onsite Audit Phase

The site visit was conducted on June 24, 2018. The entrance meeting was attended by facility Director Angela Wilson, PREA Compliance Manager Roderick Abrams, and PREA Auditor Marlean Ames.

There were no barriers in completing any phase of the on-site audit. The Auditor had unfettered access to the facility and all encountered staff members were receptive to the site visit and responsive to the Auditor. The audit notices were posted in various areas of the facility six weeks prior to the site visit, and contained the contact information of TrueCore Behavioral Solutions and the name of the original auditor. No type of correspondence was received by TrueCore or the auditor from residents or staff regarding any PREA related issue. The signs were easily visible during the facility walk-through.

During the facility walk-through the auditor was accompanied by facility PCM, and Director with various other staff joining in their respective areas to provide an overview of their areas and offices. Various areas were identified as places where residents are prohibited and areas where residents are only permitted with staff supervision. The facility staff had signs in place where residents were prohibited and only permitted with staff supervision. Signs were posted appropriately in view for both residents and staff observance. All staff and resident restrooms were also appropriately marked with signs. Cameras are strategically placed throughout the facility that assist in the monitoring of residents and reduce blind spots. There are two (2) units with each containing 15 individual secure rooms with sinks and toilets. There are cameras within each unit but privacy is provided for residents while using toilets or changing clothes. All doors to closets and storage rooms are kept locked. There are two (2) control rooms monitored by staff and thirty (30) cameras strategically placed throughout the detention facility excluding the bedrooms and shower/bathroom areas. The medical area is located on one (1) of the wings and contains an examining table, medication cart and storage. Each wing has a shower/bathroom area, laundry room and storage area. The detention facility has a maintenance area and residents are restricted from this area.

During the comprehensive site review, the printed notifications of the PREA site visit were observed posted in the areas previously identified in the pictures sent to the Auditor, such as living units, and common areas for residents and staff. The notices contained large enough print to make them accessible and easy to see and read. Posted signs were also observed around the facility regarding general PREA information including the abuse reporting hotline numbers and information regarding access to victim advocacy services through the Esther House of Stanley County, Inc. All residents that were interviewed had a very good grasp of services offered through the hotline and that an advocate can provide emotional support as well as reporting allegations of sexual abuse. Telephones were observed for reporting allegations of sexual abuse and sexual harassment. The phones were tested and the reporting of information was discussed with the operator. Additionally, during the site review and subsequent walkthroughs, residents were observed engaged in program and leisure activities. The direct care staff members were observed providing engaged supervision to residents and the monitoring of the facility.

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Thirty-one staff members are currently employed at the facility that may have contact with residents and there are 7 volunteers and contractors who are currently authorized to enter the facility. A total of 31 residents were in the facility during the site visit. Ten residents were interviewed after randomly selecting the names from the facility population report. A previous inquiry was made regarding vulnerable categories within the resident population related to the selection of targeted interviews. Residents were randomly selected for interviews from the population roster, considering each housing unit and information regarding the make-up of the population. The interviews with the residents, staff, contractors and volunteers indicated their receipt of PREA training, which was also verified by a review of sign-in documentation and power point presentations also included on the pre-audit flash drive.

Policies, procedures and supporting documentation were reviewed prior to the on site visit and while onsite. The supporting documents reviewed involved some of the interviewees and persons not interviewed. The supporting documentation reviewed again included but was not limited to various forms; personnel files including background checks; risk and other screening instruments; investigations; education and training acknowledgement forms; training records; checklists; and other documentation. During the site review, the grievance boxes and forms and medical forms were observed posted in the living units. Additional documentation was presented on-site for the 5 investigator's specialized training who conduct investigations on PREA allegations

The following specialized staff interviews were conducted in addition to random staff (direct care), Director and PREA Compliance Manager:

- Contract Administrator (1)
- Intermediate or higher level staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment (1)
- Contractors who have contact with residents (2)
- Medical Staff (1)
- Mental Health Staff (1)
- Administrative (Human Resources) Staff (1)
- Volunteers who have contact with residents (2) Telephone interviews
- Investigative staff (3)
- Staff who perform screening for risk of victimization and abusiveness (1)
- Staff on the sexual abuse incident review team (1)
- Designated staff member charged with monitoring retaliation (1)
- Intake Staff (1)
- First Responder Non-security Staff (1)

The facility reports and there was no allegations of sexual harassment or sexual abuse reported in the past 12 months.

All staff members working in the facility are considered mandatory reporters by policy and/or personal licensure. The facility's website contains PREA information, including how to report allegations. Research and interviews with the Director and PREA Compliance Manager indicated no known litigation involving the facility. During the comprehensive site review, records were observed to be stored securely with limited key access by identified staff. Residents were randomly selected from both wings for the interview process. A total of ten (10) residents were interviewed. Residents were well informed of their right to be free from sexual abuse and harassment and how to report sexual abuse and harassment using several ways of communication such as trusted staff, administrative staff, family member, and the hot line. The community victims 'advocacy service and telephone number is available to the residents. There is evidence of Cabarrus JDC's Detention Director obtaining a Memorandum of Understanding to provide confidential emotional support to residents who are victims of sexual abuse and forensic exams. Esther House of Stanley County, Inc. is the program identified to provide the victim advocacy services for the residents at the detention facility. Emergency services and forensic examinations are conducted at the North East Cabarrus Hospital.

After the completion of the site visit process, an exit briefing was held with the facility Director and PREA Compliance Manager to recap the onsite process and review program strengths. The facility staff members were given the opportunity to ask additional questions about the PREA audit process and there were none. During the closeout, the auditor and facility Director discussed modification of the Risk Assessment Tool to meet the spirit of the standard. The current tool was not objective and did not cover the minimum eleven (11) points in the standard. Since the on-site audit, the facility director has provided the needed documentation that the new objective assessment was being used by facility intake staff. A memorandum was also provided that the State of NC was currently working with the PREA Resource Center for modification of policy and technical assistance. The timelines for the submission of PREA reports were reviewed by the Auditor.

Post Onsite Audit Phase

The Esther House of Stanley County, Inc. was called for confirmation of facility MOU and services provided. According to the PREA Compliance Manager, services for a victim may be directly requested by the resident, facility staff member or law enforcement. It was confirmed the advocacy services to be provided as stated in the MOU including accompanying the victim through the forensic medical examination and investigative interviews if requested. North East Cabarrus Hospital was also contacted to confirm the use of SAFE/SANE staff for all forensic medical examinations. Two volunteers were also interviewed via telephone.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special

housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Cabarrus Juvenile Detention Center (Cabarrus JDC) located in Concord, North Carolina was designed and has the capacity for thirty (30) male and female residents. At the time of the audit, the detention facility had only male residents. The detention facility's physical plant is a single story building within a fenced secure area and an outdoor recreation area. Cabarrus JDC has a secured main entrance with an administrative area with several offices and conference room, two (2) classrooms, intake area with several secure rooms, and two (2) separate living quarters referred to as A-Wing and B-Wing. Each wing has fifteen (15) single bedrooms with individual sinks and toilets and one of the bedrooms on each wing is handicap accessible. There are two (2) control rooms monitored by staff and thirty (30) cameras strategically placed throughout the detention facility excluding the bedrooms and shower/bathroom areas. The medical area is located on one (1) of the wings and contains an examining table, medication cart and storage. Each wing has a shower/bathroom area, laundry room and storage area. The detention facility has a maintenance area and residents are restricted from this area.

Residents receive information regarding PREA and their rights during the intake process. The PREA information is printed in English and Spanish. Additionally, after residents are admitted to the facility they are provided additional information about sexual abuse and harassment in both individual and group treatment. Resident who have experienced trauma, abuse, or victimization are provided treatment services, as identified in their treatment process with on site psychological staff. Referrals are made upon release for ongoing emotional and comprehensive treatment within the community. The facility was clean, in good repair and very well maintained. The building is spacious and well lit with ample room for staff to meet with residents during educational and group treatment time. Upon entering the facility, there is a visitor sign-in area which has various facility information posted and pamphlets for the rape crisis hotline and reporting instructions for third-party reporting from parents or visitors. PREA brochures written in both English and Spanish are also available to both visitors and family members.

All Agency Policies that were submitted to this PREA Auditor via thumb drive were reviewed prior to arrival for the on-site audit. Additionally, during the on-site audit many of these documents and relevant information were again reviewed. Policies included but not limited to:

Additional documents were reviewed such as: North Carolina Department of Public Safety Policy and Organizational Charts, employee and resident handbooks, NCDPS General Directives various statutes, internal and external facility audit reports, PREA audit guide, PREA audit notices, facility layouts/schematics, facility program specific to their coordinated response plan, PREA juvenile standards, statewide and internal PREA-related memorandums and emails, policy amendment emails, staffing plan, various facility postings, staffing breakdown and rosters, master schedules, camera listings and locations, various logbooks, Staff Training Acknowledgement Forms, various staff training sign in sheets, resident educational information, Agency Mission Statements, MOU's and agreements.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

***Auditor Note:** No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Number of Standards Exceeded: 1

Number of Standards Met: 41

Number of Standards Not Met: 0

Summary of Corrective Action (if any):

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No

- 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 ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ 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.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy: Juvenile Justice Facilities Sexual Abuse and Harassment Policy and Requirements and Procedures and NCGS 14-27.7
Facility Organization Chart
Job Descriptions

Interviews:
PREA Compliance Manager
Random Staff
Resident Interviews

The Policies contain the methods demonstrating zero-tolerance regarding all forms of sexual abuse and sexual harassment and identifies the approach for preventing such allegations. The Policy provides approaches for detecting and responding to allegations of sexual abuse and sexual harassment. The Policy also outlines the strategies for addressing the provisions of the PREA Standards and includes the following: prevention and responsive planning; training and education; risk screening; reporting; official response following a resident report; investigations; discipline; medical and mental care; and data collection and review. Definitions of the prohibited behaviors are included in the Policy which addresses sanctions to be used when the PREA related policies are violated.

The initial review of the North Carolina Department of Public Safety (NCDPS) Sexual Abuse and Harassment Policy and Requirements and Procedures (R&P) Document reviewed and approved by both the Commissioner and Deputy Commissioner in June 2013 and NC General Statute 14-27.7 (Intercourse and sexual offenses with certain victims; consent no defense) outlines how each facility implements its approach to preventing, detecting and responding to all approaches of sexual abuse and harassment, including the definitions of prohibited behaviors as well as sanctions for staff, contractors, volunteers and residents who had violated those prohibitions. Additionally, the policy provides comprehensive guidelines and a training foundation for implementing each facility's approach to include the zero tolerance towards reducing and preventing sexual abuse and harassment of residents. It is evident, the executive administration has taken the PREA Standards to another level since their first audit and it is reflected in

their commitment to protecting the residents in their care throughout the State of North Carolina. NC Department of Public Safety has a designated PREA Coordinator, her official title is PREA Director and reports directly to the General Counsel, NCDPS. The PREA Director works statewide to implement the PREA Standards and has the authority to develop, implement and oversee the agency's efforts toward PREA compliance. Cabarrus YDC's PREA Compliance Manager is one (1) of the Youth Center Shift Supervisors. The PREA Compliance Manager stated during the interview, he has the time and authority required to fulfill his PREA related duties. He discussed his coordination efforts and process for continuous monitoring for PREA compliance and resident education. Interviews with direct care/random staff members confirmed the supervision and monitoring of the PREA efforts by the Compliance Manager and revealed their awareness of the role of the PREA Coordinator performed by the Compliance Manager. The conditions of the facility and the interviews with random staff and residents support adherence to the Policy. The review of the Policy, Job Description and organization chart/table of organization documents the identification of the Compliance Manager as the PREA Coordinator for the facility. The interviews with the random staff and the Compliance Manager and the interaction and correspondence between the Auditor and the Compliance Manager support the documentation reviewed and confirms the role as PREA Compliance Manager and the Agency's PREA Coordinator's involvement.

Standard 115.312: Contracting with Other Entities for the Confinement of Residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- 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.) ☐ Yes ☐ No ☒ NA

115.312 (b)

- 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".) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The interview with the facility Director and the PREA Compliance Manager revealed the Agency does not contract with other facilities for the confinement of its residents.

Standard 115.313: Supervision and Monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.313 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 internal or external oversight bodies? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?☒ Yes ☐ No

115.313 (d)

- 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 ☐ No

- 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 No

- 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 ☐ No

- 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 ☐ No

115.313 (e)

- 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 ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- 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 functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy JJ Facilities SAH (pg. 11); and NCGS§143B-709
Work Schedules
Staffing Plan
Sample of Unannounced Rounds
Inspection forms

Interviews:
Director
Intermediate or Higher Level Staff
PREA Compliance Manager

The various work schedules reviewed and observations during the comprehensive site review and subsequent walkthroughs revealed the general adherence to the policy and current required ratios. The Work Stoppage Plan provides guidance to staff for obtaining additional staff in the event of emergency, work stoppage or other job action occurs.

The Policies provide for an annual staffing plan assessment to be conducted by the Director in conjunction with the Compliance Manager/PREA Coordinator. A review of the annual Staffing Plan Review reveals a completion date in 2018. The Staffing Plan Review includes but is not limited to consideration of adjustments to the staffing plan; monitoring system; resources available and committed to ensure adherence to the staffing plan; and prevailing staffing patterns. A review of a sample of documented unannounced rounds support unannounced rounds are conducted by intermediate level and higher-level staff. The unannounced rounds are recorded on the PREA Unannounced Facility Visit form. The areas assessed during the unannounced rounds include but are not limited to: routines being followed; staff positioning; staff deployment; and groups in appropriate locations; locked doors; and appropriate interactions between staff and residents. Staff members are not informed of the unannounced rounds and there is not a routine schedule regarding the rounds. Staff members are encouraged not to alert other staff members regarding the unannounced visits.
The interview and documentation confirmed unannounced rounds are conducted to identify and deter sexual abuse and sexual harassment and are documented. The facility practice provides for compliance to the staffing plan and the deviations are to be documented however there have been no deviations from the staffing plan in the past 12 months.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- 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 ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- 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 ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- 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 ☐ No ☐ NA

115.315 (e)

- 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 ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- 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 ☐ No

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Facility Policy JJ Facilities SAH (pgs. 11-12)
Policy RP_DC 1-3 (pgs. 10-11)
Policy YC R&P 2.0 (pg. 18)
General Directive 12-01 - Control of Contraband/Searches Special Incident Report form;
Training Video slides Cross Gender Acknowledgement OPA T30
Training Logs/acknowledgement forms

Interviews:
Random Staff,
Residents
PCM

The Policy provides that no type of cross-gender search will be done unless there are exigent circumstances or conducted by medical personnel. If a cross-gender search is conducted, it must be documented. Body cavity searches are prohibited at the facility. The interviews with random staff stated

the same and that the likelihood of a cross-gender pat-down search occurring is extremely low due to males always being present in the facility. All the residents interviewed indicated they had not been involved in a cross-gender pat-down search. Random staff members' interviews revealed the practice of females not conducting pat-down searches. All information reviewed and discussed was aligned with the Policy.

The Policy prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status; this information was also verified through interviews with random staff. When the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner. There were no residents in the facility that identified as transgender or intersex during the site visit. The Policy ensures residents are able to shower, change clothes and perform bodily functions without being viewed by staff. Staff of the opposite gender must verbally announce their entrance of each living unit prior to entering. The verbal announcement was observed and confirmed during the facility site walkthrough when entering a living unit and through interviews with staff and residents.
The interviews, review of training materials, including training roster support staff members' participation in the training for searching residents, including cross-gender pat-down searches and searches of transgender and intersex residents in a respectful manner consistent with security needs. All random staff members have received the training and based on the Policy, interviews and training documents are prepared to conduct searches as required and in accordance with Policy and the provisions of the PREA standard. Additionally, the staff revealed in interviews in conjunction with Policy that if a cross-gender search is conducted, the justification for the search must be documented on a Special Incident Report form. No Cross Gender searches have been conducted and all staff are aware of the prohibition except in exigent circumstances.

Standard 115.316: Residents with Disabilities and Residents Who Are Limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- 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 ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- 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 ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Agency SOP 907
Policy JJ Facilities SAH (pg. 7)
PREA Juvenile Orientation Materials (English and Spanish)
Posted information throughout the facility in English and Spanish;
Resident sign-in sheets and resident orientation materials
Brochures and pamphlets in English and Spanish
Interpreter Service contract

Interviews:
Random Staff
PREA Compliance Manager
Residents

The facility Policies address the provisions of support services for disabled residents by providing these residents the equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, performance of first responder duties, or the investigation of the allegations.
The facility staff has access to interpreters and other resources for the provision of support services, including services for the hearing impaired; Deaf; intellectual, psychiatric and speech disabilities; low

vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. Documentation was reviewed of a State Wide Term Contract 961 B between the facility for telephone interpretation services and for the provision of services for residents in the aforementioned categories. PREA information is posted in various areas of the facility in English and Spanish. The facility has an Intervention Specialist on site that will assist with support services through the education team. The direct care staff interviews revealed the practice is no resident interpreters, resident readers or any type of resident assistants are used for the provision of PREA information and have not been used during this audit period. The documentation reviewed, including the Policy and Procedures, and interviews with PREA Compliance Manager supported that all residents will have the opportunity to participate in and benefit from all of the facility's PREA initiatives. There was not a resident identified as being limited English proficient.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- 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 ☐ No

- 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 ☐ No

- 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 question immediately above? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 question immediately above? ☒ Yes ☐ No

115.317 (b)

- 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 ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- 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 ☐ No

115.317 (f)

- 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 ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- 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 ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Policy DJJDP Youth Development Policy and Requirements & Procedures
Form HR013 DPS Employment Statements
Form HR008 Professional Reference Check
Form HR005 Applicant Verification
Hiring & Promotion/Background Checks
Background Check Log
Sample of Personnel Files
Staff/Contractor Records Checks log
Memo 10-1013 PREA Hiring and Promotion

Addendum to memorandum

Interview:
Administrative (Human Resources) Staff
Director
PCM

Facility Policy addresses hiring and promotion processes, and decisions. Employee background checks are also included. The Policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial Criminal History Record Checks and five-year checks were reviewed on the background check log and in the personnel files while on site.

The interview with the human resource staff and a review of Policy provide details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard. At least 10 personnel files were reviewed either through review of personnel documents on the flash drive or review of personnel files during the site visit. There is also a consult with the child abuse registry. The documented background checks are aligned with the Staff/Contractor Records Checks log and confirmed the information provided by Policy and the interview. According to the interview, staff has a continuing duty to report related misconduct. Omission of sexual misconduct or providing false information will be grounds for termination. The background check includes consulting child abuse registries. Information is gleaned from applicants regarding previously related sexual misconduct allegations and convictions. The Policy prohibits hiring or promoting anyone or enlisting the contract services of anyone who may have contact with residents who has engaged in previous sexual misconduct. A review of the hiring documents and the interview confirmed the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire a person, contract for services, or whether to promote an employee.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- 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.)
  ☐ Yes ☐ No ☒ NA

115.318 (b)

- 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 ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

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Documents reviewed:
Regular checks are made to maintain current cameras and monitors are in working condition.

The interview:
PCM
Director

Interviews with Director, PCM and according to the Pre-Audit Questionnaire, no substantial modification to the facility or upgrades since the last PREA audit. Regular maintenance is conducted on current monitoring equipment.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- 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 ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for resident where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- 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 ☐ No ☐ NA

115.321 (c)

- 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 evidentiary or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- 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 ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- 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 ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- 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 ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- 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/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- 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.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Policy JJ Facilities SAH (pgs. 14-27)
Form OPA I20 (Incident Scene Tracking Log)

Form OPA I12 (Chain of Custody)
North Carolina Statute
1. §115.321 (c)-2:

North Carolina General Statute Chapter 15B
2. §115.321 (d)-2:

PREA Office memos (internal) (PREA- The NC Approach)
Evidence Protocol & Forensic Medical Examinations, Training
PSP training curriculum (lesson plan, PowerPoint, roles & responsibilities)

Interviews:
Direct Care Staff
Facility Investigative Staff (administrative investigations only)
Phone call with Esther House to verify advocacy services to hospital
Phone call with North East Cabarrus Hospital to verify SAFE/SANE services
Director
PCM

The facility Policy and staff interviews confirmed facility staff members are responsible for conducting administrative investigations. The Cabarrus County Sheriff Department is responsible for conducting criminal investigations. The Cabarrus County Sheriff Department (CCSO) office agrees to follow the protocol set forth in the PREA Standards 115.321 (a) through (f). The directive states that the facility and the CCSO Office agree to cooperate with each other during the investigation process and in the completion of the investigation. Forensic examinations will be conducted at the North East Cabarrus Hospital. The medical center has the services of a Sexual Assault Nurse Examiner (SANE) as determined through a letter to the PREA Compliance Manager and through and phone interview with staff at the North East Cabarrus Hospital. Medical forensic examinations will be provided at the appropriate hospital at no cost to the victim. The Esther House will provide emotional support and access for residents to report allegations of sexual abuse. The documentation reviewed and staff interviews confirmed their awareness of who is responsible for conducting sexual abuse investigations and the uniform evidence protocol is adhered to and is appropriate to resident. Staff interviews also confirmed their knowledge of maintaining and preserving usable physical evidence. Resident interviews confirmed that all resident have access to the Hotline, Esther House and were well aware of the purpose for reporting and advocacy services. No medical forensic examinations have been conducted during this audit period. The facility Director confirmed allegations of sexual abuse are reported to the Cabarrus County Sheriff Office, and the other appropriate notifications are made for information purposes such as court, parent/guardians, and appropriate Child Social Services agency.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice 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 ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- 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 ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 10-11, 14)
YD-001
YD-002
Policy Refresher memo
PREA Pre-Audit Questionnaire

Interviews:
Random Staff
Investigative Staff (3)
Director
PREA Compliance Manager

The Policy directs staff to report all allegations of sexual abuse and sexual harassment and to document the reports and to cooperate with investigations. Staff members are aware of the Policy requirements as verified through their interviews. The facility reports no sexual abuse or sexual harassment investigations during this audit period. No criminal investigations were referred. There are protocols in place for monitoring for retaliation and resident notification once completion of investigation. Incident reviews are completed accordingly when allegations are made.

The facility's website provides the information and related policies for reporting allegations of sexual abuse. A third-party reporting form is also on the website. Reporting information is also posted in various areas of the facility including but not limited to the front entrance, visitation and living units in both English and Spanish. The posted information is accessible to residents, staff, contractors and visitors. The Policy and interviews confirmed allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by the facility staff. Allegations of sexual abuse that are criminal in nature are investigated by the Cabarrus County Sheriff Office. Allegations of sexual abuse are also reported to local Children's Services Division.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- 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 ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pg. 6)
SAH 101 training curriculum
Employee Brochure
New Employee Orientation (pg. 91)
Form OPA-T10
Staff and Offender Relations training curriculum
Form OPA-T10
Training Documentation
Staff PREA Training Check-off Sheet

PREA Trainings log
PREA Training Power Points

Interviews: Random Staff
PREA Compliance Manager

The facility Policy addresses PREA related training for staff. All interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policy and training documents. The documents and staff interviews support refresher training is also conducted and is documented. The direct care staff interviewed and the PREA Coordinator reported the training is provided as required. The facility houses male and female residents and the training considers the needs of the population. All direct care staff members interviewed and document review verified the general topics below were included in the training:
1. Zero-tolerance PREA related policies.
2. Staff responsibilities and how to fulfill them regarding allegations or incidents of sexual abuse or sexual harassment.
3. Residents' right to be free from sexual abuse and sexual harassment.
4. The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation.
5. Dynamics of sexual abuse and sexual harassment in juvenile facilities.
6. Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment.
7. How to avoid inappropriate relationships with residents.
8. Common reactions of sexual abuse and sexual harassment by juvenile victims. PREA Audit Report Page 34 of 95 Facility Name – double click to change
9. Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents.
10. Mandatory reporting.
11. Relevant laws regarding the applicable age of consent.
The Policy, training materials, staff interviews, review of the trainings log and acknowledgement statements verify the staff training occurs.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- 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 ☐ No

115.332 (b)

- 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 ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

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Documents Reviewed:
Policy JJ Facilities SAH (pgs. 6-7)
SAH 101 training curriculum
Volunteers and Agents Brochure
Form OPA-T10
Prohibited Conduct of Staff, Interns, Volunteers, and Contractors,
Specialized Medical Staff Training Acknowledgments
Agency wide Power Point slides Zero Tolerance Policy of Sexual Abuse & Sexual Harassment
Training acknowledgments
PREA Power Point Training
PREA Training Check-off Sheet Contractor/Volunteer Training Log

Interviews:
Contractors (2)
Volunteers (2)

The Policies require volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of training records, including signed Check-off Sheets (training acknowledgement statements) and Power Point presentation document the training occurs. The interviews revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided by the contractors and volunteers. The contractors and volunteers also stated the training includes a review of the zero-tolerance policy regarding sexual abuse and sexual harassment of residents.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- 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 sexual abuse and sexual harassment? ☒ Yes ☐ No
- 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 ☐ No
- 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 ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No
- 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 ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:

Policy JJ Facilities SAH (pg. 7)
Juvenile brochure
Juvenile rack card
Expect Respect curriculum
Form OPA-T300
PREA Juvenile Orientation Flyer (unisex) in English and Spanish
PREA Education Sheet/Acknowledgement Statement
Screening/Education Checklist

Interviews:
Residents (10)
Intake Staff

Facility Policy provides all residents admitted receive information about the facility, including PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. According to the facility PREA Compliance Manager who provides PREA education to residents and the residents interviewed, an orientation is provided to residents during the intake process. Policy provides that the education is completed within 72 hours of admission to the facility and a review again in 60 days. The results of the staff and resident interviews indicated the information is comprehensive and age-appropriate. The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. A brochure is provided to each resident to eliminate incidents of sexual abuse and sexual harassment. The brochure is available in both English and Spanish and provides educational information regarding sexual abuse and victims. A second brochure is provided in both a female version and a male version. The residents revealed they can report allegations of sexual abuse or sexual harassment by telling a staff member; telling a family member who may report the allegation for them; access to the hotline to report allegations of sexual abuse or sexual harassment; call the Esther House or complete a grievance form. A sample of signed acknowledgement statements were reviewed which supported the residents' involvement in PREA education sessions. The residents were aware of PREA information, including their rights regarding PREA, how to report allegations and that they would not be punished for reporting allegations of sexual abuse or sexual harassment. The facility PREA Compliance Manager was interviewed regarding PREA education for residents. He discussed the process for ensuring residents' receipt of the information, including the resident signing the acknowledgement form. Follow-up or refresher PREA information is provided to residents after the initial PREA education session. A review of documentation showing dates and indicating residents' participation in PREA education sessions confirmed the PREA education sessions occur. The PREA related information is provided to staff in policies and procedures, training and staff meetings. The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. Documentation was reviewed for the provision of services for residents in the aforementioned areas by a Special Education teacher that can assist with support services. PREA information is posted in various areas of the facility in English and Spanish. The information is in view for residents, staff, contractors, volunteers, and visitors. Staff interviews confirmed residents are not used as translators or readers for other residents.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- 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 ☐ No ☐ NA

115.334 (b)

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

115.334 (c)

- 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 ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Policy JJ Facilities SAH (pg. 16)
Understanding Sexual Violence curriculum
SAH Investigator curriculum
Coordinated Response Overview

PREA Training Log
Power Point Presentations
Specialized training for sexual abuse investigations – training verification

Interviews:
Investigators (3)

It is the Policy, and practice of the North Carolina Department of Public Service that all reports of sexual abuse and sexual assault shall be reported in accordance with the North Carolina Statutes. All allegations of sexual assault, sexual abuse and sexual harassment are to have an administrative investigation by facility investigative staff. Facility staff were all aware of the processes and protocols for reporting PREA allegations. All PREA allegations of a criminal nature are investigated by the Cabarrus County Sheriff Office and referred to appropriate office for prosecutorial review.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

115.335 (b)

- 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.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- 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? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 7-8)
Form OPA-T330 (M/MH PREA Acknowledgement)
Training for medical and mental health staff
Specialized Training: Medical & Mental Health Care PREA Specialized Training Log
Medical and Mental Health Staff PREA Training Log Acknowledgement Statements

Interviews:
Nurse
Human Services Coordinator
PCM

The Policy and facility practice provide medical and mental health staff members receive the regular PREA training as well as the specialized training. Training records document specialized training for medical and mental health staff members. The documentation indicates completion of specific power point presentations (phase 6) health care training. The mental health course and the PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting were both sourced from the PREA Resource Center Training center. The interviews with the Nurse and Human Services Coordinator and a review of documentation confirmed completion of training. Medical and mental health staff completed the general training that is provided for all staff members as documented by acknowledgement statements. The training documents and the interviews with medical and mental health staff confirmed receipt of the required training. Forensic medical examinations are not conducted at this facility. Forensic medical examinations will be conducted at North East Cabarrus Hospital for the residents.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- 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 ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- 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 ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No

- 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 ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No
- Is this information ascertained: During classification assessments? ☒ Yes ☐ No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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Documents Reviewed:
Policy JJ Facilities SAH (current policy is being reviewed and revised)
Vulnerability Assessments screening tool
Admissions Log
Sample of completed Assessments signed by residents and dated

Interviews:
Residents

PREA Compliance Manager
Facility Program Treatment Administrator

The facility Policy addresses the initial screenings and reassessments for the risk level of sexual victimization and abusiveness. The vulnerability screening is conducted by the using the Vulnerability Assessment instrument. The Vulnerability Assessment is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his own safety.

The North Carolina Department of Public Safety is currently working with the PREA Resource Center for technical assistance on their policy revision. The facility has a signed memo that has included the use of an objective tool that will be used during the interim. The screening tool meets the expectations of the standard and covers at a minimum the eleven (11) points within the standard. Samples were provided to the auditor once used during the intake process.

The Vulnerability Assessment is administered to glean information to assist staff in keeping residents safe. The Policy states residents will be screened within 24 hours of admission however all resident interviews revealed the screening occurs on the same day of admission to the facility. A review of a sample of documents confirmed residents are routinely screened for risk of victimization and abusiveness on the same day of admission. This vulnerability screening occurs for all admissions, according to staff interviews and the Policy which requires an assessment to be conducted on each resident admitted to the facility.

Disclosure of prior victimization or perpetrated sexual abuse is addressed during the time of disclosure. The information is related to mental health personnel following the disclosure of the information. There was no resident currently in the facility who had disclosed prior victimization. A review of documentation, interviews with residents and staff confirmed the Vulnerability Assessment is administered. The information for the instrument may be obtained by asking questions from the form and probing where indicated, according to the facility director.

All residents interviewed could identify specific areas inquired about in the administration of the Vulnerability Assessment. Reassessments are conducted every 45 days if resident is still there or if a PREA allegation is made. A log was reviewed and it is maintained indicating the administration of the initial assessment and the completion of the follow-up assessments. The completed risk assessment instruments are accessible to the treatment staff, facility director, PCM and medical staff as necessary. Copies are kept in resident files and maintained securely in a locked area with limited key access.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.342 (b)

- 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 ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☐ Yes ☒ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.342 (d)

- 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 ☐ No

- 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 ☐ No

115.342 (e)

- 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 ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- 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?) ☒ Yes ☐ No ☐ 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?) ☒ Yes ☐ No ☐ NA

115.342 (i)

- 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 ☒ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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Documents Reviewed:
Policy JJ Facilities SAH (pgs. 9-10)
Policy RP_YC 2 (pg. 19)
Policy RP_DC 1-3 (pg. 33)
Policy PS_YC 3.0 (pgs. 15-18)
Vulnerability Assessments Screening Tool
Facility Memo – Use of Isolation only in exigent circumstances

Interviews:
Residents
PREA Compliance Manager
Director
Human Services Coordinator
Nurse
Random Staff

The facility Policy provides guidance to staff regarding the use of the information obtained from the Vulnerability Assessment. The staff interviews and information obtained through the administration of the screening instrument assist in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. This information was verified

through a review of a sample of the completed screening instruments, Vulnerability Assessments. The facility has isolation cells where, according to Policy and staff interviews, residents at risk for sexual victimization would only be placed for a short period of time until an alternative could be arranged to separate a victim from a likely abuser. The facility reports no residents were placed in isolation in the past 12 months due to the residents being at risk of sexual victimization. During the comprehensive site review no residents were observed in observation. The Policy which was supported by the staff interviews states that residents in isolation will receive a status review every 30 days and will have daily access to medical staff or mental health staff, education programming and other services. The isolation cells were observed during the site review and were observed on the printed facility schematics prior to the site visit. Random staff interviews indicated protective measures would be taken immediately if it was determined a resident was at risk for imminent sexual abuse and responses included separating residents by changing rooms or living units and alerting the PREA Compliance Manager and other management and treatment staff of the situation. The Director and random staff indicated the expectations are for protective measures to be implemented immediately when it has been determined a resident is at risk of imminent sexual abuse. The Policy prohibits placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The Policy prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. The Policy also provides that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis and these residents would not be placed in particular or special housing designated for transgender residents only. This practice was evident from staff interviews. There was no targeted resident interview for this area. During the comprehensive site review, there were no rooms observed to be reserved for transgender or intersex residents. The restroom/showers were observed and were configured for residents 1 at a time. Signs are posted for shower procedures where both staff and residents can observe and follow.

The resident's concern for his own safety is taken into account through the administration of the Vulnerability Assessment for all housing placements. The residents confirmed in the interviews, they are asked about their safety concerns. A review of the PREA Screening log demonstrated the additional documentation of the screening assessments and re-assessments completed for each resident. The staff interviews revealed staff members are aware of the Policy.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- 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 ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- 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 ☐ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pg. 14)
DJJ Brochure
Policy Abuse and Neglect (pgs. 3-4)
New Employee Orientation
Acknowledgement Statements
Form OPA-T10 (PREA Acknowledgement)
OPA Contact (webpage)
Fraud, Waste, and Abuse (hotline)
JJ Visitation Poster
Grievance Forms
Youth Safety Brochures (male and female)
Facility website review for third party reporting forms
Third Party Reporting Forms accessible within facility

Interviews:
Random Staff
Residents
PREA Compliance Manager

Facility Policy addresses this standard and provides for multiple internal ways a resident may report allegations of sexual abuse and sexual harassment, including how he or she can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to such. Residents may report allegations of sexual abuse or sexual harassment by calling the Esther House of Stanley County 24 hour hotline. The agency is not a part of the facility as confirmed by resident interviews, posters, staff, MOU, and posted phone instructions. Direct care staff interviews revealed residents may use the telephone, located on each unit, to privately report sexual abuse and sexual harassment. The telephone was tested during the comprehensive site review and was found to be in working order. There are several resources available to the resident by the use of the emergency telephone on each unit. The resident may push the appropriate number to directly access the hotlines. A sign is posted identifying each agency, the services provided by the agency, and the number to push to speak with someone. The sign also indicates which agency is for reporting allegations and/or the agency that provides emotional support/advocacy services. Direct care staff also revealed staff could use the emergency phone for that same purpose or contact any of the agencies at any time. The residents also identified internal ways a resident may report such as completing an emergency grievance; talking to a trusted staff member; completing a Medical Request Form; or tell an outside person or family member. There are designated locked boxes and forms on the living units for depositing the written grievance forms. There is also a Request Form that may be used by a resident to ask in writing to speak to a specific staff member, including but not limited to the Director, a teacher, caseworker, program treatment administrator, therapist, or attorney. Writing materials are readily available for residents to complete the accessible forms. If a resident uses a grievance form to report allegations of sexual abuse or sexual harassment, he/she just needs to place their name on the form and

place it in the grievance box. The resident receives a facility booklet, Guides to keep safe and various brochures that contain information for reporting allegations of sexual abuse and sexual harassment. Posters are located in the living units and other areas visible to residents, staff and visitors. The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, or through a third-party. The residents were aware third-party reports could be made and that reports can be made anonymously. Staff members revealed they are required to accept third-party reports and to document verbal reports. All residents interviewed stated they have contact with someone who does not work at the facility such as a family member or other person they could report abuse to if needed. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- 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 ☒ No ☐ NA

115.352 (b)

- 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 ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- 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 ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- 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 ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension 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 ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- 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 ☐ No ☐ NA

- 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 ☐ No ☐ NA

115.352 (f)

- 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 ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

- 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 ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy YD 6 (pg. 3)
Policy Refresher memo
Youth Handbook
Brochures
Grievance Forms

Interviews:
Residents
PREA Compliance Manager
Facility Director

The Policy contains the procedures regarding the process for dealing with resident grievances related to sexual abuse and sexual harassment. Information regarding submitting a grievance to report an allegation of sexual abuse is contained in the Youth Handbook. Residents may submit a grievance related to PREA allegations at any time regardless of when the incident is alleged to have occurred and the residents are not required to use the informal process for any situation regarding sexual abuse. The Policy provides details aligned with the provisions of the standard including the timelines. The Policy and documents reviewed indicate PREA related grievances are immediately sent to the facility Director for investigative assignment. Grievance forms and the locked grievance box were observed during the comprehensive site review. All allegations of sexual abuse and sexual harassment are investigated by facility trained investigators or when criminal in nature, the Cabarrus County Sheriff Office. Allegations are also reported to applicable Children's Services. Facility Policy provides a resident may be disciplined when it has been determined a report alleging sexual abuse has been made in bad faith. Residents understand they will not be punished if a report is made in good faith, as determined through the interviews. Residents and staff interviewed identified the use of a grievance form as one of the methods that may be used to report allegations of sexual abuse or sexual harassment and the residents are aware of how emergency grievances are handled regarding sexual abuse. After a review of grievances and interviews with residents it was determined that during the past 12 months, no grievances were submitted alleging sexual abuse. Additionally, there was no indication of any grievances filed alleging substantial risk of imminent sexual abuse.

Standard 115.353: Resident Access to Outside Confidential Support Services and Legal Representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report
115.353 (a)

- 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 assessible mailing

addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- 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 ☒ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- 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 ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 8-9, 16)
Juvenile Brochure
Juvenile Educator Manual
PREA- The NC approach (PREA Office attempts)
Policy YD 4.4 (pgs. 1, 3)
Policy YD 4 (pg. 1)
Policy DC_RP 1-3 (pgs. 25-27)
Memorandum of Understanding, Esther House (advocacy services)
Youth Safety Guides/Brochure
Resident Handbook
Posted Information

Interviews:
Residents
Director
PREA Coordinator

The Policy addresses communication with parents/guardians and legal representation and the residents' access to outside confidential support services. There are two resources identified and available by telephone to the resident for outside confidential support services. The resident may use the phone, located on each living unit, and dial the appropriate number to directly access the Esther House for advocacy services or reporting. The agency is identified on the sign by the telephone indicating the agency may be used to report an allegation as well as request emotional support. The facility has a Memorandum of Understanding (MOU) with the Esther House of Stanley County, for the provision of victim advocacy services as well as reporting allegations of sexual abuse or sexual assault. Advocacy services are provided for males and females. The agency provides access to their 24-hour hotline services. The Director, the PREA Compliance Manager and staff confirmed the availability and accessibility of outside confidential support services to residents. Contact information for advocacy services is a part of the PREA education sessions and is also provided to each resident in the Resident Handbook. Information is also provided through signs and posters in various parts of the facility including each living unit in English and Spanish. The resident interviews revealed their knowledge of the advocacy services available to them and the limitations of confidentiality. The hotline telephone was observed in each living unit and the contact information for services from the agencies posted at the telephone. The telephone was tested and deemed in working order. The interviews also confirmed access to attorneys and court workers and reasonable access to their parents/legal guardians. The site review revealed areas where residents could meet privately with a legal representative and the visitation area for visits with family members. All residents interviewed stated family could visit and they provided the days and times of visitation and for phone calls. Residents confirmed they had someone on the outside to report allegations of sexual abuse and sexual harassment if they needed to and these persons could make reports for them and without giving the resident's name.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Internal and external webpage- anyone can access and submit reports
DPS Fraud/Waste/Abuse hotline- anyone can call and submit reports
Third Party Reporting brochure / Community Flyer
Third Party Reporting Form
Juvenile Educator Manual
Website

Interviews:
Random Staff
Residents
PCM

The Policy addresses third-party reporting and interviews revealed random staff/direct care staff members are aware third-party reporting of sexual abuse and sexual harassment can be done and stated they will be accepted and reported. Staff members also stated they are to document all verbal reports received. The interviews revealed they may report allegations privately through the use of the abuse reporting hotline. All residents interviewed stated they knew someone who did not work at the facility they

could report to regarding allegations of sexual abuse and that person could make a report for them. The interviews with the residents revealed their knowledge of third-party reporting. The residents identified the methods within the facility in which they may make third-party reports such as file an emergency grievance, report to staff or a family member, or utilize the abuse reporting hotline telephone. Information regarding reporting is provided through observed postings located in areas of the facility accessible to visitors, residents, facility staff, contractors and volunteers. The facility's website contains information regarding third-party reporting of allegations of sexual abuse. The Third Party Reporting Form is observed to be located on the website and during the site review. The Third Party Instructions sheet is provided for parents/guardians.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- 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 ☐ No

115.361 (d)

- 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 ☐ No

- 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 ☐ No

115.361 (e)

- 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 ☐ No

- 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 ☐ No

- 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 the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- 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 ☐ No

115.361 (f)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 14, 15, 20)
Document: Contract Employees (pgs. 4-5)
Policy Refresher Memo
Policy Abuse and Neglect (pgs. 4-6)
Forms – Medical Report of Sexual Abuse/Assault/Harassment
Form - Administrative Investigation Forms

Interviews:
Random Staff
Nurse
Human Services Coordinator
Director
PREA Compliance Manager

The Policy addresses provisions of the standard including providing all staff immediately report any knowledge, suspicion, information, or receipt of information regarding an incident or allegation of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws of the State of North Carolina. The facility trained investigators conduct administrative investigations and allegations that are criminal in nature are referred to the Cabarrus County Sheriff Office (CCSO). Allegations of sexual abuse are also reported to the appropriate office/branch of Children's Services. Reporting according to the State's mandatory reporting laws and the agency/facility Policy was evident through document review regarding complaints and the subsequent documentation regarding the investigation conducted. The staff interviews were aligned with the requirements of the Policy and standard. A review of documentation demonstrates information reported to staff is reported, investigated and addressed. Staff members are instructed to immediately report all allegations of sexual abuse or sexual harassment to the designated supervisor and subsequent contact is made to the PREA Compliance Manager, Director, and Human Services Coordinator. The Policy requires notification to the alleged victim's parents/legal guardians unless there is documentation saying the parents/guardians should not be notified. If the resident is under the custody of County Children's Services, the Case Worker will be notified. If the court retains jurisdiction, the attorney of record and other legal representative will be notified of the allegation within 14 days of receipt of the allegation. This information was verified through Policy / SOP review and the interview with the facility Director. The interviews with random staff, mental health and medical staff revealed their awareness of the requirements regarding the reporting duties. All staff interviewed acknowledged they are mandated reporters and a written report must immediately follow reported allegations or incidents. The direct care staff members interviewed provided the reporting requirements and that staff is expected to document receipt of verbal reports immediately. The facility staff members are also required by the Policy to report allegations that were made anonymously or by a third-party. During this audit period, there were no allegations of abuse received through an anonymous report or third-party. The facility Policy prohibits staff from revealing any related information to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions. The medical and mental health staff interviewed stated residents

are informed at the initiation of services of the limitations of confidentiality and the duty of the staff members to report. A sign was observed posted in the medical clinic reminding residents of the medical staff's duty to report.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:
Policy JJ Facilities SAH (pgs. 18, 20-21)
Policy YD 6 (pg. 3)
Vulnerability Assessments

Interviews:
Director
Random Staff
PREA Compliance Manager

Facility Policy requires staff to protect the residents through implementing protective measures. Administration of the Vulnerability Assessment provide information that assist and guide staff in keeping

residents safe through housing and program assignments. The interviews of the random staff and the Director revealed protective measures include but are not limited to alerting supervisor; separating the residents including moving to a different pod (housing unit); monitor more closely; and document the situation. The Director and the direct care staff stated that the expectation is that any action to protect a resident would be taken as soon as possible. The interviews with the residents revealed during the intake process, how they feel about their safety is part of the inquiries by staff in completing paperwork. A review of a sample of Vulnerability Assessments supports the information provided by residents. The Director and PCM report during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse which was also supported by informal interviews with other staff members.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- 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 ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Policy JJ Facilities SAH (pg. 11, 16 & 19)
Report of Sexual Abuse/Assault/Harassment form
Report log / data

Interviews:
Director

The Policy addresses the proper notification to be made when alleged abuse occurred at another facility. Upon receipt of an allegation a resident was sexually abused while confined in another facility, the head of that facility must be contacted. Notification must be made as soon as possible but no later than 72 hours after receipt of the allegation. Once the Director notifies the other facility head, the allegation will be reported to the appropriate investigative agency for investigation. A written report will be completed on the Report of Sexual Abuse/Assault/Harassment form. The Director reports during this audit period, there was not a report about an incident of abuse occurring while the resident was confined in another facility. The facility Director is aware of the requirements and the required duties regarding reporting to other confinement facilities and the requirement of allegations received from other facilities must be investigated. The facility has no receipt of reports from other facilities during the past 12 months.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.364 (b)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pg. 21)
SAH 101 (new) (effective as of 7/1/15
Staff First Responder Duties/ Facility Coordinated Response
Incident Report Form

Interviews:
Random Staff
Program Treatment Administrator
PREA Compliance Manager

The Policy requires any staff acting as a first responder to separate the alleged victim from the alleged abuser; call for help; and take the appropriate steps for the preservation and collection of any evidence. The Policy directs the first responder to request the alleged victim does not wash; brush their teeth;

change clothes; wash or do anything that may destroy evidence. The Incident Report Form and the Facility Coordinated Response serves as a reminder of what to do, while confirming the actions taken by the staff involved. The Form documents the steps to take when an identified staff member is the first to respond including the steps to take to assist in preserving evidence from the victim and the perpetrator; and the staff and other contacts to make. The Policy instructs non-security staff who may act as a first responder to request physical evidence be preserved and to contact direct care staff for assistance. The staff members who would serve as first responders are aware of their duties as determined from the interviews and the non-security staff revealed she is aware of her duties. There were no incidents or allegations of sexual abuse during this audit period.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Facility Policy – for Coordinated Response to Sexual Assault
Staff First Responder Duties/Coordinated Response
Plan for Coordinated Response to Sexual Abuse or Assault
Incident Report Form
Resident Sexual Assault Notification Checklist

Interviews:
Director
Random Staff
PREA Compliance Manager

The facility has a written coordinated response plan which is to be implemented in the event of an allegation or incident of sexual abuse. The Plan for Coordinated Response to Sexual Abuse or Assault outlines the actions of the identified staff members such as the first responder; supervisors; medical; mental health; and management. The Plan is formatted in a checklist where the steps are easily identified. The Plan is aligned with the facility Policy and the standard. The interviewed direct care staff members were familiar with their role regarding the response to an allegation of sexual abuse. The Director discussed the coordinated actions in response to an incident of sexual abuse which was aligned with the written Plan. Staff members are directed to follow the steps outlined in the Policy and Plan and to utilize the Incident Initial Contact Form in addressing the situation. The Incident Report Form is aligned with the Plan for Coordinated Response to Sexual Abuse or Assault as well as the Resident Sexual Assault Notification Checklist are intended to ensure that the required protocols are implemented when there is an incident of sexual abuse.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- 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 ☒ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Interview:
Director

The facility is not involved in collective bargaining agreements as confirmed by the facility Director. The State of North Carolina does not permit collective bargaining.

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- 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 ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- 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 ☐ No

115.367 (c)

- 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 ☐ No

- 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 ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No
- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- 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 ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documentation Reviewed:
Policy JJ Facilities SAH (pgs. 8, 9. 13)
Form OPA-I22 (Staff Retaliation Report)
Form OPA-I24 (Juvenile Retaliation Report)
Form OPA-I18 (PSP Designation)
Form OPA-I16 (PCM Designation)
Retaliation Monitoring Checklist

Interviews:
Retaliation Monitor
Director
PREA Compliance Manager

Facility Policy provides protection to residents and staff from retaliation because they reported sexual abuse, sexual harassment or participated with an investigation regarding such. The role of monitoring retaliation was understood by the staff assigned these duties. It was explained during the interview how she discharges those duties, including monitoring to assist in preventing retaliation against residents and staff who report sexual abuse or sexual harassment or who cooperates with an investigation. The PCM indicated that status checks are made daily and disciplinary reports and applied sanctions are monitored. Measures which may be taken when retaliation is detected and include various responses and is not limited to housing changes, removal from the facility, and constant and continual supervision. The Retaliation Monitoring Checklist will be used to document monitoring activities when an allegation is made or there is cooperation with an investigation. There have been no allegations or incidents requiring retaliation monitoring during this audit period.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

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Documents Reviewed:
Policy JJ Facilities SAH (pg. 16)
Policy RP_DC 1-3 (pgs. 21-22)
Policy PS_YC 3.0 (pgs. 15-18)

Interviews:
Director
Nurse
Human Services Coordinator
PREA Compliance Manager

The Policy provides for a resident who alleges to have suffered sexual abuse may only be separated from the general population as a last resort and only until an alternative for keeping the resident safe can be arranged. The Policy requires that where a resident is placed in isolation because he alleged sexual abuse, he must have opportunity for large muscle exercise and visits from medical or mental health staff and access to legally required education services. Additionally, the Policy states, a review of continued separation must be conducted every 30 days to determine whether there is a continued need for separation from the general population. The Director confirmed the information in the Policy. No residents have be placed in isolation during this audit period as a result of victimization or fear of victimization

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.371 (b)

- 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 ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- 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 ☐ No

115.371 (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 ☐ No

- 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 ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- 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 ☐ No

115.371 (h)

- 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 ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
  ☒ Yes ☐ No

115.371 (j)

- 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 ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- 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 ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:
Policy JJ Facilities SAH (pgs. 16-19)
Coordinated Response Overview
Policy Refresher memo
Policy related to criminal and administrative agency investigations

Interviews:
Investigative Staff (3)
Director
Random Staff

Facility Policy, staff interviews, and a review of documentation reveal administrative investigations are conducted by facility investigators and criminal investigations are conducted by the Cabarrus County Sheriff Office. Substantiated allegations as a result of a criminal investigation will be referred for prosecution. Allegations of sexual abuse are also reported to the appropriate County Children's Services. The MOU with the CCSO provides for the Office to conduct investigations that are criminal in nature and identifies the applicable PREA standard that will be followed. The facility investigators have received specialized training on conducting administrative investigations as well as the agency wide PREA training for all staff. Training was verified through training logs/signed acknowledgement and review of the power point training slides as well as interviews. The training collectively included but was not limited to: interviewing techniques for juvenile sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and criteria and evidence required to substantiate a case of administrative or prosecution referral. The interviews with the investigators and random staff revealed their knowledge of gathering and preserving evidence. The interviews and

investigative reports reviewed revealed that electronic monitoring data is reviewed and will be made available to outside agency investigators regarding PREA related investigations. The interviews with the agency based investigators revealed that investigations are not terminated because a resident recants an allegation. The Policy and the interviews with the investigators revealed investigations are not terminated due to the departure from the facility of an alleged abuser or victim. The PREA reports are retained in accordance with the PREA standard. The files are stored securely with access limited.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Document Reviewed:
Policy JJ Facilities SAH (pgs. 17)

Interviews:
Investigative Staff

The agency's policy and interviews revealed the investigators impose a standard of a preponderance of the evidence for determining whether allegations are substantiated.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- 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 ☐ No ☐ NA

115.373 (c)

- 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 ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- 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 ☐ No

- 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 ☐ No

115.373 (d)

- 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 ☐ No

- 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 ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

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Documents Reviewed:
Policy JJ Facilities SAH (pgs. 8, 19)
Form OPA-I30 (Support Services)
Coordinated Response Overview
Form OPA-I30A (Support Services Notifications)
Reporting to Residents Support Services Notification

Interviews:
Investigative Staff
Director
PREA Compliance Manager

Facility Policy addresses the resident being informed by staff when the investigation is completed, informed of the outcome of the investigation, and the documentation of the notification. The Director and the PREA Compliance Manager will remain abreast of an investigation conducted by any of the investigative entities by serving as the primary contact person(s), as determined by the interviews. The Policy requires, following an allegation of sexual abuse committed by staff, the resident is to be informed when the staff member is no longer posted in the unit or employed in the facility and of the staff member's indictment or conviction. Additionally, following an allegation of sexual abuse committed by another resident, the alleged victim is to be informed if the alleged abuser has been indicted, charged, or convicted. The Support Services Notification is used for informing residents of the results of an investigation and any disposition of the alleged perpetrator. Evidence shows through signed forms that all residents will be informed of the outcome of investigations. The facility has not had any allegations or investigations into sexual abuse in which the alleged aggressor was a staff member and they were removed from their position or indicted within the past 12 months.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- 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 ☐ No

115.376 (d)

- 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 ☐ No

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Document Reviewed:
Policy JJ Facilities SAH (pg. 12)
Agency Policy (Website)
New Employee Orientation (pgs. 2, 102-103)
Form OPA-T10 (PREA Acknowledgement)

Interviews:
Director
PCM

The Policy provides for disciplinary sanctions, up to and including termination for those staff violating the facility's sexual abuse and sexual harassment zero-tolerance Policy. Disciplinary sanctions for violations of facility policies relating to sexual abuse, other than actually engaging in the act, and sexual harassment are appropriate to the circumstances of the incident, staff's disciplinary history, and the sanctions for similar cases of other staff and are handled in conjunction with the court.

Terminations or resignations by staff that would have been terminated if not for their resignation are reported to law enforcement if the situation appears to be criminal in nature and to relevant licensing bodies. During this audit period, no staff members have been terminated or have resigned for violating the facility's PREA related policies.

Standard 115.377: Corrective Action for Contractors and Volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Document Reviewed:
Policy JJ Facilities SAH (pg. 12)
Form OPA-T10 (PREA Acknowledgement)
Memo – No allegations of sexual assault/abuse/harassment against a volunteer or contractor during audit period.
PREA Training power point slides for volunteers and contractors.
Training Logs
Signed Acknowledgments

Interview:
Director
PREA Compliance Manager

Facility Policy provides any volunteer or contractor who engages in sexual abuse is prohibited from contact with residents. The Policy also provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement and to relevant licensing bodies. The documentation reviewed revealed the facility provides volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer. Volunteers and contractors are provided PREA training, verified through a review of documentation and interviews with two contractors and two volunteers. The training documentation for contractors and volunteers indicate the PREA training occurs and the contractors and volunteers are made aware of the zero-tolerance policy and how to report allegations of sexual abuse and sexual harassment of residents.

Standard 115.378: Interventions and Disciplinary Sanctions for Residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- 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 ☐ No

115.378 (b)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.378 (c)

- 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 ☐ No

115.378 (d)

- 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 ☐ No

- 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 ☐ No

115.378 (e)

- 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 ☐ No

115.378 (f)

- 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 ☐ No

115.378 (g)

- 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 ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pg. 12)
Policy PS_YC 3.0 (pgs. 15-18)
Policy RP_DC 1-3 (pgs. 16, 21-22)
Disciplinary Sanctions for Residents – PREA
Handbook for residents
Memo – No substantiated reports of sexual abuse during the audit period. Therefore, there have been no disciplinary actions against a resident for sexual conduct with staff.

Interviews:
Human Services Coordinator
Director
PREA Compliance Manager

The Policy addresses an administrative process for dealing with rule violations. Sanctions are directly related to the seriousness of the negative behavior. The interview with the facility Director supports holding the residents accountable for their actions. The behavior management system fosters accountability of the residents. The Policy states if disciplinary sanction results in the isolation of a resident, he will not be denied daily large-muscle exercise or access to 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 will also have access to other programs and work opportunities to the extent possible. Additionally, the Policy supports that anyone reporting an allegation of sexual abuse or sexual harassment in good faith does not constitute lying on the part of the resident. Sexual activity between residents is prohibited in the facility. Court and/or administrative processes and sanctions occur after determination the sexual activity was coerced. A resident may be referred by law enforcement for charges and there could be possible removal from the facility regarding resident-on-resident sexual abuse, based on the Court's decision as indicated by the interview with the Director. According to the Policy, residents may be disciplined for sexual contact with staff only when it has been determined the staff member did not consent to the sexual contact. According to the facility Director and the Clinical Director, staff will examine a resident's behavior and disciplinary history when deciding disciplinary matters. Additionally, staff will 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 interviews support interventions will be offered to address the underlying reasons or motivations for abuse when the resident remains in or returns to the facility after an incident. Any type of interventions or treatment services provided are not as a condition for the resident to access participation in the education or other programs. There have not been any substantiated reports of sexual abuse during the audit period.

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

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, 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 ☐ No

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, 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 ☐ No

115.381 (c)

- 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 ☐ No

115.381 (d)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 9-10; 10-19 & 22)
Policy YC_RP 1.4
Consent Form
Vulnerability Assessments Progress Notes

Interviews:
PREA Compliance Manager
Nurse
Human Services Coordinator

Facility Policy address the provisions of this standard and includes the provision for a follow-up meeting with a medical or mental health practitioner within 14 days when the resident discloses any prior incidents of sexual abuse as a victim or perpetrator. Interviews with medical and mental health staff and a review of the identified and general documentation confirmed the facility practice of residents being provided services by treatment staff. Vulnerability Assessments and Progress Notes were reviewed that documented situations where residents are referred to mental health staff due to the results on the Vulnerability Assessment. Residents were seen by mental health staff either the same or next day of the referral. Medical and mental health staff members are aware of informed consent as expressed during their interviews. Clinical staff would obtain informed consent from residents 18 years and older prior to reporting information disclosed about prior sexual victimization that did not occur in an institutional setting. The form, Consent for Residents Age 18 and over to Report Allegations of Abuse, is used for this purpose. No information is to be shared with other staff unless it is required for security and management decisions regarding a resident's sexual abuse history.

Standard 115.382: Access to Emergency Medical and Mental Health Services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- 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 ☐ No

115.382 (b)

- 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 ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- 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 ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 20-27)
Policy YC_RP 1.4 (pg. 11)
Form YD-001
Form YD-002
North Carolina General Statute Chapter 15B
Coordinated Response Overview
MOU – North East Cabarrus Hospital

Memo – No Crisis Intervention or medical services provided for sexual assault during audit period.

Interviews:
Nurse
Human Services Coordinator
PREA Compliance Manager

Facility Policy revealed emergency services will be provided by medical and mental health staff. Interviews confirmed processes and services are in place for a victim to receive timely access to sexually transmitted infection prophylaxis, where medically appropriate, and with follow-up as needed by the facility's medical and mental health staff. Review of documentation shows that medical and mental health staff members maintain secondary materials and documentation of resident encounters. The medical and mental health staff interviews revealed they are knowledgeable of actions to take regarding an incident of sexual abuse. It is documented through Policy and understood by the medical and mental health staff that treatment services will be provided at no cost to the victim, whether or not the victim names the abuser, or whether or not the victim cooperates with the investigation. The interviews confirmed timely information would be provided to a victim regarding sexually transmitted infection prophylaxis. The interviews with clinical staff revealed residents have access to unimpeded access to emergency services. The interviews revealed the medical and mental health services are determined according to the professional judgment of the practitioner. Residents are informed of medical services during intake and the residents have access to Medical Request Forms on their living units. The Policy and the written Plan for Coordinated Response to Sexual Abuse or Assault provide guidance to staff in protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff. A review of the Plan, observations of the interactions among residents, medical and mental health practitioners, and staff interviews indicated unimpeded medical and crisis intervention services will be available to a victim of sexual abuse.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- 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 ☐ No

115.383 (b)

- 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 ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.383 (e)

- 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.) ☒ Yes ☐ No ☐ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 25-27)
Coordinated Response Overview

Interviews:
Nurse
Human Services Coordinator
Esther House Advocate

The Policy and interviews support follow-up and on-going assessments and services would be provided as ordered and indicated. Advocacy services may also be provided by Esther House, in accordance with their respective MOU and the standards. All treatment services will be provided at no cost to the victim. Facility Policy, staff interviews and observations revealed medical and mental health services are consistent with the community level of care. The Policy and interviews support medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse. Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate, including assessments and therapy. Facility Policy provides for efforts to be made for a mental health practitioner to conduct a mental health evaluation within 60 days on all known resident-on-resident abusers and offer appropriate treatment by mental health staff. The Human Services Coordinator's interview supported the Policy

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- 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 ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- 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 ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pgs. 9, 17)
Form OPA-I10 (Post Incident Review)
Coordinated Response Overview
PREA Sexual Abuse Incident Review form
PREA Incident Debrief form

Interview:
Incident Review Team Member
PREA Compliance Manager

Facility Policy provides for an incident review to be conducted within 30 days of the completion of an investigation. The Policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The Policy also identifies the general positions that comprise the team such as upper-level management and input from line supervisors, investigators, medical, or mental health staff.

The PREA Compliance Manager is a member of the incident review team and is knowledgeable of the purpose of the incident review process. The interview with the PREA Compliance Manager, review of Policy and documentation method confirmed the incident review team is charged with considering many factors regarding the results of the investigation, including but not limited to the following:

- considering the make-up and vulnerability of the population such as gang affiliation;
- whether the resident identifies as: gay, bisexual, transgender, or intersex
- other group dynamics;
- assessment of the area relative to the allegations; and
- adequacy of staffing.

A form has been developed for documenting the incident review team meeting and it allows for documentation of the aforementioned considerations. The form also provides for recommendations for improvement by the team members. There were no allegations of sexual abuse in the past 12 months.

Standard 115.387: Data Collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- 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 ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?
  ☒ Yes ☐ No

115.387 (c)

- 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 ☐ No

115.387 (d)

- 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 ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.387 (f)

- 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 ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Policy JJ Facilities SAH (pg. 10)
Form OPA-I10 (PIR)
Sexual Abuse Data Collection

Data Review for Corrective Action
Data Storage,
Publication, and Destruction
PREA Sexual Abuse/Harassment/Allegation Log
Annual Report

Interviews:
PREA Compliance Manager
Director

The Policy and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data. The data capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ). The interview with the PREA Compliance Manager also confirmed this information.

The facility maintains and collects various types of identified data and related documents regarding PREA. The facility collects and maintains data in accordance with Policy directives and North Carolina Department of Public Safety and aggregates the data which culminates into an annual report. The facility provides DOJ with data as requested, per Policy and the interviews.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- 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 ☐ No

- 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 ☐ No

- 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 ☐ No

115.388 (b)

- 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 ☐ No

115.388 (c)

- 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 ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:
Memorandum – Reporting process
NC DPS 2015-2016 Sexual Abuse Annual Report
Memo – Investigative files
Annual Report
Website review for posting

Interviews:
PREA Compliance Manager
Director

The Policy provides guidance regarding provisions of this standard. Formal and informal interviews revealed the collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related efforts and initiatives by identifying problem areas; developing and implementing corrective actions where needed; and preparing an annual report based on the collected data. The interviews

supported the provisions of the Policy and the standard. The Policy also indicates an annual report will be prepared that will provide information regarding the facility's corrective actions in addressing sexual abuse. The annual report is approved as required by Policy, per the interviews and a review of the report which is reviewed by the Director. The interviews and annual report reflect a comparison of the results of annual data reports, by calendar year, and used them to continuously improve policies; procedures; practices; and training. The annual report has been reviewed and the report is accessible to the public through the facility's website. There are no personal identifiers on the annual report.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- 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 ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- 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 ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Document Reviewed:
Policy JJ Facilities SAH (pg. 10)
Annual Report

Interviews:
PREA Compliance Manager
Director

The Policy provides that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless State or local statutes require otherwise. According to the facility Policy, the aggregated sexual abuse data will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified there are no personal identifiers and it was observed posted on the website, as required. Related documentation in the facility is securely stored. Additionally, data is securely stored electronically with password protection. Investigative files are stored in hard files at the NCDPS Central Office according to the agency PREA Coordinator and Policy.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the three-year period starting on August 20, 2013, and during each three-year period thereafter, 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? (N/A before August 20, 2016.) ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, 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? ☒ Yes ☐ No

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility ensured the completion of PREA audits for the facility as required for the initial three-year period. The facility, in conjunction with the North Carolina Department of Public Safety has embarked on fulfilling the auditing requirements for this second three-year period. The facilities have provided the Auditor with the required documentation which the auditor has maintained as required by the standards and the auditing process. A comprehensive site review was provided to the Auditor during the site visit and additional documentation was reviewed during the site visit. The facility staff members were cooperative in providing additional documentation as requested. The facility Director provided appropriate work spaces which included conditions for conducting interviews in private with the residents

and staff. The facility PCM and Director provided any additional documentation that was requested during the on-site portion of the audit and post audit period.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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 that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This facility was previously audited in 2016 and the Auditor confirmed the audit report was posted on the agency's website as is the practice with the facility. This report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility

policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report. The audit findings were based on a review of policies and procedures and supporting documentation; interviews with staff and residents; and observations.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.

Marlean Ames September 6, 2018

Auditor Signature **Date**