PREA Facility Audit Report: Final

Name of Facility: Great Lakes Recovery
Facility Type: Juvenile
Date Interim Report Submitted: 12/01/2019
Date Final Report Submitted: 04/30/2020

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Tracy V. Kingera	**Date of Signature:** 04/30/2020

AUDITOR INFORMATION	
Auditor name:	Kingera, Tracy
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Telephone number:	702-379-2712
Start Date of On-Site Audit:	10/01/2019
End Date of On-Site Audit:	10/02/2019

FACILITY INFORMATION	
Facility name:	Great Lakes Recovery
Facility physical address:	104 Malton Road, Negaunee, Michigan - 49866
Facility Phone	
Facility mailing address:	

Primary Contact	
Name:	Derrick DePetro
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Superintendent/Director/Administrator	
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Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	
Name:	Derrick DePetro
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Facility Characteristics	
Designed facility capacity:	16
Current population of facility:	9
Average daily population for the past 12 months:	10
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	
Age range of population:	12-17
Facility security levels/resident custody levels:	Low Security
Number of staff currently employed at the facility who may have contact with residents:	18
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	3
Number of volunteers who have contact with residents, currently authorized to enter the facility:	3

AGENCY INFORMATION	
Name of agency:	Michigan Department of Health and Human Services
Governing authority or parent agency (if applicable):	
Physical Address:	235 S Grand Avenue, Lansing, Michigan - 48933
Mailing Address:	
Telephone number:	

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

Agency-Wide PREA Coordinator Information			
Name:	Soleil Campbell	**Email Address:**	campbells6@michigan.gov

AUDIT FINDINGS

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

The Prison Rape Elimination Act (PREA) audit that is the subject of this report was completed by Tracy V. Kingera (sole auditor) of Henderson, Nevada, a U.S. Department of Justice Certified PREA Auditor for juvenile facilities. The facility that is the subject of this audit report is the Great Lakes Recovery Center Adolescent Services Center (GLRC), located in Negaunee, Michigan. This audit is the second PREA Audit for GLRC, with its first audit completed in 2016.

PRE-AUDIT

This auditor and the State of Michigan Department of Health and Human Services (MDHHS), the entity that contracts with GLRC for juvenile residential substance abuse treatment, entered into contract for the PREA audit in June 2019. Audit-specific contact with the MDHHS PREA Coordinator and MDHHS PREA Compliance Managers began in July 2019, and the introductory telephonic conference was held with the MDHHS PREA Coordinator, the MDHHS PREA Compliance Managers assigned to monitor and assist GLRC, and the MDHHS Contracts Manager on July 9, 2019. During this meeting this auditor explained the auditor's role as an independent party who is tasked with verifying compliance with the PREA standards by triangulating document evidence, staff and resident interviews and observing facility practice. It was discussed that the goal of the practice-based PREA audit was to identify areas where the facility excels in compliance of the PREA standards, as well as those areas that may require additional efforts. This auditor also discussed that corrective action on some standards was to be expected, and that this auditor would work collaboratively with GLRC to help them achieve full compliance with the PREA standards. The facility requested the audit be opened in the Online Audit System (OAS) on July 23, 2019. As the GLRC audit was one of this auditor's first two audits, the use of the OAS was mandatory. The PREA audit notices were forwarded to the MDHHS PREA Compliance Managers for posting on August 7, 2019. The notices this auditor provided for posting used large font and included this auditor's mailing address for any written correspondence from residents or staff. Verification of the PREA audit notifications was received on August 14, 2019, in compliance of the six-week period prior to the on-site audit. The eight audit notifications in both English and Spanish were printed on green paper and posted in both housing units, the dining area and group room. This auditor conducted internet research of GLRC, which produced no information regarding past reports of sexual abuse or concerns for sexual safety at GLRC. No information regarding consent decrees or outside oversight specific to GLRC was discovered. This auditor reviewed the agency and facility websites and conducted research on the mandatory reporting laws and age of juvenile certification to adult status in the State of Michigan. As GLRC refers any potentially criminal PREA incidents to local law enforcement, contact was made with the Negaunee City Police Department detective. The detective provided information regarding their investigative practices and the working relationship between GLRC and local law enforcement. The detective related a staff sexual misconduct report that was received involving GLRC staff and a resident in 2017. Although that incident was outside of the 12-month reporting period, this auditor requested documentation from the facility regarding the investigation to analyze the facility's response. This auditor

contacted Just Detention, International (JDI) to check for a history of complaints for GLRC and a response was received that JDI had no history of reports for the facility.

The Pre-Audit Questionnaire (PAQ) was completed by the facility on August 16, 2019 and review of the PAQ began on August 25, 2019. This auditor reviewed all uploaded documentation and responses provided by the facility in the PAQ. This auditor forwarded the Issue Log to the facility and MDHHS representatives on September 4, 2019 and additional telephonic conferences were held on September 6 and 24, 2019 to discuss the items on the Issue Log. The latter two telephonic conferences included the facility Program Manager, who functions as the PREA Compliance Manager, Superintendent and de facto PREA Coordinator for the agency, in addition to other specialized PREA roles. Questions this auditor had regarding facility policies, procedures, training content and attendance and other topics were addressed during these teleconferences, as well as through email correspondence with the MDHHS PREA Compliance Managers and the GLRC PREA Compliance Manager. Additional documentation to address items on the Issue Log was provided by the MDHHS PREA Compliance Managers assigned to GLRC, as well as the PREA Compliance Manager for GLRC, at this auditor's request. This auditor advised the PREA Compliance Manager for GLRC of the specialized staff positions that would need to be available for interview at the time of the on-site audit and they indicated they would have all the requested staff available to this auditor. A proposed schedule for the on-site audit was forwarded to the MDHHS and GLRC PREA Compliance Managers by this auditor on September 24, 2019 and discussions regarding on-site audit logistics, including unimpeded access to the facility, staff, residents and documents were addressed at the telephonic conference held on the same date.

This auditor received the resident and staff rosters on September 24, 2019, six days prior to travel to Negaunee. This auditor also requested the complete list of residents admitted to GLRC over the past 12 months, as well as the employee roster for the same time period. Those rosters were provided electronically on September 30, 2019. This auditor requested the facility identify on the resident roster any residents who reported prior victimization, lesbian/gay/bisexual/transgender/intersex (LGBTI) residents, disabled residents, residents who had limited English proficiency, residents placed in isolation and residents who reported sexual abuse. The facility reported there were no transgender or intersex residents, residents in isolation, residents who reported sexual abuse, disabled residents or residents with limited English proficiency at GLRC at the time of the on-site audit. While conducting random resident interviews this auditor identified a resident who reported sexual abuse at the facility. This auditor did not identify any transgender or intersex residents, disabled residents or residents with limited English proficiency at the on-site audit. No residents at a heightened risk of sexual abusiveness were identified, but the facility identified residents at a heightened risk of victimization in conjunction with identifying the residents who reported prior victimization. Residents in isolation will be discussed in detail in the standards review. It is noted this auditor received no written correspondence from residents, staff or others pre-audit or post-audit. The facility provided the volunteer and contractor list on site. The facility reported no grievances or other reports of sexual abuse or sexual harassment or hotline calls to report sexual abuse or sexual harassment over the prior 12 months on the Pre-Audit Questionnaire. However, the facility produced a grievance alleging staff voyeurism post-audit. It is noted the grievance post-dates the completion of the Pre-Audit Questionnaire. As previously indicated, this auditor identified a resident that reported sexual abuse. In this instance, the staff member whom the resident reported to did not document or forward the matter for investigation.

ON-SITE AUDIT

The first day of the on-site portion of the PREA Audit for GLRC was October 1, 2019 and concluded on

October 2, 2019. This auditor arrived at GLRC on October 1, 2019 at 0800 hours and met with the PREA Compliance Managers for MDHHS and the one staff member acting as the Superintendent, PREA Coordinator, PREA Compliance Manager, Intermediate or Higher-Level Staff, Staff Who Monitors for Retaliation and Investigative Staff for GLRC (herein referred to as the GLRC PREA Compliance Manager). At that time this auditor conducted a brief introductory meeting and reviewed the proposed audit schedule with the MDHHS and GLRC PREA Compliance Managers. Specialized staff was identified and this auditor worked with the GLRC PREA Compliance Manager to schedule those staff members' interviews to create as little disruption to facility operations as possible. Facility contractors and an intern were identified for interview. This auditor was provided with the printed list of staff who worked at the facility over the past 12 months once on site. The resident population on the first day of the on-site audit was 13 residents.

This auditor conducted the site review of the facility on October 1, 2019 in the company of the PREA Compliance Manager for MDHHS and the GLRC PREA Compliance Manager. The GLRC is a single-story facility comprised of a single building located off a main road in the township of Negaunee, Michigan. One vacant building that formerly housed a health care business sits adjacent to GLRC. The facility backs up to a wooded area, where residents are taken on hikes by facility staff. This auditor observed a greenhouse (enclosed by semi-opaque plastic), maintenance shed, a shed for recreational equipment and a "sugar shack" as structures on the perimeter of the GLRC building. The maintenance and recreational equipment sheds were observed to be locked with padlocks. The PREA Compliance Manager advised they and maintenance staff have keys to the maintenance shed and all staff have keys to the recreation shed. The sugar shack, which will process maple syrup, was completed the previous week. As a result, there was no locking mechanism installed, but the PREA Compliance Manager indicated one would be added. There is no lock on the greenhouse. This auditor was able to examine the entire facility, which is rectangular in design with a courtyard in the center. Upon entering the facility through a secured front door is the lobby of the facility and two offices off the lobby. One of the offices belongs to the Great Lakes Recovery Look Uncover Nurture and Act (LUNA) Neuro-Trauma Assessment Program. The other large front office off the lobby is where intakes and visitation take place at GLRC. The inside of the facility is comprised of two housing units, one for males and one for females, a community room for conferences, classroom, group session room and lounge, clinical staff offices, dining area, kitchen, a chemical closet, pantry, staff locker area, weight room, medical office/exam room, laundry room and art room. There is a unisex toilet located off the kitchen and a shower/toilet located off the administrative hallway where residents shower unobserved upon arrival at GLRC. There is a total of ten offices, including a LUNA Program administrative office. The Girls Unit has a common area furnished with couches and chairs, staff office and four resident rooms with two beds in each room. The rooms are furnished with two beds and two dressers, and the windows are covered with curtains. There is a closet with the door removed and a bathroom consisting of a toilet, sink and stall shower. There is a door on the bathroom facilities which can be locked. The Boys Unit is identical to the Girls Unit and is located on the opposite side of the dining area. It is noted the pantry, staff lockers and chemical closet are locked, with all staff having key access. The mechanical room is locked, with only the GLRC PREA Compliance Manager and maintenance staff having key access. The laundry room, located immediately off the dining room, is unlocked. The doors leading to the outside of the facility are not secured by locking mechanism but are alarmed to alert staff if they are opened. There are no work assignment areas at GLRC.

This auditor observed the PREA audit announcements posted throughout the facility, including the living units, dining area and group session room. Grievance boxes were observed posted in the living units, the lobby and outside the group session room/lounge. This auditor also observed the "Zero Tolerance" and "No Means No" posters throughout the facility, including the living units, the lobby and outside the group

session room. The “No Means No” posters list the ways to report sexual abuse and sexual harassment and provides the telephone number to the Children’s Protective Services hotline, as well as the name, address and telephone number for victim supportive services. Residents were observed in the classroom and escorted by staff to the medical office and therapist offices. Two staff members, one being the teacher, were observed in the classroom. Residents were not seen outside of staff line of sight. This auditor was provided access to the video monitoring system. The monitors are located in both staff offices inside the living units and the GLRC PREA Compliance Manager’s office. This auditor observed one camera mounted in the entrance to the facility, two cameras placed in each common area of the living units, two cameras in the group session room/lounge, two cameras in the dining area, one camera in the small hallway off the kitchen pointed toward an exterior door and the pantry, two cameras in the classroom and five hallway cameras. The art, laundry and weight rooms do not have cameras; however, there is one mounted in the hallway just outside the entrances. There are no exterior cameras. There were no opportunities to view residents changing clothes, showering or toileting observed on the video monitoring system.

The classification process was not observed due to the fact GLRC has only two living units, one for males and one for females. The resident education was not observed as there was no resident intake at the time of the on-site audit. This auditor was walked through the grievance process, access to the language line/interpretive services and a mock intake post on-site audit.

It is noted that the power to the facility was knocked out on the second day of the on-site audit (October 2, 2019). This auditor was able to complete the resident interviews before the residents were taken off property due to the lack of power. This resulted in limited opportunities for this auditor to observe some resident activities and interactions with staff, such as cross-gender staff announcements (which is addressed in the standards review).

This auditor was provided space for confidential and private interviews with residents and staff. The roster of residents was provided to this auditor on September 24, 2019 and an updated resident roster was provided on the first day of the on-site audit. This auditor was able to interview all staff selected at random. There was not a random selection to be made for specialized staff interviews; there was only one staff assigned to each specialized role, and one staff member performed the roles in six different interview protocols. The only exception to this was in the number of Volunteers/Contractors working at GLRC, of which there are a total of seven, three contractors and four volunteers (unpaid interns). One contractor and one intern were interviewed, with the contractor selected being first alphabetically and the volunteer selected being last alphabetically. The interviews were conducted using the Department of Justice interview protocols. Four random staff interviews and 14 specialized staff interview protocols were completed over the course of the on-site audit. Staff interviews were conducted with staff from all three shifts (0645-1530, 1500-2300, and 2245-0800) and from both living units. The random staff was selected by choosing every third name down the staff roster; however, this auditor had to make one selection that deviated from this method to ensure a day-shift staff was interviewed. Based on the size of the resident population, it was this auditor’s intention to interview all residents. All but two residents were interviewed; one resident was on an overnight family visit outside of the facility and the other declined to be interviewed. In total, 11 resident interviews were conducted, with six of the interviews being specialized interviews. The GLRC did not house a Limited English Proficient, Disabled, or Transgendered/Intersex resident at the time of the on-site audit. The interview protocol for Residents Placed in Isolation was not completed and is discussed in the standards analysis.

This auditor conducted the following specialized staff interviews: (1) Agency Head, (1) Superintendent,

(1) PREA Compliance Manager, (2) Medical/Mental Health, (2) Volunteers and Contractors Who May Have Contact With Residents, (1) Contract Administrator, (1) Administrative Staff, (1) Designated Staff Charged With Monitoring for Retaliation, (1) Intake Staff, (1) Intermediate or Higher-Level Staff, (1) Investigative Staff and (1) Staff That Perform Screening For Risk of Victimization and Abusiveness. The interview protocol for Security and Non-Security Staff Who Have Acted As First Responders was not completed as there was no reported or discovered instance of sexual abuse in the facility over the previous 12 months. The interview protocols for Staff That Supervise Residents In Isolation and Non-Medical Staff Involved In Cross-Gender Strip or Visual Searches were not completed as the facility is prohibited from these practices. The Incident Review Team interview protocol was not conducted, which will be discussed in the standards analysis.

The following specialized resident interviews were conducted: (4) Residents Who Disclosed Prior Sexual Victimization During Risk Screening, (1) Resident Who Reported a Sexual Abuse and (1) Transgendered, Intersex, Gay, Lesbian or Bisexual Resident. It is noted the facility indicated there were no reported sexual abuse incidents over the past 12 months on the Pre-Audit Questionnaire. This auditor discovered there was a resident that reported sexual abuse while conducting a random resident interview and the specialized protocol was completed. A total of five random resident interviews were conducted for the 13 total residents. There was a total of seven residents who disclosed prior sexual victimization, one resident that reported sexual abuse and one transgendered, intersex, gay, lesbian or bisexual resident present at the facility at the time of the on-site audit.

A total of 14 resident and employee files, as well as one investigation detail, were reviewed. Active resident files are maintained in three-ring binders, which are kept in the staff offices of the living units in locked file cabinets. Discharged resident records are kept in file cabinets outside the clinical offices at GLRC. It is noted this auditor found these file cabinets to be unlocked at the time of the site review. This auditor used the list of residents admitted to GLRC over the past 12 months and selected nine files at random by counting every ten names from a list of 52 residents. One resident file was missing the intake screening tool. Five resident files were missing documentation regarding follow-up medical and mental health referrals for residents who reported prior victimization on the intake screening tool and none of these five files had a specific notation of a periodic reassessment for risk of victimization or abusiveness during the resident's stay. This auditor reviewed the therapeutic notes in one of these files to ascertain if the prior sexual abuse was being addressed in treatment, but no mention of sexual abuse victimization was noted. Also of concern on the intake screening tool was the notation "No apparent risk factors at this time", when five of the resident files reviewed indicated prior victimization. Two of the older resident files did not record the date the resident viewed the comprehensive PREA educational video, but the intake screening tool has since been updated to record that date. This auditor used the list of staff employed at the facility over the past 12 months and selected five files at random by counting every five names from a list of 23 staff, plus one. One of the five employee files was complete for PREA documentation. One file indicated prior references were checked but there was no date recorded for the verification. In that same file the applicant listed an out of state residency, but no child abuse registry check was done for that state. Three of the files were missing the initial PREA training acknowledgments, but subsequent PREA trainings were documented in the files. The facility noted that documentation of initial employee PREA training was not consistent prior to 2016, but documentation of said training is now standard procedure. The contracted medical services through Upper Great Lakes (UGL) maintain electronic records for residents and provide treatment summaries, which are placed in the residents' binders. Mental health treatment records are also kept in the residents' binders. As a result, separate medical/mental files were not reviewed.

This auditor reviewed the investigation detail from a reported staff sexual misconduct incident from 2017,

outside of the reporting period for this audit, for the sole purpose of analyzing the facility response to a report of sexual abuse or sexual harassment at the facility. The investigation detail reflected the appropriate notifications to law enforcement, Children's Protective Services, the alleged victim's parent and Probation Officer were made. Inquiries about the alleged victim's mental health status and offers of victim supportive services were documented. However, staff receiving the report from the resident did not notify facility administration or document the incident until the following day. It is noted that the staff member allegedly involved in the sexual misconduct was interviewed in detail on the same date as the incident was reported to facility administration and they were subsequently suspended and advised not to return to the facility. A formal suspension notice was issued to the staff member two days after they were interviewed. Although the decision to suspend the staff member pending the outcome of the investigation was appropriate, the solicitation of statements from the accused staff member could create problems with a criminal investigation without clear guidance from law enforcement or prosecuting entities. This auditor also reviewed the Root Cause Analysis and Action Plan completed for this incident. The analysis was comprehensive and involved multiple parties, including facility administration, clinical and direct care staff, MDHHS and Children's Services. The analysis format could easily be labeled to include sexual abuse incident review language.

This auditor contacted the Central Intake (Children's Protective Services) hotline number (1-855-444-3911) on October 2, 2019 to test the GLRC's outside reporting mechanism. This auditor explained the nature of the call was as a test for GLRC's outside reporting process for reports of sexual abuse or sexual harassment at GLRC. The Central Intake staff was asked to provide notification to the facility through their designated processes. This call was placed at 1530 hours; the GLRC PREA Compliance Manager reported he received notification of the test report at 1930 hours the same date.

This auditor conducted an exit briefing with the MDHHS and GLRC PREA Compliance Managers and the Agency Head at the GLRC administrative offices. This auditor provided general insight into which standards would likely require corrective action. Timelines for submission of the interim report were previously discussed and MDHHS and GLRC were advised they would receive the interim report on or before December 1, 2019.

POST-AUDIT

Upon return from the on-site audit, this auditor transcribed interviews and reviewed interview responses, additional documentation and site tour information obtained on site to ascertain compliance with each standard. As reported in the Pre-Audit Questionnaire, GLRC reported no incidents of sexual abuse or sexual harassment over the past 12 months. However, subsequent to the on-site portion of the audit the facility forwarded a client grievance which alleged the resident's genitalia was viewed by the GLRC PREA Compliance Manager during the intake search. The client grievance was dated August 20, 2019 and the facility received the grievance on August 23, 2019 (it is noted the facility completed the Pre-Audit Questionnaire on August 16, 2019, predating the client grievance). Since the grievance involved the staff member who collects and reviews grievances, the matter was referred to another agency administrator. The information collected in response to the client grievance was titled a PREA Investigation, but it was not recorded on the standard format that MDHHS provided to this auditor post on-site audit. The outcome of the grievance was that the facility search policy was forwarded for revision and the need for consistent training on search procedures for staff. A specific finding of "Substantiated", "Unsubstantiated" or "Unfounded" was missing from the documentation. This auditor subsequently requested all facility grievances over the past 12 months for review. The GLRC PREA Compliance Manager responded that the facility doesn't keep a list of grievances and instead provided a summary of the nature of the

grievances. This auditor later had the GLRC PREA Compliance Manager walk through each step taken to process grievances and it was at that time the GLRC PREA Compliance Manager reported that grievances are kept in a binder and the outcome of the grievance is listed on or attached to the grievance. Based on this it is not clear whether GLRC maintains a tracking system to appropriately document the nature of, response to and outcome of resident grievances. As there were no new intakes at the time of the on-site audit, this auditor had the Intake Staff walk through each step taken when completing an intake with a new resident.

This auditor contacted the UP Health System Marquette Hospital Emergency Room Nurse Supervisor and completed the SANE/SAFE Staff interview protocol. This auditor made contact with the Sexual Assault Program Coordinator for the Women's Center, the facility's outside supportive services provider for sexual victimization. They confirmed they have a Memorandum of Understanding with GLRC, which dates back to 2014. The Sexual Assault Program Coordinator indicated they conduct weekly groups at GLRC and are available to meet one on one with residents as needed. They advised the Women's Center's Sexual Assault Response Team would be available to a GLRC resident in the event of a sexual abuse incident and that they would be contacted by the UP Health System Marquette Hospital and/or law enforcement in those circumstances. The Sexual Assault Program Coordinator advised they would also respond if contacted directly by GLRC staff. Additional communication with the PREA Compliance Managers for MDHHS and GLRC was required to obtain information that was not previously provided/requested. The MDHHS and GLRC PREA Compliance Managers were responsive throughout the pre and post-on-site audit and provided this auditor with the majority of the documentation or information requested.

FINAL AUDIT UPDATE

The Interim PREA Audit Report issued on December 1, 2019 reflected GLRC was non-compliant with 24 standards. Following the submission of the Interim PREA Audit Report, the facility entered the 180-day maximum Corrective Action Period, beginning December 1, 2019. This auditor provided recommendations for each standard found to be non-compliant for GLRC to bein working toward full compliance. Follow-up telephonic conferences were held with the MDHHS PREA Compliance Manager, the facility Director and other GLRC administration on December 18, 2019 and January 15, 2020, and email communication was used to address various issues. This auditor conducted telephonic interviews with the agency's newly designated PREA Coordinator and facility PREA Compliance Manager on March 17, 2020. Confidential telephonic interviews with three random residents and three random staff to verify corrective action were conducted on April 15, 2020. All corrective action documentation and verification was completed on April 24, 2020.

AUDIT FINDINGS

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

Facility Residents and Staff

The GLRC Adolescent Services Center is a 16-bed co-ed facility under the control of GLRC Behavioral Health Services. This facility is contracted with the MDHHS for adolescent residential substance abuse treatment. The GLRC is staff-secured with 24-hour supervision. The average daily population of GLRC over the past 12 months is ten residents and the average length of stay is 60 to 90 days. The facility admitted 51 residents over the past 12 months. The racial makeup of the resident population over the 12-month period is approximately 75% Mixed Race of Caucasian and Native American, and approximately 25% of the residents claiming one of those two races exclusively. Of the 13 residents present at the facility at the time of the on-site audit, five were male and eight were female. The facility has two residential housing units, one for male residents and one for female residents. Each residential unit has a total of eight beds situated in four rooms, two beds to a room. The GLRC houses residents between the ages of 12 and 17 and accepts placement from multiple sources, including the MDHHS, Indian Health Services, Michigan Access to Recovery and private placements. Residents are accepted from all parts of the State of Michigan. According to the employee roster the GLRC is staffed with one Program Supervisor, one Clinical Supervisor, three Certified Addiction Counselors, one LUNA Case Manager, one Head of Maintenance, one Therapist, one Nurse-RN and eight Addiction Counselors. The Addiction Counselors are considered front-line staff and clinical casework is done by the Therapist and Certified Addiction Counselors. One of the Addiction Counselors is designated the Day-Shift Supervisor; however, the facility does not utilize that staff member in a supervisory capacity over other staff for the purposes of acting as Intermediate or Higher-Level Staff. The facility contracts with the Marquette Alger Regional Education Service Agency for their educational services, which provides one teacher. One medical doctor and one nurse are also contracted through UGL. Four interns currently work at GLRC on a volunteer basis. According to the employee roster there is a total of 18 employees at GLRC, excluding contractors and volunteers. A review of staff schedules from April 2019 to October 2019 revealed a consistent scheduling of five staff for day and swing shifts and two staff for night shifts. With a bed capacity of 16 (eight to a unit), this staffing pattern exceeds the PREA requirements.

Programming

The GLRC provides programming including educational services, individual, group and family therapy, music/art, equine and recreational therapy and community service learning projects. The primary focus of treatment at GLRC is substance abuse and the facility is capable of addressing co-occurring disorders and medication management. In addition to GLRC staff, the facility has a Memorandum of Understanding with the Marquette Women's Center, which provides weekly group sessions, victim advocate services, domestic violence counseling and supportive services for victims of sexual abuse. Residents are assigned to one primary clinician, who works with the resident and their family to develop an individualized treatment plan. Weekly family sessions are conducted as part of the treatment process and discharge planning is completed with the resident and their family. The GLRC indicated all staff,

contractors and volunteers, except for the LUNA Case Manager, have contact with residents.

Medical/Mental Health

The services of a medical doctor and nurse are provided through a contract with UGL, who come to GLRC weekly. The doctor conducts initial resident physicals and wellness checks and continues to see each resident weekly, unless the resident's private insurance prevents that frequency of care. In addition, a nurse employed by GLRC comes to the facility twice a week to coordinate services with the UGL doctor, pick up and coordinate medications and may see a resident on an as needed basis to screen for appropriate level of care for a medical issue. Mental health services are provided by facility clinicians and a contract psychologist.

Housing Units

The two housing units in the GLRC are identical in layout. The units consist of four rooms, with two beds in each room, for a total of eight beds. The rooms are generous in size and are furnished with two beds, two dressers and a nightstand with a lamp. Each room has a closet with the doors removed and a bathroom consisting of a stall shower, sink and toilet. The solid bathroom door locks from the inside with a push button lock. The resident rooms have a solid door with no lock. Each room has a large operable window covered with curtains. The rooms are directly off the common areas of the units. The common areas are furnished with couches, chairs and tables. Each unit has a staff office, which has a view of the common area and resident rooms; however, staff lose line of sight once the resident room doors are closed. There are grievance boxes in each unit. Two cameras for video monitoring are located in each unit, covering the entrance to the units and the common areas. Cameras are not placed in resident rooms. A review of staff schedules from April 2019 to October 2019 revealed a consistent scheduling of five staff for day and swing shifts and two staff for night shifts. This staffing pattern complies with the standards found in 115.313(c).

Facility Layout

The GLRC is configured in a rectangle, with a courtyard in the center. The entrance of the GLRC is secured and requires staff to give access. The lobby of the GLRC is furnished with two couches, chairs, lamps and tables. Immediately off the lobby are two offices, one used by the LUNA Program and the other used for intakes and visitation. The medical office is located in the hallway right off the lobby, followed by the administrative and clinical offices, staff restroom and a shower/sink/toilet used for newly placed residents as part of the intake process. Closed resident files are maintained in the clinical office in a file cabinet near the copy machine area. The group room/lounge is located next to the administrative and clinical offices, and the mechanical room is located off the hallway next to the group room/lounge. There is an alarmed door off the group room/lounge leading to the exterior of the facility. On the other side of the hallway is the entrance to the Girl's Unit. Inside both residential units are staff offices, where resident binders (as opposed to files) are kept in locked file cabinets. Video monitoring monitors are located in the staff office, as is the telephone residents use for all phone calls. Further down the hallway is the dining hall, kitchen and staff room. Inside the staff room are tables and lockers for staff property. The pantry and chemical room are located off the kitchen, as is an alarmed back door leading to the exterior of the facility. The laundry room and a unisex toilet/sink are located off the hallway adjacent to the dining hall. The Boy's Unit is located down this hallway, and the classroom follows around the corner. The art room and weight room are adjacent to the classroom. The entrance to the large community room, primarily used for conferences and trainings, sits between the art room and the weight room.

The exterior of the facility starts with a front parking lot and a circular drive to the front entrance. On the side of the facility is a greenhouse, used for resident growing projects, and a maintenance shed. Toward the rear of the facility is a shed for recreational equipment and the aforementioned “sugar shack”. These two structures are located off a large asphalt basketball/recreation area. The facility property is not fenced or otherwise secured around its exterior and woods back up the facility property.

AUDIT FINDINGS

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

Number of standards exceeded:	0
Number of standards met:	43
Number of standards not met:	0

The agency and facility administration and staff were cooperative with the audit process. The MDHHS and GLRC PREA Compliance Managers were accommodating of this auditor's needs and adjusted according to the requirements of the audit. The facility was well maintained and clean and staff was observed maintaining line of sight supervision of the residents. Residents did not express concern for their safety or welfare and were generally content with the programming, staff and services at GLRC. The agency is in the preliminary stages of obtaining full understanding and compliance with the PREA standards and the agency and facility administration expressed a willingness to learn and improve in their PREA efforts.

The following is a summary of the standard findings for the Great Lakes Recovery Center in the Interim Report:

Exceeds Standards – 0
Meets Standards – 19
Does Not Meet Standards – 24

Corrective Action was required for the following standards:

115.311 - The agency must designate an upper-level administrator as the agency's PREA Coordinator. This position must have sufficient time and authority to develop, implement and oversee the agency and facility responsibilities to comply with the PREA standards. In addition, the GLRC PREA Compliance Manager must be given sufficient time and authority to coordinate the facility's PREA responsibilities.

115.313 - GLRC needs to create and implement a PREA-compliant staffing plan, which considers the 11 factors outlined in this standard. The facility will need to create a mechanism to record deviations from the staffing plan, regardless of whether the facility experiences deviations. Once the PREA-compliant staffing plan is developed, the facility will need to review the staffing plan on at least an annual basis. The facility needs to update its unannounced rounds log to record the specific time these rounds occur and ensure the rounds are conducted at varying times and days of the week.

115.316 – Facility staff must be aware of how to access services for limited English proficient and

disabled residents. GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and the adopted MDHHS policies added to address compliance with this standard.

115.317- GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and staff must be trained on the new policy language added to address compliance with this standard.

115.322 - GLRC will need to retrain staff on the procedures to respond to an incident of sexual abuse or sexual harassment, regardless of whether staff believes the incident constitutes sexual abuse or sexual harassment. Staff will also need to acknowledge understanding of the information provided in the training. Residents will also need to be educated that they must receive a response from facility staff regarding the status of any reported incidents of sexual abuse or sexual harassment. Residents will need to acknowledge understanding of the information provided in the educational session.

115.332 - The contracted medical doctor will need to complete PREA training to achieve compliance with this standard.

115.333 - GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and how staff can access services for limited English proficient and disabled residents.

115.335 - The facility's contracted medical doctor will need to either complete the PREA training GLRC provides to its medical/mental health staff or provide proof of training in the detection of signs of sexual abuse, preserving physical evidence, effective response to reports of sexual abuse, and reporting responsibilities from another source, such as medical continuing education units (CEU's).

115.342 - GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and the adopted MDHHS policies to address compliance with this standard.

115.351 - Residents must be afforded as much privacy as possible when they want to contact the CPS hotline, with limits still in place to restrict residents' ability to make unauthorized phone calls. The facility must make calls to CPS private by 1) modifying GLRC Policy No. GLO 149.0 to eliminate requirements for staff to notify a supervisor to place a call to CPS and, 2) creating a calling system that adds anonymity to the purpose of the call.

115.352 - The facility must be able to produce a record of grievances that allows for review, not only for the purpose of establishing PREA compliance, but to accurately track grievance outcomes, patterns and areas in need of correction/modification. Sexual abuse and sexual harassment grievances also need to have a clear finding of "Substantiated", "Unsubstantiated" or "Unfounded". The facility will need to update the GLRC Policy No. GLO 149.0 to include language that allows parents or legal guardians of residents to file a grievance alleging sexual abuse, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf. The facility must create a

procedure for identifying and responding to emergency grievances of sexual abuse/sexual harassment and imminent threats of sexual abuse. Residents and staff also need to know how GLRC will address an emergency grievance for sexual abuse and sexual harassment. GLRC will need to train staff and educate residents on the procedure.

115.361 - The GLRC Policy No. GLO 149.0 must be updated to include the staff requirement to report incidents of sexual harassment, retaliation as a result of a report made for sexual harassment or neglect of staff duties that contributed to an incident of sexual harassment. The updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard. The facility will need to review and reiterate the requirement that staff report all incidents of sexual abuse or sexual harassment in conjunction with training on new policy language. The facility will need to notify a resident's legal counsel in the event of a sexual abuse incident, either with direct and specific contact if a release of information has been signed by the resident, or in a vague and generic fashion as described in the standard review. The facility will need to include verification that legal counsel has been notified and the date of the notification on the institutional plan.

115.365 - The facility needs to create an institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators and facility leadership. Mechanisms to document actions with names of the staff responsible, dates and times must be included. The MDHHS 5809 PREA Investigation Tool details First Responder Actions, Supervision Actions, and Facility Director or Program Manager Actions. The tool requires staff to enter their name, date and time when the action was taken and requires a description of the action taken. The institutional plan needs to be distributed to all staff and staff must be trained on how to execute their responsibilities in the plan.

115.367- The GLRC Policy No. GLO 149.0 must be updated to include monitoring for retaliation after a reported incident of sexual harassment. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard.

115.371 - The GLRC Policy No. GLO 149.0 must be updated to include monitoring for retaliation after a reported incident of sexual harassment. The GLRC Policy No. GLO 149.0 also must be updated to clarify that law enforcement will collect physical evidence for the criminal investigation and that GLRC staff does not collect physical evidence. In addition, soliciting statements from accused staff should be done after consulting with law enforcement and/or prosecutors. The facility will need to add a section to capture contact with law enforcement/prosecutors for the purpose of obtaining clearance to interview accused staff to their institutional plan, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard.

115.373 - The GLRC Policy No. GLO 149.0 will need to be updated to include a provision to notify the resident whether the allegations of sexual abuse were substantiated, unsubstantiated or unfounded after the facility's investigation. A section to capture this information must be added to the facility’s institutional plan. The institutional plan will also need to include a section to capture the request of the criminal investigation report, as well as a section to record notification to residents regarding that report. The updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and the adopted MDHHS policies added to address compliance with this standard.

115.378 - The facility must update policy language in relation to its practice regarding isolation as a disciplinary action. The updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff

must be trained on the new policy language and the adopted MDHHS policies added to address compliance with this standard.

115.381 - The facility is lacking documentation regarding follow-up appointments with medical/mental health staff for residents who report prior victimization on the facility risk screening tool. The facility will need to document that the follow-up appointment was offered during the intake screening and the date it was offered. In conjunction with this, medical/mental health staff who see residents for follow-up appointments will need to complete documentation to record the date and general outcome of the appointment.

115.382 - The facility will need to include a procedure in their Coordinated Response Plan/institutional plan to require first responders to notify medical/mental health staff of a sexual abuse incident if the facility Director/designee is not immediately available to do so.

115.383 - The facility will need to develop a protocol to address the actions required by medical and mental health staff to assess and treat the needs of a resident victim. This protocol must include specific evaluations needed to assess treatment needs and the timelines these assessments and subsequent treatment are implemented. The dates of the actions by medical/mental health staff will also need to be recorded in the facility's Coordinated Response Plan/institutional plan. The GLRC needs to include 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 placement in their medical/mental health protocol. The GLRC needs to include documentation of pregnancy tests in applicable sexual abuse incidents in their medical/mental health protocol. The GLRC Policy No. GLO 149.0 also needs to be updated to eliminate non-specific information regarding the provision of pregnancy tests. The GLRC needs to include documentation that victim residents were offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis where medically appropriate in their medical/mental health protocol in both the Coordinated Response Plan and the medical/mental health protocol. The GLRC must include documentation that resident victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate in both the Coordinated Response Plan and the medical/mental health protocol. Also, if GLRC will not continue to house a resident who committed resident-on-resident sexual abuse, it will need to include this information in the GLRC Policy No. GLO 149.0 to address this provision.

115.386 - Overall, GLRC has demonstrated it reviews sexual abuse incidents with a multidisciplinary team and makes recommendations to address issues identified in the review. The facility will need to include an analysis of 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. For the purpose of demonstrating compliance for this Corrective Action, GLRC will need to create a template for the sexual abuse incident review which includes a narrative section for consideration of the aforementioned factors specific to the victim.

115.387- The facility will need to standardize the definitions of the types of offenses it is tracking in its GLRC Policy No. GLO 149.0 and the PREA Compliance Data Report to reflect the same definitions on both documents. The facility will also need to create a secured standardized instrument used to collect and maintain the data used to populate the PREA Compliance Data Report and complete the Department of Justice Survey of Sexual Violence, with controlled and limited access. The standardized instrument will also need to document and demonstrate how the data collected is aggregated on an annual basis, at a minimum. The facility will need to develop a system to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident

reviews. Such a system must be secured, with access limited to upper administration.

115.388 - GLRC will need to generate its own agency annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The information used to provide the MDHHS with data for their report is the same data GLRC will utilize for its annual report. The GLRC will need to include comparisons of the current year's data with prior years and an assessment of the agency's progress in addressing sexual abuse in its own agency annual report and publish its annual report to the GLRC agency website to make it available to the public.

115.389 - The facility will need to create a written protocol which clearly demonstrates how the facility secures its aggregated data. This protocol should be instructive enough for anyone to understand the process of securing the data (how is it stored) and who has access to the data. In conjunction with the Corrective Action required for 115.387, the facility will need to develop a system to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Such a system must be secured, with access limited to upper administration, and a mechanism to discard data that was collected ten or more years prior (unless otherwise prescribed by Federal, State or local law).

The 180-day Corrective Action period for GLRC began on December 1, 2019. Staff and administration from GLRC and MDHHS worked with this auditor to develop and implement the actions required of the Corrective Action Plans for each standard requiring corrective action. The agency took the steps necessary to designate key personnel to fill the roles of PREA Coordinator and PREA Compliance Manager, This, in addition to the creation of the required procedures and protocols to accurately collect, track and analyze PREA-related data, will greatly enhance GLRC's ability to forward and maintain compliance with the PREA standards. As a result of the collective efforts of GLRC and the MDHHS, the facility is now in compliance with all 43 PREA standards.

Standards

Auditor Overall Determination Definitions

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

Auditor Discussion Instructions

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

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *PREA Coordinator *PREA Compliance Manager **Documents reviewed:** *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact 115.311(a)- The GLRC Policy No. GLO 149.0, Page 3, Prevention of Resident Sexual Assault/Rape section states, "Residential juvenile justice staff must have zero tolerance for sexual abuse and sexual harassment of residents." The same policy includes definitions for resident-on-resident sexually abusive penetration, resident-on-resident sexually abusive contact, resident-on-resident sexual harassment, staff-on-resident sexually abusive contact, staff-on-resident sexually abusive penetration, staff-on-resident indecent exposure, staff-on-resident voyeurism, staff-on-resident sexual harassment, staff sexual misconduct, sexual exploitation, age of consent in Michigan and first responder. The facility does not have a designated policy or section of the GLRC Policy No. GLO 149.0 specifying the agency's strategy to implement prevention, detection and response to sexual abuse and sexual harassment; however, the GLRC Policy No. GLO 149.0 as a whole covers the requirements of 115.311(a). Page 8, Section D1 of the policy references line of sight supervision and staff-to-youth ratios. Page 9, Sections 2 and 3 of GLRC Policy No. GLO 149.0 references staff's responsibility to be aware of warning signs in youth of possible sexual abuse and awareness to sexually aggressive behavior. Pages 9-10, Section E provides youth responses to sexual assault/rape/sexual harassment and Pages 11-12, Section F provides staff response to sexual assault/rape; this section is lacking staff instruction for reports of sexual harassment. 115.311(b) - In the interview with the staff person who acts as PREA Coordinator, it was evident the agency does not employ or designate an upper-level agency-wide PREA Coordinator. The staff person who acts as PREA Coordinator is the Program Manager for one of the agency's four residential facilities. That staff member appears to be the agency's most knowledgeable in the PREA requirements and, as a result, has the sole responsibility for all of the agency's PREA efforts. This same staff person acts in the capacity of Superintendent, PREA Compliance Manager, Intermediate or Higher Level Staff, Staff Responsible for Monitoring for Retaliation and Investigative Staff. The GLRC has one level of administration between the Agency Head and facility administration, and no other supervisory staff assigned to the facility. The staff person who acts as PREA Coordinator acknowledged the do not have sufficient time to oversee the facility's PREA responsibilities. They admitted they do not have a full understanding of all of the PREA requirements and may not have authority to implement necessary changes to become compliant with the PREA standards. 115.311(c) - Just as in 115.311(b), it was clear the staff person who acts as PREA Compliance Manager does not have sufficient time to fully attend to the facility's PREA efforts. The staff person who acts as PREA Compliance Manager has the sole administrative responsibility for the facility and reports to a Residential Director.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.311(b) - The agency must designate an upper-level administrator as the agency's PREA Coordinator. This position must have sufficient time and authority to develop, implement and oversee the agency and facility responsibilities to comply with the PREA standards. It appears this level of administrator currently exists in the agency structure in the Residential Director position.

115.311(c) - The PREA Compliance Manager is appropriately designated to the staff member currently acting in that capacity. However, they simply have too many responsibilities at the facility to adequately address all the necessary PREA responsibilities. As there is no supervisory staff other than the staff member acting in multiple PREA roles, it makes it difficult to delegate responsibilities to allow for the time necessary to attend to all facility PREA responsibilities. If the agency/facility is not able to create a supervisory position in its current structure, delegation of other non-PREA responsibilities may free up time for the PREA Compliance Manager to fully administer the facility's PREA efforts.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 27, 2020 and conducted interviews on March 17, 2020 to substantiate corrective actions taken for this standard.

GLRC Adolescent Services Center (ASC) PREA Organizational Chart - The updated organizational chart now includes an Agency Level PREA Coordinator, who is positioned at an equal level as the agency Residential Director, and a Facility Level PREA Compliance Manager. The facility PREA Compliance Manager reports to the facility Director, who previously managed both responsibilities.

Interviews with PREA Coordinator and PREA Compliance Manager - The newly designated agency PREA Coordinator and facility PREA Compliance Managers were interviewed by telephone on March 17, 2020. The PREA Coordinator advised she has sufficient time and authority to manage and implement the agency's PREA efforts. She has worked in her capacity as PREA Coordinator since December, 2019 and has participated in the agency's work on the Corrective Action Plan for this PREA audit. She indicated she has familiarized herself with the PREA standards, is working on quality improvement for all PREA-related reports and securing PREA data with limited access.

The PREA Compliance Manager was hired in January, 2020 as a supervisory level position at GLRC. Although he is still in the process of familiarizing himself with the PREA standards he demonstrated knowledge of GLRC's policies and procedures related to sexual safety in the facility. He indicated he has sufficient time to ensure the facility's compliance with its PREA efforts and will be heading facility PREA training for staff and new hires.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Contracts Administrator **Documents reviewed:** *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact 115.312(a) - The GLRC is a contracted agency for the Michigan Department of Health and Human Services. The agency does not contract for the confinement of residents. 115.312(b) - The GLRC Policy No. GLO 149.0, Page 7, Section 1 states, "All facility staff, and contractors and volunteers that have regular contact with youths must complete initial and annual training for sexual assault/rape prevention, incident response and reporting." In the interview with the Agency Contracts Administrator, it was confirmed that GLRC does not contract for the confinement of residents. However, the facility does contract for resident medical services. The Agency Contracts Administrator advised contractors are required to complete the same PREA training required for staff.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Coordinator *PREA Compliance Manager *Intermediate or Higher-Level Staff *Random Residents **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC PREA Staffing Plan Review, 2018-2019 *Unannounced Rounds Log *State of Michigan Department of Health and Human Services Licensing Rules for Child Caring Institutions *Staff Schedules, April 2019-October 2019 *Site Review 115.313(a) - The GLRC Policy No. GLO 149.0, Page 17, Section 5 requires the facility to develop, document and implement a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents from sexual abuse. The policy also requires facility administration and the facility PREA Compliance Manager to conduct a review of the staffing plan at least annually, taking into consideration the 11 criteria provided in 115.313(a). The GLRC PREA Staffing Plan Review for 2018-2019 was provided by the facility to substantiate compliance with this standard. This Staffing Plan Review lists four (4) criteria for consideration; Staff-to-Youth Ratios and Staff Supervision, Supervisory Personnel, Video Monitoring Systems, and Applicable Laws, Regulations and Findings. It is noted the document provided does not satisfy the requirements of this provision. Please see comments for 115.313(d). 115.313(b) - The GLRC Policy No. 149.0, Page 17, Section 5 requires the facility to develop, document and implement a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents from sexual abuse. However, this policy does not provide for the recording of deviations from the staffing plan. In the Pre-Audit Questionnaire, the facility indicated there had been no deviations from the staffing plan. The Superintendent interview revealed they have not had a situation where they were unable to satisfy the requirement of the staffing plan for staff to youth supervision ratios. 115.313(c) - The Superintendent interview revealed they have not had a situation where they were unable to satisfy the requirement of the staffing plan for staff to youth supervision ratios, since their requirements through the State of Michigan Licensing requires a higher ratio (1:6 waking and 1:8 sleeping) than what PREA requires. It is noted the MDHHS Licensing Rules for Child Caring Institutions, Rule R 400.4127 reflects a staffing ratio requirement of 1:10 waking

hours and 1:20 during normal sleeping hours. This auditor confirmed with the PREA Compliance Managers for the MDHHS that the latter staffing ratio applies to GLRC for licensing. In interviews with the staff person who acts in the capacity of Superintendent, they advised that should staff call in sick for a shift, the staff on duty would need to remain at their post until a replacement is located. That staff person also advised that staff is assigned "on call" status on a weekly basis to cover such situations, and that they would report to the facility to cover if necessary. A review of staff schedules from April 2019 to October 2019 revealed a consistent scheduling of five staff for day and swing shifts and two staff for night shifts. With a bed capacity of 16 (eight to a unit), this staffing pattern exceeds the PREA requirements.

115.313(d) - The facility provided the GLRC PREA Staffing Plan Review, 2018-2019 to substantiate compliance with this standard in the Pre-Audit Questionnaire. The Staffing Plan Review provided by the facility is lacking in several areas: the consideration of all 11 factors that are mandated to be considered; designated positions to be posted on each shift, where those positions are posted, a description of staff duties on those shifts and, video monitoring requirements to promote sexual safety, including where cameras are posted and known blind spots. The Staffing Plan Review was signed by the Program Manager. In interviews with the staff person who acts in the capacity of PREA Coordinator, they advised they were the sole contributor to the Staffing Plan Review, and they were uninformed as to what was required for the annual review. In interviews with the staff person who is both the Superintendent and the PREA Compliance Manager, they acknowledged they were the sole contributor to the Staffing Plan Review and was unaware a cross-section of facility personnel should participate in the staffing plan review. This issue is exacerbated by the fact this staff person is responsible for multiple PREA roles and appears to be the agency expert who has all the responsibility for PREA compliance. In the Superintendent interview, that staff member indicated they ensure the video monitoring system is functional, the facility is staffed at the required levels, they make contact with residents on a regular basis and monitor grievances or other reports from residents to check for compliance with the staffing plan. During the site review this auditor viewed the resident rooms and found each room contained a bathroom (shower, sink and toilet). Each room is configured to sleep two residents to a room. Through interviews with random residents and conversations with the staff acting as PREA Compliance Manager, both residents are present in the room with the door closed while showering, toileting and changing of clothing is taking place. The concern for this arrangement is that sexual abuse could be perpetrated by one roommate on the other and staff has no way of supervising the interaction between the two residents. This situation must be addressed when creating and implementing a PREA-compliant staffing plan to fully address concerns for sexual safety and how supervision and monitoring can mitigate those concerns.

115.313(e) - The GLRC Policy No. GLO 149.0, Pages 17-18, Section 6 states, "Mid or upper-level supervision must make documented unannounced rounds to identify and deter staff sexual misconduct and sexual abuse. All staff are (sic) prohibited from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational function of the facility." The interview with the staff person who acts in the capacity of Intermediate or Higher-Level Staff revealed they maintain a log of unannounced rounds. This auditor requested the logs for the past six months, which was provided by the facility. The log reflected that unannounced rounds on varying dates and shifts were recorded. However, the unannounced rounds log does not specify the time the unannounced rounds were conducted. Therefore, patterns in the time of unannounced rounds

could not be ascertained. It is noted that due to the size of the facility and staff, it is common for the Intermediate or Higher-Level Staff to walk through all parts of the facility throughout the workday, which helps to deter staff sexual misconduct.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.313(a) - GLRC needs to create and implement a PREA-compliant staffing plan, which considers the 11 factors outlined in this standard. In addition, the staffing plan must include discussion on the facility's video monitoring system, any gaps in video coverage and how those gaps are covered by staff supervision. The staffing plan must include the number of staff needed at the required posts and a description of the duties performed by those staff positions. The facility must consider the specific characteristics of the population it serves, such as gender, age, prior victimization or sexual abusiveness when drafting the staffing plan. The facility will need to modify its practice of having both residents present in a resident room behind closed doors while showering, toileting and changing of clothing is taking place. This may require one resident to remain in the common area of the unit under staff supervision while one resident showers, toilets or changes clothing, which may create a change to the current staffing pattern. This auditor has provided the PREA Resource Center publication, "Developing and Implementing a PREA-Compliant Staffing Plan" to assist the facility administration in drafting a staffing plan that will meet PREA requirements.

115.313(b) - The facility will need to create a mechanism to record deviations from the staffing plan, regardless of whether the facility experiences deviations. This can be accomplished in conjunction with the daily staff schedule or on a separate document, such as a spreadsheet.

115.313(d) - Once the PREA-compliant staffing plan is developed, the facility will need to review the staffing plan on at least an annual basis. This review must include participation from multiple sources, including the agency PREA Coordinator and PREA Compliance Manager, and must consider the 11 factors outlined in 115.313(a). This auditor has provided the PREA Resource Center publication, "Developing and Implementing a PREA-Compliant Staffing Plan" to assist the facility administration to draft a staffing plan that will meet PREA requirements.

115.313(e) - The facility needs to update its unannounced rounds log to record the specific time these rounds occur and ensure the rounds are conducted at varying times and days of the week.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 27, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard.

Prison Rape Elimination Act (PREA) Staffing Plan for GLRC - This auditor was provided the completed staffing plan for GLRC on February 27, 2020. The Staffing Plan includes a description of the facility characteristics, physical plant, medical and educational programming and the 11 factors required for consideration in a PREA-compliant staffing plan. The Staffing Plan lists the position descriptions and number of staff required to meet the facility's 6:1 waking and 20:2 sleeping resident-to-staff ratios, which exceed the PREA requirements. This Staffing Plan creates the foundation for annual staffing plan reviews.

	Staff Meeting Notes dated January 28, 2020 - These staff meeting notes reflect the procedural change to create a shower schedule and to have one resident remain outside of the room while the other resident showers/changes clothing. Resident Interviews - This auditor conducted telephonic interviews with three residents selected at random from the resident roster on April 15, 2020. The residents confirmed the practice of roommates leaving the resident rooms while one resident showers or changes clothes. Unannounced Rounds Log - This auditor was provided with the updated Unannounced Rounds Logs from November 19, 2019 through February 27, 2020. The Unannounced Rounds Log has been updated to include the time the rounds are being conducted. The recorded rounds were conducted on varying times and days of the week and include all shifts. Updated GLRC Staff Schedule - This auditor was provided the updated GLRC Staff Schedules for the months of January and February 2020, which includes a section to record staffing deviations for each work day. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Random Staff *Random Residents **Documents Reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC Policy No. GLO 251.0, Search *PREA Resource Center “Guidance in Cross-Gender and Transgender Pat Searches” Training Video and completed training certificates *Video Surveillance Review 115.315(a) - The GLRC Policy No. GLO 251.0, Page 3, Section D prohibits body cavity, cross-gender observed or cross-gender pat down searches. According to the GLRC PREA Compliance Manager, an observed search is synonymous with a strip search. In interviews with random staff and random residents it was reported that neither cross-gender body cavity nor strip searches take place at GLRC. An interview with Non-Medical Staff who conduct cross-gender strip or visual searches was not conducted as it was established through staff and resident interviews that those searches were not occurring at the facility. 115.315(b) - The GLRC Policy No. GLO 251.0, Page 3, Section D prohibits cross-gender observed or pat-down searches. The policy states that in the event of an urgent unforeseen circumstance when staff of the same gender is not available, the resident will stay with a staff member in a private area until staff of the same gender is available. Page 4, Section b of the same policy provides that pat-down searches are to be conducted by staff of the same gender as the resident, and that two staff members of the same gender must be present during a pat-down search. In interviews with random staff and random residents it was reported that cross-gender pat searches or observed strip searches do not take place at GLRC. 115.315(c) - According to the Pre-Audit Questionnaire, the facility would document any cross-gender strip or body cavity searches. However, the GLRC Policy No. GLO 251.0 prohibits such searches. As such, there was no cross-gender strip or body cavity documentation available for review. 115.315(d) - The GLRC Policy No. GLO 149.0, Page 9, Section 4 provides that non-medical staff of the opposite gender may not observe youth changing clothing, showering or performing other bodily functions where buttocks or genitalia of youth are exposed except in exigent circumstances or when such viewing is incidental to routine room checks. Page 9, Section 5 of the same policy provides that staff of the opposite gender must announce their presence when entering resident sleeping and bathroom areas. In interviews with random staff and random residents it was reported that staff of the opposite gender knock on closed bedroom doors before entering resident sleeping/bathroom areas. All but one of the residents interviewed indicated staff of the opposite gender wait for a response from residents before

	entering their rooms, and that resident indicated staff “usually” knocks and waits for a response before entering. A review of the video surveillance system revealed there is no video coverage inside resident sleeping or bathroom areas. 115.315(e) - The GLRC Policy No. GLO 149.0, Page 7, Section 6 provides that staff must not search or physically examine a transgender or intersex resident for sole purpose of determining a youth's genital status. Interviews with random staff members confirmed they would not search or physically examine a transgender or intersex resident to determine genital status. As there were no transgender or intersex residents present at GLRC at the time of the on-site audit, that interview protocol was not completed. 115.315(f) - The GLRC Policy No. GLO 149.0, Page 8, Section 5 provides that searches of transgender and intersex residents must be conducted in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. In interviews with random staff members, they indicated they have been provided training on appropriate search techniques for transgender and intersex residents. The facility provided the PREA Resource Center “Guidance in Cross-Gender and Transgender Pat Searches” Training Video as their curriculum for staff training for transgendered or intersex resident searches.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Random Staff **Documents reviewed:** *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *MDHHS Policy SRM 400 - Reasonable Accommodations *MDHHS Policy SRM 401 - Effective Communication for Persons Who Are Deaf, Blind or Hard of Hearing *MDHHS Policy SRM 402 - Limited English Proficiency and Bilingual Interpreter Services 115.316(a) - The GLRC Policy No. GLO 149.0, Page 4, Section 2 states, "The information must be provided verbally and in written form, and the information must be in a language and format that the youth can understand. Translation and/or other interpretive services must also be provided as needed so that all youth may benefit from all aspect of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment." Page 4, Section 3 of the same policy indicates GLRC has adopted the MDHHS Policy SRM 400 - Reasonable Accommodations and MDHHS Policy SRM 401 - Effective Communication for Persons Who Are Deaf, Blind or Hard of Hearing. The MDHHS Policy SRM 400 requires the review of "MDHHS Non-Discrimination in Service Delivery", which details the requirements for the Americans With Disabilities Act requirements for compliance and how to request services for protected persons through the MDHHS. As there were no disabled residents at the facility at the time of the on-site audit, interviews with residents with disabilities were not conducted. It is noted this adoption of MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit. 115.316(b) - The GLRC Policy No. GLO 149.0, Page 4, Section 2 as stated above addresses this provision. Page 4, Section 3 of the same policy indicates GLRC has adopted the MDHHS Policy SRM 402 - Limited English Proficiency and Bilingual Interpreter Services to satisfy this standard. The MDHHS Policy SRM 402, Pages 5 and 6 provides instructions for direct Human Services contractors to contact language interpretation services and how to bill MDHHS for the cost of the services. As there were no limited English proficiency residents at the facility at the time of the on-site audit, interviews with residents with limited English proficiency were not conducted. It is noted this adoption of MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit. 115.316(c) - The GLRC Policy No. GLO 149.0, Page 4, Section 5 states, "Resident readers or interpreters may not be used to provide this (PREA resident education) information, except when not allowing this would cause an unnecessary delay that could compromise the youths' safety. Interviews with random staff revealed they would not allow another resident to interpret PREA information unless it was an emergency. As there were no limited English proficiency

residents at the facility at the time of the on-site audit, interviews with residents with limited English proficiency were not conducted.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.316(a) - The GLRC's adoption of the MDHHS policies referenced above to address providing equal opportunity for disabled residents to fully benefit from the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment is sufficient to satisfy this standard. The MDHHS policies provide information and instruction on how to access services for disabled residents, services that are extended to this facility as an MDHHS contractor. However, the adoption language appears to have been recently added to address this audit's requirements. For the adoption of MDHHS policies, GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and the adopted MDHHS policies added to address compliance with this standard. Staff must be able to demonstrate an understanding of how to access these services through the MDHHS to assist disabled residents in understanding all aspects of PREA.

115.316(b) - The GLRC's adoption of the MDHHS policies referenced above to address providing equal opportunity for limited English proficient residents to fully benefit from the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment is sufficient to satisfy this standard. The MDHHS policies provide information and instruction on how to access services for limited English proficient residents, services that are extended to this facility as an MDHHS contractor. However, the adoption language appears to have been recently added to address this audit's requirements. For the adoption of MDHHS policies, GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and the adopted MDHHS policies added to address compliance with this standard. Staff must be able to demonstrate an understanding of how to access these services through the MDHHS to assist limited English proficient residents in understanding all aspects of PREA.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 10 and April 15, 2020 to substantiate corrective actions taken for this standard.

Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact.

Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, as

	well as the adopted MDHHS policies referenced in the updated policy and how to access services for limited English proficient and disabled residents. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Administrative Staff *Random employee files **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *MDHHS Policy JR1 100, Screening and Ongoing Checks for Staff *GLRC Policy No. PP0231.0, New Hire Protocol 115.317(a) - The facility provided a section of GLRC Policy No. GLO 149.0, Page 2, which includes the language specified in this provision. However, in reviewing the four different versions of this policy obtained or provided by the facility, it was located on Page 1, under the Purpose section. It is noted this language appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit. 115.317(b) - The facility answered that GLRC considers prior incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents in the Pre-Audit Questionnaire. This was confirmed through interviews with Administrative staff. 115.317(c) - The facility provided a section of GLRC Policy No. GLO 149.0, Page 2, which includes the language specified in this provision. However, in reviewing the four different versions of this policy obtained or provided by the facility, this language is found on Pages 18-19, Section (J)(5). In that section it states, "MDHHS Policy JR1 100-Screening and Ongoing Checks for Staff has been adopted by the facility which states that "the facility designee must conduct background checks at least every five years for current employees and contractors who have contact with youth." The MDHHS Policy JR1 100, Page 6 and 7 requires criminal background checks, child abuse registry checks and verification of prior institutional employment. Sex Offender Registry checks are also required by the MDHHS policy. Interviews with Administrative staff confirmed that criminal background, child abuse registry and sex offender registry checks are conducted before hiring potential staff who would have contact with residents, as well as verification of prior institution employment. This auditor reviewed random employee files and found the majority of these checks completed and documented. However, it is noted one of the employee files reviewed was for an out of state resident, and there was no documentation that a child abuse registry check was done in the employee's former home state. In addition, one employee file reflected prior institutional employment had been verified, but there was no documentation to support the verification. It is noted this adoption of MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit.

115.317(d) - Interviews with Administrative staff confirmed that criminal background, child abuse registry and sex offender registry checks are conducted before securing the services of any contractor who would have contact with residents.

115.317(e) - The GLRC Policy No. GLO 149.0, Page 19, Section 6 states, "MDHHS Policy JR1 100-Screening and Ongoing Checks for Staff has been adopted by the facility which states that "the facility designee must conduct background checks at least every five years for current employees and contractors who have contact with youth." The MDHHS Policy JR1 100, Page 10, Criminal History Background Checks states, "Pursuant to the Prison Rape Elimination Act Standards for Juvenile Facilities, 28 CFR 115.317(e), the facility designee must conduct background checks every five years for current employees and contractors who have contact with youth." It is noted this adoption of MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit.

115.317(f) - Interviews with Administrative staff confirmed that applicants for employment are asked the questions about previous misconduct outlined in 115.317(a) on the employment application and that staff have an ongoing affirmative duty to report any such misconduct. In reviews of random employee files this auditor viewed the questions required under 115.317(a) on the employee's application for employment, as well as the same questions solicited annually during facility PREA refresher trainings.

115.317(g) - The GLRC Policy No. PP0231.0, Page 1, Purpose states, "In the event of problematic findings, GLRC, under the established False Information Policy, may terminate the hiring process or terminate the employee if it is found or discovered that false information was provided regarding criminal or other background."

115.317(h) - Interviews with Administrative Staff revealed they would provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from another institutional employer, unless it was prohibited by law.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.317(a) - The GLRC Policy No. GLO 149.0 contains the language required to comply with this provision; however, the adoption language appears to have been recently added to address this audit's requirements. For the adoption of MDHHS policies, GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and staff must be trained on the new policy language added to address compliance with this standard.

115.317(c) - The GLRC Policy No. GLO 149.0 contains the language required to comply with this provision; however, the adoption language appears to have been recently added to address this audit's requirements. For the adoption of MDHHS policies, GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and staff must be trained on the new policy language added to address compliance with this standard.

	115.317(e) - The GLRC Policy No. GLO 149.0 contains the language required to comply with this provision; however, the adoption language appears to have been recently added to address this audit's requirements. For the adoption of MDHHS policies, GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and staff must be trained on the new policy language added to address compliance with this standard. It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires. **VERIFICATION OF CORRECTIVE ACTION:** This auditor was provided appropriate supplemental documentation on April 10, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard. Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact. Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, as well as the adopted MDHHS policies referenced in the updated policy. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Superintendent or Designee **Documents reviewed:** *Pre-Audit Questionnaire 115.318(a) - Although the Pre-Audit Questionnaire indicates the agency or facility has acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012, or since the last PREA audit, it appears that is not the case. In interviews with the Agency Head, they advised they look at eliminating corners, blind spots and other supervision barriers when acquiring new facilities or expanding existing facilities. They also indicated they are relatively new to the position, and this will be first time they are in a position to make decisions about sexual abuse protection when considering additions or modifications to their facilities. In interviews with the staff acting as Superintendent, they advised the facility relocated to its current location in 2014 and they are not aware of what was previously taken into consideration, as they were not in their current position at that time. 115.318(b) - This auditor was provided a schematic of the facility and the placement of cameras in the video monitoring system and was able to review all camera views in the facility. In interviews with the Agency Head, they advised the process is as supervisors go through their programs, they identify deficiencies and make requests to IT to update the video monitoring systems. In interviews with the staff acting as Superintendent, video monitoring was updated as a root cause response to a 2017 staff sexual misconduct investigation. They also advised supervisors did not have camera access at that time. but supervisor access was granted as a result of the incident.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Medical/Mental Health Staff *SAFE/SANE Staff *PREA Compliance Manager *Random Staff *Resident Who Reported Sexual Abuse **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *Michigan Model Policy: The Law Enforcement Response to Sexual Assault *Memorandum of Understanding Between GLRC and the Negaunee City Police Department *Referral and Qualified Service Organization Agreement Between GLRC and the Women's Center 115.321(a) - The GLRC Policy No. GLO 149.0, Page 14, Section H states, "All allegations of sexual abuse or sexual harassment will be referred for investigation to the police unless the allegation does not involve potentially criminal behavior." The Pre-Audit Questionnaire indicates the Negaunee City Police Department (NCPD) is responsible for any criminal investigations and they would refer those incidents to them. Contact was made with the Detective for the NCPD. They advised they would be contacted to respond to GLRC if there was an incident of sexual assault or sexual misconduct. The facility submitted the "Michigan Model Policy: The Law Enforcement Response to Sexual Assault" document as evidence of a uniform evidence protocol in sexual assault investigations. The NCPD Detective was familiar with the document and indicated they follow a uniform protocol for evidence collection in sexual assault cases. In interviews with random staff, they were aware that the facility conducts administrative sexual abuse and sexual harassment investigations, and local law enforcement and Child Protective Services conduct any criminal investigations for sexual abuse. 115.321(b) - The Michigan Model Policy: The Law Enforcement Response to Sexual Assault document is specified for adults and young adults. This auditor is satisfied the protocol is age appropriate for the residents at GLRC. The protocol is victim centered, taking into consideration various victim responses to trauma, the preservation of physical evidence, SAFE/SANE exams and the need for victim supportive services. The 79-page protocol is comprehensive and appears to be modeled after the "National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents" publication or similar publications. 115.321(c) - The facility does not employ medical staff for SAFE/SANE exams. A review of the Pre-Audit Questionnaire reveals the facility would transport a resident to the UP Health Systems Marquette Hospital for a SAFE/SANE exam. Contact with the Emergency Room Nurse Supervisor revealed they are equipped to conduct SAFE/SANE exams. They indicated none of their nurses are certified but have been trained on the evidence collection process.

The facility provided documentation indicating they have communicated with the UP Health Systems Marquette Hospital to confirm those services are available.

115.321(d) - The Referral and Qualified Service Organization Agreement Between GLRC and the Women's Center, #4 states, "Implement of the Prison Rape Elimination Act (PREA) specifically PREA Standard 115.353(a) which requires that juvenile justice residential facility residents be provided access to outside victim advocates for emotional support services related to sexual abuse." In interviews with the staff acting as PREA Compliance Manager, they advised they have a close working relationship with the Women's Center. The Women's Center provides weekly groups at the facility and their staff is very familiar to the residents. As a result, they make themselves available to GLRC residents. The PREA Compliance Manager also advised that facility mental health staff would be available to a resident should the Women's Center staff not be able to respond. In interviews with the resident who reported sexual abuse, they indicated they were allowed to call their parent(s), but they did not consider what happened enough of an issue to talk to a counselor.

115.321(e) - In interviews with the staff acting as PREA Compliance Manager, they advised the Women's Center staff is available if they are needed to accompany a resident for a SAFE/SANE exam, investigatory interviews, and/or to provide emotional support, crisis intervention, information and referrals. They also advised facility mental health staff is available to provide the same services at the request of the resident. In interviews with the resident who reported sexual abuse, they advised they did not feel the need to contact anyone, but they were allowed to call their parent(s).

115.321(f) - As previously indicated, GLRC is responsible for completing administrative investigations, while the NCPD is responsible for completing criminal investigations. The aforementioned Memorandum of Understanding Between GLRC and the NCPD does not specify the expectation that NCPD follow all the provisions of 115.321 (a) through (e). However, the Michigan Model Policy: The Law Enforcement Response to Sexual Assault, which NCPD confirmed they follow, provides for compliance with 115.321 (a) through (e).

115.321(h) - The facility provided certificates of completion for the Department of Justice "PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting" for all of its clinicians. As indicated in 115.321(c), the Emergency Room Nurse Supervisor advised they are trained in SAFE/SANE exam procedures.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Investigative Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC PREA Coordinated Response Plan *Memorandum of Understanding Between GLRC and the Negaunee City Police Department *GLRC Website 115.322(a) - The GLRC Policy No. GLO 149.0, Page 14, Section H states, "Each incident of alleged or reported sexual harassment, sexual abuse or sexual assault/rape must be investigated to the fullest extent possible." In interviews with the Agency Head, they advised all employees are mandated reporters and all staff is required to review agency and facility policies regarding what is required for sexual abuse or sexual harassment reports. They advised staff is required to generate an Incident Report in the event of a report of sexual abuse or sexual harassment, which is disseminated to staff on a need to know basis. The Agency Head advised a four-person team also reviews the investigative process and that there are multiple layers of accountability if staff doesn't forward the required information. It is noted a resident disclosed to this auditor they reported an incident of sexual abuse to staff, but there was no documentation or response from staff to their knowledge. 115.322(b) - In interviews with the staff acting as Investigative Staff, they confirmed all reports of sexual abuse or sexual harassment are investigated. They indicated the facility would be in charge of any administrative investigation and any criminal investigation would be referred to the NCPD. Contact was made with the Detective at the NCPD and they confirmed they would be called to GLRC to conduct any criminal investigations. This auditor confirmed the GLRC Policy No. GLO 149.0 is posted to the facility website. 115.322(c) - The Memorandum of Understanding Between GLRC and the NCPD outlines the responsibilities of each party in the event of a sexual abuse incident at GLRC. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:** 115.322(a) - As indicated in the analysis for this provision, it appears an incident of sexual abuse was reported to staff by a resident, but there was no investigation initiated. Had there been, the facility would have been required to report it as part of this audit process, but the facility reported no incidents of sexual abuse or sexual harassment over the past 12 months. To be compliant with this provision GLRC will need to retrain staff on the procedures to respond to an incident of sexual abuse or sexual harassment, regardless of whether staff believes the incident constitutes sexual abuse or sexual harassment. Staff will also need to acknowledge understanding of the information provided in the training. Residents will also

need to be educated that they must receive a response from facility staff regarding the status of any reported incidents of sexual abuse or sexual harassment. Residents will need to acknowledge understanding of the information provided in the educational session.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 27 and April 10, 2020 to substantiate corrective actions taken for this standard.

Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact. The updated policy includes the requirement for all staff to report any incidents of sexual abuse or sexual harassment, as well as the protocol and process for reporting such incidents to facility administration and outside agencies, as appropriate.

Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, which included how to respond to an incident of sexual abuse or sexual harassment.

Resident Acknowledgments - This auditor received acknowledgments signed by 11 residents that indicate they are aware they should receive a response from facility staff on the status of any report of sexual abuse or sexual harassment.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Random Staff **Documents reviewed:** *Pre-Audit Questionnaire *Random Employee Files 115.331(a) - In interviews with random staff, they indicated they received training in the agency's zero-tolerance policy on sexual abuse and sexual harassment, how to fulfill staff responsibilities regarding sexual abuse and sexual harassment prevention, detection, reporting, and response, in accordance with agency policies and procedures, the residents' right to be free from sexual abuse and sexual harassment, residents' and employees' right to be free from retaliation for reporting sexual abuse and sexual harassment, the dynamics of sexual abuse and sexual harassment in confinement, the common reactions of sexual abuse and sexual harassment victims, how to detect and respond to signs of threatened and actual sexual abuse, how to avoid inappropriate relationships with residents, how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex or gender nonconforming residents, how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities and relevant laws regarding the applicable age of consent. A review of random employee files revealed documentation of PREA training in all reviewed files. 115.331(b) - The GLRC is a co-ed facility. As a result, facility PREA training is not gender-specific. 115.331(c) - A review of random employee files revealed documentation of annual PREA refresher trainings in all reviewed files. 115.331(d) - A review of random employee files revealed an acknowledgment of understanding accompanied the PREA training documentation.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Contractor/Intern/Volunteer **Documents reviewed:** *Pre-Audit Questionnaire *Contractor/Intern/Volunteer PREA training documentation 115.332 (a) - This auditor reviewed PREA training records for the facility teacher, intern and psychologist. However, the contracted medical doctor has not completed PREA training through GLRC. During the Contractor interview with the medical doctor, she advised she has received training in forensic medical exams and how to appropriately interact with juvenile victims of sexual abuse through her professional medical training. 115.332 (b) - In interviews with facility Contractors/Interns/Volunteers, they advised they completed PREA training. They were able to articulate the facility's zero tolerance policy toward sexual abuse and sexual harassment. A review of random PREA training records for Contractors/Interns/Volunteers reflected the signed acknowledgments regarding the facility's zero tolerance policy toward sexual abuse and sexual harassment. 115.332 (c) - This auditor reviewed random PREA training records and found the PREA training and policy acknowledgments signed for the facility's contracted teacher, psychologist and intern. As previously indicated, the contracted medical doctor has not completed PREA training. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:** 115.332(a) - The facility must insure that all of its Contractors/Interns/Volunteers have completed PREA training and have signed an acknowledgment of understanding of the training and the facility's zero tolerance policy toward sexual abuse and sexual harassment. At this time it appears the facility's contracted medical doctor is the only contractor lacking PREA training. The contracted medical doctor will need to complete PREA training to achieve compliance with this standard. **VERIFICATION OF CORRECTIVE ACTION:** This auditor was provided appropriate supplemental documentation on February 27, 2020 to substantiate compliance with this standard. Certificate of Completion, Department of Justice PREA 201 For Medical and Mental Health Professionals - The facility's contracted doctor completed the required PREA training on February 10, 2020. Based on the above-noted additional evidence, the faiclity has demonstrated compliance with

	this standard.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Intake Staff *PREA Compliance Manager *Random Residents **Documents reviewed:** *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *Pre-Audit Questionnaire *Preventing Sexual Abuse Youth Orientation Packets *Random resident files *State of Idaho Juvenile Corrections PREA video *MDHHS Policy SRM 400 - Reasonable Accommodations *MDHHS Policy SRM 401 - Effective Communication for Persons Who Are Deaf, Blind or Hard of Hearing *MDHHS Policy SRM 402 - Limited English Proficiency and Bilingual Interpreter Services *Site Review 115.333(a) - The GLRC Policy No. GLO 149.0, Pages 4-5, Section A states, "The facility youth orientation process includes policy and procedures relating to prevention of and response to reports of sexual assault/rape and harassment. This orientation must occur within the first 72 hours of youth intake." A review of the Preventing Sexual Abuse Youth Orientation Packet reveals residents are provided with information regarding the agency's zero-tolerance policy, how to report sexual abuse or sexual harassment, definitions of prohibited behaviors, how residents can keep themselves safe and services for victims of sexual abuse. In interviews with Intake staff, they confirmed they provide residents with the aforementioned information within 72 hours of their intake. Interviews with random residents revealed they were provided PREA information at the time of their intake. 115.333(b) - This auditor reviewed files of residents discharged within the past 12 months as part of the resident file reviews. The reviewed files contained documentation that all but one of the current residents had been provided comprehensive PREA training. However, documentation was missing for comprehensive PREA training for one current resident and two discharged residents. According to Intake staff, the facility was providing the comprehensive PREA training at the time the discharged residents were in the facility. In interviews with random residents, they all indicated they received comprehensive PREA training by watching the PREA video shortly after or as part of their intake. 115.333(c) - In interviews with the staff acting as PREA Compliance Manager, they advised the facility considers all residents, regardless of whether they are coming from another facility, as new residents to the program and would conduct an intake in the same fashion in both circumstances. According to Intake staff, they go over the entire intake binder that includes the zero tolerance policy and the Preventing Sexual Abuse Youth Orientation Packet. This auditor

has been provided with comprehensive PREA training verification for the one current resident missing comprehensive PREA training in their resident file.

115.333(d) - The GLRC Policy No. GLO 149.0, Page 5, Section 2 states, "The information must be provided verbally and in written form, and the information must be in a language and format that the youth can understand. Translation and/or other interpretive services must also be provided as needed so that all youth may benefit from all aspects of the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. Accommodations must be provided so that LEP, deaf, blind or otherwise disabled residents have full access to this information." Page 4, Section 3 of the same policy indicates GLRC has adopted the MDHHS Policy SRM 400 - Reasonable Accommodations and MDHHS Policy SRM 401 - Effective Communication for Persons Who Are Deaf, Blind or Hard of Hearing. The MDHHS Policy SRM 400 requires the review of "MDHHS Non-Discrimination in Service Delivery", which details the Americans With Disabilities Act requirements for compliance and how to request services for protected persons through the MDHHS. The facility provided the "Preventing Sexual Abuse Youth Orientation" Packets in Spanish and Arabic to aid residents with limited English proficiency. However, the facility did not provide any PREA educational materials in alternate formats for deaf, blind or low vision or residents with reading limitations or other disabilities to utilize. As there were no disabled residents at the facility at the time of the on-site audit, interviews with residents with disabilities were not conducted. It is noted this adoption of MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit.

115.333(e) - This auditor reviewed files of residents discharged within the past 12 months as part of the file reviews. The reviewed files contained documentation that all but one of the current residents had been provided comprehensive PREA training.

115.333(f) - This auditor observed PREA posters throughout the GLRC facility, including both housing units, the group room and the front lobby, during the site review.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.333(d) - The GLRC Policy No. GLO 149.0 indicates that residents who are limited English proficient, deaf, blind or have low vision, have reading disabilities or are otherwise disabled have access to resident education in formats they can understand. The policy also adopts MDHHS Policies SRM 400 and 401, which provides the process for GLRC to access these services through the State of Michigan to educate residents. However, the adoption language appears to have been recently added to address this audit's requirements. For the adoption of MDHHS policies, GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and how staff can access services for the resident populations named above through the MDHHS.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed

	for conciseness and clarity to aid the reader to clearly understand what the policy requires. **VERIFICATION OF CORRECTIVE ACTION:** This auditor was provided appropriate supplemental documentation on April 10 and April 15, 2020 to substantiate corrective actions taken for this standard. Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact. Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, as well as the adopted MDHHS policies referenced in the updated policy, and how to access services for residents who are imited English proficient, deaf, blind or have low vision, have reading disabilities or are otherwise disabled. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Investigative Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *Investigative staff Certificate of Completion 115.334(a) - The GLRC Policy No. GLO 149.0, Page 8, Section 7 states, "All full and part time staff who conduct PREA investigation (sic) must receive training in conducting such investigations in confinement settings. Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and criteria and evidence required to substantiate a case for administrative action or prosecution referral. Training will be documented in personnel records." In interviews with the staff acting as Investigative staff, they advised they completed the Department of Justice "PREA: Investigating Sexual Abuse in a Confinement Setting" training and the certificate of completion was included in the Pre-Audit Questionnaire. 115.334(b) - In interviews with the staff acting as Investigative staff, they confirmed the training included techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and criteria and evidence required to substantiate a case for administrative action or prosecution referral. 115.334(c) - The GLRC Policy No. GLO 149.0, Page 8, Section 7 states, "All full and part time staff who conduct PREA investigation (sic) must receive training in conducting such investigations in confinement settings. Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and criteria and evidence required to substantiate a case for administrative action or prosecution referral. Training will be documented in personnel records." In interviews with the staff acting as Investigative staff, they advised they completed the Department of Justice "PREA: Investigating Sexual Abuse in a Confinement Setting" training and the certificate of completion was included in the Pre-Audit Questionnaire.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Medical/Mental Health Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *Medical/Mental Health Staff Training Certificates 115.335(a) - The GLRC Policy No. GLO 149.0, Page 8, Section 6 states, "All full and part time medical and mental health care practitioners who work regularly with residents must receive specialized training on: Detecting signs of sexual abuse, preserving physical evidence, effective response, and reporting. Training will be documented in personnel records." Interviews with medical/mental health staff revealed they have been trained on how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment and how and whom to report allegations or suspicions of sexual abuse and sexual harassment. Although GLRC indicated 100 percent of their medical and mental health practitioners have been trained in the four above-noted factors, the contracted medical doctor has not been trained through GLRC, and documentation of training from another source was not provided. 115.335(b) - The facility reported agency medical staff does not perform forensic medical examinations. 115.335(c) - This auditor was provided copies of the National Institute of Corrections Certificates of Completion for the "PREA: Behavioral Health Care for Sexual Assault Victims in an Confinement Setting" training. As previously indicated, the facility's contracted medical doctor has not completed PREA training through the facility. 115.335(d) - As previously indicated, the facility's contracted medical doctor has not completed PREA training through the facility. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:** 115.335(a) - The facility's contracted medical doctor will need to either complete the PREA training GLRC provides to its medical/mental health staff or provide proof of training in the detection of signs of sexual abuse, preserving physical evidence, effective response to reports of sexual abuse, and reporting responsibilities from another source, such as medical continuing education units (CEU's). 115.335(d) - The facility's contracted medical doctor will need to either complete the PREA training GLRC provides to its medical/mental health staff or provide proof of training in the detection of signs of sexual abuse, preserving physical evidence, effective response to reports

	of sexual abuse, and reporting responsibilities from another source, such as medical continuing education units (CEU's). **VERIFICATION OF CORRECTIVE ACTION:** This auditor was provided appropriate supplemental documentation on February 27, 2020 to substantiate corrective actions taken for this standard. PREA 201 for Medical and Mental Health Practitioners Certificate of Completion - This Certificate of Completion was issued for the facility contracted medical doctor. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *PREA Coordinator *Staff Responsible for Risk Screening *Random Residents **Documents reviewed**: *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *Michigan Department of Health and Human Services PREA Screening Tool *Random Resident Files *Site Review 115.341(a) - The GLRC Policy No. GLO 149.0, Page 5, Section B provides that a resident's behavior history must be reviewed using an objective screening tool within 72 hours of arrival at the facility, as part of orientation to determine the resident's potential risk of sexual vulnerability and sexual abusiveness. The policy does not provide for the periodic reassessment of resident risk levels. A review of random resident files found the risk screening tool, which reflected completion within 72 hours of admission, in eight of the nine files reviewed. Interviews with staff responsible for risk screening indicated they conduct the risk screening assessment within 72 hours of the resident's admission to the facility. In terms of reassessment, they advised they had never used the tool for reassessment, but indicated the therapists working with the residents on an individual basis reassess risk every 30 days. In interviews with the staff member who acts as the PREA Coordinator, they advised changes in residents' risk for victimization and sexual abusiveness are reviewed on a weekly basis in staff meetings. 115.341(b) - The GLRC Policy No. GLO 149.0, Page 5, Section B requires a resident's behavior history be reviewed using an objective screening tool within 72 hours of arrival at the facility as part of orientation to determine the resident's potential risk of sexual vulnerability or sexual abusiveness. This policy requires the assessment based on ten factors: age, physical stature, developmental disability, mental illness, sex offender status (per offense history), first-time offender status, past history of victimization, physical disabilities and the resident's own perception of vulnerabilities, any perception of gender non-conforming and /or LGBTI status and any other specific information. Although the factors contained in the aforementioned policy do not include emotional and cognitive development, this factor is discussed below. 115.341(c) - The facility uses the Michigan Department of Health and Human Services PREA Screening Tool to assess residents placed in their program. This screening tool consists of questions for the resident that include: assigned sex at birth, preferred pronoun, gender identification, gender expression, sexual orientation, attraction, special education status and the nature of the special education classification, current offense and offense history, sex offender history, sexual victimization and concerns for possible victimization in the facility. The

	screening tool also captures staff observations and records review, which considers the current offense and offense history, staff impressions of the resident's physical size and stature, gender nonconforming appearance, mannerisms or identification, resident's emotional and cognitive development, mental illness or mental disabilities, and physical disabilities. The screening tool requires staff to articulate these factors and how those factors could impact the resident's risk of victimization or the resident's risk to victimize other residents. The screening tool requires documentation for special housing needs, education and treatment services as a result of the findings of the screening tool. According to staff responsible for intake screening, they ask residents about past sexual abuse history as a victim or perpetrator, the resident's age at time of abuse, triggers and any disabilities. Intake screening staff also reported they observe the resident's behavior and demeanor at the time of intake and utilize other available records, either provided by the referring source or facility prior records, to augment decisions made based on the risk screening tool. 115.341(d) - The interview with staff responsible for intake screenings advised they go over the risk screening tool with the resident and solicit their answers to the questions, as well as reviewing records provided by the placement source (i.e., Probation, court) and consulting parents/legal guardians and Probation Officers. 115.341(e) - In interviews with the staff person who is both the PREA Coordinator and PREA Compliance Manager, they advised all staff members, with the exception of kitchen and maintenance staff, have access to resident risk screening tools. They advised the risk screening tool is kept in the resident's binder, which is locked in the staff office on the housing unit. They also advised all staff members working with the residents have a need to access the risk screening tool, as they all participate in the residents' ongoing treatment needs. The facility has only two units, one for males and one for females. As a result, housing decisions are limited. However, according to the staff person who is acting as the PREA Compliance Manager, all staff who work directly with residents meet weekly to discuss each resident and address any changes in risk factors, including PREA-related concerns. This auditor checked the filing cabinets in the staff offices in both the boys' and girls' units and found them both locked.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent *PREA Coordinator *PREA Compliance Manager *Staff Responsible for Risk Screening *Medical/Mental Health Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *MDHHS PREA Screening Tool *MDHHS Policy JR 6 630, Isolation and/or Confinement *Random Resident files *Site Review 115.342(a) - The GLRC Policy No. GLO 149.0, Page 5, Section B3 states, "The agency must use all information obtained to make housing, bed, program, education and work assignments for residents with the goal of keeping residents safe and free from sexual abuse and that the agency must document how the assessment information was used to inform placement and assignments." In interviews with staff responsible for risk screening they advised they go over the risk screening information in weekly staff meetings and review all placements for risk of sexual victimization or abusiveness. They stated they would give a resident their own room if the risk assessment tool and review of all other information sources demonstrated that necessity. According to the staff acting as PREA Compliance Manager, PREA is a standing agenda item at weekly staff meetings and all staff involved in direct care of residents discuss any issues with residents that are related to PREA and safety concerns. This auditor reviewed nine risk screening tools from random resident files and found all but one file contained the completed tool with notations on housing assignments and any special concerns as a result of information gathered during risk screening. 115.342(b) - The GLRC Policy No. GLO 149.0, Page 6, Section 5 states, "A youth may be isolated from other youth as a preventive and protective measure, but only as a last resort when other less restrictive measures are inadequate to keep the youth safe from other youth, and then only until an alternate means of keeping all youth safe can be arranged." The policy also provides that residents must not be denied access to daily large-muscle exercise and legally required educational programming or special education services. The same policy also adopts the MDHHS Policy JR 6 630, Isolation and/or Confinement. This policy provides that confinement may only be used at the direction of a medical professional or the facility/center director or designee for medical purposes or upon the request of a youth with approval of a supervisor for a period of 30 minutes or less. This policy also provides that isolation may only be used for the purposes listed under confinement or when the youth's behavior is out of control, to protect the safety of the youth, other youth, staff and/or visitors, or for a total of 72

consecutive hours including any period of confinement if the isolation is due to the youth's culpability for a major offense. It is noted this adoption of MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit. The interview with the staff member acting as Superintendent revealed GLRC does not practice isolation other than on a strictly short-term basis and not as a specific housing designation. The facility had no residents in isolation at the time of the on-site audit, therefore, the interviews with a Resident in Isolation and Staff Supervising Residents in Isolation were not conducted. Case file reviews of residents in isolation were not conducted, as the facility reported no residents in isolation over the preceding 12 months on the Pre-Audit Questionnaire.

115.342(c) - The GLRC Policy No. GLO 149.0, Page 6, Section 4 states. "Lesbian, gay, bisexual, transgender or intersex (LGBTI) residents may not be housed solely on the basis of such identification or status. In addition, the agency must: “a) Decide on a case by case basis whether to place a transgender or intersex youth in a facility for male or female residents. Placement decision are based on whether the placement would ensure the resident's health and safety and, and whether the placement would present management or security problems. The youth's own view of his gender identity should be considered when determining placement. b) Review placement and programming assignments at least twice each year to assess any threats to safety experienced by the resident c) Allow transgender and intersex youths the opportunity to shower separately from other residents. d) The student's own view of his/her gender identity should be considered when determining placement d) Youth must not be considered more likely to perpetrate sexual abuse solely because of LGTBI identity.” Interviews with the staff acting as PREA Coordinator and PREA Compliance Manager revealed PREA is a standing agenda item at weekly staff meetings to discuss any issues with residents that are PREA related, which would include housing issues for lesbian, gay, bisexual, transgendered and intersex residents. They also indicated the facility would go off of what the resident feels and may have to make some room changes to accommodate that resident. This auditor interviewed the one resident who identified as lesbian, gay, bisexual, transgendered or intersex and that resident advised they had never been placed in a housing area only for lesbian, gay, bisexual, transgendered or intersex residents.

115.342(d) - The GLRC Policy No. GLO 149.0, Page 6, Section 4a states the agency must, "Decide on a case-by-case basis whether to place a transgender or intersex youth in a facility for male or female residents. Placement decisions are based on whether the placement would ensure the resident's health and safety, and whether the placement would present management or security problems. The youth's own view of his gender identity should be considered when determining placement." In interviews with the staff person acting as the PREA Compliance Manager, they advised the facility takes the client’s views and places them according to the client's request, mostly for therapeutic reasons to make the resident feel comfortable and trusting. The interview with a Transgendered/Intersex resident was not conducted, as the facility had no transgendered or intersex residents in placement at the time of the on-site audit.

115.342(e) - The GLRC Policy No. GLO 149.0, Page 6, Section 4b states for lesbian, gay, bisexual, transgender or intersex residents the agency must, "Review placement and programming assignments at least twice each year to assess any threats to safety

experienced by the resident." In interviews with the staff member acting as PREA Compliance Manager, they advised the agency considers whether the resident's placement and programming would present management or security problems and modifies placement/programming as needed, with the caveat that the facility does not house residents for that length of time. The interview with a Transgendered/Intersex resident was not conducted, as the facility had no transgendered or intersex residents in placement at the time of the on-site audit.

115.342(f) - The GLRC Policy No. GLO 149.0, Page 6, Section 4a considers the youth's own view of his/her gender identity for placement purposes, but this policy does not address considering a transgendered or intersex resident's views of his/her own safety. In interviews with the staff member acting as PREA Compliance Manager, they advised transgender or intersex resident's own views with respect to his or her own safety are given serious consideration when making placement and programming assignments.

115.342(g) - The GLRC Policy No. GLO 149.0, Page 6, Section 4c states the agency must, "Allow transgender and intersex youths the opportunity to shower separately from other residents." In interviews with the staff member acting as PREA Compliance Manager, they advised they have not housed a transgendered or intersex resident, but they indicated all residents shower separately, and any issues would be reviewed on a weekly basis at staffings. They also stated staff has authority to make room changes or any other required accommodation if there are immediate issues. Interviews with staff responsible for risk screening confirmed that all residents shower separately. During the site review this auditor was able to view the resident showers, which were in each room occupied by two residents, much like a hotel room. The shower/sink/toilet has a door with a lock. This allows for privacy for each resident when showering and using the toilet.

115.342(h) - The facility reported no residents held in isolation over the past 12 months in the Pre-Audit Questionnaire, and no evidence was revealed to the contrary.

115.342(i) - As indicated in the analysis for 115.342(b), conclusive information has been proffered to support the facility contention they do not utilize isolation as a placement designation. As indicated by the staff member acting as PREA Compliance Manager, the facility reviews all PREA-related issues on a weekly basis with direct care and mental health staff, and a resident who was at risk for victimization who was placed in isolation would fall under that review. As the facility had no residents in isolation or staff designated to supervise residents in isolation at the time of the on-site audit, those interviews were not conducted.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.342(b) - The GLRC Policy No. GLO 149.0 contains language adequate for addressing the limitations on isolation required for this provision. However, the adoption language appears to have been recently added to address this audit's requirements. For the adoption of MDHHS policies, GLRC will need to update the date the MDHHS policy adoption language was added to the GLRC Policy No. GLO 149.0. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and the adopted MDHHS policies to address compliance with this standard.

	It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires. **VERIFICATION OF CORRECTIVE ACTION:** This auditor was provided appropriate supplemental documentation on April 10 and April 15, 2020 to substantiate corrective actions taken for this standard. Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact. Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, as well as the adopted MDHHS policies referenced in the updated policy, and the clarification of the facility use of isolation. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *PREA Compliance Manager *Random Staff *Random Residents **Documents reviewed:** *Pre-Audit Questionnaire *Centralized Intake (CI) Procedure for Immediate Notification to Juvenile Justice Residential Facilities in Compliance with the Prison Rape Elimination Act (PREA) *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *Site Review 115.351(a) - The *GLRC Policy No. GLO 149.0, Page 9-10, Section E states, "Youth must be supported and encouraged to report sexual assault/rape, attempted sexual assault/rape, and/or sexual harassment and be protected from retaliation. A youth that believes that they were the victim of a sexual assault/rape, attempted sexual assault/rape, and/or sexual harassment, or believes another youth was the victim of sexual assault/rape, attempted sexual assault/rape, and/or sexual harassment must report this information to a staff member. Youths may also write down their report and turn it in to staff, or use the facility grievance process to report. An option must exist for youths to report sexual abuse to someone outside of the facility. The outside reporting option for Facility is to place a call to Children's Protected Services (CPS), 1-855-444-3911. If a youth request to report outside of the facility, the following must occur: a) Contact the on-duty Supervisor or Manager to facilitate the call. The call is confidential. The Supervisor/Manager will not listen to the youth's reporting. b) The Supervisor/Manager will maintain line of sight supervision of the youth at all times. c) Following completion of the call, the Supervisor/Manager will notify the facility Director or designee in the Director's absence and report that a youth made a call to the hotline." The policy does not include reporting retaliation from other youth or staff or reporting staff neglect or violation of responsibilities that may have contributed to the incident. Interviews with random staff revealed the majority of staff could articulate the ways residents could report sexual abuse or sexual harassment. Random residents indicated they could tell staff, call the hotline or write a grievance to report sexual abuse, sexual harassment, retaliation or staff neglect of duties. 115.351(b) - The facility utilizes the Children's Protected Services Central Intake as a hotline for reports of sexual abuse or sexual harassment. The Centralized Intake (CI) Procedure for Immediate Notification to Juvenile Justice Residential Facilities in Compliance with the Prison Rape Elimination Act (PREA) provides instruction for Children's Protected Services Central Intake staff to follow in the event they receive a call from a juvenile justice facility reporting sexual abuse or sexual harassment. The instructions include a list of statewide facilities and the names and phone numbers at each facility to contact immediately following the report of sexual abuse or sexual harassment. The instructions indicate the substance of the report is to be disclosed to the facility but not the identity of the caller, as that information is strictly

confidential. The instructions do not address receiving a report of retaliation or staff neglect or violation of responsibilities. In the interview with the staff acting as PREA Compliance Manager, they advised residents can contact the CPS 800 number, their attorney, Probation Officer or doctor to make a report outside of the agency, and that Central Intake is supposed to contact them if they receive a report. Random residents indicated they could tell their parents or Probation Officer or call the hotline to make a report. This auditor contacted the Central Intake Hotline during the on-site audit and made a test report at 1530 hours. The Central Intake staff did not seem familiar with the process and this auditor had to walk them through the process. The staff acting as the PREA Compliance Manager confirmed he received telephonic notification of the test report at 1930 hours. The facility reported on the Pre-Audit Questionnaire it does not hold individuals solely on civil or immigration purposes.

115.351(c) - The GLRC Policy No. GLO 149.0 Page 11-12, Section 1 provides that staff who become aware of sexual abuse, sexual harassment, retaliation or any staff negligence or violation of responsibilities that may have contributed to an incident must immediately report the information to a supervisor. Page 12, Section 2 requires an Incident Report be completed before the end of the staff member's work shift. Interviews with random staff confirmed they are required to take reports verbally, in written form, from anonymous sources and third parties. Most random residents interviewed confirmed the same, but some residents were not clear on how to make a written report. It is noted that through the course of resident interviews a resident disclosed they reported a sexual abuse incident to staff, however, this incident was never documented by staff.

115.351(d) - During the site review, this auditor observed the grievance boxes in the resident housing units. The grievance boxes had forms for residents to fill out to make a written report. In interviews with the staff acting as PREA Compliance Manager, they advised residents can complete the grievance process to make a written report, which would be accepted on a grievance form or other piece of paper, or the facility can process a report that has been mailed. The resident that reported sexual abuse advised they did not make a written report.

115.351(e) - The facility provided a policy on the Pre-Audit Questionnaire that does not address 115.351(e). The Pre-Audit Questionnaire indicates staff receives this information in Mandated Reporter training. In interviews with random staff, they were aware they could report sexual abuse or sexual harassment privately and indicated they could ask to speak with the Superintendent/PREA Coordinator/PREA Compliance Manager/ privately, call the hotline or put a written report in through the resident grievance boxes.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.351(a) - GLRC indicates it has established multiple ways for residents to privately report sexual abuse, sexual harassment, retaliation and staff neglect of duties; however, one of those methods, calling CPS, is not private. By policy, if a resident wants to call CPS, staff is required to notify the supervisor, who then places the call for the resident but does not listen to the call. The Supervisor is then required to contact the facility Director or designee to report a resident called CPS. By adding multiple layers of facility staff that must be involved in a resident calling CPS, this can potentially discourage a resident from utilizing that option to report an incident. In addition, calls to CPS are made for the single reason of reporting sexual abuse or sexual harassment. Residents must be afforded as much privacy as possible with

limits still in place to restrict residents' ability to make unauthorized phone calls. The facility must make calls to CPS private by: 1) modifying GLRC Policy No. GLO 149.0 to eliminate requirements for staff to notify a supervisor to place a call to CPS and, 2) creating a calling system that adds anonymity to the purpose of the call. This second requirement can be accomplished in several ways, such as installing a stand alone telephone that dials directly to CPS and is accessible to residents in as private a setting as possible. Another option would be to enter a new Memorandum of Understanding with CPS to receive reports from facility residents that would include other issues, such as unfair treatment or other general grievances. These resident reports would need to be forwarded to the facility in the same manner as a sexual abuse or sexual harassment report.

115.351(b) - As indicated above, the method established for outside reporting is not considered private. The facility will need to create a calling system that adds anonymity to the purpose of the call. This requirement can be accomplished in several ways, such as installing a stand alone telephone that dials directly to CPS and is accessible to residents in as private a setting as possible. Another option would be to enter a new Memorandum of Understanding with CPS to receive reports from facility residents that would include other issues, such as unfair treatment or other general grievances. The facility can utilize either of these two options or create another option that meets the privacy needs of residents wanting to report sexual abuse or sexual harassment. If neither of these options are feasible, this auditor will work with GLRC to help develop an option that satisfies this provision.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 21, 2020, March 27, 2020 and April 6, 2020 to substantiate corrective actions taken for this standard.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated to reflect that residents reporting an incident of sexual abuse or sexual harassment to staff will dial the Children's Protective Services Hotline Number for the resident and the resident can make the call in private. The requirement for staff to alert a supervisor that a resident wants to contact the Hotline has been removed.

Youth Orientation Handout - This auditor received 11 documents titled "Youth Orientation Handout", dated March 23, 2020. This handout details that residents are able to contact the Children's Protective Services Hotline to report any type of complaint, not just sexual abuse or sexual harassment incidents.

Youth Orientation Handbook - The section of the Youth Orientation Handbook entitled "Preventing Sexual Assault" has been updated to include the Children's Protective Services Hotline takes calls on any complaints from facility residents, not just sexual abuse or sexual harassment incidents.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *PREA Compliance Manager *Resident Who Reported Sexual Abuse **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC Residential Services Handbook *Preventing Sexual Abuse Youth Orientation Packet 115.352(a) - The GLRC Policy No. GLO 149.0, Page 11, Section 5 provides that a grievance alleging sexual abuse can be filed at any time regardless of when the incident allegedly occurred. This section of policy does not provide a procedure for grievances, but the GLRC Residential Services Handbook, Pages 14-15 describes how grievances are processed. In on-site audit interviews with the staff acting as the PREA Compliance Manager, they advised they collect grievances from the grievance boxes every other day. However, in post-audit conversations the PREA Compliance Manager indicated they check the grievance boxes twice a week, usually on Mondays and Thursdays. They described how grievances are processed, which includes reviewing the grievance document, looking for supporting documentation in the daybook or other sources, meeting with the resident and involved staff and working toward a resolution. The PREA Compliance Manager reported the grievance would be forwarded to the agency Corporate Compliance and Quality Assurance representative in the event the matter cannot be rectified at the facility level. The PREA Compliance Manager advised once the grievance and supporting documents are completed the information is kept in a binder for the year and then uploaded into the agency's shared drive, where it will remain for years. It is noted this auditor requested documentation of all grievances over the prior 12 months; however, the PREA Compliance Manager responded that they were informed to just provide this auditor with the dates and types of grievances, as they don't keep a list of grievances. The facility was able to provide this auditor with a Client Grievance Form alleging staff voyeurism, dated August 20, 2019, and was received by GLRC on August 23, 2019. Since the grievance involved the staff member who collects and reviews grievances, the matter was referred to another agency administrator. The information collected in response to the client grievance was titled a PREA Investigation but it was not recorded on the standard format that MDHHS provided to this auditor post on-site audit. The outcome of the grievance was that the facility search policy will be forwarded for revision and staff needs consistent training on search procedures. 115.352 (b) - The GLRC Policy No. GLO 149.0, Page 11, Section (5)(a) states, "A grievance alleging sexual abuse can be filed at any time regardless of when the incident allegedly occurred.", and Section(5)(e) states, "There is no requirement that youth use an informal process for resolving grievances alleging sexual abuse or sexual harassment." The "Preventing Sexual Abuse Youth Orientation Packet", fifth page of the six-page document, section "The Importance of Reporting" informs residents they can fill out a grievance form to

report sexual abuse, and that the forms and locked boxes are located throughout the facility. The GLRC Residential Services Handbook, Page 14, Client Grievance Procedure, details the procedures for filing grievances in three different steps: Informal Grievance Procedure, Informal Grievance at the Agency Level, and Formal Recipients Rights Grievance filed following State Guidelines. The latter option provides for the resident to telephone the agency-level Rights Advisor and for the resident to follow the steps provided by the Advisor.

115.352(c) - The GLRC Policy No. GLO 149.0, Page 10, Section 5c provides that a grievance alleging sexual abuse or sexual harassment does not have to be submitted to the person that is the subject of the allegation, and Section 5d provides that a grievance alleging sexual abuse or sexual harassment must not be referred to the staff member who is the subject of the complaint. This process was followed in the grievance submitted as referenced in 115.352(a).

115.352(d) - The GLRC Policy No. GLO 149.0, Page 17, Section J(1) states, "The facility must issue a final decision (initial decision and appeal decision if appealed) on the merits of a grievance alleging sexual abuse or harassment within 90 calendar days of the initial filing of the grievance." Section (J)(2) states, "The facility may claim an extension of time to respond to of up to 70 calendar days if the normal time period for a response is insufficient to make a decision. The facility must notify the youth and the youth's parent/guardian in writing of any such extension." In interviews with the resident who reported sexual abuse, they advised they were never advised of the outcome of their verbal report and did not hear from anyone regarding a decision or consequences for the alleged perpetrator. The facility reported no grievances alleging sexual abuse or sexual harassment over the past 12 months.

115.352(e) - The GLRC Policy No. GLO 149.0, Page 18, Section(J)(3) states, "Third parties, including fellow youths, staff, family, attorneys and outside advocates may assist a youth filing grievances relating to allegations of sexual abuse and harassment, If a third party other than the parent or guardian files a grievance on the youth's behalf, the facility must request as a condition of processing that the alleged victim agree to the grievance filed on his behalf and may also require that the alleged victim pursue any subsequent steps in the remedy process. If the alleged victim declines to have the grievance processed on his behalf, the facility must document the youth's decision." The policy does not address allowing parents or legal guardians of residents to file a grievance alleging sexual abuse, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf. As previously indicated, GLRC reported no grievances alleging sexual abuse or sexual harassment over the past 12 months.

115.352(f) - The GLRC Policy No. GLO 149.0, Page 10, Section 5 (f) states, "Emergency grievances alleging sexual abuse and/or the imminent threat of sexual abuse must be responded to immediately." However, there does not appear to be specific procedures outlined to process an emergency grievance, nor are instructions on how to file an emergency grievance communicated to residents. In addition, there does not appear to be policy and procedure requiring a final agency decision be issued within five days for emergency grievances alleging substantial risk of imminent sexual abuse. As previously indicated, GLRC reported no grievances alleging sexual abuse or sexual harassment over the past 12 months. In on-site audit interviews with the staff acting as the PREA Compliance Manager, they advised they collect grievances from the grievance boxes every other day. However, in post-audit conversations the PREA Compliance Manager indicated they check the grievance boxes

twice a week, usually on Mondays and Thursdays.

115.352(g) - The GLRC Policy No. GLO 149.0, Page 4, Section 1(g) indicates that residents will not be disciplined for making an allegation of sexual abuse or sexual harassment if the investigation determines that the abuse did not occur, so long as the allegation was based upon a reasonable belief the abuse occurred and the allegation was made in good faith. As previously indicated, GLRC reported no grievances alleging sexual abuse or sexual harassment over the past 12 months; therefore, there has not been an occasion to determine whether a report was made in bad faith.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.352(a) - The facility must be able to produce a record of grievances that allows for review, not only for the purpose of establishing PREA compliance, but to accurately track grievance outcomes, patterns and areas in need of correction/modification. Sexual abuse and sexual harassment grievances also need to have a clear finding of "Substantiated", "Unsubstantiated" or "Unfounded". If GLRC keeps a written record of its grievances in hard copy, sexual abuse and sexual harassment grievances must be readily identifiable and readily available to an auditor for review. The facility can also choose to create an electronic form to enter, track and sort grievances. The facility will need to provide this auditor with verification that one of the aforementioned methods has been established.

115.352(e) - The facility will need to update the GLRC Policy No. GLO 149.0 to include language that allows parents or legal guardians of residents to file a grievance alleging sexual abuse, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf.

115.352(f) - The current practice of collecting grievances from the grievance boxes twice a week does not allow for the facility to discover an emergent issue of sexual abuse or sexual harassment. The facility must create a procedure for identifying and responding to emergency grievances of sexual abuse/sexual harassment and imminent threats of sexual abuse. This can be accomplished simply by checking the grievance boxes daily to screen for any emergency grievances and documenting the the procedural steps GLRC will take once an emergent sexual abuse or sexual harassment situation is identified. Residents and staff also need to know how GLRC will address an emergency grievance for sexual abuse and sexual harassment. GLRC will need to train staff and educate residents on the procedure and the information will need to be added to the Preventing Sexual Abuse Youth Orientation Packet.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 27, 2020, March 6, 2020 and April 6, 2020 to substantiate corrective actions taken for this standard.

	Grievance Log (Excel Document) - The Grievance Log captures the date of the grievance, the date it was reviewed, the nature of the grievance, whether the grievance is PREA-related, the first name and last initial of the resident, whether an investigation is required and whether the grievance was substantiated, unsubstantiated or unfounded. Four grievances submitted between December 20, 2019 and February 19, 2020 were recorded on the Grievance Log, all with completed information entered. All four grievances were reviewed within the following calendar day. This change in the pattern of review demonstrates GLRC's ability to respond to emergency grievances. Client Grievance Forms - In communications with GLRC, they advised the client grievance form is used agency-wide and some of their programs do not fall under PREA requirements. GLRC advised they will not modify the form to include "Substantiated", "Unsubstantiated" or "Unfounded" language, but that language is captured on the Grievance Log. GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated on Page 10, Section 5 to include, "A youth's parents or guardian(s), that are alleging sexual abuse are accepted, regardless of whether or not the resident agrees to having the grievance filed on their behalf." The policy has also been updated on Page 10, Section F to address emergency grievances, stating, "The Program Supervisor or Designee will screen the grievance box daily for emergent grievances. If an emergency grievance is discovered or given to staff, the standard procedure will be followed, but the grievance will be fast-tracked and handled immediately." Updated Youth Orientation Handbook - This document now designates the facility will provide a response within 24 hours for emergency grievances. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Compliance Manager *Resident Who Reported Sexual Abuse *Random Residents **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC Residential Services Handbook *Referral and Qualified Service Organization Agreement Between GLRC and the Women's Center *Site Review 115.353(a) - The Referral and Qualified Service Organization Agreement Between GLRC and the Women's Center details that outside supportive services are available to GLRC residents. According to the staff who is acting as the PREA Compliance Manager and Superintendent, the Women's Center is present at the facility on a weekly basis to facilitate group sessions and their staff is familiar to the residents. "Zero Tolerance" and "No Means No" posters were posted throughout the facility, including both housing units, the group room and the dining area. The Zero Tolerance poster listed the Women's Center as an outside supportive service and listed the address and telephone number to contact the Women's Center. It is noted the Women's Center serves as the local rape crisis center. In interviews with random residents this auditor found that several of the residents could not recall any outside supportive services and, if they did, they didn't know how to get a hold of the services. The resident who reported sexual abuse advised they were not provided any information about outside supportive services. They stated they thought that if they did speak with outside supportive services the conversations would be kept confidential unless they said otherwise, but they thought the staff acting as PREA Compliance Manager/Superintendent would have to be made aware. The GLRC reported on the Pre-Audit Questionnaire that it does not hold residents on civil or immigration matters. 115.353(b) - The GLRC Residential Services Handbook, page 14, Confidentiality states, "Violations of this (confidentiality) Federal law is a crime. Suspected violations may be reported to appropriate authorities in accord with Federal regulations. Federal law and regulations, however, do not protect any information of suspected child abuse or neglect and must be reported to appropriate State or local authorities. Federal law and regulations also do not protect information from disclosure under a "duty to warn" provision if harm to another person or persons is suspected." The GLRC Policy No. GLO 149.0, Page 9, Section 2 states, "Clients must be informed prior to giving them access to outside victim advocates for

emotional support services related to sexual abuse 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. Clients over the age of 18 must give written informed consent before medical/mental health personnel engage in mandatory reporting regarding victimization occurring outside of an agency or institution setting." In interviews with random residents this auditor found that residents did not know whether these conversations were confidential or if there were circumstances where their conversations were reported to others. Some residents thought all communications with outside supportive services were confidential. According to the resident who reported sexual abuse, they did not wish to access outside supportive services, nor were those services offered at the time of the report. The facility provides information to residents regarding the confidentiality limitations of conversations with outside services; however, this auditor recommends GLRC place more emphasis on informing residents of the limits of confidentiality when providing the comprehensive PREA education to residents.

115.353(c) - The Referral and Qualified Service Organization Agreement Between GLRC and the Women's Center, effective October 1, 2014 and signed by both agency heads, provides for emotional support services for GLRC residents related to sexual abuse, as well as other treatment services where treatment vacancies exist. The Agreement is reviewed on a bi-annual basis from the date signed in accordance to the GLRC Quality Improvement and remains in effect until either party wishes to terminate the Agreement.

115.353(d) - According to the staff who is acting as the PREA Compliance Manager and Superintendent, they indicated contact with legal counsel is part of the residents' rights and they can request contact with their attorney whenever they want. They indicated there is no circumstance where contact with a resident's attorney is limited. In relation to parental contact, the staff who is acting as the PREA Compliance Manager and Superintendent advised residents are given two calls to parents/legal guardians per week, in addition to a family session each week, facilitated by the resident's therapist. They indicated family visits occur on a case by case basis and residents are also able to communicate with their parents/legal guardians by writing and receiving letters. They advised if a resident has program rules violations they could lose phone call privileges, but weekly therapy sessions with the parents/legal guardians still take place. In interviews with random residents they reported they are able to contact their attorneys or other legal representation, either by telephone or if the attorney schedules a visit at the facility. They also confirmed they are able to contact their parents/legal guardians a minimum of twice a week by telephone and parents/legal guardians can visit them at GLRC. Residents indicated they are able to earn privileges to contact parents/legal guardians more frequently as well. In interviews with the resident who reported sexual abuse, they indicated they did not request to speak with their attorney, but they were allowed to make contact with their parent.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents reviewed: *Agency website 115.354(a) - The GLRC website provides public access to the "No Means No" poster, which lists the Children's Protective Services telephone number and the PREA Coordinator/PREA Compliance Manager's name and contact information. The poster speaks to residents, but includes the information that a family member, friend, legal counsel or anyone else outside the facility can make a report for them.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Compliance Manager *Medical/Mental Health Staff *Random Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact 115.361(a) - The GLRC Policy No. GLO 149.0, Page 10-11, Section F(1) states, "Staff receiving a report of sexual assault/rape or attempted sexual assault/rape that occurred in a facility, whether or not it is part of the agency; staff that become aware of sexual activity between residents or between a resident and staff, contractor, visitor, or volunteer; become aware of retaliation against students or staff that reported such an incident; and/or, become aware of any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation must immediately report this to the supervisor." This policy section does not include the requirement that incidents of sexual harassment must be immediately reported. Interviews with random staff confirm the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility, retaliation against residents or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Random staff acknowledge their responsibility to report incidents of sexual abuse or sexual harassment, retaliation for said reports and staff neglect of duties which may have contributed to an incident of sexual abuse or sexual harassment. However, it was discovered during the course of random resident interviews that a resident had reported an incident of sexual abuse to staff and they failed to report it to facility administration. 115.361(b) - The GLRC Policy No. GLO 149.0, Page 1, Section 3 states, "Upon the client's consent and/or observing the State Mandatory Reporting Requirements indicating duty to warn, inform the police of the matter if an assault incident (physical or sexual) has occurred. Provide the authorities with appropriate information." Interviews with random staff confirmed they received training in the mandated reporting requirements in the State of Michigan as part of their PREA training. 115.361(c) - The GLRC Policy No. GLO 149.0, Page 14, Section i states, "Staff must not discuss the details of sexual abuse allegations or incidents, beyond the extent needed to maintain safety and security at the facility, with persons other than Supervision/Management, investigators and prosecuting officials." In interviews with random staff, none of them indicated that the confidentiality of a sexual abuse incident/investigation was part of staff duties. 115.361(d) - In interviews with Medical/Mental Health staff, they advised they are required to disclose the limitations of confidentiality and your duty to report at the initiation of services to a

resident. They advised they are required to report any knowledge, suspicion or information regarding an incident of sexual abuse and sexual harassment to the Superintendent or the on-call administrative official immediately upon learning of it. As indicated in the analysis for 115.361(b), staff is required to comply with State Mandatory Reporting Requirements.

115.361(e) - In interviews with the staff acting as the PREA Compliance Manager and Superintendent, they indicated they would report the incident to the victim's parent or legal guardian and caseworker if the resident is under the guardianship of the child welfare system as soon as possible, following notification to agency administration, CPS and law enforcement. Regarding notification to the victim resident's attorney or other legal representative, they would contact the victim's legal representative only if a release of information has been signed by the resident, as dictated by Federal law, 42 CFR Part 2. A review of this statute confirms that it protects the confidentiality of all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated or directly or indirectly assisted by any department or agency of the United States. The PREA Compliance Manager/Superintendent advised, if authorized, they would notify legal counsel no later than the next day following an incident of sexual abuse in the facility. Guidance was sought from the PREA Resource Center regarding this legal issue. According to the Department of Justice, for juveniles confined in certain drug and alcohol-abuse treatment programs, federal statutes and regulations prohibit the disclosure of certain information about the residents to third parties (See 42 U.S.C. s. 290dd-2; 42 C.F.R. ss. 2.1-2.67). These regulations provide no general exception to the disclosure restrictions for the patient's attorney or defense counsel. However, not all information about the patient is protected from disclosure. For example, most information regarding a patient may be disclosed to a third party with the express consent of the patient. If such consent is not available or not obtainable within PREA's 14-day timeline, the facility may still report certain non-protected facts to the patient's attorney. For example, the facility may disclose the fact that a client has alleged sexual victimization in a facility to the patient's attorney, so long as the disclosure does not reveal the patient's participation in a substance abuse treatment facility. For example, a facility staff person could communicate to the attorney: "Your client, John Doe, has made an allegation of sexual abuse in a facility. For additional information, please contact the patient's parents, legal guardian, or Child Protective Services (whichever entity where such information has been lawfully disclosed. See 42. C.F.R. s. 2.12(e)(3)). The restrictions on disclosure apply to any information which would identify a patient as having or having had a substance use disorder.

115.361(f) - In interviews with the staff acting as the Superintendent, they advised all allegations of sexual abuse and sexual harassment (including those from third-party and anonymous sources) are reported directly to designated facility investigators. It is noted this auditor discovered an alleged sexual abuse incident that a resident reported to staff, but was not forwarded to the facility's designated investigator. The facility's designated investigator is the same staff acting as the Superintendent, PREA Coordinator and PREA Compliance Manager, so the problem in that situation was that staff failed to report it to their supervisor and failed to document the report.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.361(a) - Although facility staff members indicated they are required to immediately report

all incidents of sexual harassment, the GLRC Policy No. GLO 149.0 does not require staff to report any knowledge, suspicion, or information they receive regarding an incident of sexual harassment, retaliation as a result of a report made for sexual harassment or neglect of staff duties that contributed to an incident of sexual harassment. The GLRC Policy No. GLO 149.0 must be updated to include the staff requirement to report incidents of sexual harassment, retaliation as a result of a report made for sexual harassment or neglect of staff duties that contributed to an incident of sexual harassment. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard. The facility will need to review and reiterate the requirement that staff report all incidents of sexual abuse or sexual harassment in conjunction with training on new policy language.

115.361(e) - The facility will need to notify a resident's legal counsel in the event of a sexual abuse incident. If a release of information to legal counsel has not been signed or authorized by the victim resident, GLRC will need to notify legal counsel within the required 14-day time period, utilizing the generic disclosure language listed in the aforementioned standard analysis. The facility will need to include verification that legal counsel has been notified and the date of the notification on the institutional plan.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 27, 2020, April 6, 2020, April 10, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated on Page 10-11, Section F, to include the staff requirement to report all incidents of sexual harassment and retaliation as a result of a report made for sexual harassment or neglect of staff duties that contributed to an incident of sexual abuse or sexual harassment. Page 16, Section 4b of the policy provides if a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile’s attorney or other legal representative of record within 14 days of receiving the allegation.

GLRC Authorization to Release Protected Health Information - GLRC provided three Authorization to Release Protected Health Information forms, all authorizing release of information to the resident's attorney. The names and telephone numbers of each resident's attorney was listed on the forms.

MDHHS PREA Investigation Tool - GLRC previously documented adoption of the MDHHS Form 5809, PREA Investigation Tool. Page 9 of the PREA Investigation Tool contains a section to capture notification to a victim resident's legal counsel.

Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact.

	Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, as well as the adopted MDHHS policies referenced in the updated policy. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Superintendent or Designee *Random Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact 115.362(a) - The GLRC Policy No. GLO 149.0, Page 12-13, Section G states, "The facility Director or designee must take immediate steps to protect the alleged victim from further potential sexual assault or rape (if still at the facility) by separating the alleged victim from the alleged perpetrator(s) including arranging for separate housing, dining, and/or other elements of daily routine to the extent necessary to ensure protection. These same protections must also be provided to youth(s) believed to be in imminent danger of sexual abuse. In interviews with the Agency Head and Superintendent, they indicated they would immediately make sure that the resident is safe, separate the parties, notify staff, and watch for changes in behavior in the alleged victim resident. They also advised they would look toward discharging or transferring the aggressor in that situation. In interviews with random staff, they indicated they would immediately separate the parties, discuss with the victim how they feel regarding safety, control contact between the alleged victim and perpetrator, and communicate with the Superintendent to find out if the alleged perpetrator should remain in program.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Superintendent or Designee **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact 115.363(a) - The GLRC Policy No. GLO 149.0, Page 13, Section 10 states, "If a report is received of sexual abuse from another facility, the facility Director must report Director-to-Director to the other facility within 72 hours. (All other applicable reporting requirements still apply.)" While the verbiage "all other applicable reporting requirements still apply" may minimally satisfy this standard, it is not explicitly clear that the facility is responsible to contact the law enforcement agency in the jurisdiction where the alleged sexual abuse occurred, in addition to notifying the Director of the facility where the abuse allegedly occurred. 115.363(b) - The GLRC Policy No. GLO 149.0, Page 13, Section 10 states, "If a report is received of sexual abuse from another facility, the facility Director must report Director-to-Director to the other facility within 72 hours." 115.363(c) - The facility indicated the aforementioned notification is documented in the Pre-Audit Questionnaire. The facility indicated it received no allegations of resident sexual abuse while the resident was placed in another facility over the past 12 months. 115.363(d) - The GLRC Policy No. GLO 149.0, Page 13, Section 11 states, "Allegations received from other agencies or facilities are investigated in accordance with the PREA standards." In interviews with the staff acting as Superintendent, they indicated an investigation would be initiated with the available information. In interviews with the Agency Head, they advised the Program Supervisor would be the point of contact for any report of sexual abuse that occurred at GLRC coming from another agency. The Agency Head reported the Program Supervisor would contact that facility within 72 hours to confirm that an investigation is moving forward.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Security and Non-Security Staff First Responders *Random Staff *Resident Who Reported Sexual Abuse **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC PREA Coordinated Response Plan 115.364(a) - The GLRC PREA Coordinated Response Plan lists first responder duties in a bullet point list as follows: Contact Administration/Supervision, Separate the victim and alleged perpetrator, Protect incident scene if identified, Report allegation to Children's Protective Services 855-444-391, Request that the victim not wash, change clothes, etc. (pending forensic exam if applicable), Ensure that the alleged perpetrator does not wash, change clothes, etc. (as applicable), Document all information and activities in an incident report and Cooperate with investigators, prosecutors, facility Administration." It is noted the GLRC Policy No. GLO 149.0 also lists some first responder duties on Page 1, Sections 1-8, as well as Pages 11-12, Sections 1-4, but none of these sections in the GLRC Policy No. GLO 149.0 indicate the first responder should separate the alleged victim and alleged perpetrator. The facility reported no incidents of sexual abuse over the past 12 months on the Pre-Audit Questionnaire and no evidence was uncovered to the contrary. As a result, the interview protocol for Security and Non-Security Staff Who Have Acted As First Responders was not completed. In interviews with random staff, they were able to articulate that they would separate the parties, preserve the scene, not allow the alleged victim and alleged perpetrator to shower, change clothing, use the bathroom, eat or drink or brush their teeth. The resident who reported sexual abuse indicated no one came to assist them, but they went to staff to report the incident. They indicated staff listening to their report was the only action that was taken and that the staff acting as the PREA Compliance Manager came to them the next day and inquired about an injury that was received as a result of a physical altercation after the alleged sexual abuse. 115.364(b) - The GLRC Policy No. GLO 149.0 and the GLRC PREA Coordinated Response Plan do not make a distinction between security and non-security staff. In interviews with random staff, they were able to articulate that they would separate the parties, preserve the scene, not allow the alleged victim and alleged perpetrator to shower, change clothing, use the bathroom, eat or drink or brush their teeth. The facility reported no incidents of sexual abuse over the past 12 months on the Pre-Audit Questionnaire and the sexual abuse incident that was reported to this auditor by a resident was not referred for investigation. As a result, the interview protocol for Security and Non-Security Staff Who Have Acted As First Responders was not completed.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee **Documents reviewed:** *Pre-Audit Questionnaire 115.365(a) - According to the staff acting as Superintendent, they have a lot to improve upon in this area. They indicated they are working with MDHHS to use their investigation and coordinated response forms. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:** 115.365(a) - The facility needs to create an institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators and facility leadership. Mechanisms to document actions with names of the staff responsible, dates and times must be included. The MDHHS 5809 PREA Investigation Tool details First Responder Actions, Supervision Actions, and Facility Director or Program Manager Actions. The tool requires staff to enter their name, date and time when the action was taken and requires a description of the action taken. The tool is comprehensive and collects all the information on one report. Should GLRC choose to adopt the MDHHS 5809 PREA Investigation Tool or create their own, the institutional plan needs to be distributed to all staff and staff must be trained on how to execute their responsibilities in the plan. **VERIFICATION OF CORRECTIVE ACTION:** This auditor was provided appropriate supplemental documentation on April 6, 2020, April 10, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard. MDHHS PREA Investigation Tool - GLRC previously documented the adoption of the MDHHS Form 5809, PREA Investigation Tool (referenced in the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, Page 11, Section 2). The PREA Investigation Tool is a comprehensive tool that captures the facility's actions and responses to a reported incident of sexual abuse or attempted sexual abuse. The PREA Investigation Tool contains sections to record first responder, supervisory, medical/mental health and facility Director actions, the dates and times the actions were completed, and the name of the staff member completing the action(s). The PREA Investigation Tool includes a section for retaliation monitoring, the PREA Incident Review and appropriate documentation for tracking and recording annual incidents. Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, which included review of the MDHHS Form 5809, PREA Investigation Tool. Staff Interviews - This auditor conducted telephonic interviews with three staff selected at

	random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, which included the adopted MDHHS 5809 PREA Investigation Tool referenced in the updated policy. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interview conducted: *Agency Head 115.366(a) - According to the Agency Head, GLRC does not participate in collective bargaining.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Superintendent or Designee *Designated Staff Member Charged With Monitoring Retaliation *Resident Who Reported Sexual Abuse **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact 115.367(a) - The GLRC Policy No. GLO 149.0, Page 13, Section 12 states, "A designated facility employee must monitor staff and youth to prevent retaliation for a minimum of 90 days after a sexual abuse report is made. Monitoring to prevent retaliation must utilize multiple monitoring techniques, including but not limited to: Direct observation, file and log reviews, and face-to-face contact with victims and /or supporting witnesses. Monitoring activities must be documented in the designated log." The policy does not address monitoring for retaliation for reports of sexual harassment. The staff member assigned this responsibility is the GLRC Program Manager. 115.367(b) - According to the Agency Head, agency policy covers their process to keep residents and staff safe from retaliation, including keeping separation between the victim and perpetrator. The Agency Head advised if staff is retaliating against another staff member or resident, they would make staff moves. In interviews with the staff acting as Superintendent and staff charged with monitoring retaliation, they would look for changes in behavior from the staff or resident who made the report of sexual abuse and make note of any Incident Reports regarding those parties. They also advised that moving forward GLRC will use the newly created State of Michigan Retaliation Monitoring Form to document periodic checks over a minimum of a 90-day period and any concerns regarding retaliation. The resident who reported sexual abuse did not have any concerns regarding someone seeking revenge or retaliating against him for making the report. 115.367(c) - Interviews with the staff acting as Superintendent and staff charged with monitoring retaliation revealed they haven't had any reported incidents of retaliation, but they would make sure the individual who is being retaliated against is safe and possibly remove the party retaliating against a staff member or resident if they are a hindrance to treatment. They also advised that moving forward GLRC will use the newly created State of Michigan Retaliation Monitoring Form to document periodic checks over a minimum of a 90-day period and any concerns regarding retaliation. The facility reported no incidents of retaliation over the past 12 months, therefore, documentation of retaliation monitoring was unavailable. 115.367(d) - Interviews with the staff acting as Superintendent and staff charged with monitoring retaliation revealed they look for Incident Reports, changes in behavior and disciplinary actions to monitor for retaliation. The facility reported no incidents of retaliation

over the past 12 months, therefore, documentation of retaliation monitoring was unavailable.

115.367(e) - According to the Agency Head, agency policy covers their process to keep residents and staff safe from retaliation, including keeping separation between the victim and perpetrator. The Agency Head advised if staff is retaliating against another staff member or resident, they would make staff moves. In interviews with the staff acting as Superintendent and staff charged with monitoring retaliation, they would address issues of retaliation by moving the party who was retaliating against a staff member or resident who reported sexual abuse.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.367(a) - As in 115.361, the GLRC Policy No. GLO 149.0 is missing the requirement to monitor for retaliation in reports of sexual harassment. The GLRC Policy No. GLO 149.0 must be updated to include monitoring for retaliation after a reported incident of sexual harassment. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 6, 2020, April 10, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated on Page 13, Section 14, to include retaliation monitoring after a reported incident of sexual harassment.

Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact.

Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, which included retaliation monitoring after a reported incident of sexual harassment.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *Medical/Mental Health Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *MDHHS Policy JR6 630 *Site Review 115.368(a) - The GLRC Policy No. GLO 149.0, Page 7, Section 5 states, "A youth may be isolated from other youth as a preventive and protective measure, but only as a last resort when other less restrictive measures are inadequate to keep the youth safe from other youths, and then only until an alternate means of keeping all youths safe can be arranged. During any periods of protective isolation, facility staff may not deny a youth otherwise under control, access to daily large-muscle exercise and legally-required educational programming or special education services. Any youth in isolation must receive daily visits from a medical or mental health care clinician and must have access to other programs to the extent possible. Should isolation occur, a review of the isolation will occur every 30 days. Furthermore, GLR has adopted MDHHS Policies JR6 630 - Isolation And/Or Confinement and JR6 631 Due Process, should an exceptional circumstance occur where short-term isolation is required for safety reasons." The MDHHS Policy JR6 630 provides that confinement may only be used at the direction of a medical professional or the facility/center director or designee for medical purposes or upon the request of a youth with approval of a supervisor for a period of 30 minutes or less. This policy also provides that isolation may only be used for the purposes listed under confinement or when the youth's behavior is out of control, to protect the safety of the youth, other youth, staff and/or visitors, or for a total of 72 consecutive hours including any period of confinement if the isolation is due to the youth's culpability for a major offense. In interviews with the staff acting as Superintendent, they advised the facility does not practice isolation. This was confirmed through interviews with Medical/Mental Health staff, who also reported they do not have clients in isolation at GLRC. This auditor did not observe residents isolated from the other residents in the program, nor was there a room/location observed in the facility where a resident could be housed in isolation. Based on the absence of youth placed in isolation, the Staff Who Supervise Residents In Isolation and Residents In Isolation interview protocols were not completed, nor were specific files of residents placed in isolation subsequent to a sexual abuse incident available for review. It is noted this adoption of MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Coordinator *PREA Compliance Manager *Intermediate or Higher-Level Staff *Random Residents **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *2017 Staff Sexual Abuse Investigation Report 115.371(a) - The GLRC Policy No. GLO 149.0, Page 14, Section H, Investigation Protocols, states, "Each incident of alleged or reported sexual harassment, sexual abuse or sexual assault/rape must be investigated to the fullest extent possible." The section covers procedures for youth-on-youth sexual abuse, staff-on-youth sexual abuse, and any other intentional youth-on-youth sexual touching or abusive contact. These procedures include preservation of evidence, documentation, notifications to law enforcement and Children's Protective Services, parents/legal guardians and juvenile court, and removal of a suspected employee/contractor/volunteer. Although the policy states each incident of alleged or reported sexual harassment must be investigated to the fullest extent possible, the policy does not cover procedures of investigating sexual harassment reports. According to the staff acting as Investigative Staff, they would initiate an investigation into a sexual abuse report within the next day, depending on when they receive the complaint, situation and allegation. They advised it is better to start an investigation right away if possible. They advised they would handle anonymous or third-party reports of sexual abuse and sexual harassment using the same process as a report received directly from a victim. 115.371(b) - The GLRC Policy No. GLO 149.0, Page 8, Section 7 states, "All full and part time staff who conduct PREA investigation (sic) must receive training in conducting such investigations in confinement settings. Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Training will be documented in personnel records." Interviews with the staff acting as Investigative Staff revealed they received training in all those areas from the PREA Resource Center online investigators training. This auditor was provided the certificates of completion for investigative staff as verification. Interviews with local law enforcement confirm they are trained to conduct sexual abuse investigations and their training includes interviewing juvenile victims. 115.371(c) - The staff acting as investigative staff stated they would start with interviews and determine if the allegations required notification to CPS and law enforcement. They also advised they do not gather evidence in a criminal investigation, but simply protect the scene

and preserve physical evidence for law enforcement to process. This auditor reviewed the investigation detail for the 2017 staff sexual misconduct report and found no indication that the facility collected or processed evidence, and that the matter was referred to local law enforcement. It is noted the GLRC Policy No. GLO 149.0, Page 14, Section (1)(d) states, "Qualified investigators must take victims statements, open an investigation and, if applicable, collect physical evidence." This statement is confusing in that it may lead facility staff who has taken the online Investigations in Confinement Settings training through the PREA Resource Center to believe they may be responsible to collect physical evidence. This should be clarified to state that law enforcement will collect physical evidence for the criminal investigation and that GLRC staff does not collect physical evidence.

115.371(d) - The GLRC Policy No. GLO 149.0, Page 14, Section H states, "GLR will not terminate an investigation solely because the source of the allegation recants the allegation." According to the staff acting as investigative staff, they would continue an investigation until it was completed regardless of whether the source of the allegation recanted.

115.371(e) - This auditor reviewed the investigation detail for the 2017 staff sexual misconduct report and found that the staff alleged to have committed sexual abuse against a resident was interviewed on the same date the allegation was received by facility administration. It is unclear whether this interview was "compelled", but the staff member made statements specific to the allegations. Interviews with the staff acting as investigative staff advised they have not consulted with prosecutors in sexual abuse incidents.

115.371(f) - Staff acting as Investigative Staff advised they cannot assume a resident is making a false statement when reporting sexual abuse and they have to take the information they are given as factual until it is learned otherwise. They advised a resident's previous history cannot dictate the outcome of a report, but that it has to be based on the information they have at that time. They advised they would not require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation.

115.371(g) - Interviews with the staff acting as Investigative Staff indicated they would look for the root cause by reviewing video monitoring recordings and for any deviations from the normal plan to see if staff actions or inactions contributed to a sexual abuse incident. They advised everything from start to finish is documented in a report, which includes dates and times, records of interviews and logs of contacts.

115.371(h) - The GLRC had no cases that were forwarded for prosecution as examples for review. Interviews with the staff acting as Investigative Staff advised local law enforcement investigating a criminal matter would draft such a report and they would request the information from law enforcement.

115.371(i) - Interviews with the staff acting as Investigative Staff advised they do not refer cases for prosecution, but local law enforcement would handle any referral for prosecution.

115.371(j) - The GLRC Policy No. GLO 149.0, Page 13, Section 9 states, "The facility will retain all written reports for both criminal and administrative investigations 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." The facility reported on the Pre-Audit Questionnaire that they had no sexual abuse incidents over the required 12-month reporting period. However, this auditor was advised there was a 2017 report of staff sexual misconduct with a resident. This auditor reviewed the 2017 staff sexual abuse investigation report, which the facility had readily available for review.

115.371(k) - The GLRC Policy No. GLO 149.0, Page 14, Section 8 states, "GLR will not terminate an investigation due to the alleged victim or alleged perpetrators leaving the facility." Interviews with the staff acting as Investigative Staff advised the investigation would still move forward to the best of their ability and they would remain in contact with the criminal investigator to follow that process.

115.371(m) - The staff acting as Superintendent, PREA Coordinator, PREA Compliance Manager and Investigative Staff revealed they would stay in contact with the investigating law enforcement officer and the prosecutor to see if they can be of assistance and to check on the status of the investigation. They indicated Licencing would be involved as well and they would maintain contact with Licensing officials. They advised it would be their expectation to receive written reports from all investigating entities.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.371(a) - As in 115.361, the GLRC Policy No. GLO 149.0 is missing the requirement to monitor for retaliation in reports of sexual harassment. The GLRC Policy No. GLO 149.0 must be updated to include monitoring for retaliation after a reported incident of sexual harassment. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard.

115.371(c) - The GLRC Policy No. GLO 149.0 gives the impression that evidence collection may be part of staff duties in relation to a sexual abuse incident, when in practice the facility does not collect physical evidence. The GLRC Policy No. GLO 149.0 must be updated to clarify that law enforcement will collect physical evidence for the criminal investigation and that GLRC staff does not collect physical evidence. In addition, all staff must be trained on the new policy language.

115.371(e) - In reference to the 2017 staff sexual abuse incident, it is not clear if the statements by the accused staff member were compelled. However, GLRC needs to understand that obtaining statements from accused staff prematurely may compromise the outcome of a criminal investigation. The facility has the clear ability to suspend staff pending the outcome of a criminal investigation, but soliciting statements from accused staff should be done after consulting with law enforcement and/or prosecutors. The facility will need to add a section to capture contact with law enforcement/prosecutors for the purpose of obtaining clearance to interview accused staff to their institutional plan.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 12, 2020, April 10, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated on

	Page 14, Section 16, to reflect facility investigators will not solicit statements from accused staff unless they have consulted with law enforcement/prosecutors and received explicit clearance, and if clearance is received, statements shall be documented on the PREA Investigation Report. Page 14, Section H, Investigative Protocols has also been updated to reflect that the collection of physical evidence is completed by law enforcement. This policy has also been updated on Page 13, Section 14, to include retaliation monitoring after a reported incident of sexual harassment. Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, which included the requirement to monitor for retaliation in reports of sexual harassment and the collection of physical evidence is completed by law enforcement. Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interview conducted: *Investigative Staff 115.372(a) - Interviews with staff acting as investigative staff reveals preponderance of the evidence is the standard utilized in determining whether allegations of sexual abuse or sexual harassment are substantiated.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *Investigative Staff *Resident Who Reported Sexual Abuse **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *2017 Investigative Detail 115.373(a) - The facility provided the GLRC Policy No. GLO 149.0, Page 11, Sections 3 and 4 as demonstrations of compliance with this standard. However, the language in these sections relates to notifying the resident about preventing contact with the perpetrator and the status of a criminal charge. This portion of the policy does not speak to notifying the resident whether the allegations were substantiated, unsubstantiated or unfounded after the facility's investigation, and another section of the policy was not located to satisfy compliance with this standard. 115.373(b) - The 2017 Investigative Detail into the staff sexual misconduct incident contains a final report from the MDHHS Division of Child Welfare Licensing, concluding there were no licensing violations as a result of the reported incident. The investigative detail did not include a final report with findings from law enforcement and documentation indicating the facility requested this information was not noted. 115.373(c) - The GLRC Policy No. GLO 149.0, Page 11, Section 3 states, "Following a client's allegation that a staff member or (sic) has committed sexual abuse against the resident, GLR subsequently informs and documents informing the client (unless the agency has determined that the allegation is unfounded) whenever: a) The staff member is no longer posted within the resident's unit, b) The staff member is no longer employed at the facility, c) GLR learns that the staff member has been indicted on a charge related to sexual abuse within the facility, or d) GLR learns that the staff member has been convicted on a charge related to sexual abuse within the facilty." Interviews with the resident who reported sexual abuse revealed they did not allege staff sexual misconduct. 115.373(d) - The GLRC Policy No. GLO 149.0, Page 11, Section 4 states, "Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, GLR subsequently informs and documents informing the client whenever: a) GLR learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or b) GLR learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility." Interviews with the resident who reported sexual abuse revealed they were not advised of any disposition in relation to their report of sexual abuse from another resident.

115.373(e) - The aforementioned language in the analysis for 115.373 (c) and (d) provides for documentation of the notification to residents.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.373(a) - The GLRC Policy No. GLO 149.0 will need to be updated to include a provision to notify the resident whether the allegations of sexual abuse were substantiated, unsubstantiated or unfounded after the facility's investigation. As the facility develops a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership, it will need to include a section to record notification to residents regarding the findings of the facility investigation. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language policies added to address compliance with this standard.

115.373(b) - As there was no provision in policy to notify a resident of the outcome of the facility's investigation, there is also no evidence for obtaining documentation of a criminal investigation to inform a resident of the status/outcome of that investigation. Facility staff indicated they would request the report from the criminal investigation in 115.371. As the facility develops a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership, it will need to include a section to capture the request of the criminal investigation report, as well as a section to record notification to residents regarding that report.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 21, 2020, April 10, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard.

MDHHS Forms 5809 and 5810, PREA Investigation Report and PREA Investigation Tool - The MDHHS PREA Investigation Report and PREA Investigation Tool contain sections to record notifications to residents as to the outcome of the criminal and administrative investigations and a section to record actions in coordination with external agency investigations. The adoption of the MDHHS PREA Investigation Report and PREA Investigation Tool is included in the GLRC Policy No. GLO 149.0 policy update, Page 11, Section 2.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated on Page 19, Section J, 3 to reflect the PREA Compliance Manager will communicate findings of investigations with the residents.

Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact.

Staff Interviews - This auditor conducted telephonic interviews with three staff selected at

	random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, as well as the adopted MDHHS forms referenced in the updated policy. PREA Coordinated Response Plan - The PREA Coordinated Response Plan has been updated to reflect the the MDHHS PREA Investigation Report and PREA Investigation Tool will be used to document all facility actions and responses to a sexual abuse incident. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents reviewed: *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *2017 Investigative Detail 115.376 (a) - The GLRC Policy No. GLO 149.0, Page 15, Section (2)(d) states, "Dismissal is the presumptive employee discipline upon a substantiated finding of sexual abuse of a resident." This policy language does not address dismissal or other sanction for violation of agency sexual harassment policies. 115.376 (b) - The facility reported no staff terminations or resignations as a result of staff sexual abuse or sexual harassment over the required 12-month reporting period. A review of the 2017 staff sexual misconduct documentation reveals that staff member was terminated for violation of agency policies. 115.376 (c) - The GLRC Policy No. GLO 149.0, Page Page 15, Section (2)(f) states, "Disciplinary sanctions for violation of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories." The facility did not provide examples of staff discipline for violating said agency policies and indicated they have not had such an incident over the past 12 months. 115.376 (d) - The GLRC Policy No. GLO 149.0, Page 15, Section (2)(d) states, "All termination for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies."

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact 115.377(a) - The GLRC Policy No. GLO 149.0, Page 15, Section (2)(e) states, "Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies." The facility reported no such incidents with contractors or volunteers over the past 12 months. 115.377(b) - According to the staff acting as Superintendent, they would treat a sexual abuse or sexual harassment incident involving a contractor or volunteer in the same manner as they would handle an allegation against a staff member and would prevent the contractor or volunteer from coming on to the facility property until the investigation had been completed.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *Medical/Mental Health Staff **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *MDHHS "Preventing Sexual Abuse" Youth Orientation Packet *MDHHS Policy JR6 630, Isolation and/or Confinement 115.378(a) - The GLRC Policy No. GLO 149.0, Page 5, Section g states, "Clients may be subject to disciplinary sanctions only pursuant to positive findings that the youth engaged in youth-on-youth sexual abuse or sexual harassment." The facility reported no incidents of resident-on-resident sexual abuse or sexual harassment over the past 12 months; however, this auditor received a report of resident-on-resident sexual abuse during the resident interview process. As previously noted, there was no formal investigation conducted as a result of the resident's report, therefore, documentation regarding sanctions for resident-on-resident sexual abuse does not exist for this incident. 115.378(b) - The GLRC Policy No. GLO 149.0, Page 7, Section 5 states, "A youth may be isolated from other youth as a preventative and protective measure, but only as a last resort when other less restrictive measures are inadequate to keep the youth safe from other youths, and then only until an alternate means of keeping all youths safe can be arranged, During any periods of protective isolation, facility staff may not deny a youth otherwise under control, access to daily large-muscle exercise and legally-required educational programming or special education services. Any youth in isolation must receive daily visits from a medical or mental health care clinician and must have access to other programs to the extent possible. Should isolation occur, a review of the isolation will occur every 30 days. Furthermore, GLR has adopted MDHHS Policies JR6 630- Isolation And/Or Confinement and JR6 631 Due Process, should an exceptional circumstance occur where short-term isolation is required for safety reasons." The MDHHS Policy JR6 630, Pages 1-2 provides that confinement may only be used at the direction of a medical professional or the facility/center director or designee for medical purposes or upon the request of a youth with approval of a supervisor for a period of 30 minutes or less. This policy also provides that isolation may only be used for the purposes listed under confinement or when the youth's behavior is out of control, to protect the safety of the youth, other youth, staff and/or visitors, or for a total of 72 consecutive hours including any period of confinement if the isolation is due to the youth's culpability for a major offense. Although this policy language addresses isolation, none of it applies to a situation where a resident is being placed in isolation as a disciplinary sanction. It is also noted the adoption of this MDHHS policy appears to have been added as a result of the current PREA audit process, as this language does not appear in the three other versions of GLRC Policy No. GLO 149.0 that were provided/obtained for this audit. According to the staff acting as Superintendent, residents found to have engaged in resident-or-resident sexual abuse would likely be

discharged from the program. They indicated if the resident was not discharged they would be placed on "Reflection" status and their privileges would be restricted. The staff acting as Superintendent stated they do not use isolation as a disciplinary sanction.

115.378(c) - According to the staff acting as Superintendent, they would likely consider a resident's mental disability or mental illness when determining sanctions for resident-on-resident sexual abuse, but they advised it is unlikely a resident with those deficiencies would be placed in their program.

115.378(d) - The facility indicated in the Pre-Audit Questionnaire that it offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for resident-on-resident sexual abuse, but it did not provide any documentation to support this assertion. In interviews with medical/mental health staff, they indicated they do not provide sex offender specific treatment.

115.378(e) - The GLRC Policy No. GLO 149.0, Page 5, Section g states, "Clients may be subject to disciplinary sanctions for sexual contact with staff only upon findings that the staff member to (sic) not consent to such contact." The facility reported no such incidents over the past 12 months, therefore, documentation was unavailable for review.

115.378(f) - The GLRC Policy No. GLO 149.0, Page 5, Section g states, "Clients will not be disciplined for making an allegation of sexual abuse or sexual harassment if the investigation determines that the abuse did not occur, so long as the allegation was based upon a reasonable belief that the abuse occurred and the allegation was made in good faith." The facility reported no such incidents over the past 12 months, therefore, documentation was unavailable for review.

115.378(g) - The GLRC utilizes the MDHHS "Preventing Sexual Abuse" Youth Orientation Packet to educate its residents. Page 1 of the packet states, "Sexual activity of any type is prohibited at all residential facilities in the State of Michigan." The GLRC Policy No. GLO 149.0, Page 16, Section (3)(e) states, "GLR prohibits all sexual activity between residents and will remove privileges from youth for engaging in any form of sexual acting out, however sexual activity is NOT deemed sexual abuse IF the activity was not coerced, as determined through investigation."

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.378 (b) - The language specific to residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse is not present in the policies provided by GLRC and it appears isolation as a disciplinary sanction would violate the MDHHS Policy JR6 630 it cites in this provision. If the facility practices isolation as a disciplinary sanction, that language must be added to the GLRC Policy No. GLO 149.0. If the facility does not practice isolation under those circumstances, it needs to indicate that in the policy. In addition, the updated GLRC Policy No. GLO 149.0 must be distributed to all staff and all staff must be trained on the new policy language and the adopted MDHHS policies added to address compliance with this standard.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the

corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 6, 2020, April 10, 2020 and April 15, 2020 to substantiate corrective actions taken for this standard.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated on Page 13, Section G to indicate isolation cannot be used as a disciplinary action.

Staff Training - This auditor received confirmation that 22 GLRC staff members were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact.

Staff Interviews - This auditor conducted telephonic interviews with three staff selected at random from the GLRC staff roster on April 15, 2020. The staff interviews confirmed they were trained on the updated GLRC Policy No. GLO 149.0, Reporting of Sexual Contact, which included the MDHHS policy regarding isolation.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Staff Responsible for Risk Screening *Medical/Mental Health Staff *Residents who Disclose Sexual Victimization at Risk Screening **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *MDHHS Prison Rape Elimination Act (PREA) Screening Tool *Random Resident Files *Residents who Disclose Sexual Victimization at Risk Screening Files 115.381(a) - The GLRC Policy No. GLO 149.0, Page 6, Section (B)(1) states, "Note: If the assessment indicates that the resident has been a victim of sexual abuse or has committed sexual abuse, the resident will be examined by a medical or mental health provider within 14 days of the completed assessment." The facility reported on the Pre-Audit Questionnaire that all residents are seen by mental health staff within 14 days pursuant to licensing requirements, but that mental health staff does not keep secondary records of these sessions. The facility utilizes the MDHHS Prison Rape Elimination Act (PREA) Screening Tool for their resident intake screening. Page 4, Section IV of the screening tool is where follow up appointments with mental health are recorded for residents who report prior victimization. In reviewing the five files of residents who reported prior sexual victimization it was noted that none of them had documentation recorded for a follow-up appointment with medical/mental health. According to the staff responsible for risk screening, they offer the resident a follow-up appointment with medical/mental health staff and advised they would arrange it as soon as possible, as the mental health clinician is on site and the medical doctor is at the facility weekly. Of the six residents interviewed who reported prior sexual victimization, three indicated they were offered a follow-up appointment with medical/mental health at or shortly after the time of intake screening, and the other three said they were not offered follow-up appointments. 115.381(b) - The GLRC Policy No. GLO 149.0, Page 6, Section (B)(1) states, "Note: If the assessment indicates that the resident has been a victim of sexual abuse or has committed sexual abuse, the resident will be examined by a medical or mental health provider within 14 days of the completed assessment." The facility reported on the Pre-Audit Questionnaire that all residents are seen by mental health staff within 14 days pursuant to licensing requirements, but that mental health staff does not keep secondary records of these sessions. Of the nine total resident files reviewed, none of the risk screening tools indicated the resident was at risk for sexual abusiveness. The staff responsible for risk screening indicated they have never had a resident who reported sexual abusiveness on the intake risk screening, but that they would arrange for a follow-up appointment with mental health staff as soon as possible if a resident reports prior sexual abusiveness.

115.381(c) - The facility reported on the Pre-Audit Questionnaire that information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners. While there was no documentation provided by the facility of such an instance, it is noted that the risk screening tools are kept in the residents' binders, which are located in the staff offices. The GLRC reported that all staff, with the exception of maintenance staff, have access to the intake screening tools so they are informed of the history and background of each resident for the purpose of informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, as indicated in the standard.

115.381(d) - Interviews with mental health staff revealed they obtain informed consent from residents before reporting about prior sexual victimization and that the process for obtaining consent is to speak to the parent or legal guardian after discussing it with the resident.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.381(a) - The facility is lacking documentation regarding follow-up appointments with medical/mental health staff for residents who report prior victimization on the facility risk screening tool. The facility will need to document that the follow-up appointment was offered during the intake screening and the date it was offered. In conjunction with this, medical/mental health staff who see residents for follow-up appointments will need to complete documentation to record the date and general outcome of the appointment.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 27, 2020 to substantiate corrective actions taken for this standard.

PREA Risk Screening Tools and Clinical Follow-Up Notes- This auditor received PREA Risk Screening Tools for two new residents, dated March 13 and March 18, 2020. These PREA Risk Screening Tools reflected the residents reported prior sexual abuse victimization, and the accompanying clinical follow-up notes, dated March 20 and March 24, 2020, respectively were provided to demonstrate compliance.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Medical/Mental Health Staff *Random Staff (in lieu of Security and Non-Security First Responders) *Resident Who Reported Sexual Abuse **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC PREA Coordinated Response Plan 115.382(a) - The GLRC Policy No. GLO 149.0, Page 12, Sections 3 and 6 provide for a resident who reports sexual abuse to be transported to Marquette General Hospital for evidence collection, care for physical injuries, pregnancy tests and mental health assistance and counseling, as appropriate. The GLRC PREA Coordinated Response Plan also lists facilitating transportation of the resident victim for forensic examination, post-incident medical exams and counseling. Of the two Medical/Mental Health staff interviewed, one indicated the nature and scope of emergency medical treatment and crisis intervention services are determined by medical and mental health practitioners according to their professional judgment, and the other indicated the nature and scope of these services is pretty well-defined. According to the Pre-Audit Questionnaire, the facility's medical/mental health staff does not maintain secondary materials, such as a form or log documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; or the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Facility medical/mental health staff advised that information would be provided by the Emergency Room SANE staff at Marquette Hospital. According to the resident who reported sexual abuse, they were provided follow-up medical care two days after the incident. 115.382(b) - According to the GLRC PREA Coordinated Response Plan, first responders are to, "Contact Administration/Supervision, separate victim and alleged perpetrator, protect incident scene if identified, report allegation to Children's Protective Services, request that the victim not wash, change clothes, etc., ensure that the alleged perpetrator does not wash, change clothes, etc., document all information and activities in an incident report and cooperate with investigators, prosecutors, facility Administration." From the same Coordinated Response Plan, it is the responsibility of the facility Director or designee to ensure that the victim received follow up medical examinations and psychological and counseling services with the Women's Center or qualified staff. Interviews with random staff revealed they would protect the victim and notify facility administration as part of their initial steps in the event a resident reported sexual abuse. 115.382(c) - According to medical/mental health staff, residents would get the information

regarding timely access to emergency contraception and sexually transmitted infections prophylaxis at the Marquette Hospital Emergency Room, or the facility doctor or nurse could also provide it. The resident who reported sexual abuse indicated they talked to their primary counselor about the incident and were told they could see another counselor or therapist if they wanted to address the issue.

115.382(d) - The GLRC Policy No. GLO 149.0, Page 13, Section 6 states, "...All medical and counseling services will be provided at no charge to the victim."

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.382(b) - This provision requires that security and non-security first responders contact medical/mental health staff in the event medical/mental health staff is not present at the time the incident is reported. The facility's current Coordinated Response Plan/Institutional Plan places that responsibility on the facility Director or designee, who may or may not be present at the time the incident is reported. This procedure may create a delay in notification to medical/mental health staff. The facility will need to include a procedure in their Coordinated Response Plan to require first responders to notify medical/mental health staff of a sexual abuse incident if the facility Director/designee is not immediately available to do so.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 24, 2020 to substantiate corrective actions taken for this standard.

Coordinated Response Plan - This document now reflects it is the responsibility of the first responder to an incident of sexual abuse to notify Medical personnel in the event there are injuries to the victim. This auditor discussed with facility administration the issue of notifying GLRC medical and mental health personnel at length. In the likelihood any incident of sexual abuse would occur during the evening or weekends when facility medical and mental health staff is not present, it was agreed that first responders would be made responsible to seek medical care for any injuries sustained by a victim, and the responsibility to notify facility medical and mental health staff would remain with the facility Director or designee. Facility administraton expressed confidence that the notification by the Director or their designee would be done expeditiously.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

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

Auditor Overall Determination: Meets Standard

Auditor Discussion

Interviews conducted:
*Medical/Mental Health Staff
*Resident Who Reported Sexual Abuse

Documents reviewed:
*Pre-Audit Questionnaire
*GLRC Policy No. GLO 149.0, Reporting of Sexual Contact

*Site Review

115.383(a) - The GLRC Policy No. GLO 149.0, Pages 12-13, Section 6 states, "The victim of sexual assault or attempted sexual assault must be provided mental health assistance and counseling as determined necessary and appropriate. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member."

115.383(b) - Regarding evaluation and treatment of residents who have been victimized, interviews with medical/mental health staff indicated such evaluation entails the resident going to the Emergency Room, where the resident's stability and feeling of emotional and physical safety is assessed. The resident who reported sexual abuse indicated staff told them if they needed to talk to someone they could.

115.383(c) - The facility did not provide documentation of medical and mental health services for a resident victim of sexual abuse to verify consistency with the community level of care, and the incident discovered during the on-site audit did not have any such accompanying documentation. Interviews with medical/mental health staff revealed care to resident victims is consistent with community levels of care.

115.383(d) - The GLRC Policy No. GLO 149.0, Page 12, Section 4 states, "...Female youths must be provided with pregnancy tests." Page 13, Section 6 states, "...Female victims of sexually abusive vaginal penetration must be offered pregnancy tests." A pregnancy test was not required in the incident described by the resident who reported sexual abuse.

115.383(e) - The GLRC Policy No. GLO 149.0, Page 13, Section 6 states, "...Resident victims of sexual abuse will be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis in accordance with professionally accepted standards of care, where medically appropriate." Interviews with medical/mental health staff revealed this information would be provided to residents at the Emergency Room. A pregnancy test was not required in the incident described by the resident who reported sexual abuse.

115.383(f) - The GLRC Policy No. GLO 149.0, Page 12, Section 5 states, "Victims and perpetrators of sexual assault must be encouraged to complete tests for sexually transmitted

diseases, including an HIV test." The facility did not provide documentation that demonstrated victims were offered tests for sexually transmitted infections, and the incident discovered during the on-site audit did have any such accompanying documentation. The resident who reported sexual abuse indicated they were not offered tests for infections as a result of the alleged sexual abuse.

115.383(g) - The GLRC Policy No. GLO 149.0, Page 13, Section 6 states, "...All medical and counseling services will be provided at no charge to the victim." The resident who reported sexual abuse indicated they thought insurance would take care of any counseling or medical treatment.

115.383(h) - The facility did not provide documentation that demonstrated the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. Interviews with medical/mental health staff revealed they do not conduct mental health evaluations on resident-on-resident abusers.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.383(a) - Although the GLRC Policy No. GLO 149.0 provides that victims of sexual assault or attempted sexual assault must be provided mental health assistance and counseling as determined necessary and appropriate, the rest of the section addressing victim mental health assistance and counseling speaks more to victim advocacy and not medical and mental health evaluation and treatment. No other documentation regarding protocol for medical and mental health staff follow-up actions subsequent to a reported incident of sexual abuse was provided by GLRC. The facility will need to develop a protocol to address the actions required by medical and mental health staff to assess and treat the needs of a resident victim. This protocol must include specific evaluations needed to assess treatment needs and the timelines these assessments and subsequent treatment are implemented. The dates of the actions by medical/mental health staff will also need to be recorded in the facility's Coordinated Response Plan.

115.383(b) - The GLRC needs to include 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 placement in their medical/mental health protocol.

115.383(d) - The GLRC needs to include documentation of pregnancy tests in applicable sexual abuse incidents in their medical/mental health protocol. The GLRC Policy No. GLO 149.0 also needs to be updated to eliminate non-specific information regarding the provision of pregnancy tests in the GLRC Policy No. GLO 149.0, Page 12, Section 4.

115.383(e) - The GLRC needs to include documentation that victim residents were offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis where medically appropriate in their medical/mental health protocol in both the Coordinated Response Plan and the medical/mental health protocol indicated in 115.383(a). This documentation should include the date said information was provided and by whom it was provided.

115.383(f) - The GLRC must include documentation that resident victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate in both the Coordinated Response Plan and the medical/mental health protocol indicated in 115.383(a).

115.383(h) - The interviews with the staff acting as Superintendent revealed a resident who committed resident-on-resident sexual abuse would likely be discharged from the program as a result of such actions, and interviews with medical/mental health staff indicated they do not provide sex offense specific treatment at GLRC. If GLRC will not continue to house a resident who committed resident-on-resident sexual abuse, it will need to include this information in the GLRC Policy No. GLO 149.0 to address this provision.

It is noted this auditor was provided four different versions of the GLRC Policy No. GLO 149.0, Reporting of Sexual Contact over the course of the audit process. In addition to the corrections discussed in each provision, the GLRC Policy No. GLO 149.0 should be reviewed for conciseness and clarity to aid the reader to clearly understand what the policy requires.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 9, 2020 to substantiate corrective actions taken for this standard.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - Page 11-12, Sections 5 and 6 of this policy clarifies the language regarding pregnancy testing, emergency contraception and testing for sexually transmitted infections. Specific responsibilities for these required services are detailed in the updated Coordinated Response Plan. Page 13, Section G of this policy reflects the facility will not continue to house a resident accused of perpetrating resident-on-resident sexual abuse.

Coordinated Response Plan - The updated Coordinated Response Plan includes detailed responsibilities for Medical and Mental Health staff. The Plan requires facility Medical staff to follow up with UP Health-Marquette Emergency Room personnel to confirm pregnancy testing, sexually transmitted infection testing and prophylaxis and emergency contraception have been provided as necessary. The Plan requires Medical staff to provide follow-up services with the resident, including coordinating appointments and transport to outside medical providers, and a Continuing Care Plan for the resident upon discharge from the facility. The Plan also requires Medical staff to document all activities in the agency AWARDS data collection system and the MDHHS PREA Investigation Report form. Mental Health providers are required by the Plan to conduct mental health counseling with the resident and coordinate with the Women's Center for ongoing mental health services. Mental Health providers are required to document all services provided.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Compliance Manager **Documents reviewed:** *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *2017 Staff Sexual Abuse Investigative Detail 115.386(a) - The facility indicated it conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The GLRC Policy No. GLO 149.0, Page 17, Section 4 states, "A sexual abuse incident review will be conducted at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The sexual abuse incident review team will include at a minimum an upper level Administrator and a supervisor. The review will occur within 30 days of the conclusion of the investigation. The review team must review each incident of sexual abuse for cause, staffing and physical barriers, and make recommendations for prevention. Recommendations must be implemented or the reason(s) if not implemented must be." The facility reported no sexual abuse incidents over the past 12 months. As a result, this auditor reviewed the 2017 Staff Sexual Abuse Investigative Detail previously cited. Although there was no accompanying document titled "Sexual Abuse Incident Review", there was a Root Cause Analysis and Action Plan Report related to the alleged staff sexual misconduct. This document demonstrated the matter was reviewed by a multidisciplinary team and recommendations were included in the review. 115.386(b) - The aforementioned staff sexual misconduct allegation was made by a resident on June 19, 2017 and the date of the above-noted report was July 3, 2017, within the 30-day requirement. 115.386(c) - The GLRC Policy No. GLO 149.0, Page 17, Section 4 states, "...The sexual abuse incident review team will include at a minimum an upper level Administrator and a supervisor." In the Root Cause Analysis and Action Plan Report related to the alleged staff sexual misconduct incident, the Program Supervisor (staff acting as Superintendent, PREA Coordinator and PREA Compliance Manager), the Children's Services Director, staff from the MDHHS, clinical staff and floor staff participated in the review. In interviews with the staff acting as Superintendent, they advised the facility does not have a sexual abuse incident review team. However, this auditor notes that the team formed for the Root Cause Analysis and Action Plan is sufficient to meet the requirements of this provision and the same analysis and documentation can be titled "Sexual Abuse Incident Review". 115.386(d) - The aforementioned Root Cause Analysis and Action Plan address all of the factors in this provision, with the exception of consideration for 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. In interviews with the staff acting as Superintendent and PREA Compliance Manager, they advised the facility does not have a sexual abuse incident review team. As a result, an answer regarding what is reviewed and how the information is used by the sexual abuse incident review team was not provided. For the same reason the Incident Review Team interview was not conducted.

115.386(e) - The GLRC Policy No. GLO 149.0, Page 17, Section 4 states, "...Recommendations must be implemented or the reason(s) if not implemented must be." The aforementioned Root Cause Analysis and Action Plan lists recommended actions to address the issues analyzed and whether or not those recommendations would be implemented, along with the reasons why certain recommendations would not be implemented.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.386(d) - On the whole, GLRC has demonstrated it reviews sexual abuse incidents with a multidisciplinary team and makes recommendations to address issues identified in the review. The facility will need to include an analysis of 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. For the purpose of demonstrating compliance for this Corrective Action, GLRC will need to create a template for the sexual abuse incident review which includes a narrative section for consideration of the aforementioned factors specific to the victim.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 6, 2020 and April 7, 2020 to substantiate corrective actions taken for this standard.

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - This policy has been updated on Page 17, Section 4 to include GLRC will utilize the MDHHS 30 Day Sexual Abuse Incident Review Form to conduct reviews of sexual abuse incidents.

MDHHS Form 5818, 30 Day Sexual Abuse Incident Review Form - This form requires the Incident Review Team to consider whether the incident or allegation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender or intersex identification, status or percieved status, gang affiliation or ther group dynamics at the facility. GLRC has indicated this form will be used for future sexual abuse incident reviews.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents reviewed: *Pre-Audit Questionnaire *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC PREA Compliance Data Report 2018 115.387(a) - The facility provided the definitions in the GLRC Policy No. GLO 149.0 listed on Pages 3 and 4 on the Pre-Audit Questionnaire as evidence of compliance with this standard. These definitions included the following: Resident-on-resident sexually abusive penetration; Resident-on-resident sexually abusive contact; Resident-on-resident sexual harassment; Staff-on-resident sexually abusive contact; Staff-on-resident sexually abusive penetration; Staff-on-resident indecent exposure; Staff-on-resident voyeurism; Staff-on-resident sexual harassment; Staff sexual misconduct and Sexual Exploitation. However, the GLRC PREA Compliance Data Report 2018 posted to the agency website lists the following categories: Youth on Youth Non-Consensual Sexual Acts; Youth on Youth Abusive Sexual Contacts; Youth on Youth Sexual Harassment ; Staff Misconduct and Staff Sexual Harassment. The facility was unable to provide a standardized instrument used to collect and maintain the data. 115.387(b) - The facility indicated it aggregates the incident-based sexual abuse data at least annually on the Pre-Audit Questionnaire. The GLRC PREA Compliance Data Report 2018 listed no incidents in any of the aforementioned categories. Therefore, it is difficult to assess whether or not data is aggregated. 115.387(c) - The facility provided a blank copy of the Department of Justice Survey of Sexual Violence (SSV) issued on September 25, 2018 and the GLRC Policy No. GLO 149.0, Page 18, Section 8 on the Pre-Audit Questionnaire to demonstrate compliance with this provision. This section of policy states, "The facility must collect accurate, uniform data for every allegation of sexual abuse. At a minimum the data must be sufficient to answer all questions on the annually-required Survey of Sexual Violence (SSV). Aggregated data must be: a) Reviewed in order to assess and improve sexual abuse prevention, detection and response practices, b) Made available to the public through a public website or some other means at least annually." The facility was unable to provide a standardized instrument used to collect and maintain the data. 115.387(d) - No documentation was provided by GLRC to substantiate compliance with this provision. 115.387(e) - The facility reported in the Pre-Audit Questionnaire that GLRC does not contract with private facilities for the confinement of residents. 115.387(f) - The facility indicated the Department of Justice has not requested agency data on the Pre-Audit Questionnaire. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:**

115.387(a) - The facility will need to standardize the definitions of the types of offenses it is tracking in its GLRC Policy No. GLO 149.0 and the PREA Compliance Data Report to reflect the same definitions on both documents. The facility will also need to create a secured standardized instrument used to collect and maintain the data used to populate the PREA Compliance Data Report, with controlled and limited access.

115.387(b) - The facility will need to create a secured standardized instrument used to collect and maintain the data used to populate the PREA Compliance Data Report. The standardized instrument will also need to document and demonstrate how the data collected is aggregated on an annual basis, at a minimum.

115.387(c) - The facility will need to create a secured standardized instrument used to collect and maintain the data used to complete the Department of Justice SSV.

115.387(d) - The facility will need to develop a system to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Such a system must be secured, with access limited to upper administration.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 25, 2020, April 9, 2020 and April 22, 2020 to substantiate corrective action taken for this standard.

Additional Documents Reviewed:

GLRC Policy No. GLO 149.0, Reporting of Sexual Contact - The definitions in this policy have been updated to include Youth on Youth Non-Consensual Sexual Acts, Youth on Youth Abusive Sexual Contacts, Youth on Youth Sexual Harassment, Staff Sexual Misconduct and Staff Sexual Harassment.

PREA Compliance Data Report 2019 - The definitions in the PREA Compliance Data Report 2019 have been updated to include Youth on Youth Non-Consensual Sexual Acts, Youth on Youth Abusive Sexual Contacts, Youth on Youth Sexual Harassment, Staff Sexual Misconduct and Staff Sexual Harassment.

GLRC PREA Private Documents Folder - A screenshot of this folder on the agency network was provided by the agency IT Manager. He advised access to this folder is limited to five members of agency and facility administration. The folder contains the PREA Risk Screening Tools, PREA Investigation Reports and Checklist,PREA Incident Review Reports, Unannounced Rounds Logs, PREA Staffing Plans, Retaliation Monitoring Forms, PREA Grievance Log/Spreadsheet (two different documents, one recording information from grievances and the other recording reports of sexual abuse or sexual harassment reported by other methods), PREA Compliance Data Reports and original copies of PREA-related documents. The PREA Grievance Log/Spreadsheet records incidents of reported sexual abuse and sexual harassment and will be utilizied to maintain, review and collect data. The PREA Grievance Log/Spreadsheet will also capture information necessary to complete the Department of Justice SSV. The facility Director provided a video demonstration of them accessing the folder and staff who does not have access to the folder attempting to access the

	folder unsuccessfully. GLRC PREA Data Protocol - This Protocol outlines what is contained in the GLRC PREA Private Documents Folder and who has access to the folder. The Protocol also provides step-by-step instructions to access the folder with the appropriate security access. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *PREA Coordinator *PREA Compliance Manager **Documents reviewed:** *GLRC Performance Improvement Committee Meeting Minutes 115.388(a) - Interviews with the Agency Head revealed the agency holds quarterly improvement meetings, where all incidents over that quarter are reviewed. The Agency Head advised they look for trends and address any issues with a plan. They also indicated their Board of Directors reviews incident data on a regular basis. This auditor reviewed the minutes from the November 7, 2019 GLRC Performance Improvement Committee Meeting for verification of the quarterly review process. The staff acting as PREA Coordinator and PREA Compliance Manager advised the data collected and aggregated pursuant to 115.387 is not reviewed and they will do so moving forward; however, they indicated the agency has prepared an annual report of the findings from the data review for the past two years. The facility provided the website for the MDHHS annual report but did not provide documentation of a GLRC agency report. 115.388(b) - The facility provided the website for the MDHHS annual report but did not provide documentation of a GLRC agency report. 115.388(c) - The facility provided the website for the MDHHS annual report but did not provide documentation of a GLRC agency report. 115.388(d) - The facility indicated it redacts only specific materials where publication would present a clear and specific threat to the safety and security of the facility and explains the nature of the redacted information. The facility provided the website for the MDHHS annual report but did not provide documentation of a GLRC agency report. According to the staff acting as PREA Coordinator, they redact personal identifying information from the annual report. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:** 115.388(a) - GLRC will need to generate its own agency annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The information used to provide the MDHHS with data for their report is the same data GLRC will utilize for its annual report. 115.388(b) - GLRC will need to include comparisons of the current year's data with prior years and an assessment of the agency's progress in addressing sexual abuse in its own agency annual report.

115.388(c) - The facility will need to publish its annual report to the GLRC agency website to make it available to the public.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 7, 2020 to substantiate corrective actions taken for this standard.

PREA Compliance Data Report 2019 - This report lists the number of residents admitted to GLRC, the number of residents discharged, the number and gender breakdown of residents in the program at year end and the number of residents under the age of 18. The report also breaks down incidents of Youth on Youth Non-Consensual Acts, Youth on Youth Abusive Sexual Contacts, Youth on Youth Sexual Harassment, Staff Sexual Misconduct and Staff Sexual Harassment.

GLRC Website - The GLRC PREA Compliance Data Reports for 2018 and 2019 were found posted on the agency website.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *PREA Coordinator **Documents reviewed:** *GLRC Policy No. GLO 149.0, Reporting of Sexual Contact *GLRC PREA Compliance Data Report 2018 *MDHHS Policy JR5 560, Sexual Abuse Prevention and Response Overview *MDHHS Residential Foster Care Contract 115.389(a) - The facility provided the MDHHS Policy JR5 560, Pages 6 and 7 to demonstrate compliance with this provision, This section of policy states, "Data collection and review procedures must include....Provisions for secure maintenance and storage of sexual abuse and harassment incident data." This section of policy was entitled "MDHHS Umbrella Policy #560". The facility did not provide any agency-specific protocol or policy, nor did it provide any agency documentation adopting the MDHHS Policy JR5 560. Contact with MDHHS representatives reveals all MDHHS residential foster care contracts have a provision requiring contractors to comply with all applicable MDHHS Juvenile Justice Residential (JJR) policies and MDHHS JJR policy amendments, including interim policy bulletins and all applicable Administrative Codes. According to the staff acting as PREA Coordinator, the agency does not review collected and aggregated data. 115.389(b) - The GLRC Policy No. GLO 149.0, Page 18, Section (8)(b) states, "Aggregated data must be made available to the public through a public Website or some other means at least annually. (Note: Personal identifiers must be removed.)" This auditor located the "PREA Compliance Data Report 2018" on the agency website. 115.389(c) - The GLRC Policy No. GLO 149.0, Page 18, Section (8)(b) states, "Aggregated data must be made available to the public through a public Website or some other means at least annually. (Note: Personal identifiers must be removed.)" No personal identifying information was found on the GLRC PREA Compliance Data Report 2018. 115.389(d) - As indicated in 115.387, the facility did not provide standardized instrument used to collect and maintain the data used to populate the PREA Compliance Data Report or a system to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. As a result, the facility appears to have no policy on how long such data is kept. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:** 115.389(a) - The documentation provided by both GLRC and MDHHS is insufficient to substantiate compliance with this provision. The MDHHS contract language that requires contractors to comply with all MDHHS policies has no specificity to the issue of securely retaining aggregated data, and GLRC has not provided a policy, procedure or protocol to

direct the process for keeping and securing aggregated data. The facility will need to create a written protocol which clearly demonstrates how the facility secures its aggregated data. This protocol should be instructive enough for anyone to understand the process of securing the data (how is it stored) and who has access to the data.

115.389(d) - In conjunction with the Corrective Action required for 115.387, the facility will need to develop a system to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Such a system must be secured, with access limited to upper administration, and a mechanism to discard data that was collected ten or more years prior (unless otherwise prescribed by Federal, State or local law).

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 9, 2020 and April 22, 2020 to substantiate corrective actions taken for this standard.

GLRC PREA Private Documents Folder - A screenshot of this folder on the agency network was provided by the agency IT Manager. He advised access to this folder is limited to five members of agency and facility administration. The folder contains the PREA Risk Screening Tools, PREA Investigation Reports and Checklist, PREA Incident Review Reports, Unannounced Rounds Logs, PREA Staffing Plans, Retaliation Monitoring Forms, PREA Grievance Log/Spreadsheet, PREA Compliance Data Reports and original copies of PREA-related documents. The PREA Grievance Log/Spreadsheet records incidents of reported sexual abuse and sexual harassment and will be utilizied to maintain, review and collect data. The PREA Grievance Log/Spreadsheet will also capture information necessary to complete the Department of Justice SSV. The facility Director provided a video demonstration of them accessing the folder and staff who does not have access to the folder attempting to access the folder unsuccessfully.

GLRC PREA Data Protocol - This Protocol outlines what is contained in the GLRC PREA Private Documents Folder and who has access to the folder. The Protocol also provides step-by-step instructions to access the folder with the appropriate security access.

Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews Conducted: *Superintendent *Site Review 115.401(a) - The Great Lakes Recovery Centers as an agency operates a total of four residential programs, with the GLRC in Negaunee, Michigan being the only juvenile facility. According to the GLRC Policy No. GLO 149.0, Page 15, Section(I)(1), "In addition to internal administrative review and analysis, and DCWL reviews, an independent and qualified auditor must audit the agency at least every three years." This auditor located the 2016 PREA facility audit, the PREA Compliance Data Report 2018, the PREA Right to Report Form and the PREA Policy on the agency website. 115.401(b) - According to the staff acting as Superintendent, GLRC's adolescent program is the only one of four facilities that is subject to PREA regulations. 115.401(h) - This auditor was granted access to all areas of the facility and was able to observe all areas of the facility. 115.401(i) - This auditor requested and received copies of documents. This auditor was provided, in secured format, requested data that was stored electronically. 115.401(m) - This auditor was able to conduct interviews with staff and residents in a private office, without other staff present. 115.401(n) - This auditor confirmed that the PREA Audit Notices were posted six weeks prior to the on-site portion of the audit beginning on October 1, 2019. Confirmation was obtained through photographs of the posted audit notices in multiple locations throughout the facility, which were emailed to this auditor on August 14, 2019. This auditor's mailing address was included on the audit notices.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.403(f) - The GLRC 2016 PREA Audit was located on the agency website. The 2016 PREA Audit Report is dated November 23, 2016. The date the Audit Report was posted to the website is unknown.

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	yes
	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
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.312 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	na
115.313 (a)	**Supervision and monitoring**	

	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels	yes

	and determining the need for video monitoring: The number and placement of supervisory staff?	
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes
115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	yes
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes

115.313 (d)	Supervision and monitoring	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities)	yes
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes

115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	no
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	yes
115.315 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.315 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
115.316 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all	yes

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

	through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	yes

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

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

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

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

115.321 (e)	Evidence protocol and forensic medical examinations	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is not responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	yes
115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes

115.322 (c)	Policies to ensure referrals of allegations for investigations	
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes

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

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

115.333 (a)	Resident education	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes

115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.335 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment?	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse?	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment?	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment?	yes
115.335 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.)	no
115.335 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?	yes
115.335 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331?	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332?	yes
115.341 (a)	**Obtaining information from residents**	
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes

115.341 (b)	Obtaining information from residents	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes

115.341 (c)	Obtaining information from residents	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident’s own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes

115.341 (d)	Obtaining information from residents	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	yes
115.342 (a)	**Placement of residents**	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes

115.342 (b)	Placement of residents	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes
115.342 (c)	**Placement of residents**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes

115.342 (d)	Placement of residents	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?	yes
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	na
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	na
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes

115.351 (a)	Resident reporting	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	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?	no
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes

115.352 (a)	Exhaustion of administrative remedies	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	no
115.352 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	yes
115.352 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes

115.352 (d)	Exhaustion of administrative remedies	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes

115.352 (e)	Exhaustion of administrative remedies	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	yes
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	yes
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	yes
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	yes

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

115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	no
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes

115.354 (a)	Third-party reporting	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes

115.361 (e)	Staff and agency reporting duties	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	yes
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?	yes
115.362 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.363 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes

115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.364 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.364 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.365 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes

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

115.367 (c)	Agency protection against retaliation	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes

115.367 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes
115.371 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	no
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes

115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.371 (f)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.371 (h)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes
115.371 (k)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes

115.371 (m)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.372 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes

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

115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.376 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes

115.378 (a)	Interventions and disciplinary sanctions for residents	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes
115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	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?	no

115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes
115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	
	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?	yes

115.382 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.382 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes

115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	yes
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)	yes
115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	no
115.386 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes

115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes

115.387 (c)	Data collection	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.387 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.388 (b)	**Data review for corrective action**	
	Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?	yes

115.388 (c)	**Data review for corrective action**	
	Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes

115.401 (b)	Frequency and scope of audits	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	yes
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	na
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	na
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes