PREA Facility Audit Report: Final

Name of Facility: Lakes Area Residential Group Home
Facility Type: Juvenile
Date Interim Report Submitted: 10/16/2020
Date Final Report Submitted: 05/03/2021

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:** 05/03/2021

AUDITOR INFORMATION	
Auditor name:	Kingera, Tracy
Email:	tracy.kingera@gmail.com
Start Date of On-Site Audit:	09/15/2020
End Date of On-Site Audit:	09/16/2020

FACILITY INFORMATION	
Facility name:	Lakes Area Residential Group Home
Facility physical address:	7820 State Hwy M123, Newberry, Michigan - 49868
Facility Phone	
Facility mailing address:	7820 State Hwy M123, Newberry, Michigan - 49868

Primary Contact	
Name:	Dustin Hogue
Email Address:	dhogue@tfhomes.org
Telephone Number:	906-286-9617

Superintendent/Director/Administrator	
Name:	Dustin Hogue
Email Address:	dhogue@tfhomes.org
Telephone Number:	906-249-5437

Facility PREA Compliance Manager	
Name:	Heather Srock
Email Address:	srockh@michigan.gov
Telephone Number:	O: (517) 897-0795

Facility Characteristics	
Designed facility capacity:	8
Current population of facility:	4
Average daily population for the past 12 months:	4
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	5 to 17
Facility security levels/resident custody levels:	Minimum
Number of staff currently employed at the facility who may have contact with residents:	10
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	2
Number of volunteers who have contact with residents, currently authorized to enter the facility:	1

AGENCY INFORMATION	
Name of agency:	Teaching Family Homes of Upper Michigan
Governing authority or parent agency (if applicable):	
Physical Address:	1000 Silver Creek Road, Marquette , Michigan - 49855
Mailing Address:	7820 State Hwy M123, Newberry, Michigan - 49868
Telephone number:	906 293 5670

Agency Chief Executive Officer Information:	
Name:	Dustin Hogue
Email Address:	dhogue@tfhomes.org
Telephone Number:	906 286 9617

Agency-Wide PREA Coordinator Information			
Name:	Dustin Hogue	**Email Address:**	dhogue@tfhomes.org

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.

Narrative:

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 Lakes Area Teaching Family Home (LATFH), located in Newberry, Michigan. This audit is the third PREA audit for LATFH, 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 LATFH for juvenile residential pre- and post-adjudication housing and programming for male residents, entered into contract for the PREA audit in June 2020. This auditor corresponded with the MDHHS PREA Compliance Manager by email in June 2020 and audit dates of September 15-16, 2020 were set. Audit-specific contact began on June 30, 2020, with the introductory telephonic conference with the MDHHS PREA Coordinator, the MDHHS PREA Compliance Managers assigned to monitor and assist LATFH, and the LATFH PREA Compliance Manager. 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 LATFH 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, 2020. The PREA audit notices were forwarded to the MDHHS PREA Compliance Manager for posting on July 31, 2020. 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 7, 2020, a few days short of the required six-week period prior to the on-site audit. The eight audit notifications in both English and Spanish were printed on green and yellow paper and posted throughout the facility, including in the hallways, classroom area, point card area and resident restroom doors. This auditor conducted internet research of LATFH, which produced no information regarding sexual abuse or sexual harassment reports for the facility. No information regarding consent decrees or outside oversight specific to LATFH was discovered. This auditor reviewed the agency website and conducted research on the mandatory reporting laws and age of juvenile certification to adult status in the State of Michigan. This auditor contacted Just Detention, International (JDI) to check for a history of complaints for LATFH 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 6, 2020 and review of the PAQ began the following day. 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 August 15, 2020. A telephonic conference was held on August 19, 2020 to review the Issue Log; however, the LATFH staff that held the responsibilities of PREA Coordinator, PREA Compliance Manager, Superintendent and Investigative Staff had just taken the position of Agency Head and did not have a chance to review the Issue Log prior to the conference call. At that time, it was discussed with the State of Michigan PREA Coordinator, PREA Compliance Managers and the LATFH Agency Head/PREA Coordinator/PREA Compliance Manager/Superintendent/Investigative Staff (hereafter referred to as the LATFH PREA Compliance Manager, unless specific standards require interview protocol designation) on that date regarding COVID-19 and the facility and auditor's desire to limit contact with residents and staff. After consultation with the PREA Resource Center, this auditor decided to conduct as many required staff interviews over secure video conference on Microsoft Teams to limit exposing the residents, staff, and this auditor to the COVID-19 virus. It was agreed that the interviews would occur prior to the on-site audit. On August 24, 2020, video conference interviews were scheduled via email for September 3 and 4, 2020. This auditor also requested the list of specialized staff and residents to prepare to make interview selections at that time. However, those lists were not forthcoming. This auditor sent additional requests for this information on August 29 and September 2, 2020. On September 2, 2020, the LATFH PREA Compliance Manager responded with a list of direct care staff, but no lists for specialized staff and residents were provided. This auditor conducted Random Staff interviews with three direct care staff on September 3, 2020. Following the video conference interviews this auditor emailed the LATFH PREA Compliance Manager to confirm the interviews for the following day. However, a response was not received, and this auditor subsequently canceled the interviews for September 4, 2020. This auditor sent a list of missing documents to the LATFH PREA Compliance Manager on September 4, 2020 and requested the documents be uploaded to the OAS as soon as possible. Additional video conference interviews were scheduled for and completed on September 11, 2020 with four Random Staff members and one Intermediate or Higher- Level Staff member. This auditor requested the lists of specialized staff and residents a total of five times by email. The LATFH PREA Compliance Manager provided the specialized resident list on September 11, 2020, four days prior to travel to Newberry, Michigan. No resident names were recorded in any of the specialized categories, but the names of the four residents who would be present at the time of the on-site audit on September 15, 2020 were provided. The list of specialized staff was never received pre-audit, nor was any of the documentation on the Issue Log and Document List forwarded to the facility on August 15 and September 4, 2020, respectively. This auditor also forwarded the PREA Request for Specialized Files Identification Listing on August 19 and September 4, 2020. This auditor requested the lists of all staff and residents at LATFH over the past 12 months as part of the Document List; however, that information was not received until the on-site audit. It is noted this auditor received no written correspondence from residents, staff or others pre-audit or post-audit. This auditor sent a proposed audit schedule to the MDHHS PREA Compliance Managers and the LATFH PREA Compliance Manager on September 14, 2020.

ON-SITE AUDIT

The first day of the on-site portion of the PREA Audit for LATFH was September 15, 2020 and concluded on September 16, 2020. This auditor arrived at LATFH on September 15, 2020 at 0800 hours and met in person with the LATFH PREA Compliance Manager and MDHHS PREA Compliance Managers. At that time, this auditor conducted a brief introductory meeting and reviewed the proposed audit schedule. The specialized staff members were identified on-site, and it was determined the vast majority of the specialized interview protocols would be completed with the LATFH PREA Compliance Manager. Other staff still to be interviewed were identified and this auditor worked with LATFH staff to schedule those staff members' interviews to create as little disruption to facility operations as possible. Two facility

contractors were identified for interview. The LATFH PREA Compliance Manager reported there were no volunteers providing services at LATFH. The resident population on the first day of the on-site audit was four residents.

This auditor conducted the site review of the facility on September 15, 2020 in the company of the LATFH PREA Compliance Manager. The LATFH is a two-story, home setting facility comprised of two buildings, located off a main road in Newberry, Michigan. The LATFH facility is staff-secured, with no controlled barriers to entering or exiting the facility. The yard of the facility is unfenced, and a small condominium building and a Michigan State Police building border the facility. The front yard of the facility has a driveway for several vehicles, as well as grass and mature landscaping. The front door to the facility has a small porch area. Upon entering the facility, visitors are required to sign in to the LATFH visitation log and temperatures are checked by staff for COVID-19 precautions. Directly to the right is a large living room furnished with one sofa, several chairs, a coffee table, and bookshelf, with a large picture window facing the road in front of the facility. Beyond the living room are five bedrooms and two full bathrooms. One of these bedrooms is set up for two residents, however, the rest of the six bedrooms in the facility are single-bunked rooms. The bedrooms are spacious and are furnished only with a bed. There are shallow closets in each room with the doors removed and shelving for residents to store items. Each bedroom has a window, covered by window coverings, and the bedroom doors are solid. Resident artwork was posted in some of the bedrooms. Heading back toward the center of the facility is the dining room and kitchen area, both resembling a typical family residence. There are French doors off the dining room that lead to a deck/barbeque, and a stairway off the deck leads to the lower level. On the other side of the facility are two more bedrooms and a half-bathroom, employee lockers, laundry room and a hallway area where resident point cards, a board for chore assignments and posted information are kept. Around the corner is the stairwell that leads to the classroom, counseling room, furnace and electrical rooms, staff offices, a large refrigerator and freezer, dry storage pantry, staff restroom and storage rooms for resident property and other items. The pantry and storage rooms were locked at the time of the site review, and the LATFH PREA Compliance Manager advised all staff members have key access to these areas. The classroom area occupies an open area directly off the stairwell, and staff offices are behind and adjacent to the classroom. Video surveillance cameras were observed in the classroom, counseling room, living room, dining room, stairwell, kitchen, and hallways. No cameras were observed in the bedrooms or bathrooms, and residents are required to shower, toilet and change clothes behind closed bathroom doors. This auditor observed the camera views from the video monitor located in the staff office. Camera views were observed to cover the doors leading into bedrooms and bathrooms, but none of the camera views showed the interiors of bedrooms or bathrooms. According to the LATFH PREA Compliance Manager, video footage is stored for 15-30 days and can only be viewed from the monitor located in the staff office. There are two doors off the lower level of the facility that lead to the outside of the facility. In the back of the facility is a large grassy area, basketball court and a separate building. That building was originally used for teaching woodworking and other skills to residents; however, it is no longer functioning in that capacity and is currently used for storage. The building was locked at the time of the on-site audit, and the LATFH PREA Compliance Manager advised all staff has key access to the building. Intake staff advised they typically conduct intakes with newly placed residents in the dining or living room areas and ensure they have privacy for the intake procedure. The telephone residents use is a land line located in the kitchen, however, there is also a cordless telephone located in the living room that residents can use for private conversations. When more privacy is required, the resident is escorted to the basement conference room to use the telephone there. The resident's therapist reviews the comprehensive PREA education (PREA educational video) and completes the risk screening tool with the residents in the counseling room downstairs.

This auditor observed four of the eight beds in the facility were occupied, and each resident had their own room. No rooms designated as isolation rooms were noted during the site review, and the practice of isolation will be discussed in detail in the standards analysis. A padlocked "Drop Box" for grievance forms, rights violations and feedback is located in the classroom, and grievance forms were found on the top of the box. Intermediate or Higher-Level Staff reported they check the Drop Box daily. The toilet/shower rooms are configured like traditional home bathrooms, and residents and staff reported residents use those facilities one at a time with the door closed. There are no work assignment areas at LATFH.

During the site review this auditor observed the PREA audit announcements posted throughout the facility, including the front entrance, bathroom doors, dining room, hallways, and classroom area. The audit notices were posted in both English and Spanish. This auditor also observed informational postings for sexual abuse reporting and support in those same areas. These postings will be addressed in detail in the standards analysis. The "Say No to Sexual Abuse", "This Facility Complies with Federal PREA Standards" and "End the Silence" postings list the ways to report sexual abuse and sexual harassment and provides the telephone numbers to the facility PREA Compliance Manager, Children's Protective Services Hotline, the Women's Center and Marquette General Hospital. It is noted the latter three agencies are listed as emergency resources. There were no addresses listed for victim supportive services, although the Women's Center is a victim supportive service. Residents were observed throughout the facility to be supervised by staff, and residents were supervised by the appropriate ratio of staff to youth for adequate supervision under the PREA standards.

The classification and resident education processes were not observed as there was no intake taking place during the on-site audit. It is noted the resident population over the past 12 months has allowed for all residents to have their own rooms, which minimizes some of the housing decisions. Intake staff walked this auditor through the process for intakes, including reviewing the "Youth Safety Guide" and the location where they conduct intakes. As previously indicated, Intake staff does not complete the risk screening tool with the resident when they first arrive. The risk screening tool is completed by the resident's assigned therapist and, according to the therapist interviewed as Staff Performing Risk Screening, the screening is performed within 72 hours of a resident's placement. The use of the risk screening tool will be discussed in detail in the standards analysis.

The roster of residents was provided to this auditor on September 11, 2020. This auditor was provided space for confidential and private interviews with residents and the remaining staff who were not interviewed pre-on-site audit. This auditor was able to interview all seven of the facility's line staff for Random Staff interviews. Random selections were not made for the specialized staff interviews, as the facility had only one staff member designated in each specialized staff category, with the exception of contracted staff. This auditor interviewed the two contractors assigned to LATFH for the Volunteers and Contractors Who Have Contact With Residents interview protocol. The LATFH PREA Compliance Manager advised there are no volunteer services at LATFH. The interviews were conducted using the Department of Justice interview protocols. Seven random staff interviews and 15 specialized staff interview protocols were completed over the course of the pre- and on-site audit. Staff interviews were conducted with staff from all three shifts (07:00-15:00, 15:00-23:00, and 23:00-07:00). Four random resident interviews and four specialized resident interviews were completed. In total, eight resident interview protocols were completed. The LATFH did not house a 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 Coordinator, (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) Incident Review Team, (1) Investigative Staff and (1) Staff That Perform Screening For Risk of Victimization and Abusiveness. 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 it was reported the facility prohibits these practices. The Security and Non-Security Staff Who Have Acted As First Responders interview protocol was not completed as there were no staff members who fit that criteria present during the pre-audit and on-site audit.

The following specialized resident interviews were conducted: (1) Resident Who Disclosed Prior Sexual Victimization During Risk Screening, (1) Resident Who Reported a Sexual Abuse, (1) Disabled Resident and (1) Transgendered, Intersex, Gay, Lesbian or Bisexual Resident. As the resident population of LATFH was so small, all four of the residents were interviewed and three of the four residents were interviewed for the specialized interview protocols. There was a total of one resident who disclosed prior sexual victimization, one disabled or limited English-proficient resident, one resident who reported sexual abuse and one LGBTI resident present at the facility at the time of the on-site audit.

A total of six resident and employee files were reviewed. Active and discharged resident files are maintained in three-ring binders, which are kept in the staff office, which is locked when staff is not present in the office. Staff members have access to active and closed resident files. This auditor used the list of residents admitted to LATFH over the past 12 months to make file selections. Resident files were chosen by selecting every fourth of 12 names. All resident files contained the risk screening tool; however, the risk screening tool was missing some required information, which will be discussed in the standards analysis. This auditor asked for all the risk screening tools for residents placed over the past 12 months and found the information was missing on all risk screening tools. Of the 13 risk screening tools reviewed, all of them had factors for risk of victimization or risk of sexual abusiveness. Of those 13 risk screening tools, five were noted as high risk for potential victimization or abusiveness and eight did not designate an elevated risk. No reassessments were noted in the resident files that were reviewed and random resident interviews revealed residents were not asked the screening questions again at a later point in their placement. One of the three resident files reviewed reflected the risk screening was conducted beyond 72 hours of admission. All the resident files reflected the resident received PREA information at intake. The comprehensive PREA education documentation was problematic, in that two of the three resident files reflected the resident watched the PREA video, however, no date was recorded. It appears the video may have been shown to the resident in conjunction with the completion of the risk screening tool, as that is where the notations were found; however, that is not evident with this system of documentation. One of the three resident files had no documentation the resident viewed the PREA video. None of the 13 risk screening tools contained documentation of an offer to schedule a follow-up appointment with Medical/Mental Health, as there was nowhere on the tool to specifically record that information. According to the LATFH PREA Compliance Manager, the facility does not maintain secondary medical or treatment records. The contracted Registered Nurse advised they maintain resident medical records in their off-site office in a locked, secure format. Mental health records are also kept off-site by the contracted psychologist, and treatment records are provided to caseworkers and Probation Officers if they submit a request through LATFH. As a result, separate medical/mental files were not reviewed.

This auditor used the list of staff employed at the facility over the past 12 months and selected three files at random by counting every fourth name from a list of 13 current and former staff. One of the three files contained criminal record (including annual checks), child abuse registry, and national sex offender

registry checks, as well as institutional reference checks, PREA training documentation and the employment application questions for the administrative adjudication check. A second employee file contained all of these except the initial PREA training documentation. It is noted the initial PREA training was not documented at the time of this employee's hire. The third employee file was missing all of the required documentation, with the exception of the employment application questions for the administrative adjudication check, institutional reference check and national sex offender registry check. This employee file was discussed with facility administration and they advised they were told by agency administration they did not need that documentation in the employee file. It is noted the facility currently does not utilize an employee PREA training acknowledgment, just a signed roster to document PREA training.

The facility reported no incidents of sexual abuse or sexual harassment over the past 12 months. The facility advised there was an incident in 2019 that was reported to law enforcement and this auditor requested the documentation for this incident to assess LATFH's response to the reported sexual abuse incident. The facility provided this auditor two incident reports for the two residents involved in the incident and the report from the Luce County Sheriff's Office. The documentation for this incident was lacking a facility administrative investigation report and findings, documentation for staff actions and when those actions were taken (other than what was mentioned in the incident reports), an incident review report, and documentation for the outcome of the Luce County Sheriff's Office report. The incident reports reflect the facility attempted to contact the two residents' caseworkers, but there was no documentation the facility contacted the Children's Protective Services Hotline or Licensing. There was also no documentation the residents' parents/legal guardians, legal counsel or their therapists were contacted. In the course of conducting random resident interviews, a resident revealed they had reported a sexual abuse incident to staff in June or July of this year. The resident indicated to this auditor that they were unsure if the physical contact from the other resident was accidental or purposeful, as they were playing basketball when it happened. However, the resident was clear that they reported telling a staff member approximately two days later. With acknowledgment from the resident, this auditor notified facility administration of this report and requested they follow up on the resident's report. The facility provided this auditor a follow-up investigation, which concluded the contact was accidental. The investigation also revealed the staff member to whom the resident reported the incident did in fact notify the LATFH PREA Compliance Manager and was reportedly told that the incident "wasn't a big deal and not to worry about it". That staff member also reported they were told by the LATFH PREA Compliance Manager that the matter did not need to be documented in the morning report, shift log or daily shift notes.

This auditor conducted an exit briefing with the MDHHS PREA Compliance Managers, the LATFH PREA Compliance Manager and the LATFH Intermediate or Higher-Level Staff. This auditor provided general insight into which standards would likely require corrective action. Timelines for submission of the interim report were discussed and MDHHS and LATFH were advised they would receive the interim report on or before October 17, 2020.

POST-AUDIT

Upon return from the on-site audit, this auditor transcribed interviews and reviewed interview responses, additional documentation provided on-site and site tour information to ascertain compliance with each standard. Contact was made with the Emergency Room Manager at the Helen Newberry Joy Hospital in Newberry, Michigan, with which LATFH has a Memorandum of Understanding (MOU) for services. The Emergency Room Manager indicated they conduct most SANE exams in Luce County, Michigan. They advised they would prefer a Pediatric SANE Nurse conduct exams for juveniles, and one is available in

Chippewa County. The Emergency Room Manager indicated they would conduct a SANE exam on a juvenile if there was a situation where the resident could not be taken to War Memorial Hospital one hour away. It is noted the MOU with Helen Newberry Joy Hospital only addresses emergency medical care and makes no mention of sexual abuse forensic examinations. In addition, the MOU is unsigned.

This auditor contacted the Central Intake (Children's Protective Services) Hotline number (1-855-444-3911) on September 21, 2020 to test the LATFH's outside reporting mechanism. This auditor explained the nature of the call was as a test for LATFH's outside reporting process for reports of sexual abuse or sexual harassment at LATFH. The Central Intake staff was asked to provide notification to the facility through their designated processes. This call was placed at 13:22 hours PST and an email was forwarded to the facility administration to advise them they should receive notification for the test call. The LATFH PREA Compliance Manager reported they received notification of the test call at 16:56 PST the same day. It is noted a call to the Children's Protective Services Hotline was attempted during the on-site audit, which will be discussed in the standards analysis. This auditor contacted the Luce County Sheriff's Office for information regarding their history of sexual abuse investigations at LATFH. The Deputy Sheriff confirmed they have jurisdiction for sexual abuse reports at LATFH; however, depending on their agency's availability, the Michigan State Police may respond to such calls. The Deputy Sheriff indicated they know of one report of sexual abuse over the last two years at LATFH, which they believe resulted in criminal charges. The Deputy Sheriff advised LATFH staff has been cooperative with their agency and that the majority of calls for service at LATFH are for runaway reports. The Deputy Sheriff indicated they would provide a copy of their sexual abuse investigative reports if the facility requested them. The facility provided an MOU with the Luce County Sheriff's Office as part of the audit process. It is noted this MOU is also unsigned. This auditor made contact with the Program Director for the Women's Center, the provider for outside supportive services. The Program Director advised they have an MOU with LATFH. They indicated they have not provided outside supportive services to residents at LATFH, but they have worked with residents from other programs within the agency. The Program Director reported that if an LATFH resident called to report sexual abuse occurring within the facility, they are required to report to Children's Protective Services. However, they advised they would require a release from the resident to report the information to LATFH administration. According to the Program Director, they would advise an LATFH resident of the limits to confidentiality at the initiation of services for the resident.

Additional communication with the PREA Compliance Managers for MDHHS and LATFH was required to obtain information that was not previously provided/requested. As previously indicated, there were challenges to communication pre-audit with facility administration and documentation was not forthcoming in the timeframe that would allow for appropriate preparation for interviews and file selections. Communication with facility administration improved post-audit.

FINAL AUDIT UPDATE

The Interim PREA Audit Report submitted on October 16, 2020 reflected 32 standards required corrective action. Following the submission of the Interim PREA Audit Report, the facility entered the 180-day maximum Corrective Action Period, beginning on October 16, 2020. This auditor provided recommendations for each standard found to be non-compliant for LATFH to begin working toward full compliance. Follow-up telephonic and video conferences were held with the Agency Head/PREA Coordinator/Investigative Staff, PREA Compliance Manager (newly designated), and the MDHHS PREA Compliance Manager on November 4, 2020, February 24, March 10, April 5, and April 12, 2021. Follow-up video conferences were held with staff and residents on April 13, 2021 to obtain additional verification of training and education required by corrective action. In addition, email communication was used to

address various issues and sensitive information was submitted by secured transmission.

This auditor reviewed and analyzed additional documentation submitted to address compliance with the non-compliant standards. All corrective action documentation and verification was completed on April 16, 2021. Facility staff and administration have created, trained, and implemented new policies and procedures to address deficiencies identified in the Interim Report. The LATFH successfully completed all corrective action and is now compliant with all 43 PREA standards.

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 LATFH is an eight-bed male facility under the control of Teaching Family Homes. This facility is contracted with the MDHHS for post-adjudication juvenile justice services, including therapeutic services, psychoeducation, and life skills. The LATFH operates three other youth residential programs; however, LATFH is the only residential facility in the agency housing juvenile justice youth. The program offers treatment for issues such as aggression, self-harming behavior, and sexualized behaviors through the Teaching Family Model, as well as specialized sex offense treatment through the Pathways treatment book. The LATFH is a staff-secured facility with 24-hour supervision. The average daily population of LATFH over the past 12 months is 4.5 residents and the average length of stay is nine to 12 months. The facility admitted five residents over the past 12 months. The LATFH houses residents between the ages of five and 17. It is noted the agency website characterizes LATFH as a medium-security facility housing male residents between the ages of 12 and 17. However, the facility information provided in the Pre-Audit Questionnaire reflects the facility is a minimum security facility for males ages five to 17. Residents are accepted from the MDHHS and the Keweenaw Bay Indian Community Tribal Center. The racial makeup of the resident population over the 12-month period is approximately 75% Caucasian and 25% Native American.

According to the employee roster, the LATFH is staffed with one Chief Administrator, one Program Supervisor, one Program Manager, two full-time Lead Direct Care Workers, three full-time Direct Care Workers and four part-time Direct Care Workers. The Lead Direct Care Workers and Direct Care Workers are considered front-line staff. The facility contracts for psychological/therapeutic services with a psychologist, and a contracted registered nurse provides medication management services and well checks. The facility contracts with the Odysseyware online educational program, as well as the local school district for the services of a teacher part time. It is noted the school district teacher has not been present at the facility since the outbreak of COVID-19. Facility staff members are present in the classroom during classroom time and provide assistance to residents, as necessary. There are no volunteer positions at LATFH. According to the employee roster there is a total of 12 employees at LATFH, excluding contractors. A review of staff schedules from April 2020 to September 2020 revealed a consistent scheduling of two staff members on duty for first and second shifts and one staff member for third shift. This staffing ratio exceeds the requirements for this standard. According to the Superintendent, the facility must maintain staffing ratios of 1:4 pursuant to their licensing and MDHHS contract requirements.

Programming

The LATFH is part of the Teaching Family Homes of Upper Michigan agency. The agency services are modeled after the Boys Town Program, which emphasizes teaching families and children life-changing skills, building healthy relationships, and caring for children in a family-style environment. The LATFH program provides mental health behavioral stabilization that focuses on delinquency issues. Treatment for substance abuse and sexually affected issues is also provided. Educational services, including

special education services, are coordinated through the local school district and the aforementioned online learning program. Recreation is provided to facility residents daily, and typically includes playing basketball, football, kickball or other assorted games, weather permitting. Residents are also taken on outings for fishing, hiking, swimming, and snow activities.

Medical/Mental Health

The LATFH has one contracted psychologist who provides treatment for all residents at the facility. Psychiatric services for residents, including medication management, is provided through telepsychiatry, as there are no child psychiatrists in the Upper Peninsula of Michigan. The facility contracts with a registered nurse who comes to the facility on a weekly basis to coordinate medication management and conduct well checks for residents. Emergency and general medical and dental care are provided in the community and such care is coordinated by parents/guardians and caseworkers.

Housing Units

As previously indicated, LATFH is a home setting with seven bedrooms. One of the bedrooms is set up to house two residents; however, the resident population has been low enough to place each resident in their own room. The resident rooms are furnished with a mattress on a wood box frame. There are wall cubby holes/shelves for storage. Residents may place pictures and arts and crafts up on the wall in their rooms. The doors to the rooms are wood and do not have windows to view residents inside their rooms. All resident rooms have windows looking out to the back or side of the property. Video monitoring at LATFH consists of ten cameras placed in the bedroom/bathroom hallways, dining room, living room, stairwell, classroom, hallway area where resident point cards, a board for chore assignments and posted information are kept, and the laundry room. A review of staff schedules from April 2020 to September 2020 revealed a consistent scheduling of two staff members on duty for first and second shifts and one staff member for third shift. This staffing pattern complies with the standards found in 115.313(c).

Facility Layout

The LATFH is configured like a traditional single-family home. The facility is staff-secured, with no controlled barriers to entering or exiting the facility. The yard of the facility has grass and mature landscaping. The front door to the facility has a small porch area. Off the front entrance, directly to the right is a large living room. Beyond the living room are five bedrooms and two full bathrooms. One of these bedrooms is set up for two residents, however, the rest of the six bedrooms in the facility are single-bunked rooms. The bedrooms are spacious and are furnished only with a bed. There are shallow closets in each room with the doors removed and shelving for residents to store items. Each bedroom has a window, covered by window coverings, and the bedroom doors are solid. The bathrooms consist of a toilet, sink and stall shower. The center of the facility is the dining room and kitchen area, both resembling a typical family residence. There are French doors off the dining room that lead to a deck/barbeque, and a stairway off the deck leads to the lower level. On the other side of the facility are two more bedrooms and a half-bathroom, employee lockers, laundry room and a hallway area where resident point cards, a board for chore assignments and posted information are kept. Around the corner is the stairwell that leads to the basement, where the classroom, counseling room, furnace and electrical rooms, staff offices, a large refrigerator and freezer, dry storage pantry, staff restroom and storage rooms for resident property and other items are located. The classroom area occupies an open area directly off the stairwell, and staff offices are behind and adjacent to the classroom. Video surveillance cameras were observed in the classroom, living room, dining room, stairwell, kitchen, laundry room, and hallways. There are two doors off the lower level of the facility that lead to the outside of the facility. In the back of the facility is a large grassy area, basketball court and a separate building originally used for

teaching woodworking and other skills to residents.

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 generally cooperative with the audit process. The MDHHS and LATFH PREA Compliance Managers were accommodating of this auditor's needs and adjusted according to the requirements of the audit. The facility provides a home-like environment for residents and staff appeared vested in the well-being of the residents. Staff was observed providing line of sight supervision and residents were compliant with staff during the on-site audit. Residents did not express concern for their safety or welfare at LATFH. It appears the level of supervision provided by LATFH staff is directly responsible for the lack of sexual abuse and sexual harassment incidents at the facility, and this auditor recognizes those efforts.

The following is a summary of the standard findings for the Lakes Area Teaching Family Home:

Exceeds Standards – 0

Meets Standards – 11

Does Not Meet Standards – 32

Corrective Action is required for the following standards:

115.311 - The PREA Coordinator and PREA Compliance Manager positions are currently occupied by the same person, who now has additional agency responsibilities. Given that the agency only has one facility that is subject to PREA standards, it appears feasible they would be able to continue to oversee the agency PREA efforts in their current role. However, the day-to-day involvement required of the PREA Compliance Manager must be delegated to staff who is on site and who has sufficient time and authority to effectively oversee all the requirements of PREA at the facility.

115.313 – All section of the staffing plan must be completed and/or updated. Facility administration has been forwarded the "Developing and Implementing a PREA-Compliant Staffing Plan" resource, available through the PREA Resource Center, to assist with completing the facility staffing plan. The facility must complete the MDHHS-5817-PREA (8-19a) Form for subsequent staffing plan reviews once a completed staffing plan has been submitted for this audit. The facility must exhaust all efforts to provide the remaining unannounced rounds log. The facility must also create a centralized or secondary location to maintain the unannounced rounds log, so there is a backup mechanism in place. Staff must be trained on

any updated information in the GH Policy No. 14 M policy.

115.315 - The LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff, and staff must also be trained on the updated policy information and procedures.

115.316 - As language interpretation services are available to LATFH as a contractor with MDHHS, facility staff and administration will need to be trained on the policy and procedure contained in the MDHHS Policy SRM 402, Limited English Proficiency and Bilingual Interpreter Services.

115.317 - The facility will need to add policy language that prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who has engaged in any of the actions listed in 115.317 (a). The facility will need to add policy language to addresses consideration for incidents of sexual harassment when hiring, promoting, or contracting with anyone who may have contact with residents. The facility will need to create a process to run and monitor contractor background checks. The current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.321 - The LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff, and staff must also be trained on the updated policy information and procedures.

115.322 - The LATFH GH Policy No. 14 M must be modified to include the requirement to investigate sexual harassment. The LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff, and staff must also be trained on the updated policy information and procedures for reports of sexual abuse or sexual harassment.

115.331 - The facility will need to create and utilize an acknowledgment for staff PREA training that documents the staff member attended and understood the information provided at the training.

115.332 - The facility must ensure the contracted psychologist and nurse complete the PREA training provided for new employees and the specialized PREA training for medical professionals. The facility must document training for all contractors and volunteers and require those receiving the training to acknowledge they understand the material covered in training.

115.333 - The facility is lacking documentation that residents have viewed the State of Idaho Department of Juvenile Corrections PREA Video for comprehensive resident education. The facility will need to create a form that records the date the PREA video was shown and requires the resident's signature to acknowledge they viewed and understood the material, or add that documentation to an existing form. Facility administration will need to review the MDHHS SRM 400 Policy, Reasonable Accommodation and associated policies and train staff on how to access services through MDHHS for limited English proficient, deaf, visually impaired, and otherwise disabled residents. Documentation of completed training for all staff must be provided to substantiate compliance with this provision. The facility must update its sexual abuse postings to reflect accurate information.

115.335 - The facility's contracted medical provider must complete specialized PREA training for medical professionals in a juvenile setting, as well as the PREA training provided to new employees. The facility's contracted mental health provider must complete the PREA training provided to new employees.

Documentation of the completed general and specialized PREA trainings must be provided.

115.341 - The LATFH GH Policy No. 14 M must be updated to include the requirement that the risk screening instrument must be completed within 72 hours of intake. In addition, the policy must be updated to include the requirement that residents be reassessed periodically throughout their confinement. The facility will also need to accurately record the date the risk screening instrument is completed, as it likely differs from the date of intake. The Teaching Family Homes of Upper Michigan PREA Intake Screenings must be updated to include questions to residents as to whether they identify as transgender or intersex. Any staff member who may complete the resident risk screening tool must be trained on how to access such additional records and incorporate that information into the overall risk screening assessment. Proof of such training is required for compliance with this provision. The LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy and updated intake screening instrument must be distributed to staff, and staff must also be trained on the updated policy information and procedures.

115.342 - The facility must add a statement in the LATFH GH Policy No. 14 M that indicates the facility does not use or practice isolation as a designated housing assignment. The updated policy must be distributed to staff and staff must also be trained on the updated policy information. Facility administration and staff must complete the "Respectful Classification Practices with LGBTI Inmates Training", available on the PREA Resource Center website under Training and Technical Assistance. Documentation of completed training for administration and staff is also required.

115.351 - The facility must make calls to CPS private by creating a calling system that adds anonymity to the purpose of the call. This can be accomplished by informing residents they can make a report to the CPS Hotline for any complaint, not just reports of sexual abuse or sexual harassment. The procedure for residents to request a call to the CPS Hotline needs to be documented and residents and staff must be educated on the procedure. The LATFH GH Policy No. 14 M and the Youth Safety Guide need to be updated to include instruction to residents to report retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. The facility must update the Youth Safety Guide to reflect the telephone number for the Children's' Protective Services Hotline as a source to report sexual abuse or sexual harassment, and will need to include "sexual harassment" as part of the issues to report. The facility will also need to update its sexual abuse postings to reflect accurate information. The telephone number for the Children's Protective Services Hotline must be corrected and reposted.

115.352 - Residents need to be provided additional information regarding submitting grievances alleging sexual abuse. Specifically, residents need to understand there is no requirement they use an informal process for resolving grievances alleging sexual abuse or sexual harassment, 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 they do not need to be concerned their grievance will be referred to the staff member who is the subject of the complaint. The facility will need to provide documentation of how it has provided this information to residents to demonstrate compliance with this provision. The LATFH GH Policy No. 14 M must be updated to include the requirement that the facility document the outcome of a resident's emergency grievance. The LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff, and staff must also be trained on the updated policy information and procedures.

115.353 – The facility will need to post information about available outside victim advocates for emotional support services related to sexual abuse. This information should be clearly differentiated from a resource to report sexual abuse. The facility will need to create a system to allow residents to contact

those services confidentially. Residents will also need to be educated on how to make confidential phone calls to outside supportive services, to what extent their contact with outside victim advocates is confidential and what information may be reported to others as required by law. The facility may choose to add this information to the Youth Safety Guide or provide the information through postings or other sources. The facility will need to provide documentation of how it has provided this information to residents to demonstrate compliance with this provision.

115.361 - Notifications to CPS, Licensing and law enforcement must be completed in cases that require such notifications, according to LATFH policy. Notifications to caseworkers and parents/legal guardians must be done promptly and notifications to attorneys must be completed in each investigation and within the 14-day requirement. Contact information for residents' attorneys needs to be readily available for such notifications. The facility will also need to ensure notifications are documented accordingly. Facility administration will need to review the LATFH GH Policy No. 14 M with respect to the parties they are responsible to notify after a report of sexual abuse and provide written confirmation of understanding.

115.364 – The facility needs to add additional preventative victim and perpetrator actions to LATFH GH Policy No. 14 M, to include urinating, defecating, smoking, drinking, or eating. The facility needs to add language to LATFH GH Policy No. 14 M that would require non-security staff, such as the facility's contracted Medical/Mental Health staff, to follow the same protocol as is required for security staff. The updated policy must be distributed to staff and staff must also be trained on the updated policy information. Medical/Mental Health Staff must also be trained on the PREA Coordinated Response Plan.

115.365 - The facility will need to create an institutional plan which will coordinate and document all actions taken by all staff, including contracted staff, in a sexual abuse incident. The facility may choose to create its own or utilize the MDHHS 5809 PREA Investigation Tool. The institutional plan needs to be distributed to all staff and staff must be trained on how to execute their responsibilities in the plan.

115.371 – The facility will need to update the LATFH GH Policy No. 14 M to include investigations of sexual harassment incidents and clarification that LATFH is not responsible for collecting physical evidence in a sexual abuse incident. The facility needs to understand that, at a minimum, an administrative investigation is required in each report of sexual abuse or sexual harassment. As a result, the LATFH GH Policy No. 14 M needs to be updated to address and correct that issue. Facility administration and staff need to specifically review the facility's required notification procedures for sexual abuse incidents as indicated in the LATFH GH Policy No. 14 M. The facility's Investigative Staff will need to complete the National Institute of Corrections "PREA: Investigating Sexual Abuse in a Confinement Setting" training to refresh their recollection of the administrative investigation process, including the appropriate documentation for an administrative investigation report, a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The updated LATFH GH Policy No. 14 M must be distributed to staff and staff must also be trained on the updated policy information.

115.373 - The LATFH GH Policy No. 14 M will need to be updated to include notification to the alleged victim of the requirements in 115.373 [c] and 115.373(d). The institutional plan required for 115.365 will also need to include a section to capture the request and receipt of the criminal investigation report, as well as a section to record notification to residents regarding that report. The updated LATFH GH Policy No. 14 M must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard.

115.376/115.377/115.378 – The current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must

be distributed to staff and staff must also be trained on the updated policy information.

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 add taking preliminary steps to protect the victim to the LATFH PREA Coordinated Response Plan. First responders are required to immediately notify the appropriate medical and mental health practitioners in this provision. This requirement must be added to both the LATFH GH Policy No. 14 M and the LATFH PREA Coordinated Response Plan. In addition, the updated LATFH GH Policy No. 14 M and the LATFH PREA Coordinated Response Plan must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard.

115.383 –The facility will need to create a detailed protocol for Medical/Mental Health staff to follow and record the actions that are required to be offered to residents who have been victimized by sexual abuse under this standard, which include: medical and mental health evaluations and, as appropriate, treatment; 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 and, tests for sexually transmitted infections as medically appropriate. These articulated Medical/Mental Health responsibilities also need to be added to the Teaching Family Homes, Lakes Area PREA Coordinated Response Plan. Staff must be informed of and trained on the changes to the Coordinated Response Plan and the mechanism used to record Medical/Mental Health protocol actions plan to address compliance with this standard.

115.386 – The facility must conduct a sexual abuse incident review after each incident, in accordance with their policy. The facility will need to designate staff, consisting of upper-level management, line supervisors, investigators, and medical/mental health practitioners, to comprise the Incident Review Team. The facility will need to keep minutes for all Incident Review Team meetings, which must include the analyses for the factors outlined in 115.386 (c) and complete a written Incident Review Report. The facility can utilize the MDHHS Form 5818 or create its own documentation for incident review. An update to the LATFH GH Policy No. 14 M is required to clarify language between the two versions of the policy. The updated policy must be distributed to staff and staff must also be trained on the updated policy information. The MDHHS Form 5818, 30-Day Sexual Abuse Incident Review must be distributed to all staff and all staff must be trained on the MDHHS form to address compliance with this standard.

115.387 – The facility must update the untitled tracking sheet to include a title to clearly explain the purpose of the document. The tracking sheet must also be updated to include a standardized set of definitions for offense types and a clearly defined breakdown of what type of incident is being recorded and a mechanism to collect year end totals. The facility must aggregate its sexual abuse and sexual harassment data on at least an annual basis and be able to produce the aggregated data for review. Once the facility creates a compliant standardized instrument, the recorded data must be clear enough to answer all questions from the most recent version of the SSV. Specifically, the data must be able to answer whether the allegations were for nonconsensual sex acts, abusive sexual contact, or sexual harassment. In addition, specific categories to record whether the allegations were substantiated, unsubstantiated or unfounded and whether the perpetrator was a resident or staff are required to complete the Survey of Sexual Victimization (SSV). In addition to a comprehensive standardized instrument, the facility must have a centralized location to maintain incident reports, investigative reports,

incident review reports and any other data related to incidents of sexual abuse or sexual harassment at LATFH.

115.388 – The facility will need to document its data review on an annual basis to substantiate compliance with this provision. The facility administration will need to meet for the purpose of data review, keep minutes of the meeting, and include in the minutes what documentation was reviewed and what steps the facility takes to use the review to improve its effectiveness of its sexual abuse prevention, detection, response policies, and training. If the facility has no reported incidents of sexual abuse or sexual harassment, then that information should also be recorded to reflect the review was held. The facility should correct the data currently posted to the agency website to reflect accurate data collection years. The facility will also need to create annual reports to quantify incidents of sexual abuse and sexual harassment and provide analysis and response to such incidents, as well as an analysis of what is working well for the facility's PREA efforts and what improvements have been made to enhance sexual safety. LATFH 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 and sexual harassment in its annual report.

115.389 - The facility did not provide information on how it retains incident-based data, and the length of time sexual abuse/sexual harassment data is maintained after its initial collection. The facility will need to identify a secured means of maintaining sexual abuse/sexual harassment data with limited access and create a retention schedule to track how long that data has been maintained and when it is due for purging.

115.401 - The facility will need to create a system to allow for confidential mail correspondence with legal counsel, outside supportive services and future PREA auditors. This process must be explained to residents in resident educational material or postings. Verification that this process has been established and communicated to residents is required to demonstrate compliance with this provision.

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: *Pre-Audit Questionnaire *LATFH Policy No. 36, Anti-Harassment Policy *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH PREA Staffing Plan *Unannounced Rounds Log 115.311 (a) – LATFH Policy 36 was attached as proof of compliance, but that policy applies more toward employment-based harassment. The LATFH GH Policy: 14 M, Prison Rape Elimination Act Standards and Compliance is the comprehensive agency policy that is more applicable to this standard. Page 1, Policy Section states, "Teaching Family Homes Residential Group Home Staff must have zero tolerance for sexual abuse and sexual harassment of residents." The same section states, "Facilities must ensure that preventive plans are in place and, should allegations regarding sexual abuse or harassment be made, that staff are appropriately trained to take actions to rapidly restore safety, attend to and support the victim, and promptly initiate the investigative process." Strategies to implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment are contained throughout the policy. Page 1, Definitions Section details definitions for prohibited behaviors regarding sexual abuse and sexual harassment. Pages 14 and 15, Section K, lists disciplinary sanctions, up to and including termination, for staff, contractors and volunteers who violate the agency's sexual abuse or sexual harassment policy. The same section, Subsection (2)(a), states, "Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse." 115.311 (b) – The agency has designated a PREA Coordinator, whose position in the organizational structure is Chief Administrator. In the interview with the staff acting as PREA Coordinator, they advised they were recently promoted to this position in the organizational structure, and their primary work location is now off-site from the facility. The PREA Coordinator indicated that although they have sufficient authority, they do not have sufficient time to develop, implement, and oversee agency efforts to comply with the PREA standards at the facility, in addition to the other duties of the new position and the other PREA responsibilities currently designated to them. The LATFH is the only facility in the agency that falls under PREA requirements, with the other facilities housing abuse/neglect populations.

115.311 (c) – At present, the same person functions as the PREA Coordinator and PREA Compliance Manager, as well as other specialized PREA roles. In the interview with the PREA Compliance Manager, they indicated they do not have sufficient time to oversee all of the PREA responsibilities they currently have. Their current position in the organizational structure would have them reporting to the agency Chief Executive Officer, which is presently unfilled.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.311(b)(c) - The PREA Coordinator and PREA Compliance Manager positions are currently occupied by the same person, who now has additional agency responsibilities. Given that the agency only has one facility that is subject to PREA standards, it appears feasible they would be able to continue to oversee the agency PREA efforts in their current role. However, the day-to-day involvement required of the PREA Compliance Manager must be delegated to staff who is on site and who has sufficient time and authority to effectively oversee all of the requirements of PREA at the facility. The facility will need to designate a PREA Compliance Manager who has sufficient time and authority to oversee the facility PREA requirements.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 19, 2021 to substantiate corrective actions taken for this standard.

115.311 (b)(c) - The facility provided the updated the Teaching Family Homes Organizational Chart dated January 2021, which reflects the Director of Residential Services is now designated as the PREA Coordinator, and the LATFH Manager is now designated as the PREA Compliance Manager. This division of PREA responsibilities will adequately allow staff who is on site to monitor the facility PREA efforts.

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
	Interview conducted: *Contract Administrator 115.312 (a) – In the interview with the Contract Administrator, they advised the agency does not contract for the confinement of residents. They advised they are a contracted agency for the MDHHS. 115.312 (b) – In the interview with the Contract Administrator, they advised the agency does not contract for the confinement of residents. They advised they are a contracted agency for the MDHHS.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Coordinator *Intermediate or Higher-Level Staff Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH PREA Staffing Plans/Review for 2019 and 2020 *Unannounced Rounds Log *LATFH Staff Schedules *Daily Population Report September 2019-September 2020 115.313 (a) – The LATFH staffing plan, utilizing the MDHHS-5833-PREA (12-19) Form and dated August 5, 2020, was provided as evidence of compliance with this standard. The staffing plan indicates it was developed by the PREA Compliance Manager/Social Services Worker, Consultant and the Program Manager. It lists the facility characteristics, a description of the physical plant, and completed information for Sections 3 through 6. However, the following sections require review: Section 1 of the staffing plan is not complete; the information in Section 2 does not address the requirement correctly; Section 7 needs additional information regarding the licensing and any other State requirements; Section 8 is lacking specific information; the Relieved Posts or Positions Section includes the PREA Compliance Manager, Consultant, Social Worker and Program Manager (which needs clarification because the facility employs one employee for most of those positions); the staffing plan is missing the titles of the positions and the number of staff in each position required on each shift; the Surveillance Section/Video Monitoring, the facility answered both yes and no to the last portion of the section, and the no response needs to be deleted and, the Trauma Informed Approaches Section does not provide an adequate response, nor does it address what training staff receives for trauma informed care. Additionally, under the Staffing Ratio Waking and Sleeping Hours, the facility has totaled the amount of time, as opposed to listing from when to when are waking and sleeping hours. The MDHHS PREA Compliance Manager provided what is believed to be the staffing plan review for 2019. This document contains a bullet list of nine items that the staffing plan review must take into consideration. However, the narrative portion of the 2019 staffing plan/review only addresses analysis for staffing ratios, supervisory personnel and applicable State or local laws, regulations or standards. The narrative mentions findings of inadequacy; however, it does not state whether or not they were found to have inadequacies, what the inadequacies were and what actions were required to

address the inadequacies. In the interview with the Superintendent, they indicated the facility has a staffing plan that takes into consideration the 11 factors outlined in the provision. The Superintendent advised they check for compliance with the staffing plan by making sure staff is supervising clients at all times, that staffing ratios are maintained, and they review the staffing plan periodically to ensure they are maintaining compliance.

115.313 (b) – The facility indicated it has no deviations from the staffing plan on the Pre-Audit Questionnaire. This auditor reviewed the staff schedules for April through September 2020 and found that the schedule listed adequate staffing for each shift for an average daily population of 4.5 residents. Deviations from the staffing plan were not recorded on the staff schedule, nor was another document to record deviations provided. There was nowhere on the schedules where deviations would be recorded. According to the Superintendent, they do not have deviations from the staffing plan. They indicated when a staff member is unable to work their scheduled shift, a member of the management staff fills in for that position unless and until other another staff member can fill the position. Although additional information and clarification is required on the staffing plan, the facility indicated a staffing ratio of 1:4 on the staffing plan and evidence has been provided to support the facility maintains that staffing ratio.

115.313 (c) – The facility reported on the Pre-Audit Questionnaire it is required to maintain a 1:4 staff to youth ratio pursuant to their licensing requirements with the State of Michigan. The facility provided the staff schedules for April through September 2020 and the Daily Population Report September 2019-September 2020 for the 1st, 10th and 20th of each month. The Daily Population Report reflected an average daily population of 4.5 residents over the 12-month period, and the staff schedules reflected two staff members on duty for first and second shifts and one staff member for third shift. This staffing ratio exceeds the requirements for this standard. According to the Superintendent, the facility must maintain staffing ratios of 1:4 pursuant to their Licensing and MDHHS contract requirements.

115.313 (d) – The facility submitted the MDHHS-5817-PREA (8-19a) Form to demonstrate compliance with this provision. However, the form was blank. In reviewing the staffing plan provided for 115.313 (a), it is noted it is dated August 5, 2020. The facility made a note in the Pre-Audit Questionnaire that a review was not yet needed because the staffing plan was drafted on August 5, 2020. The facility has submitted staffing plans for previous PREA audits; however, the evolving scrutiny of what constitutes a PREA-compliant staffing plan has led the MDHHS to provide more specific guidance and assistance for this standard. Moving forward, it appears the facility will work toward submitting a PREA-compliant staffing plan for this audit and staffing plan reviews will start after the first year of the updated staffing plan.

115.313 (e) – The LATFH GH Policy No. 14 M, Page 13, Section 6 states, "Mid or upper-level Supervisory staff will make documented unannounced rounds to identify and deter staff sexual misconduct and sexual abuse. Documentation of these visits will be maintained in the Consultation Manual. Staff are prohibited from alerting other staff that supervisory rounds are being conducted." The facility provided the PREA Unannounced Rounds Log 2020. The Unannounced Rounds Log contains daily entries, with most dates having multiple entries, reflecting the activities observed in the facility. Entries were made for all three shifts, with all but four entries made by the PREA Compliance Manager. The PREA Unannounced Rounds Log 2020 looks like a daily log, and the log entries stop at June 2, 2020. This auditor requested the log entries through the date of the on-site audit; however, this auditor was

advised the additional entries may have been lost when the PREA Compliance Manager had technical difficulties with their computer. It is also noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance, and one of the versions did not contain the language prohibiting staff from alerting other staff members to unannounced rounds.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.313 (a) - Section 1 of the staffing plan must be completed; the information in Section 2 needs to address the requirement correctly; Section 7 needs additional information regarding the licensing and any other State requirements; Section 8 is lacking specific information; the Relieved Posts or Positions Section includes the PREA Compliance Manager, Consultant, Social Worker and Program Manager (which needs clarification because the facility only employs one employee in most of those positions); the staffing plan is missing the titles of the positions and the number of staff in each position required on each shift; the Surveillance Section/Video Monitoring, the facility answered both yes and no to the last portion of the section, and the no response needs to be deleted and, the Trauma Informed Approaches Section does not provide an adequate response, nor does it address what training staff receives for trauma informed care. Additionally, under the Staffing Ratio Waking and Sleeping Hours, the facility has totaled the amount of time, as opposed to listing from when to when are waking and sleeping hours. Facility administration has been forwarded the "Developing and Implementing
a PREA-Compliant Staffing Plan" resource, available through the PREA Resource Center, to assist with completing the facility staffing plan.

115.313 (d) - As it appears the facility intends to utilize the MDHHS-5817-PREA (8-19a) Form, this form must be completed for subsequent staffing plan reviews once an updated staffing plan has been submitted for this audit.

115.313 (e) - The facility must exhaust all efforts to provide the remaining unannounced rounds log. The facility must also create a centralized or secondary location to maintain the unannounced rounds log, so there is a backup mechanism in place. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrections discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. Staff must also be trained on the updated information in the policy.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 30, 2021 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.313 (a) - The facility submitted an updated Michigan Department of Health and Human Services Prison Rape Elimination Act (PREA) Staffing Plan for LATFH. The Staffing Plan now includes the additional Section 7 information regarding licensing and any other State requirements, the specific information needed for Section 8, accurate positions for the Relieved Posts or Positions Section and the titles of the positions and the number of staff in each position required on each shift, corrected information in the Surveillance Section/Video Monitoring, and the Trauma Informed Approaches Section has been completed. Additionally,

	the facility corrected the Staffing Ratio Waking and Sleeping Hours to reflect the waking and sleeping hours. 115.313 (d) - Facility administration indicated moving forward it will now utilize the MDHHS-5817-PREA (8-19a) Form for annual Staffing Plan Reviews. 115.313 (e) - According to facility administration, they were unable to retrieve the Unannounced Rounds Logs for June through September 2020. The facility provided the Unannounced Rounds Logs for October 2020 through February 19, 2021 to substantiate its continued compliance with unannounced rounds. These logs continued to reflect daily rounds, on each shift. This auditor clarified with facility administration the purpose of unannounced rounds and the need for the rounds to occur on a random basis. The facility provided verification it has created a PREA Shared Folder to collect and maintain its PREA data and documents, and the Unannounced Rounds Logs are now located in the PREA Shared Folder. The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 16, Section 7 of the policy now reflects staff is prohibited from alerting other staff members when unannounced rounds are being conducted. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies. 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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH GH Policy: 14 M Appendix X *Video Surveillance Camera Views *Site Review 115.315 (a) – The facility indicated it does not conduct cross-gender strip or visual body cavity searches on the Pre-Audit Questionnaire. The LATFH GH Policy: 14 M Appendix X, Youth Search Protocol states, "Staff must not conduct cross-gender complete (strip) searches or cross-gender visual body cavity searches except in exigent circumstances or when performed by medical practitioners." There was no evidence the facility maintained a log of cross-gender strip or visual body cavity searches. 115.315 (b) – The facility indicated it does not conduct cross-gender pat searches on the Pre-Audit Questionnaire. The LATFH GH Policy No. 14 M, Page 5, Section 4 states, "Cross gender pat searches are prohibited, except in exigent circumstances. In that event, exigent circumstances shall be documented with justification of the circumstances leading to the cross-gender pat search." The LATFH GH Policy: 14 M Appendix X, Youth Search Protocol states, "Staff must not conduct cross-gender pat searches except in exigent circumstances." In the interviews with random staff and random residents, they all advised female staff do not pat search the male residents. 115.315 (c) – The LATFH GH Policy No. 14 M, Page 5, Section 4 states, "Cross gender pat searches are prohibited, except in exigent circumstances. In that event, exigent circumstances shall be documented with justification of the circumstances leading to the cross-gender pat search." The LATFH GH Policy: 14 M Appendix X, Youth Search Protocol states, "Staff must document and justify all cross-gender searches." There was no evidence the facility maintained a log of cross-gender strip, visual body cavity or pat searches. 115.315 (d) – The LATFH GH Policy No. 14 M, Page 6, Section 5 states, "Non-medical staff of the opposite gender of youth 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." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears

this language was recently added to address this audit's requirements, as the policy language does not appear in both versions. In interviews with random residents and random staff, they all indicated residents shower, change their clothing and use the toilet in privacy. All indicated each resident is allowed time to perform these functions alone behind a closed bathroom door. During the site review the bathrooms were observed to have solid doors and locks on the doorknob. This auditor observed the video monitoring system camera views, and none were seen positioned inside the bathrooms or bedrooms. Random staff and random residents indicated female staff knock on resident bedroom doors before entering, but they do not announce their presence in the common areas of the facility. Random staff and random residents advised female staff members do not enter the bathrooms while they are showering, changing or using the toilet. As the facility is set up like a family home, it would not require female staff to announce their presence anywhere but the residents' sleeping area and the bathrooms.

115.315 (e) – The LATFH GH Policy No. 14 M, Page 5, Section 7 states, "Staff must not search or physically examine a transgender or intersex resident for the sole purpose of determining a youth's genital status." Interviews with random staff revealed they would not physically examine a transgender or intersex resident for the sole purpose of determining a youth's genital status. As the facility did not house a transgendered or intersex resident at the time of the on-site audit, this interview protocol was not completed.

115.315 (f) – In interviews with random staff, they advised they received training in searches for transgendered or intersex residents. Female staff advised they received training in cross-gender pat down searches.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.315 (d) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. The current version of the LATFH GH Policy No. 14 M must be updated with an effective date and approval signature. Staff must also be trained on the updated policy information.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 26, 2021 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.315 (d) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

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

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 *Limited English Proficient/Disabled Residents Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Translation Services in Michigan *LATFH Youth Safety Guide *State of Idaho Department of Juvenile Corrections PREA Video *MDHHS Policy SRM 402, Limited English Proficiency and Bilingual Interpreter Services 115.316 (a) – The LATFH GH Policy No. 14 M, Page 3, Section 2 states, "The information must be provided verbally and in written form, through the use of the Youth PREA Orientation Handbook and Acknowledgment Form (Appendix 2). Residents with disabilities and LEP residents will be provided with interpreters or appropriate accommodations." The Translation Services in Michigan list was provided in the Pre-Audit Questionnaire as evidence of compliance with this provision. This list provides two sources for the Upper Northern region of Michigan: Northern Michigan University and Lake Superior State University. The list indicates 12 different languages are available for interpretation between the two universities. American Sign Language is not included on the list. This evidence is more applicable to 115.316(b), as it addresses services for Limited English Proficient residents. In the interview with the Agency Head, they indicated the facility can contact the language teacher at the local high school and they have a staff member who knows American Sign Language for deaf youth. They indicated staff is able to communicate with residents with intellectual disabilities, but the program would preclude admission for low functioning and blind youth. A review of the LATFH Youth Safety Guide found mostly verbiage, as opposed to simple statements or pictures, which could likely require staff assistance for an intellectually disabled resident to understand the material. The State of Idaho Department of Juvenile Corrections PREA Video, which is shown to residents for comprehensive PREA education, communicates sexual safety information in a format that intellectually disabled residents should understand. No documentation regarding staff's training in working with developmentally disabled residents was provided; however, training records reflect staff has received training in the following subjects: Three Steps to Healing Trauma; Understanding How to Provide Trauma Informed Care; Reactive Attachment Disorder and, Fetal Alcohol Syndrome. The Agency Head advised certain staff members have hands-on experience in communicating with their own disabled children. In the interview with

the Disabled Resident, they indicated the facility mostly provides information about sexual abuse or sexual harassment that they are able to understand, and that any staff member can help them with anything they do not understand.

115.316 (b) – As indicated above, the facility would utilize interpretation from the local universities or the local high school. According to the MDHHS PREA Compliance Manager, LATFH is able to utilize MDHHS resources for language interpretation. 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. The MDHHS PREA Compliance Manager advised they have notified LATFH that these services are offered to them as a contractor. The interview with a Limited English Proficient resident was not conducted, as the facility had no such residents at the time of the on-site audit.

115.316 (c) – The LATFH GH Policy No. 14 M, Page 3, Section 2 states, "The use of resident interpreters is prohibited except in limited circumstances when delay in translation could compromise resident safety or the performance of first responder duties." In interviews with random staff members, they indicated they would not use a resident to interpret for another resident. Random staff generally reported that a translation service would have to be contacted to provide services, but the majority of staff members were not sure how or where to contact such services. The Disabled resident indicated they would seek staff's assistance to understand facility PREA information. The interview with a Limited English Proficient resident was not conducted, as the facility had no such residents at the time of the on-site audit. No documentation of resident-on-resident interpretation was provided or discovered.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.316 (b) - Staff does not have a clear understanding of how to access interpretation services for Limited English Proficient residents. Although the facility provided a list of interpretation services available through local universities, staff members only indicated they would access interpretation services through the local high school. As language interpretation services are available to LATFH as a contractor with MDHHS, facility staff and administration will need to be trained on the policy and procedure contained in the MDHHS Policy SRM 402, Limited English Proficiency and Bilingual Interpreter Services.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 8, 2021 to substantiate corrective actions taken for this standard.

115.316 (b) - The facility provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) and the MDHHS Policy SRM 402, Limited English Proficiency and Bilingual Interpreter Services were covered in the training. In addition, Page 3, Section 2 of the LATFH GH Policy No. 60.O now contains a cross reference to the MDHHS Policy SRM 402. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies, and accessing services for ESL, deaf/hearing impaired, blind/low vision, or otherwise 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 *Intermediate or Higher-Level Staff Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Employee Files *"Questions for Promotion" Form *"Volunteer and Contractor Training" *Teaching Family Homes Policy 9, Employee Background Check *The State of Michigan Bureau of Children and Adult Licensing Good Moral Character Policy Acknowledgment 115.317 (a) – The facility provided the LATFH GH Policy No. 14 M, Pages 13 and 14, Section 10 as evidence of compliance for this provision. This section of the policy states, "The employee application process and promotion process, includes the following questions: a. Have you engaged in sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility, or other institution?; b. Have you been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, of if the victim did not consent or was unable to consent or refuse?; c. Have you been civilly or administratively adjudicated to have engaged in the activity described above? This section of policy does not say anything about prohibiting hiring, promoting or contracting with anyone who has engaged in sexual abuse in any of the listed settings. A review of random employee files revealed one of the three files did not contain criminal record check information, however, the employee's application, with the aforementioned questions regarding prior sexually abusive behavior, was present in the file. This issue was addressed with facility administration and the MDHHS PREA Compliance Manager. According to facility administration, agency-level administration has advised them they will not provide documentation regarding criminal records checks for employee files, and that unless they hear otherwise, they should just assume a criminal records check was done and no concerns were noted. This is a change in practice for the agency, as the files of more senior employees contained the required criminal record check documentation. The MDHHS PREA Compliance Manager advised they would make contact with agency administration to address the issue. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears this language was recently added to address this audit's requirements, as the policy language does not appear in both versions.

115.317 (b) – The facility attached a form entitled "Questions for Promotion" to demonstrate compliance with this provision. The form states, "(Facility Name) will not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents who - Please mark yes or no if any of the below-listed statements apply to you: (1) Have you engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Have you been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Have you been civilly or administratively adjudicated to have engaged in the activity described in paragraph (2) of this section." This form has no facility name or letterhead, so it cannot be attributed to LATFH. Regardless, this form is not policy, and a review of the LATFH GH Policy No. 14 M revealed no language regarding consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. In the interview with Administrative Staff, they advised the facility would consider incidents of sexual harassment if it showed up on a records check.

115.317 (c) – The facility provided the LATFH GH Policy No. 14 M, Page 13, Section 9 as evidence of compliance with this provision. This section of policy states, "The facility conducts criminal history checks and central registry checks at employee initial hire and at least every five years thereafter for all employees, contractors, and volunteers that have contact with you." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears this language was recently added to address this audit's requirements, as the policy language does not appear in both versions. The interview with Administrative Staff revealed they run criminal record checks and child abuse registry checks for everyone annually, but not for promotion. A review of random employee files revealed one of the three files did not contain criminal record check information, however, the employee's application, with the aforementioned questions regarding prior sexually abusive behavior, was present in the file. This issue was addressed with facility administration and the MDHHS PREA Compliance Manager. According to facility administration, agency-level administration has advised them they will not provide documentation regarding criminal records checks for employee files, and that unless they hear otherwise, they should just assume a criminal records check was done and no concerns were noted. This is a change in practice for the agency, as the files of more senior employees contained the required criminal record check documentation. The MDHHS PREA Compliance Manager advised they would make contact with agency administration to address the issue. Evidence of prior institutional employment verification was present in employee files.

115.317 (d) – The facility provided the LATFH GH Policy No. 14 M, Page 13, Section 9 as evidence of compliance with this provision. This section of policy states, "The facility conducts criminal history checks and central registry checks at employee initial hire and at least every five years thereafter for all employees, contractors, and volunteers that have contact with you." The facility also attached a document entitled "Volunteer and Contractor Training"; however, this appears to be Standard 115.332, verbatim, and does not offer evidence of compliance for this provision. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears this language was recently added to address this audit's requirements, as the policy language does not appear in both versions. The interview with Administrative Staff revealed they have a prompt sheet with each employee's hire date,

and they run all employees annually by their month of hire. Administrative Staff advised they do not handle contractor background checks.

115.317 (e) – The facility provided the LATFH GH Policy No. 14 M, Page 13, Section 9 as evidence of compliance with this provision. This section of policy states, "The facility conducts criminal history checks and central registry checks at employee initial hire and at least every five years thereafter for all employees, contractors, and volunteers that have contact with you." According to Administrative Staff, they have a prompt sheet with each employee's hire date, and they run all employees annually by their month of hire. Administrative Staff advised they do not handle contractor background checks.

115.317 (f) – According to Administrative Staff, the agency does not ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. They advised employees have a continuing affirmative duty to disclose any such misconduct under their Good Moral Conduct Policy. Intermediate or Higher-Level Staff advised they provide applicants and employees with the aforementioned questions on site at the facility and agency Administrative Staff is not involved with administering those questions to applicants or employees. The Teaching Family Homes Policy 9, Employee Background Check, has a section titled, "Statement of Good Moral Character". This section states, "On the first day of employment, the employee shall review the State of Michigan Administrative Rules concerning the Good Moral Character requirements of applicants and shall sign the Good Moral Character acknowledgment form." The State of Michigan Bureau of Children and Adult Licensing Good Moral Character Acknowledgment states, "By Signing below, I acknowledge and understand my responsibility to uphold the good moral character standards as listed. I further acknowledge that I will immediately report any violation of this code to my supervisor." The associated code, R 400.1152, provides a list of offenses evidencing a lack of good moral character, and criminal sexual conduct in any degree and child abuse, neglect or exploitation are included in that list.

115.317 (g) – The LATFH GH Policy No. 14 M, Page 14, Section 10 states, "Material omissions regarding such misconduct, or the provision of materially false information, is grounds for termination." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears this language was recently added to address this audit's requirements, as the policy language does not appear in both versions.

115.317 (h) – According to Administrative Staff, they would 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, as long as they were provided with a release of information signed by the former employee.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.317 (a) - The facility will need to add policy language that prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who: • Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); • Has been convicted of engaging or attempting to engage in

sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or • Has been civilly or administratively adjudicated to have engaged in any of the aforementioned activities. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.317 (b) - The facility will need to add policy language to address consideration for incidents of sexual harassment when hiring, promoting or contracting with anyone who may have contact with residents. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.317 (c) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.317 (e) - It is unclear who, if anyone, is running initial contractor background checks and subsequent checks at least every five years. The facility will need to create a process to run and monitor contractor background checks.

115.317 (g) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 15, April 6 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.317 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 6, Sections 1 and 2 reflect the language required for this standard has been added to the LATFH GH Policy No. 60.O. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the updated LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O.

115.317 (b) - The facility provided the LATFH GH Policy No. 60.O to substantiate compliance with this standard. Page 6, Section 4 of the updated policy reflects LATFH shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The facility also provided

	training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O. 115.317 (c) - The facility provided the LATFH GH Policy No. 60.O to substantiate compliance with this standard. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O. 115.317 (e) - The facility provided the Lakes Area Personnel Prompt Sheet to substantiate compliance with this standard. This Excel spreadsheet lists the dates for completed background checks and the dates the next background check is due for all employees and the two contractors at LATFH. Facility administration reported this spreadsheet is maintained and background checks are secured by the Human Resources personnel for LATFH. 115.317 (g) - The facility provided the LATFH GH Policy No. 60.O to substantiate compliance with this standard. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O. 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 *Site Review 115.318 (a) – In the interview with the Agency Head, they advised they try to identify any blind spots in their homes and make everyone aware of what they should and need to be looking for to ensure safety. They advised they have deemed the current interior video surveillance system adequate after they installed one new camera over the last three years. The Superintendent indicated they are working on exterior cameras to enhance the agency's ability to protect residents from sexual abuse. 115.318 (b) – As indicated above, the Agency Head advised the facility added one new camera to address a blind spot identified after a report of sexual abuse in 2019. During the site review, this auditor observed the camera views and the facility provided explanations for where staff is positioned when residents transition from one location to the next in the home. With the staff positioning for line of sight supervision, blind spots were not noted. The Agency Head reported that staff line of sight supervision covers residents where cameras are not located and staff has been made aware of the locations where line of sight supervision is critical. The Superintendent advised they are working on installing exterior cameras to enhance supervision and safety.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *PREA Compliance Manager *Investigative Staff *SAFE/SANE Staff *Random Staff *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Michigan Model Policy: The Law Enforcement Response to Sexual Assault, Adults and Young Adults *Memorandum of Understanding Between Helen Newberry Joy Hospital and LATFH *Memorandum of Understanding Between the Women's Center and LATFH *Memorandum of Understanding Between the Luce County Sheriff's Office and LATFH 115.321 (a) – The facility reported it is responsible for conducting administrative investigations, and they indicated the Michigan State Police or local sheriff's office is responsible for criminal investigations. Regarding a uniform evidence protocol, the facility attached an untitled document to substantiate compliance with this provision. However, the document attached is one page, and it is the exact verbiage of PREA Standard 115.334. The document provides no instruction for training investigators for administrative investigations, nor does it constitute a uniform protocol. The LATFH GH Policy No. 14 M, Pages 10-12, Section H provides staff with the necessary steps to take after a report of sexual abuse, including preserving the scene of the incident, not allowing victims and perpetrators to shower, change their clothing or brush their teeth and to transport victims to the emergency room for a forensic medical examination. The facility submitted the "Michigan Model Policy: Law Enforcement Response to Sexual Assault/Adults and Young Adults" document to confirm use of a uniform evidence protocol in sexual abuse criminal investigations. This protocol is utilized by law enforcement agencies statewide when conducting sexual abuse investigations and addresses evidence collection on scene and through the forensic medical examination. In interviews with random staff, they all indicated they would seal off the scene of the incident and would not allow the resident or perpetrator to shower, change clothing or brush their teeth. Only one staff member was aware local law enforcement or the State Police would be responsible for conducting criminal investigations.

115.321 (b) – The Michigan Model Policy: Law Enforcement Response to Sexual Assault document the facility attached as evidence of compliance for this standard is familiar to this auditor. It is specified for adults and young adults and is utilized by law enforcement agencies across the State of Michigan as a standard for sexual abuse investigations. This auditor is satisfied the protocol is age-appropriate for the residents of LATFH. The protocol is victim centered, taking into consideration various victim response 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 LATFH GH Policy No. 14 M, Page 11, Section c states, "If the assault is alleged to have occurred within the past 96 hours, the victim must be transported to the nearest hospital (Duke Life Point/Marquette General Hospital, or Helen Newberry Joy Hospital for Lakes Area Youth), or alternate if directed by Administration or emergency personnel, for examination by qualified personnel. If the assault is alleged to have occurred more than 96 hours earlier, the hospital is contacted for instructions. " This section of policy does not give any specific information about providing forensic medical examinations. The LATFH GH Policy No. 14 M, Page 8, Section (F)(3) states, "If it is believed or determined that a sexual assault/rape occurred and that the alleged sexual assault/rape occurred within the last 96 hours, the Consultant/Supervisor or designee must make immediate arrangement to transport the youth to the facility-designated emergency room, Helen Newberry Joy Hospital, for a rape kit and the area where the incident occurred must be secured for evidence collection." The LATFH GH Policy No. 14 M, Page 9, Section 4 states, "All forensic medical examinations and follow up medical treatments are provided without charge to the resident." The facility provided the Memorandum of Understanding (MOU) between Helen Newberry Joy Hospital and LATFH as evidence to substantiate compliance for this provision. However, the MOU does not mention or specify forensic medical exam services, only general healthcare provision. The MOU is unsigned. Contact with SAFE/SANE Staff, who is the Emergency Room Manager for the Helen Joy Newberry Hospital, revealed they conduct most SANE exams in Luce County, Michigan. They advised they would prefer a Pediatric SANE Nurse conduct exams for juveniles, and one is available in Chippewa County. The SAFE/SANE Staff indicated they would conduct a SANE exam on a juvenile if there was a situation where the resident could not be taken to War Memorial Hospital one hour away. .

115.321 (d) – The LATFH GH Policy No. 14 M, Page 9, Section 6 states, "The facility will provide an outside advocate, if requested by the victim, or qualified staff person, to accompany the victim through the forensic examination process, investigatory interviews, provide emotional support, crisis intervention, information and referrals." The facility provided an MOU between the Women's Center and LATFH to substantiate compliance with this provision. The MOU is dated between May 15, 2020 and May 15, 2025, but it is unsigned. The facility provided email documentation that demonstrate the facility's efforts to execute the MOU with the Women's Center and the Women's Center Program Manager confirmed the MOU was signed. In the interview with the PREA Compliance Manager, they indicated they have an MOU with the Women’s Center and the Diane Pepler Center (women’s domestic violence center) who would provide victim advocate services. The interview with the resident who reported sexual abuse indicated they did not request the services of a victim advocate.

115.321 (e) – The LATFH GH Policy No. 14 M, Page 9, Section 6 states, "The facility will

provide an outside advocate, if requested by the victim, or qualified staff person, to accompany the victim through the forensic examination process, investigatory interviews, provide emotional support, crisis intervention, information and referrals." The interview with the PREA Compliance Manager revealed the facility would provide a victim advocate, qualified agency staff member, or qualified community-based organization staff member to accompany and support the victim through the forensic medical examination process and investigatory interviews. The resident who reported sexual abuse indicated they did not request the services of a victim advocate. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears this language was recently added to address this audit's requirements, as the policy language does not appear in both versions, and the numbering of sections is incorrect.

115.321 (f) – As previously indicated, the Luce County Sheriff's Office or the Michigan State Police would conduct any criminal investigations related to an incident of sexual abuse at the facility. The facility provided an MOU between the Luce County Sheriff's Office and LATFH as evidence of compliance with this provision. The MOU indicates the Luce County Sheriff's Office will utilize investigators who have received specialized training and use investigatory protocols in sexual abuse investigations involving juvenile victims. The MOU is signed and dated, and has no expiration date.

115.321 (h) – The facility attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d).

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.321 (c) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 8, 2021 to substantiate corrective actions taken for this standard.

115.321 (c) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O.

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

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Investigative Staff *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Memorandum of Understanding Between Luce County Sheriff's Office and LATFH *Teaching Family Homes of Upper Michigan Youth Incident Reports dated January 11, 2019 *Luce County Sheriff's Office Report dated January 11, 2019 115.322 (a) – The LATFH GH Policy No. 14 M, Page 10, Section H states, "Each incident of alleged or reported sexual abuse or sexual assault/rape must be investigated to the fullest extent possible." This section of policy does not include investigations for incidents of sexual harassment. According to the Agency Head, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. They advised the facility would contact Central Intake, who would send out a caseworker to investigate. They advised if the incident was severe, they would call 911 and the State Police or Sheriff's Office would respond. The Agency Head indicated in the case of the administrative investigation they would run through what happened, ask questions, review video monitoring, talk to staff and residents and finalize a report. The facility reported no incidents of sexual abuse or sexual harassment in the past 12 months. However, during the course of interviewing random residents it was discovered a resident had reported sexual abuse to staff. The resident who made the report indicated to this auditor that they were unsure if the contact by the other resident was intentional or accidental, as they were playing basketball at the time. That resident advised they heard nothing from facility staff after their report. This was communicated to facility administration at the time of the on-site exit meeting and specifics were provided to the facility after this auditor discussed passing the information about the report to facility administration with the resident . The facility responded to the information by conducting follow-up interviews with the residents involved and the staff member to whom the resident indicated they reported the incident. From the follow-up investigation, it appears the staff member reported the incident to the PREA Compliance Manager and was instructed that no further action was needed. 115.322 (b) – The facility provided the LATFH GH Policy No. 14 M, Pages 10-12 as evidence of compliance with this provision. In the reading of this large section of policy it was noted Section (3)(b) states, "The Program Consultant/Supervisor or designee must be notified

immediately. The Program Consultant/Supervisor will make the determination whether to call police or assign a trained investigator to conduct an administrative investigation." It is noted Section 3 is specific to "any other intentional youth-on-youth sexual touching (non-penetrative touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks". This auditor reviewed the LATFH GH Policy No. 14 M, Page 8, Section (F) (1), which states, "Staff receiving a report of a sexual assault/rape or attempted sexual assault/rape, or staff that become aware of sexual activity between residents or between a resident and staff, contractor, visitor, or volunteer must immediately report this event to their Consultant/Supervisor. The supervisor must immediately relay the report to the Residential Director and CEO, according to the Reporting Events and Subsequent Documentation-Group Home Policy 4-I (Sheriff's Department MOU-Appendix VIII)". The facility provided the Teaching Family Homes of Upper Michigan Youth Incident Reports from a January 2019 resident-on-resident sexual abuse incident and a Luce County Sheriff's Office Report with the same date as evidence the facility documents referrals for criminal investigation. This auditor located the LATFH GH Policy No. 14 M on the agency website. According to Investigative Staff, allegations of sexual abuse and 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.

115.322 (c) – The MOU between the Luce County Sheriff's Office and LATFH describes the responsibilities of both the agency and the investigating entity.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.322 (a) - The LATFH GH Policy No. 14 M must be modified to include the requirement to investigate sexual harassment. The LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff, and staff must also be trained on the updated policy information and procedures for reports of sexual abuse or sexual harassment.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 19 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.322 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 10-11, Section I reflects the inclusion of the requirement to investigate all incidents of sexual harassment. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O.

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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *"Your Role: Responding to Sexual Assault" Power Point Presentation *Staff Training Records 115.331 (a) – The LATFH GH Policy No. 14 M, Page 5, Section C states, "All facility staff, and contractors and volunteers that have regular contact with youth, must complete initial and annual training for sexual assault/rape prevention, incident response, and reporting. At the conclusion of each training session, all trainees must sign that they attended and understood the training." This auditor reviewed the "Your Role: Responding to Sexual Assault" Power Point Presentation, which was provided to substantiate compliance with this provision. This training curriculum covers the topics of victim and perpetrator traits, dynamics of sexual abuse in confinement settings, avoiding inappropriate relationships with residents, staff responsibilities in response to incidents of sexual abuse, preserving crime scenes and evidence, effective communication with victims of sexual abuse, warning signs, and other topics pertinent to staff understanding of sexual safety in the facility. The facility provided employee training records for ten employees for 2019, as well as initial PREA training for newly hired employees on September 10, 2020. In interviews with random staff members, they advised they have been trained in the topics listed in this provision. 115.331 (b) – The facility responded on the Pre-Audit Questionnaire that this provision does not apply because they house an all-male population. It is noted the other facilities within the agency's control are not subject to PREA requirements, as those programs are not juvenile justice placement programs. In reviewing the "Your Role: Responding to Sexual Assault" Power Point Presentation, the training curriculum provided information specific to juveniles of both genders. 115.331 (c) – The facility reported on the Pre-Audit Questionnaire that refresher PREA trainings are conducted quarterly and provided PREA training rosters for April 11 and 16, 2019, March 5, 2020 and August 20, 2020 for all current employees. Interviews with random staff members confirmed they receive PREA training several times a year. 115.331 (d) – The LATFH GH Policy No. 14 M, Page 5, Section C states, "All facility staff, and contractors and volunteers that have regular contact with youth, must complete initial and annual training for sexual assault/rape prevention, incident response, and reporting. At the conclusion of each training session, all trainees must sign that they attended and understood

the training." However, the training records provided by the facility do not have employee acknowledgments that they understood the training.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.331 (d) - The facility will need to create and utilize an acknowledgment for staff PREA training that documents the staff member attended and understood the information provided at the training. The acknowledgment must require the employee's signature or the facility may utilize an electronic acknowledgment of understanding.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 19, 2021 to substantiate corrective actions taken for this standard.

115.331(d) - The facility submitted the LATFH Training Attestation to substantiate compliance with this standard. The Training Attestation records the name of the training, the date of the training and the signature of the employee. The Training Attestation requires the employee to indicate they understood the training and had an opportunity to ask questions during the training.

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

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Contractors Who Have Contact With Residents Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Certificate of Completion, "PREA-Behavioral Health Care For Sexual Assault Victims in a Confinement Setting" 115.332 (a) – The facility provided a Certificate of Completion dated February 9, 2016 for the "PREA-Behavioral Health Care For Sexual Assault Victims in a Confinement Setting" through the National Institute of Corrections for the facility's contracted psychologist. It is noted the facility's psychologist's name and signature does not appear on any of the PREA refresher training rosters, nor was evidence of the psychologist participating in the initial PREA training for employees at the onset of contracted services. The facility also provided a document in the Pre-Audit Questionnaire which is the PREA Standard for 115.332 verbatim. It is unclear how this section of the PREA standards is used or how it is instructive for contractors or volunteers. This auditor interviewed the facility's two contractors. The psychologist advised they go over one hour of PREA training quarterly and they completed specialized training on the PREA website. The nurse advised they had not received PREA training. 115.332 (b) – The "PREA-Behavioral Health Care For Sexual Assault Victims in a Confinement Setting" training through the National Institute of Corrections is applicable to the facility's contracted psychologist's role and responsibilities. The psychologist advised they have been trained in their responsibilities regarding sexual abuse and sexual harassment prevention, detection and response, the agency's zero-tolerance policy on sexual abuse and sexual harassment, as well as how to report incidents of sexual abuse or sexual harassment. As previously indicated, the contracted nurse advised they have not received PREA training. 115.332 (c) – Other than the aforementioned Certificate of Completion for the facility's psychologist, this auditor was not provided with documentation for contractor training. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING**: 115.332 (a) - The facility must ensure the contracted psychologist and nurse complete the PREA training provided for new employees. 115.332 (b) - The facility must insure the nurse contractor completes the specialized PREA training for medical professionals. This training can be located on the National Institute of Corrections website. 115.332(c): The facility must document training for all contractors and volunteers and require

	those receiving the training to acknowledge they understand the material covered in training. **VERIFICATION OF CORRECTIVE ACTION**: This auditor was provided appropriate supplemental documentation on February 19, 2021 and March 9, 2021 to substantiate corrective actions taken for this standard. 115.332(a) - The facility submitted Training Attestations for general PREA training for the facility psychologist and nurse, both dated March 9, 2021. 115.332 (b) - The facility submitted the National Institute of Corrections PREA 201 for Medical and Mental Health Practitioners Certificate of Completion dated February 28, 2021 for the facility's contracted nurse. 115.332(c) - The Training Attestations for the facility psychologist and nurse, both dated March 9, 2021, documents the training and reflects both parties understood the training. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Intake Staff *Random Residents Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH Youth Safety Guide *State of Idaho Department of Juvenile Corrections PREA Video *LATFH Youth and Family Orientation Manual *MDHHS SRM 400 Policy, Reasonable Accommodation *Site Review *Resident File Review 115.333 (a) – The LATFH GH Policy No. 14 M, Page 2, Section A states, "At the time of intake, the youth orientation process will include policy and procedures relating to prevention of and response to reports of sexual assault/rape. This orientation must occur within the first day of the youth's admission as part of the Orientation of New Youth-First Day of Placement Policy 7-A (Appendix 1)...The New Youth PREA Orientation information includes the following: a. The agency's zero-tolerance policy; b. Self-protection including avoiding risky situations related to sexual assault prevention/intervention; c. Reporting procedures, how to report rape, sexual activity, sexual abuse or sexual harassment. Multiple reporting options include: 1) verbally to any staff member or administrator; 2) in writing to any staff member or administrator; 3) in writing through the youth and family grievance process; and 4) externally by telephoning Children's' Protective Services. Anonymous and third-party reports must also be accepted. d. Treatment and counseling, how to obtain counseling services and/or medical assistance if victimized; e. Protection against retaliation; f) Risks and potential consequences for engaging in any type of sexual activity while at the facility; g. Disciplinary actions(s) for making false allegations..." The facility provided the Youth Safety Guide to substantiate compliance with this provision. This guide provides information regarding the facility's zero tolerance policy toward sexual abuse and sexual harassment, how to report, how residents can keep themselves safe from potential incidents and a list of resources for outside reporting and victim support. For the most part the information in the Youth Safety Guide is age-appropriate, but some verbiage may require explanation. According to Intake Staff, they go through the steps to report, advise them they are safe and that if they report an incident, they will be protected from retaliation. They indicated they advise residents the facility has zero

tolerance for any violations. Intake Staff advised they provide this information to residents within 72 hours of their placement at the facility, but they try to present the information the day of or day after intake. In the interviews with random residents, all but one indicated they received this information the same day they arrived at LATFH. Resident file reviews revealed an acknowledgment they received the initial PREA information, which was signed by the residents and dated the same day of intake.

115.333 (b) – The facility provided the Youth Safety Guide as evidence of comprehensive PREA education for residents. As indicated above, that information is provided at the time of intake and provides information regarding the facility's zero tolerance policy toward sexual abuse and sexual harassment, how to report, how residents can keep themselves safe from potential incidents and a list of resources for outside reporting and victim support. During the on-site audit it was discovered the facility utilizes the State of Idaho Department of Juvenile Corrections PREA Video, which is shown to residents most often by the facility's contracted psychologist in conjunction with completing the risk screening tool. This auditor reviewed three resident files selected at random. Two of the three files contained confirmation they received comprehensive education on their rights to be free from sexual abuse and sexual harassment, from retaliation for reporting such incidents, and on agency policies and procedures for responding to such incidents. However, the notation that the video was shown to the resident does not include the date it was shown. One of the resident files did not have documentation to substantiate the resident watched the video.

115.333 (c) – As indicated above, the resident files selected at random did not provide adequate information to confirm the residents received the comprehensive PREA education within ten days of placement. Intake Staff advised they provide the Youth Safety Guide to residents within 72 hours of their placement at the facility, but they try to present the information the day of or day after intake. The facility reported on the Pre-Audit Questionnaire that any resident coming into the program would receive the comprehensive PREA education, regardless of whether they transferred to the facility from another program.

115.333 (d) – The facility indicated on the Pre-Audit Questionnaire that deaf or hearing-impaired residents can utilize interpreters, blind/low vision, disabled or limited reading skills residents can have the PREA information read to them and staff can help them understand the information. The facility did not provide resident education materials in languages other than English. As previously indicated, the Youth Safety Guide would likely require staff assistance to understand the information or another format that allows these residents to comprehend the information. The MDHHS PREA Compliance manager advised that as a MDHHS contractor, LATFH is able to access resources for blind/low vision, limited reading skills or intellectually disabled residents through MDHHS, as provided in the MDHHS SRM 400 Policy. Page 1 of this policy states, "The obligation to provide appropriate services, policies, practices, and procedures to individuals in need of reasonable accommodations is required across all child welfare program areas, for both MDHHS and private child placing agencies and child caring institutions. All child welfare staff must review this policy item and the linked documents for details on meeting the obligations of providing appropriate services, policies, practices, and procedures, to individuals in need of reasonable accommodations."

115.333 (e) – As indicated in 115.333 (b), the documentation for the comprehensive PREA education is not sufficient to demonstrate compliance with this provision.

115.333 (f) – In the interviews with random residents, they indicated they were given a copy of

the Youth Safety Guide to keep in their rooms. During the Site Review this auditor observed posters including, "Say NO to Sexual Abuse" and "End the Silence". The posters included information on how to report sexual abuse, including telephone numbers to report abuse. However, the "End the Silence" poster has a telephone number that goes to the Kansas Department of Child Welfare. An additional posting was noted that stated, "This facility complies with federal PREA standards" and lists the PREA Compliance Manager's telephone number, as well as the telephone numbers for the Children's Protective Services Hotline, the Women's Center and the Marquette General Hospital. This auditor called the number listed for the Children's Protective Services Hotline during the on-site audit and found the number was incorrect.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.333 (b)(c)(e) - The facility is lacking documentation that residents have viewed the State of Idaho Department of Juvenile Corrections PREA Video for comprehensive resident education. The facility will need to create a form that records the date the PREA video was shown and requires the resident's signature to acknowledge they viewed and understood the material, or add that documentation to an existing form.

115.333 (d) - Facility administration will need to review the MDHHS SRM 400 Policy, Reasonable Accommodation and associated policies and train staff on how to access services through MDHHS for limited English proficient, deaf, visually impaired and otherwise disabled residents. Documentation of completed training for all staff must be provided to substantiate compliance with this provision.

115.333 (f) - The facility must update its sexual abuse postings to reflect accurate information. The telephone numbers for the "End the Silence" and the Children's Protective Services Hotline must be corrected and reposted.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 19, February 23, March 12, and April 8, 2021 to substantiate corrective actions taken for this standard.

115.333 (b)(c)(e) - The facility provided the MDHHS 5605, Juvenile Justice Residential Youth Orientation Checklist for the two youth admitted to the program since the on-site audit. These documents recorded the date the resident was provided comprehensive PREA education and the residents' signatures appear to affirm the items on the checklist were provided to them. A staff member's signature is also present on the checklist to affirm the information was provided in a format understandable to the resident.

115.333 (d) - The facility provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the MDHHS SRM 400 Policy, Reasonable Accommodation was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies, and accessing services for limited English proficient, deaf/hearing impaired, blind/low vision, or otherwise disabled residents.

115.333 (f) - The facility provided updated sexual abuse postings for LATFH. The telephone numbers for the "End the Silence" and the Children's Protective Services Hotline have been

	corrected and verification of reposting was provided. 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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Department of Justice "PREA: Investigating Sexual Abuse in a Confinement Setting" Training Certificate 115.334 (a) – The LATFH GH Policy No. 14 M, Page 6, Section 6 states, "Staff that conduct administrative investigations of sexual abuse allegations must receive specialized training on conducting such investigations." The facility provided the Department of Justice "PREA: Investigating Sexual Abuse in a Confinement Setting" Training Certificate dated July 6, 2018 for the facility's Investigative Staff. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears this language was recently added to address this audit's requirements, as the policy language does not appear in both versions. According to Investigative Staff, they completed the specialized investigator training from the PREA website. In their description of the training, they indicated the training covered separating the parties, contacting everyone who needs to be contacted, sitting in on interviews with the State Police or Sheriff, and draw up report when all is said and done. 115.334 (b) – In the interview with Investigative Staff, they advised their training covered techniques for interviewing juvenile sexual abuse victims, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative or prosecution referral. Investigative Staff advised their training did not cover the proper use of Miranda and Garrity warnings. 115.334 (c) – As previously indicated, the facility provided the Department of Justice "PREA: Investigating Sexual Abuse in a Confinement Setting" Training Certificate dated July 6, 2018 for the facility's Investigative Staff.

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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *National Institute of Corrections Certificate of Completion, Behavioral Health Care for Sexual Assault Victims in a Confinement Setting 115.335 (a) – The LATFH GH Policy No. 14 M, Pages 5 and 6, Section (c)(5) 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." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears this language was recently added to address this audit's requirements, as the policy language does not appear in both versions. The facility provided the National Institute of Corrections Certificate of Completion, Behavioral Health Care for Sexual Assault Victims in a Confinement Setting dated February 9, 2016 for the facility's contracted psychologist to substantiate compliance with this provision. This course covers detecting signs of abuse, reporting sexual abuse and preserving evidence in a sexual assault. In the interview with the facility's contracted psychologist, they indicated they received training 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. In the interview with the facility's contracted medical provider, they indicated they have not received PREA training. They indicated they have received training on how to detect and assess signs of sexual abuse and sexual harassment and how to preserve physical evidence of sexual abuse through Continuing Education Units for their medical profession, and they are knowledgeable in mandated reporting laws. They indicated they have not received juvenile-specific training on these topics. 115.335 (b) – The facility indicated their medical staff does not provide forensic medical exams. This was confirmed by the facility's contracted medical staff. 115.335 (c) – As previously indicated, the facility provided the specialized training certificate for the contracted psychologist, but there is no documentation for the contracted medical healthcare provider. 115.335 (d) – The facility did not provide any documentation of the Medical/Mental Health staff completing the general PREA training that is required of LATFH line and administrative staff.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.335 (a) - The facility's contracted nurse must complete specialized PREA training for medical professionals in a juvenile setting. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.335 (c) - The facility must provide documentation of the completed specialized PREA training for medical professionals in a juvenile setting for the contracted medical provider.

115.335 (d) - The facility's contracted psychologist and medical provider must complete the PREA training provided to new employees. Documentation of this training is also required.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9 and April 8, 2021 and to substantiate corrective actions taken for this standard.

115.335(a) - The facility submitted the National Institute of Corrections PREA 201 for Medical and Mental Health Practitioners Certificate of Completion dated February 28, 2021 for the facility's contracted nurse. In addition, this auditor received confirmation that LATFH staff members were trained on the updated LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) on March 26 and April 1, 2021.

115.335(c) - The facility submitted the National Institute of Corrections PREA 201 for Medical and Mental Health Practitioners Certificate of Completion dated February 28, 2021 for the facility's contracted nurse.

115.335(d) - The facility submitted Training Attestations for general PREA training for the facility psychologist and nurse, both dated March 9, 2021.

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 *PREA Compliance Manager *Staff Responsible for Risk Screening *Random Residents Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Teaching Family Homes of Upper Michigan PREA Intake Screenings *Site Review 115.341 (a) – The LATFH GH Policy No. 14 M, Pages 3 and 4, Section (B)(1) states, "The residents' behavior history must be reviewed during the initial referral screening and intake using the designated PREA Intake Screening Form (Appendix V). As part of the initial orientation, staff will determine the resident's potential risk of sexual vulnerability based on the following risk factors; a. Age; b. Physical stature; c. Developmental disability; d. Mental illness; e. Sex offender status (per offense history); f. First-time offender status; g. Past history of victimization; h. Physical disabilities and the residents (sic) own perception of vulnerabilities; i. Reported history of sexual activity. Section (B)(2) states, "The youth must be evaluated as part of orientation to determine if the youth is prone to victimize other youth, especially in regard to sexual behavior, based on the following risk factors: a. History of sexually aggressive behavior; b. History of violence as related to a sexual offense; c. Anti-social attitudes indicative of sexually aggressive behavior." There is no requirement in the LATFH GH Policy No. 14 M that the risk screening must be conducted within 72 hours of intake. The LATFH GH Policy No. 14 M does not require residents' risk levels be reassessed periodically throughout their confinement. The facility provided the resident risk screening instruments for the past 12 months. It is noted all five screening instruments have the identical date listed for the date of intake and the date of screening. However, in random resident file reviews it was noted that the date of intake differed from the date the risk screening instrument was completed. In the interview with Staff Responsible for Risk Screening, they indicated they or the PREA Compliance Manager complete the risk screening instrument within 72 hours of intake. They indicated they obtain the information to complete the risk screening instrument from interviews with the resident. Regarding periodic reassessment, they advised they do not do a formal periodic reassessment, but if there was an incident the resident would be reassessed. They stated they meet weekly with other staff and address resident risk issues on a regular basis. Random resident interviews revealed three residents indicated they were asked questions on

the aforementioned topics and one resident indicated they were not asked those questions. Of the three residents who indicated they were asked the questions, their answers for when they were asked these questions varied from the same day of intake to a week after intake. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions.

115.341 (b) – The Teaching Family Homes of Upper Michigan (LATFH) PREA Intake Screening was provided to substantiate compliance with this provision. The intake screening instrument captures the resident's age, current and previous charges, educational grade and Special Education status, prior sexual offending, prior sexual abuse victimization, a description of sexual identity and the resident's perception of vulnerability while in placement. The intake screening instrument requires the staff member completing the screening to address the resident's emotional and cognitive development, mental illness or mental disabilities, physical disabilities, intellectual or developmental disabilities, size and stature and gender non-conforming appearance through documentation, resident input and observations. The intake screening instrument requires staff conducting the screening to assess whether the resident may be at greater risk for sexual victimization or perpetration and whether specific assignments or precautions are necessary to ensure resident safety. The intake screening instrument does not include a comprehensive list of sexual identification or gender identity, (just "gay, straight, bisexual"). The question to the resident asks them to describe their sexual identity, but that might not trigger an accurate response from resident.

115.341 (c) – The intake screening instrument captures the resident's age, current and previous charges, educational grade and Special Education status, prior sexual offending, prior sexual abuse victimization, a description of sexual identity and the resident's perception of vulnerability while in placement. The intake screening instrument requires the staff member completing the screening to address the resident's emotional and cognitive development, mental illness or mental disabilities, physical disabilities, intellectual or developmental disabilities, size and stature and gender non-conforming appearance. The intake screening instrument does not request or require information regarding whether the resident identifies as transgender or intersex.

115.341 (d) – The intake screening instrument indicates the Treatment Team must review the completed screen, in addition to available medical and mental health screenings, classification assessments, the case file and other relevant records to make housing determinations. The intake screening instrument also indicates that information from formal assessments and evaluations, school evaluations and file information should be included in the staff's assessment. According to the Staff Responsible for Risk Screening, they obtain the information to complete the risk screening instrument from interviews with the resident.

115.341 (e) – The PREA Coordinator/PREA Compliance Manager advised all staff has access to the intake screening instrument, as all staff members are involved in the case management of each resident. The PREA Coordinator/PREA Compliance Manager indicated the intake screening instruments are kept in a locked office located away from resident access. The Staff Responsible for Risk Screening indicated they believe the information is only accessible on a need-to-know basis.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.341 (a) - The LATFH GH Policy No. 14 M must be updated to include the requirement that the risk screening instrument must be completed within 72 hours of intake. In addition, the policy must be updated to include the requirement that residents be reassessed periodically throughout their confinement. The facility will also need to accurately record the date the risk screening instrument is completed, as it likely differs from the date of intake. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.341 (c) - The Teaching Family Homes of Upper Michigan PREA Intake Screenings must be updated to include questions to residents as to whether they identify as transgender or intersex. Although current practice is either the PREA Coordinator/PREA Compliance Manager or the facility's contracted psychologist complete the intake screening instrument, the updated intake screening instrument must be distributed to staff and staff must also be trained on the updated information.

115.341 (d) - It appears the only information used by the primary staff responsible for risk screening is verbal information provided by the resident. Staff responsible for risk screening must also consider available medical and mental health screenings, classification assessments, the case file and other relevant records when completing the risk screening tool. Any staff member who may complete the resident risk screening tool must be trained on how to access such additional records and incorporate that information into the overall risk screening assessment. Proof of such training is required for compliance with this provision.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 19, March 9, 26 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.341 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. Page 3, Section B 1 reflects the youth risk screening must occur within 72 hours of intake, and that youth will be reassessed periodically throughout their stay at LATFH. The facility provided two MDHHS Prison Rape Elimination Act (PREA) Screening Tools for the two residents placed post on-site audit. Both of the screening tools reflect the screening was completed within 72 hours of intake. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

115.341 (c) - The facility provided two MDHHS Prison Rape Elimination Act (PREA) Screening Tools for the two residents placed post on-site audit. The screening tool now includes the additional gender identifiers. The facility did not include the MDHHS Prison Rape Elimination Act (PREA) Screening Tool in its general staff PREA training for this audit, due to the fact that only the facility's contracted Mental Health Staff, PREA Compliance Manager, and Agency

	Head/PREA Coordinator/Investigative Staff perform resident risk screenings. However, the facility provided email verification that it distributed the screening tool to all staff and provided an opportunity for staff to ask questions regarding the screening tool. 115.341 (d) - The facility provided a training acknowledgment dated March 22, 2021 for the MDHHS Prison Rape Elimination Act (PREA) Screening Tool for the PREA Compliance Manager. The PREA Compliance Manager confirmed their training included accessing available medical and mental health screenings, classification assessments, the case file and other relevant records when completing the risk screening tool. The PREA Compliance Manager confirmed the updated MDHHS Prison Rape Elimination Act (PREA) Screening Tool and the LATFH GH Policy No. 60.O were included in the PREA training for the contracted Medical and Mental Health staff on March 9, 2021. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Coordinator *PREA Compliance Manager *Medical/Mental Health Staff *Staff Responsible for Risk Screening *Transgendered/Intersex/Gay/Lesbian/Bisexual Residents Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH PREA Intake Screenings *Site Review 115.342 (a) – The LATFH GH Policy No. 14 M, Page 4, Section 3 states, "All information obtained from the youth, family, or referring worker will be used to make housing, bed, program, education, and work assignments for residents with the goal of keeping residents safe and free from sexual abuse. Assessment activities must be documented, including how the assessment information was used to inform placement and assignments." The LATFH PREA Intake Screenings contains the statement, "Information obtained in this screen must be used to inform housing, bed, program, seating, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse." in the instructive paragraph at the top of the instrument. A review of the intake screening instruments for residents placed at LATFH for the past 12 months revealed notations regarding whether standard procedures for placement of residents could be followed or if the resident presented specific concerns. It is noted the maximum capacity of LATFH is eight residents. At the time of the on-site audit, the facility housed four residents, and the average daily population over the past 12 months was 4.5 residents. During the site review this auditor observed seven bedrooms, with one of the bedrooms being capable of housing two residents. As a result, each resident has been placed in their own room over the past 12 months. In the interview with the PREA Coordinator/PREA Compliance Manager, they indicated the contracted psychologist completes the intake screening instrument and they would make recommendations as to how a resident should be housed in relation to other residents in the program. The Staff Responsible for Risk Screening indicated the information from the intake screening instrument is used to determine if a resident can have a roommate, what and how much does staff need to look out for in a resident's behavior, and to look for any history of

grooming behavior.

115.342 (b) – There is no mention of isolation in the LATFH GH Policy No. 14 M as a housing designation and LATFH reported having no other policies regarding isolation. The facility indicated on the Pre-Audit Questionnaire that it does not have an isolation room at LATFH, and none was noted at the time of the site review. The Superintendent and Medical/Mental Health staff indicated isolation is not practiced at LATFH. As there were no residents placed in isolation or staff supervising residents in isolation, those interview protocols were not completed.

115.342 (c) – The LATFH GH Policy No. 14 M, Page 4, Section (4)(b) states, "Lesbian, gay, bisexual, transgender, or intersex (LGBTI) residents may not be housed solely on the basis of such identification or status, and decisions must be made on a case-by case-case basis. Youth must not be considered more likely to perpetrate sexual abuse solely because of LGTBI identity." A review of the intake screening instruments for the past 12 months revealed one resident who responded they identified as bisexual. That resident's intake screening instrument contained the staff notation, "Higher risk for both; recommend eyes on supervision when out of his room; individual room" for the question, "Based on your interview and observations, please list whether you think the youth is at greater risk of being victimized, poses a greater risk to victimize others, or neither". However, this resident had no notation on their intake screening instrument that they had been convicted or adjudicated on charges of sexual abuse. According to the PREA Coordinator/PREA Compliance Manager, the facility does not have special housing units for LGBTI residents, but they would make efforts to put LGBTI residents in a room where they are not attempting to perpetrate or push their beliefs on other residents. The interview with the Transgendered/Intersex/Gay/Lesbian/Bisexual Resident revealed they have never been placed in special housing based on their LGBTI status.

115.342 (d) – Although the LATFH GH Policy No. 14 M doesn't speak specifically to transgendered or intersex residents, it does address LGBTI residents as noted in 115.342 (c). The interview with the PREA Coordinator/PREA Compliance Manager revealed they would take every precaution to maintain safety for transgendered youth and would make sure that youth was in direct line of sight at all times. The interview protocol for Transgendered/Intersex Residents was not completed as a resident meeting that criteria was not placed at the facility at the time of the on-site audit.

115.342 (e) – The LATFH GH Policy No. 14 M, Page 4, Section 3 states, "Review of placement and programming assignments must occur at least twice each year to assess any threats to safety experienced by the student." This section of policy references all residents, not transgendered/intersex residents specifically. According to the PREA Compliance Manager, the agency considers whether placements of transgendered or intersex residents will ensure the resident’s health and safety. The staff responsible for risk screening advised transgendered or intersex resident’s’ views of their safety is given serious consideration in placement and programming assignments.

115.342 (f) – According to the PREA Compliance Manager and Staff Responsible for Risk Screening, the agency considers whether the placement of transgendered or intersex residents would present management or security problems. The interview protocol for Transgendered/Intersex Residents was not completed as a resident meeting that criteria was not placed at the facility at the time of the on-site audit.

115.342 (g) – The PREA Coordinator/PREA Compliance Manager and staff responsible for risk screening indicated transgendered and intersex residents would be given the opportunity to shower separately from other residents, as all residents shower separately. The interview protocol for Transgendered/Intersex Residents was not completed as a resident meeting that criteria was not placed at the facility at the time of the on-site audit.

115.342 (h) – As indicated in the comments on 115.342 (b), the facility does not practice isolation as a housing designation. As there were no residents placed in isolation or staff supervising residents in isolation, those interview protocols were not completed.

115.342 (i) - As indicated in the comments on 115.342 (b), the facility does not practice isolation as a housing designation.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.342 (b) - The facility must add a statement in the LATFH GH Policy No. 14 M that indicates the facility does not use or practice isolation as a designated housing assignment. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.342 (c) - Although facility policy indicates LGBTI residents may not be housed solely on the basis of such identification or status and youth must not be considered more likely to perpetrate sexual abuse solely because of LGBTI identity, it appears this may be occurring based on the interview with the PREA Coordinator/PREA Compliance Manager and the intake screening instrument for the resident who identified as LGBTI. The facility must institutionalize the understanding that this practice is in direct conflict with this PREA provision and the facility's own policy. Facility administration and staff must complete the "Respectful Classification Practices with LGBTI Inmates Training", available on the PREA Resource Center website under Training and Technical Assistance. Documentation of completed training for administration and staff is also required.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.342 (b) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 4, Section 5 (a) reflects the agency does not use or practice isolation as a designated housing assignment when determining room assignments. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

115.342 (c) - The facility provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the Respectful Classification Practices with LGBTI Inmates Training was included in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on

	April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies. 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 *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH Youth Safety Guide *Policy 36, Anti-Harassment Policy *GH Policy 2D-1, Grievances *Site Review 115.351 (a) – The LATFH GH Policy No. 14 M, Page 6 and 7, Section E states, "Youths 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, 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 (See Group Home Policy 2D-1, Grievances). The facility submitted the LATFH Youth Safety Guide to substantiate compliance with this provision. Page 11 of the Youth Safety Guide provides instruction to residents to talk to or send a letter or note to direct care staff, counselors, consultant/supervisor, social worker, teachers or other staff at the facility. The Youth Safety Guide also lists filing a grievance, calling attorneys, asking staff to help research available legal services and contacting the PREA Coordinator and PREA Compliance Manager. However, the heading above this list says, "How to Report Sexual Abuse/Assault" and omits reporting sexual harassment, retaliation and neglect of staff duties. The GH Policy 2D-1 outlines the policy and procedure for resident grievances; however, it appears this information is not provided to residents. Random staff indicated residents can make a report of sexual abuse or sexual harassment by calling the CPS Hotline, calling the PREA Compliance Manager, telling any staff member or management or their caseworker, contacting family members, staff, giving a note to staff or a supervisor, contacting law enforcement or through grievance forms. Random residents reported they could go to staff, report to management or slip a note to staff.

115.351 (b) – The Youth Safety Guide does not include instructions for calling the Children's Protective Services Hotline, but the number is at the end under "Resources". During the site review this auditor noted a posting which provided the PREA Compliance Manager's name and number to report issues of sexual abuse or sexual harassment while in placement. The posting also listed emergency resources, including the Children's Protective Services Hotline, the Women's Center and the Marquette General Hospital. This auditor contacted the telephone number on this posting for the Children's Protective Services Hotline; however, the posted number was incorrect. Through conversations with facility administration, it was learned a resident would have to have staff dial the phone number to the Children's Protective Services Hotline, and the only reason a resident would contact the Hotline would be to report sexual abuse or sexual harassment. The PREA Compliance Manager indicated residents can make reports to an outside agency by using the phone numbers in the Youth Safety Guide for Central Intake and the Women's Center. Random residents reported they could contact family members, caseworkers, call the posted number, tell parents or the police. The facility reported it does not house residents detained solely for civil immigration purposes.

115.351 (c) – The facility submitted a document titled "Employee Training" to substantiate compliance with this provision. However, this document is the PREA Standard for 115.351, verbatim, which is not a policy and does not address compliance with the provision. The facility provided the LATFH GH Policy No. 14 but did not specify a section of the policy that demonstrates compliance with this provision. This auditor's review of the "Staff Response to Sexual Assault/Rape" section of the policy does not specify the requirement for staff to accept reports in these formats; however, there is a line in the "Providing Sexual Assault Rape Prevention Information to Youth" that indicates anonymous and third-party reports must be accepted (LATFH GH Policy No. 14, Page 2, Section (A)(c)). There is no requirement that staff must document such reports in this section of policy, however, the LATFH GH Policy No. 14, Page 8, Section F requires staff to report any knowledge, suspicion, or information regarding sexual abuse or sexual harassment without specifying how staff receives the information. Section (F)(2) requires staff to complete an Incident Report before the end of their work shift, as well as DHS-3200, Report of Actual or Suspected Child Abuse or Neglect Form. Random staff indicated residents can complete a grievance to report an incident in writing, and third party and anonymous reports are accepted. Random residents were not clear on whether they could make a report anonymously, but they were aware they could tell someone outside the facility or write a grievance to report sexual abuse or sexual harassment.

115.351 (d) – This auditor observed the locked Drop Box, located inside the classroom area, for grievances, rights violations and feedback. The box had grievance forms located on the top of the box. The PREA Coordinator/PREA Compliance Manager advised the facility provides residents with tools to help them make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities by providing residents with the Youth Safety Guide, which instructs residents who to write to and provides details about the grievance box. Random residents advised they could complete a Grievance Form and put it in the grievance box if they wanted to make a written report. Random residents advised they have access to pens and pencils as they need them.

115.351 (e) – The facility provided Policy 36, Anti-Harassment Policy, to substantiate compliance with this provision. However, this policy pertains to employer/employee harassment and not sexual abuse or sexual harassment of residents. Random staff advised

they could privately report sexual abuse or sexual harassment of residents, retaliation or neglect of staff duties by sending an email to or asking for a private conversation with management or by contacting the Children's Protective Services Hotline.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.351 (a) - The LATFH GH Policy No. 14 M, Page 6 and 7, Section E needs to be updated to include reporting for retaliation and neglect of staff duties.

115.351 (b) - The facility must make calls to Children's Protective Services private by creating a calling system that adds anonymity to the purpose of the call. This can be accomplished by informing residents they can make a report to the Children's Protective Services Hotline for any complaint, not just reports of sexual abuse or sexual harassment. In addition, the facility will need to afford residents some level of privacy to contact the Children's Protective Services Hotline. If the facility's telephone has the capability to program telephone numbers into memory, the resident could be given the telephone and staff could observe from a reasonable distance the resident push one button to connect them to the Children's Protective Services Hotline. The facility can employ another method that may work better for LATFH to allow residents to have confidential telephone access to the Children's Protective Services Hotline. The procedure for residents to request a call to the Children's Protective Services Hotline needs to be documented and residents and staff must be educated on the procedure. Although the telephone number for the Children's Protective Services Hotline is listed in the Youth Safety Guide, it is not listed under the section titled, "How to Report Sexual Abuse/Assault". It is not clear if a resident would associate the information as it is listed in the Youth Safety Guide as a reporting source. The facility must update the Youth Safety Guide to reflect the telephone number for the Children's' Protective Services Hotline as a source to report sexual abuse or sexual harassment and will need to include "retaliation and staff neglect of duties" as part of the issues to report. The facility will also need to update its sexual abuse postings to reflect accurate information. The telephone number for the Children's' Protective Services Hotline must be corrected and reposted, and proof of the correction must be provided.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.351 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 8, Section G includes the required language for reporting retaliation and neglect of staff duties. In addition, the facility provided the updated Youth Safety Guide, which includes information on reporting retaliation for reporting sexual abuse or sexual harassment and neglect of staff duties. In conjunction, the facility provided five Youth Safety Guide Statements of Understanding, signed by the five current program residents and dated April 5, 2021. Subsequent interviews with residents were conducted by Microsoft Teams videoconference on April 13, 2021. Residents verified their understanding of how to report sexual abuse, sexual harassment, retaliation for reporting, and staff neglect of duties that contributed to an incident. They also demonstrated understanding of how to make a confidential call to the CPS Hotline and the grievance process for reporting.

115.351 (b) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy

	No.14 M) to substantiate compliance with this standard. Page 7, Section F 1 (a) provides the procedure for youth to contact the Children's' Protective Services Hotline to report a complaint of any nature, which allows the resident to maintain privacy as to the nature of the call. Facility administration has programmed the Children's' Protective Services Hotline number into the facility telephone to aid residents in contacting the Hotline. The facility provided the updated Youth Safety Guide, which includes information on reporting retaliation for reporting sexual abuse or sexual harassment and neglect of staff duties. The Youth Safety Guide also reflects the telephone number for the Children's' Protective Services Hotline as a source to report sexual abuse, sexual harassment, retaliation, and neglect of staff duties. In conjunction, the facility provided five Youth Safety Guide Statements of Understanding, signed by the five current program residents and dated April 5, 2021. Subsequent interviews with residents were conducted by Microsoft Teams videoconference on April 13, 2021. Residents verified their understanding of how to report sexual abuse, sexual harassment, retaliation for reporting, and staff neglect of duties that contributed to an incident. They also demonstrated understanding of how to make a confidential call to the CPS Hotline and the grievance process for reporting. The facility also provided the updated sexual abuse postings, reflecting the correct telephone number for the Children's Protective Services Hotline, as well as photographic evidence of the posting. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies. Staff members were also able to articulate the process for residents to make a confidential call to the CPS Hotline. 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: *Intermediate or Higher-Level Staff *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Teaching Family Homes of Upper Michigan Youth Safety Guide *Teaching Family Homes of Upper Michigan Youth and Family Orientation Manual *Teaching Family Homes of Upper Michigan Grievance Forms 115.352 (a) – The LATFH GH Policy No. 14 M, Page 7, Section 3 states, "Client Grievances related to sexual abuse allegations: *A grievance alleging sexual abuse can be filed at any time regardless of when the incident allegedly occurred *Third party grievances alleging sexual abuse are accepted *A grievance alleging sexual abuse or sexual harassment does not have to be submitted to the person that is the subject of the allegation *A grievance alleging sexual abuse is not to be referred to the staff member who is the subject of the complaint *There is no requirement that youth use an informal process for resolving grievances alleging sexual abuse or sexual harassment *Emergency grievances alleging sexual abuse and/or the imminent threat of sexual abuse must be responded to immediately, within 48 hours of being made aware * Emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days." The Teaching Family Homes of Upper Michigan Youth and Family Orientation Manual, Page 8 has a section entitled "Grievances", but it speaks more generally to complaints and not the grievance process. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. 115.352 (b) – The LATFH GH Policy No. 14 M, Page 7, Section 3 states, "Client Grievances related to sexual abuse allegations: *A grievance alleging sexual abuse can be filed at any time regardless of when the incident allegedly occurred, and "*There is no requirement that youth use an informal process for resolving grievances alleging sexual abuse or sexual harassment". Page 11 of the Youth Safety Guide advises residents they can report sexual abuse/assault by filing a grievance and putting it in the locked grievance box in the resident's unit. This is the totality of the information provided to residents regarding reporting sexual abuse through the grievance system and it appears residents are not informed a grievance alleging sexual abuse can be filed at any time regardless of when the incident allegedly occurred or that there is no requirement that youth use an informal process for resolving

grievances alleging sexual abuse or sexual harassment.

115.352 (c) – The LATFH GH Policy No. 14 M, Page 7, Section 3 states, "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 "A grievance alleging sexual abuse is not to be referred to the staff member who is the subject of the complaint". Page 11 of the Youth Safety Guide advises residents they can report sexual abuse/assault by filing a grievance and putting it in the locked grievance box in the resident's unit. This is the totality of the information provided to residents regarding reporting sexual abuse through the grievance system and it appears residents are not informed a grievance alleging sexual abuse can be filed at any time regardless of when the incident allegedly occurred or that there is no requirement that youth use an informal process for resolving grievances alleging sexual abuse or sexual harassment.

115.352 (d) – The LATFH GH Policy No. 14 M, Page 14, Section (J)(1)(2) states, "The facility will issue a final decision (initial decision and appeal decision if appealed) on the merits of a grievance alleging sexual abuse or harassment within 90 calendar days of the initial filing of the grievance. The facility may claim an extension of time to respond 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." A review of the facility grievances over the past 12 months revealed there were no grievances submitted alleging sexual abuse or sexual harassment. The LATFH GH Policy No. 14 M, Page 8, bullet point at the top of the page states, "If a grievance alleging sexual abuse is not responded to at any level of the process within the time allotted by policy, the grievance will be deemed denied at that level." The resident who reported sexual abuse did not utilize the grievance system to submit their report. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language is under different sections in the two different versions.

115.352 (e) – The LATFH GH Policy No. 14 M, Page 14, 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 agrees 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." A review of the facility's grievances for the past 12 months revealed no grievances alleging sexual abuse or sexual harassment.

115.352 (f) – The LATFH GH Policy No. 14 M, Page 7, Section 3 states, "Emergency grievances alleging sexual abuse and/or the imminent threat of sexual abuse must be responded to immediately, within 48 hours of being made aware * Emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days." The LATFH GH Policy No. 14 M does not address whether the outcome of a resident's emergency grievance is documented. According to the Intermediate or Higher-Level Staff, the Drop Box is checked for grievances on a daily basis.

115.352 (g) – The LATFH GH Policy No. 14 M, Page 3, 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." This language is not specific to grievances alleging sexual abuse.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.352 (a) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.352 (b)(c) - Residents need to be provided additional information regarding submitting grievances alleging sexual abuse and sexual harassment. Specifically, residents need to understand there is no requirement they use an informal process for resolving grievances alleging sexual abuse or sexual harassment, 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 they do not need to be concerned their grievance will be referred to the staff member who is the subject of the complaint. This information can be added to the Youth Safety Guide or any other form of resident education. Evidence of updated resident education on the grievance process is required for compliance with this provision.

115.352 (f) - The LATFH GH Policy No. 14 M must be updated to include the requirement that the facility document the outcome of a resident's emergency grievance. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9, 19 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.352 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

115.352 (b)(c) - The facility provided the updated Youth Safety Guide, which includes information on reporting sexual abuse, sexual harassment, retaliation for reporting sexual abuse or sexual harassment and neglect of staff duties by filing a grievance. In conjunction, the facility provided five Youth Safety Guide Statements of Understanding, signed by the five current program residents and dated April 5, 2021. The Statements of Understanding include the specific topic of how to report and submit a grievance. The facility also provided the updated Youth and Family Orientation Manual. The manual indicates there is no requirement

	to use an informal process for resolving grievances alleging sexual abuse or sexual harassment, 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 they do not need to be concerned their grievance will be referred to the staff member who is the subject of the complaint. The manual includes instruction on how to submit a grievance. Subsequent interviews with residents were conducted by Microsoft Teams videoconference on April 13, 2021. Residents verified their understanding of how to report sexual abuse, sexual harassment, retaliation for reporting, and staff neglect of duties that contributed to an incident. They also demonstrated understanding of the grievance process for reporting. 115.352 (f) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 8, Section 3 now reflects the requirement to document emergency grievances. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies. 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: *Random Residents *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Memorandum of Understanding Between LATFH and The Women's Center *LATFH Youth and Family Orientation Manual *Site Review 115.353 (a) – The LATFH GH Policy No. 14 M, Page 7, 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." This section of the policy implies the facility provides access to victim advocates for emotional support services related to sexual abuse. The Youth and Family Orientation Manual was attached as proof of compliance, but reference to outside supportive services is not found in the manual. The Youth Safety Guide, Page 14, lists resources, including the Women's Center Crisis Line, and provides a telephone number. However, it is unclear if a resident would associate that information as being a source for emotional supportive services for sexual abuse victims. During the site review there were no postings in the facility noted for emotional support services. It is noted the name and telephone number of the Women's Center is posted in the facility; however, it is listed on a posting for reporting sexual abuse. The MOU between LATFH and the Women's Center reflects LATFH "will provide its residents that were victims of sexual violence telephone access to the Women's Center free of charge, to receive emotional support from someone outside of the facility, regardless of when the sexual violence incident(s) occurred." Interviews with random residents reflected they had no specific knowledge of emotional supportive services for sexual abuse victims the facility could make available to them. The resident who reported sexual abuse indicated the facility did not make emotional supportive services available to them. They indicated they thought they could have confidential conversations with such services in the classroom area of the facility if they sought such services. The location of the telephone used by residents was observed to be in the kitchen/common area during the site review. It is noted that telephone is a land line, but residents can use the cordless telephone in the family room to move to other locations of the home. However, it was learned during the site review that residents must have staff dial the telephone number for them, which would

require the resident to specifically ask staff to contact the emotional supportive services. The facility does not house residents detained solely for civil immigration purposes.

115.353 (b) – The LATFH GH Policy No. 14 M, Page 7, 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." However, as indicated in 115.353 (a), it appears residents have little information regarding emotional support services and it does not appear the LATFH GH Policy No. 14 M, Page 7 is provided to residents and/or their parents.

115.353 (c) – The facility provided the MOU between LATFH and the Women's Center to substantiate compliance with this provision. Although the MOU is expired, the facility provided email documentation between LATFH and the Women's Center administration documenting the efforts to renew the agreement. Contact with the Women's Center Program Director confirmed a new MOU has been signed.

115.353 (d) – According to the Superintendent/PREA Compliance Manager, residents are allowed to make a call to their attorney and staff gives them space to make the call. They indicated a resident can call their attorney on a daily basis unless the attorney notifies the facility otherwise. The Superintendent/PREA Compliance Manager advised residents are allowed to talk to their parents by telephone on Tuesdays, Thursdays and Sundays, and they are able to earn extra phone calls. They also reported parents can visit anytime with prior notice. Random residents confirmed they have access to their attorneys as needed and they have phone calls and visits with parents/guardians. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.353 (a) - The facility will need to post information about available outside victim advocates for emotional support services related to sexual abuse. This information should be clearly differentiated from a resource to report sexual abuse. In this case, the facility has an MOU with the Women's Center, and the facility may be able to obtain such postings directly from the Women's Center. In addition, the facility will need to create a system to add anonymity to a resident's call to outside emotional support services. If the facility's telephone has the capability to program telephone numbers into memory, the resident could be given the telephone and staff could observe from a reasonable distance the resident push one button to connect them to outside supportive services. The facility can employ another method that may work better for LATFH to allow residents to have confidential telephone access to outside supportive services.

115.353 (b) - Although the LATFH GH Policy No. 14 M references the requirement for this provision, the residents need to be educated on these services, to what extent their contact with outside victim advocates is confidential and what information may be reported to others as required by law. The facility may choose to add this information to the Youth Safety Guide or provide the information through postings or other sources. The facility will need to provide documentation of how they have provided this information to residents to demonstrate compliance with this provision.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 12 and April 5, 2021 to substantiate corrective actions taken for this standard.

115.353 (a) - The facility provided its updated PREA postings to substantiate compliance with this standard. The "Zero Tolerance" posting includes a section for "Victim Supportive Services" and lists the Women's Center address and telephone number. The "No Means No" posting includes the same information. The facility provided photographic proof the information has been posted in the facility. Facility administration advised it has programmed the Women's Center number into the facility telephone to aid residents in contacting outside supportive services and residents were instructed on contacting outside supportive services by informing staff they would like to make a confidential phone call. Facility administration reported staff has been instructed to hand the cordless phone to the resident, and the resident can select one of two memory buttons on the phone. Subsequent interviews with residents were conducted by Microsoft Teams videoconference on April 13, 2021. Residents verified their understanding of how to report sexual abuse, sexual harassment, retaliation for reporting, and staff neglect of duties that contributed to an incident. They also demonstrated understanding of how to make a confidential call to the CPS Hotline and/or outside supportive services.

115.353 (b) - The facility provided five Youth Safety Guide Statements of Understanding, signed by the five current program residents and dated April 5, 2021. The Statements of Understanding include the specific topics of resident rights regarding sexual abuse/sexual harassment privacy and confidentiality and what resources are available to residents. The facility provided the updated Youth Safety Guide, which lists the Women's Center as a resource, as well as the limits to confidentiality when contacting the listed resources. Subsequent interviews with residents were conducted by Microsoft Teams videoconference on April 13, 2021. Residents verified their understanding of how to make a confidential call to the CPS Hotline and/or outside supportive services and to what extent these calls are confidential.

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

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH Youth and Family Orientation Manual *Your Rights When Receiving Mental Health Services in Michigan" Booklet 115.354 (a) – The LATFH GH Policy No. 14 M, Page 2, Section (A)(c) states, "Anonymous and third party reports must also be accepted." Page 7, Section 3 of the same policy also states, "Third party grievances alleging sexual abuse are accepted." The facility reported on the Pre-Audit Questionnaire that, "If a report is given then staff take the report of abusive (sic). All third party are (sic) able to contact MI Centralized Intake as well." The LATFH Youth and Family Orientation Manual, Page 8, Grievances Section instructs youth, family members and caseworkers to address any concerns through various levels of staff and administration. The Youth and Family Orientation Manual also makes reference to the "Your Rights When Receiving Mental Health Services in Michigan" booklet, which the Orientation Manual indicates is given to all youth and families at the time of placement. The LATFH GH Policy No. 14 M is posted to the agency website.

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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Healthy and Professional Boundaries When Working With Youth Policy *Luce County Sheriff's Office Report dated January 11, 2019 115.361 (a) – The facility provided the "Healthy and Professional Boundaries When Working With Youth Policy" to substantiate compliance with this provision. This document is not so much a policy as it is a list of acceptable and unacceptable behavior/contact for staff to have with residents and it requires staff members' signatures of acknowledgment. There is no mention in this document about staff being required to report seeing any of the unacceptable behaviors/contacts between staff and residents. The LATFH GH Policy No. 14 M, Page 8, Section F states, "Staff must report immediately any knowledge, suspicion, or information that they receive in accordance with the program's established response plan (Appendix VI): An incident of sexual abuse or sexual harassment that occurred in a facility, whether or not the facility is part of the agency; retaliation against residents or staff that reported such an incident; and/or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation." Interviews with random staff revealed they understand their duty to report any information regarding sexual abuse or sexual harassment of residents, retaliation or staff neglect of duties that may have contributed to an incident. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. 115.361 (b) – The LATFH GH Policy No. 14 M, Page 2, First Responder Definition, "Includes any/all agency personnel to whom an incident or report of alleged sexual abuse, or any other form of abuse/neglect of youth is reported. This includes staffs (sic) own observation or suspicion, direct report (verbal or written) from youth or third parties of abuse or neglect in accordance with Mandated Reporting laws and agency policies." Interviews with Random Staff revealed they are required under mandatory child abuse reporting laws to report any information involving child abuse.

115.361 (c) – The LATFH GH Policy No. 14 M, Page 11, Section j 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 Program Consultant/Supervisor, investigators, and prosecuting officials." Interviews with Random Staff revealed they are to report allegations to their supervisor or upper administration and the Children's Protective Services Hotline.

115.361 (d) – Interviews with Medical/Mental Health Staff revealed they are required to report sexual abuse to designated supervisors and officials, as well as to the designated State or local services agency where required by mandatory reporting laws. Medical/Mental Health staff advised they disclose the limitations of confidentiality and their duty to report at the initiation of services to a resident. There was no documentation provided of such reports by Medical/Mental Health Staff, and evidence of such documentation was not found during the on-site audit.

115.361 (e) – The LATFH GH Policy No. 14 M, Page 9, Section 8 states, "The Residential Director or designee also ensures that incidents of sexual abuse/rape, findings from investigations, and other pertinent information is reported to the youth's court of jurisdiction, the youth's worker, the youth's attorney within 14 days (if youth has an attorney) and the youth's parent or legal guardian." The Superintendent/PREA Compliance Manager advised they would report allegations to Central Intake, the resident's caseworker, Licensing and the Sheriff's Department. The Superintendent/PREA Compliance Manager advised in the Superintendent's interview that the resident's caseworker would notify the resident's attorney about the alleged abuse. However, in the PREA Compliance Manager interview they advised they would notify legal counsel, usually by the next business day. The Superintendent/PREA Compliance Manager did not indicate they would contact parents/legal guardians in either interview protocol. There was no documentation provided of such reports by Medica/Mental Health Staff, and evidence of such documentation was not found during the on-site audit.

115.361 (f) – The Superintendent advised all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, are reported to the facility's designated investigators. It is noted there was no administrative investigation report provided for the January 2019 incident.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.361 (e) - Notifications to CPS, Licensing and law enforcement must be completed in cases that require such notifications. Notifications to caseworkers and parents/legal guardians must be done promptly and notifications to attorneys must be completed in each investigation and within the 14-day requirement. Contact information for residents' attorneys needs to be readily available for such notifications. The facility will also need to ensure notifications are made according to their policies and documented accordingly. Facility administration will need to review the LATFH GH Policy No. 14 M with respect to the parties they are responsible to notify after a report of sexual abuse and provide written confirmation of understanding.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 22 and April 1, 2021 to substantiate corrective actions taken for this standard.

115.361 (e) - The facility reported no new incidents of sexual abuse or sexual harassment

	where compliance with the corrective action could be demonstrated. No incidents of sexual abuse or sexual harassment subsequent to the on-site audit were reported through interviews with facility staff and residents on Microsoft Teams videoconference on April 13, 2021. The facility provided five Youth Records Face Sheets for five residents in the program. All five Youth Records Face Sheets had the resident's attorney's name and telephone number, as well as contact information for caseworkers and parents/legal guardians. The facility also provided written confirmation of understanding for the parties who must be contacted in the event of a sexual abuse incident from facility administration. This acknowledgement lists required contacts with law enforcement, CPS, Licensing, caseworkers, parents/legal guardians and legal representatives. 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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance 115.362 (a) – The Agency Head/Superintendent indicated in the Agency Head interview protocol that when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, they would immediately separate the residents, the alleged victim would be moved as far away as possible, they would conduct one-on-one staff supervision and the perpetrating youth would be removed. In the Superintendent interview protocol, they advised the facility would immediately come up with a safety plan to meet the residents' needs for the possibility of sexual harm and would review it on a daily basis to make sure staff is following that protocol. Interviews with random staff revealed they would immediately provide direct supervision and not allow contact between the potential victim and perpetrator and they would report it to ensure everyone is aware of the situation.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Superintendent Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance 115.363 (a) – The LATFH GH Policy No. 14 M, Page 9, 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.)" The facility reported no such incidents in the Pre-Audit Questionnaire and no evidence of such was discovered during the on-site audit. 115.363 (b) – As indicated above, the facility Director must report the allegations to the other facility within 72 hours. 115.363 (c) – The facility reported no such incidents in the Pre-Audit Questionnaire and no evidence of such was discovered during the on-site audit. 115.363 (d) – The LATFH GH Policy No. 14 M, Page 9, Section 11 states, "If Teaching Family Homes receives an alleation of sexual abuse or harassment that occurred in their facility from another facility director, an investigation will occur in accordiance with the PREA standards." The Agency Head/Superintendent advised in the Agency Head interview protocol they would report such an allegation to the Luce County Sheriff's Office. The Agency Head/Superintendent advised in the Superintendent interview protocol they would contact the resident's caseworker to see if the matter had already been reported, as well as Central Intake and the police. The facility reported no such incidents in the Pre-Audit Questionnaire and no evidence of such was discovered during the on-site audit.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Random Staff *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Teaching Family Homes, Lakes Area PREA Coordinated Response Plan *Follow-Up Sexual Abuse Inquiry 115.364 (a) – The LATFH GH Policy No. 14 M, Page 11, Sections (a) through (f) state, "a. The victim and alleged perpetrator must be separated, kept isolated from each other, and prevented from communicating; b. Reporting must occur as listed in Section F above; c. If the assault is alleged to have occurred within the past 96 hours, the victim must be transported to the nearest hospital (Duke Life Point/Marquette General Hospital, or Helen Newberry Joy Hospital for Lakes Area Youth), or alternate if directed by Administration or emergency personnel, for examination by qualified personnel. If the assault is alleged to have occurred more than 96 hours earlier, the hospital is contacted for instructions; d. Qualified investigators must take victim statements, open an investigation, and if applicable collect physical evidence; e. The area where the suspected assault took place is sealed off until investigators can gather evidence. Note: Staff or medical personnel can enter the area if it is necessary to ensure youth safety, for example if a victim needed medical attention or first aid before being transported but efforts must be made to disturb the area as little as possible; f. Any clothing or articles belonging to the victim are left in place and not handled or disturbed until investigators have gathered evidence. The victim must be requested to not shower, brush teeth, wash, or change clothing before being transported to the hospital. The alleged perpetrator must be prevented from showering, brushing teeth, washing, or changing clothes until evidence has been collected." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. The Teaching Family Homes, Lakes Area PREA Coordinated Response Plan lists First Responder duties as: Separate victim and alleged perpetrator; Contact Administration/Supervision; Protect incident scene if identified; Report allegation to Children's Protective Services: (855) 444-3911; 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; Cooperate with investigators, prosecutors, facility Administration. The facility did not have security staff that had acted as a first responders at the time of the on-site audit. As a result, that interview protocol was not completed. The interview with the resident who reported sexual abuse revealed when they

informed staff, that staff member indicated they would document the report, but they felt staff really didn't do anything. That resident reported they were told by staff to report it right away the next time it happened. The resident who reported sexual abuse indicated they were pretty certain the incident was accidental, so they did not pursue it. As a result of the resident disclosing this incident during the time of the on-site audit, the facility conducted a follow-up inquiry into the resident's report. The follow-up inquiry revealed the incident appeared to be an accident through contact sports and thus not requiring a typical first responder response. The facility reported no sexual abuse allegations over the past 12 months and evidence of such allegations was not found at the on-site audit, other than the aforementioned incident.

115.364 (b) – The facility advised in the Pre-Audit Questionnaire that all staff members are considered front line/security staff and the LATFH GH Policy No. 14 M is silent on the issue of non-security staff being first responders to an incident of sexual abuse. The facility reported no sexual abuse allegations over the past 12 months and evidence of such allegations was not found at the on-site audit, other than the aforementioned incident.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.364 (a) - The facility needs to add language to LATFH GH Policy No. 14 M that adds additional actions to prevent victims and perpetrators from taking, to include urinating, defecating, smoking, drinking, or eating. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.364 (b) - The facility needs to add language to LATFH GH Policy No. 14 M that would require non-security staff, such as the facility's contracted Medical/Mental Health staff, to follow the same protocol as is required for security staff. The updated policy must be distributed to staff and staff must also be trained on the updated policy information. Medical/Mental Health Staff must also be trained on the PREA Coordinated Response Plan.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 19, March 9 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.364 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. Page 9, Sections 3 and 4 include the requirements for staff to take actions to prevent victims and perpetrators from taking, to include urinating, defecating, smoking, drinking, or eating. The facility provided the updated Teaching Family Homes, Lakes Area PREA Coordinated Response Plan. The plan reflects first responder responsibilities include preventing victims and perpetrators from taking actions that would compromise physical evidence. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O and the facility Coordinated Response Plan were covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff

	members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies and the facility Coordinated Response Plan. 115.364 (b) - The facility provided the LATFH GH Policy No. 60.O to substantiate compliance with this standard. Page 8, Section G reflects all staff members, to include contractors, volunteers, medical and mental health providers, must report immediately any knowledge, suspicion, or information that they receive in accordance with the program's Coordinated Response Plan. The PREA Compliance Manager confirmed the facility Coordinated Response Plan and the LATFH GH Policy No. 60.O were included in the PREA training for the contracted Medical and Mental Health staff on March 9, 2021. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O and the facility Coordinated Response Plan were covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies and the facility Coordinated Response Plan. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Lakes Area Staffing Plan *Teaching Family Homes, Lakes Area PREA Coordinated Response Plan 115.365 (a) – The facility submitted the Lakes Area Staffing Plan to substantiate compliance with this provision. However, the attached documentation is the narrative portion of the staffing plan and has nothing to do with this provision. The Teaching Family Homes, Lakes Area PREA Coordinated Response Plan is more appropriate to address this provision. This document outlines responsibilities for First Responders, Supervision/Administration, Facility Director or designee, Medical/Mental Health Providers and Investigators. The Superintendent advised the Reporting Events protocol lists the steps to take in response to an incident of sexual abuse and who is to be contacted. The list is not a tool with which all actions taken by all of the aforementioned parties is documented. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING**: 115.365 (a) - The facility will need to create an institutional plan which will coordinate and document all actions taken by all staff, including contracted staff, in a sexual abuse incident. The facility may choose to create its own or utilize the MDHHS 5809 PREA Investigation Tool, which details all First Responder, Supervision, Medical/Mental Health and Facility Director or Program Manager actions and requires the appropriate staff to indicate the date and time such actions were completed, and a description of the action taken. The tool in comprehensive and collects all the information on one report. Should LATFH 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 February 19 and April 8, 2021 to substantiate corrective actions taken for this standard. 115.365 (a) - Facility administration advised it has adopted the MDHHS 5809 PREA Investigation Tool as its institutional plan. The Investigation Tool details all First Responder, Supervision, Medical/Mental Health and Facility Director or Program Manager actions and requires the appropriate staff to indicate the date and time such actions were completed and a

	description of the action taken. The facility provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O and the PREA Investigation Tool were covered in the training. The PREA Compliance Manager confirmed the MDHHS 5809 PREA Investigation Tool and the LATFH GH Policy No. 60.O were included in the PREA training for the contracted Medical and Mental Health staff on March 9, 2021. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies and the MDHHS 5809 PREA Investigation Tool. 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
	Interviews conducted: *Agency Head 115.366 (a) – According to the Agency Head, the facility does not participate in collective bargaining.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Agency Head *Superintendent *Designated Staff Member Charged with Monitoring Retaliation *Residents who Reported a Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance 115.367 (a) – The LATFH GH Policy No. 14 M, Page 9, Section 12 states, "The Program Consultant/Supervisor must monitor staff and youth to prevent retaliation for a minimum of 90 days after a sexual abuse report is made. Monitoring should include multiple methods, including but not limited to observation, direct questioning, and review of logs and incident reports. Retaliation monitoring will continue beyond 90 days if the initial monitoring indicates a continuing need. Staff will act promptly to remedy any such retaliation." 115.367 (b) – The Agency Head/Superintendent/Designated Staff Member Charged with Monitoring Retaliation advised in the Agency Head interview protocol any reports of sexual abuse would remain confidential. They indicated if staff is the perpetrator of sexual abuse they would be placed on administrative leave, and if a staff member is accused of retaliating they would address the issue with that staff member. The Agency Head/ Superintendent/Designated Staff Member Charged with Monitoring Retaliation advised in the Superintendent interview protocol they would make sure everybody is monitored, ensure youth involved in a sexual abuse incident stay separated as much as possible and under line of sight at all times. They would also watch for any type of bullying, chore checking, negative feedback or aggressive behavior between youth, and would look for changes on point cards to see if staff is scoring youth more negatively. The Agency Head/Superintendent/Designated Staff Member Charged with Monitoring Retaliation advised in the Monitoring for Retaliation interview protocol that they monitor all staff and youth involved to make sure there is no overteaching negatively to youth. They indicated if there was reason to believe a youth is out to get staff, they would monitor video footage and interview staff on shift to see what happened. The resident who reported sexual abuse advised they feel protected enough against possible revenge from staff or other youth. 115.367 (c) – As indicated above, the LATFH GH Policy No. 14 M, Page 9, Section 12 provides the facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff for a

	minimum period of 90 days, acts promptly to address any retaliation and extends the monitoring when necessary. The facility reported no incidents of retaliation over the past 12 months on the Pre-Audit Questionnaire. According to the Superintendent/Designated Staff Member Charged with Monitoring Retaliation, if they suspected staff was retaliating they would make staff aware they were seeing a pattern of behavior and address it or they may put staff on administrative leave until they find the best course of action. They indicated they would consider removing a youth who was retaliating against another youth. They indicated retaliation monitoring would continue until they felt it would not be an issue, and they would monitor for a minimum of six to nine months. 115.367 (d) – According to the Designated Staff Member Charged with Monitoring Retaliation, they would have periodic status checks with residents to monitor for retaliation. The facility reported no incidents of sexual abuse in the past 12 months and, as a result, there is no documentation of retaliation monitoring. 115.367 (e) – The Agency Head/Superintendent indicated management would keep a close eye on the reported concerns and address those concerns. They advised they would assure a youth who cooperated with an investigation that they were monitoring the situation and would check that resident's point cards to look for negative interactions or punitive staff actions. They indicated they would also monitor video surveillance to verify behavior.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent *Medical/Mental Health Staff *Superintendent or Designee Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Site Review 115.368 (a) – According to the Superintendent and Medical/Mental Health Staff, LATFH does not practice isolation. This auditor found no evidence to the contrarty during the site review and through interviews with staff and residents. As a result, the interview protocols for Staff Who Supervise Residents in Isolation and Residents in Isolation were not completed.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent or Designee *PREA Coordinator *PREA Compliance Manager *Investigative Staff *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Memorandum of Understanding Between LATFH and the Luce County Sheriff's Department *Luce County Sheriff's Office Report dated January 11, 2019 *Teaching Family Homes of Upper Michigan Youth Incident Reports dated January 11, 2019 *Certificate of Completion, National Institute of Corrections "PREA: Investigating Sexual Abuse in a Confinement Setting" 115.371 (a) – The facility provided a large, highlighted section of the LATFH GH Policy No. 14 M to substantiate compliance with this provision. The LATFH GH Policy No. 14 M, Page 10, Section H states, "Each incident of alleged or reported sexual abuse or sexual assault/rape must be investigated to the fullest extent possible. All referrals for investigation must be documented..." Page 12, Section (3)(b) states, "The Program Consultant/Supervisor or designee must be notified immediately. The Program Consultant/Supervisor will make the determination whether to call police or assign a trained investigator to conduct an administrative investigation." None of the highlighted section of policy refers to investigations of sexual harassment. The facility also provided a copy of the MOU between LATFH and the Luce County Sheriff's Office in relation to youth sexual abuse investigations. This MOU outlines the responsibilities of the two agencies in the event of a sexual abuse incident and details the requirement of the Luce County Sheriff's Office to utilize investigators that have received specialized training in sexual abuse investigations involving juvenile victims. In the interview with Investigative Staff, they advised they would contact law enforcement immediately after receiving a report of sexual abuse. They indicated they would handle anonymous or third-party reports of sexual abuse by going back and looking at video footage, and if they saw something they would call Central Intake and 911. Investigative Staff advised that for reports of sexual harassment they would gather as much information as possible from the third party and address it with the youth. They stated if the youth affirmed the report, they

would call those who needed to be notified. They also indicated if staff was the perpetrator, they would be placed on administrative leave, and if a youth were the perpetrator, they would keep them separated as much as possible from the victim. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions.

115.371 (b) – The facility provided the Certificate of Completion, National Institute of Corrections "PREA: Investigating Sexual Abuse in a Confinement Setting" dated July 6, 2018 for the facility's Investigative Staff. According to Investigative Staff, they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings by completing the PREA online training. They advised the training included techniques for interviewing juvenile sexual abuse victims, sexual abuse evidence collection in confinement settings, the criteria and evidence required to substantiate a case for administrative or prosecution referral. Investigative Staff did not recall the training covering the proper use of Miranda and Garrity warnings. They also advised the training included separating the parties, contacting everyone who needs to be contacted, sitting in on interview with State Police or the Sheriff, and documenting findings in a report. As indicated above, the MOU between LATFH and the Luce County Sheriff's Office requires the Luce County Sheriff's Office to utilize investigators that have received specialized training in sexual abuse investigations involving juvenile victims.

115.371 (c) – The LATFH GH Policy No. 14 M, Page 10, Section H states, "Evidence collected must be maintained under strict control." However, it appears LATFH is responsible to conduct administrative investigations, while criminal investigations are conducted by the Luce County Sheriff's Office or the State Police. With that said, the facility should not collect any evidence in a criminal investigation. Investigative Staff advised the first steps in initiating an investigation would be to gather information from staff, contact Central Intake and law enforcement and to interview staff and youth. Regarding evidence collection, they advised If there was any written material, they would gather it and give to the proper authorities. Investigative Staff reported they would search the rooms of both youths to see if they can determine anything. They also advised they may allow a youth to change clothing but would collect the clothing to be bagged. Investigative Staff advised they would not collect DNA evidence.

115.371 (d) – The LATFH GH Policy No. 14 M, Page 10, Section H states, "TF Homes will not terminate an investigation solely because the source of the allegation recants the allegation." According to Investigative Staff, they would not terminate an investigation solely because a victim recants. They advised they must follow through with the investigation in the event the youth may be retaliated against or bullied into recanting their report.

115.371 (e) - Investigative Staff advised they do not consult with prosecutors before conducting compelled interviews. They advised they would question staff immediately, then place staff on administrative leave. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit.

115.371 (f) – According to Investigative Staff, they would look at every report as credible and would investigate all reports. They indicated 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. The resident who reported sexual abuse advised they were not administered a polygraph examination or other truth-telling device.

115.371 (g) – Investigative Staff advised they look for lapses in supervision and to make sure everyone is doing what they are supposed to be doing when determining whether staff actions or failures to act contributed to the sexual abuse in an administrative investigation. They also look to see if a change in policy is necessary to address such failures. Investigative Staff indicated they document administrative investigations in written reports, which includes dates, times, who was contacted and when they were contacted. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. It is noted there was no administrative investigation documented in the aforementioned 2019 incident.

115.371 (h) – As previously indicated, LATFH is not responsible for criminal investigations, as that responsibility falls to local law enforcement. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. However, there was an incident in January 2019 which was reported to the Luce County Sheriff's Office. The facility provided the Luce County Sheriff's Office report of the incident, which summarized the nature of the call for service, interviews with the victim, witness and perpetrator and a notation the matter would be referred to the prosecutor's office. From a review of this report, it appears physical evidence was not a factor, nor was video surveillance footage.

115.371 (i) – According to Investigative Staff, local law enforcement would refer criminal cases for prosecution. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. In the 2019 incident, it is unclear if charges were filed by prosecutors.

115.371 (j) – The LATFH GH Policy No. 14 M, Page 9, Section 9 states, "Records of allegations involving an employee must be kept for as long as the employee is employed or the youth is in residence, plus five years." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit.

115.371 (k) – The LATFH GH Policy No. 14 M, Page 10, Section H states, "TF Homes will not terminate an investigation due to the alleged victim or alleged perpetrator(s) leaving the facility." According to Investigative Staff, they would not terminate an investigation solely because a victim or perpetrator leaves the program. They indicated they would complete the administrative investigation in the event staff was the perpetrator, and the case would already be turned over to local law enforcement prior to the employee being terminated or resigning. In the case of juvenile victims or perpetrators, Investigative Staff advised they would inform the caseworker of the open investigation, as well as make contact with the youth's current placement and follow up to complete the investigation.

115.371 (m) – The Superintendent/PREA Coordinator/PREA Compliance

Manager/Investigative Staff advised they would reach out to local law enforcement to get the status of the investigation and contact the prosecutor's office to follow up if they were unable to get the information from local law enforcement to demonstrate cooperation with outside investigators and endeavor to remain informed about the progress of the investigation.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.371 (a) - The facility will need to update the LATFH GH Policy No. 14 M to include investigations of sexual harassment incidents. In reference to LATFH GH Policy No. 14 M, Page 12, Section (3)(b), the administrative investigation appears to be optional, which is incorrect. The facility needs to understand that, at a minimum, an administrative investigation is required in each report of sexual abuse or sexual harassment. As a result, the LATFH GH Policy No. 14 M needs to be updated to address and correct that issue. In reference to the January 2019 incident, there appears to be no PREA investigative report generated by the facility's Investigative Staff, and the two incident reports do not reflect that Children's Protective Services Central Intake or Licensing were notified. While reviewing the LATFH GH Policy No. 14 M, facility administration and staff need to specifically review the facility's required notification procedures for sexual abuse incidents as indicated in the LATFH GH Policy No. 14 M. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.371 (c)(e) - As the facility is not responsible for criminal investigations, any reference to evidence collection in a sexual abuse investigation must be clarified in the LATFH GH Policy No. 14 M as being the responsibility of law enforcement. It appears the facility Investigative Staff may be under a misconception of the requirements of an administrative investigation, and they reported no training in the proper use of Miranda and Garrity warnings. The facility's Investigative Staff will need to complete the National Institute of Corrections "PREA: Investigating Sexual Abuse in a Confinement Setting" training to refresh their recollection of the administrative investigation process. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.371 (g) - In conjunction with the aforementioned refresher training for Investigative Staff, Investigative Staff must be trained on the documentation requirements of an administrative investigation report. Investigative Staff must participate in training that covers a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The National Institute of Corrections "PREA: Investigating Sexual Abuse in a Confinement Setting" training should be sufficient to cover those topics.

115.371 (j) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval

signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9, 19, April 8, 2021 to substantiate corrective actions taken for this standard.

115.371 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Pages 10-11, Section I now indicates each incident of alleged or reported sexual abuse, harassment or sexual assault/rape must be investigated to the fullest extent possible. The policy also states LATFH will not terminate an administrative investigation solely because the source of the allegation recants the allegation or the alleged victim or alleged perpetrator(s) leaves the facility. The facility provided a letter from the Agency Head/PREA Coordinator/Investigative Staff dated March 18, 2021 which outlines the reporting requirements in the event of a sexual abuse or sexual harassment incident, which was required to refresh understanding of reporting requirements in the absence of subsequent reports of sexual abuse/sexual harassment incidents. It is noted the facility reported no subsequent reports of sexual abuse or sexual harassment post on-site audit and interviews with facility staff and residents revealed no incidents post on-site audit. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O, the facility Coordinated Response Plan, and the PREA Investigative Tool were covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies, and the facility Coordinated Response Plan.

115.371 (c)(e) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 11, Section I reflects all potential forensic evidence identified must be maintained and protected under strict control until law enforcement investigators arrive on scene. Other inferences to facility staff collecting physical evidence have been removed from the LATFH GH Policy No. 60.O. This policy includes an effective date and signature of the Agency Head. The facility also provided a Certificate of Completion for the facility's Investigative Staff dated March 19, 2021 for the National Institute of Corrections "PREA: Investigating Sexual Abuse in a Confinement Setting". The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies, and the facility Coordinated Response Plan.

115.371 (g) - The facility provided a Certificate of Completion for the facility's Investigative Staff dated March 19, 2021 for the National Institute of Corrections "PREA: Investigating Sexual Abuse in a Confinement Setting".

115.371 (j) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head.

	Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies. 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
	Interviews conducted: *Investigative Staff Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance 115.372 (a) – The LATFH GH Policy No. 14 M, Page 15, Section (e) states, "The agency imposes a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harssment are substantiated." When asked what standard of evidence they require to substantiate allegations of sexual abuse and sexual harassment, Investigative Staff advised any allegation is serious and they would look into a matter to see if the youth is telling a lie or there is possible staff misconduct. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent *Investigative Staff Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH Follow-Up Investigation *Luce County Sheriff's Office Report dated January 11, 2019 115.373 (a) – The LATFH GH Policy No. 14 M, Page 15, Section 2 (2) states, "The agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency." The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. In that instance, the resident was informed verbally the facility determined the contact was accidental. According to the Superintendent/Investigative Staff, they would notify the resident as to the findings of the investigation. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. 115.373 (b) – As indicated in 115.371, the facility advised it would request updated information from local law enforcement for criminal investigations. 115.373 (c) – The LATFH GH Policy No. 14 M, Page 15, Section 2 (c) states, "Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded) whenever: i. The staff member is no longer posted within the resident's unit; ii.The staff member is no longer employed at the facility; iii. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; iv. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility." The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. The resident who reported sexual abuse did not report the incident involved a staff member. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy

language does not appear in both versions.

115.373 (d) – The LATFH GH Policy No. 14 M, Page 15, Section 2 (b) states, "Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: i. The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or ii. The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility." The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. As previously indicated, the resident who reported sexual abuse reported no one followed up with them to advise of outcome of the investigation. The follow-up report for that incident revealed the facility reported its findings to the resident who reported sexual abuse. In the 2019 incident investigated by the Luce County Sheriff's Office, there was no documentation provided to indicate whether the charges had been filed or if the resident had been adjudicated or convicted as a result of the incident.

115.373 (e) – The LATFH GH Policy No. 14 M does not address the requirement that such notifications to residents be documented. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.373 (a) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.373 (c) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.373 (e) - The LATFH GH Policy No. 14 M must be updated to include the requirement that all notifications to residents described in 115.373 (c) and 115.373 (d) must be documented in the institutional plan required for 115.365. The institutional plan will also need to include a section to capture the request and receipt of the criminal investigation report, as well as a section to record notification to residents regarding that report. The updated policy and institutional plan must be distributed to staff, and staff must also be trained on the updated policy information and institutional plan.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 6 and 12, 2021 to substantiate corrective actions taken for this standard.

115.373 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

115.373 (c) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

115.373 (e) - Facility administration advised it has adopted the MDHHS 5809 PREA Investigation Tool as its institutional plan. Page 10 of the Investigation Tool reflects a section to capture notification to the victim, victim's parent/legal guardian, caseworker, and attorney. The MDHHS PREA Compliance Manager provided a draft update of the MDHHS 5809 PREA Investigation Tool, which now has a section on Page 8 to capture the request of the criminal investigation report. The MDHHS PREA Compliance Manager advised this update is pending approval for use statewide and will be distributed to all state-run and contracted facilities once approved. The facility provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O and the PREA investigation tool were covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies, and the MDHHS 5809 PREA Investigation Tool.

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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance 115.376 (a) – The LATFH GH Policy No. 14 M, Page 14, Section (K)(4)(a) states, "Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. 115.376 (b) – The facility reported no staff who had violated the agency sexual abuse or sexual harassment policies on the Pre-Audit Questionnaire, and no evidence to the contrary was discovered during the on-site audit. It is noted that although this provision does not require policy language, the first version of the LATFH GH Policy No. 14 M provided to this auditor has language that termination is the presumptive disciplinary sanction for staff sexual abuse. The second version does not contain that language. 115.376 (c) – The LATFH GH Policy No. 14 M, Page 14, Section (K)(4)(a) states, "Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories." The facility reported no staff who had violated the agency sexual abuse or sexual harassment policies on the Pre-Audit Questionnaire, and no evidence to the contrary was discovered during the on-site audit. 115.376 (d) – The LATFH GH Policy No. 14 M, Page 14, Section (K)(4)(b) states, "All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal and to any relevant licensing bodies." The facility reported no staff who had violated the agency sexual abuse or sexual harassment policies on the Pre-Audit Questionnaire, and no evidence to the contrary was discovered during the on-site audit. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING**: 115.376 (a) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information. **VERIFICATION OF CORRECTIVE ACTION**:

	This auditor was provided appropriate supplemental documentation on March 9, 2021 to substantiate corrective actions taken for this standard. 115.376 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance 115.377 (a) – The LATFH GH Policy No. 14 M, Page 14, Section (K)(4)(b), with the heading "Staff/Contractors/Volunteers", states, "All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal and to any relevant licensing bodies." Section (K)(4)(c) of the same policy states, "Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents." The facility reported no contractors or volunteers who had violated the agency sexual abuse or sexual harassment policies on the Pre-Audit Questionnaire, and no evidence to the contrary was discovered during the on-site audit. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. 115.377 (b) – The LATFH GH Policy No. 14 M, Page 14-15, Section (K)(4)(c) states, "The facility take appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer." The Superintendent advised in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the contractor or volunteer would immediately be stopped from coming to the facility and legal actions would be taken. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING**: 115.377 (a) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information. **VERIFICATION OF CORRECTIVE ACTION**: This auditor was provided appropriate supplemental documentation on March 9, 2021 to substantiate corrective actions taken for this standard. 115.377 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy

	No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies. Based on the above-noted additional evidence, the facility has demonstrated compliance with this standard.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Interviews conducted: *Superintendent *Medical/Mental Health Staff Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Teaching Family Homes of Upper Michigan Youth and Family Orientation Manual 115.378 (a) – The facility provided the LATFH GH Policy No. 14 M, Page 15, Section (2)(a) to substantiate compliance with this provision, which states, "Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse." The facility reported no incidents of resident-on-resident sexual abuse over the past 12 months, and evidence to the contrary was not discovered during the on-site audit. 115.378 (b) – There is no mention of isolation in the LATFH GH Policy No. 14 M as a disciplinary option for residents. The facility indicated on the Pre-Audit Questionnaire that they do not have an isolation room at LATFH, and none was noted at the time of the site review. The Superintendent indicated isolation is not practiced at LATFH. 115.378 (c) – According to the Superintendent, the disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. 115.378 (d) – According to Medical/Mental Health Staff, the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse; however, such treatment is never a condition of access to any rewards-based behavior management system or other behavior-based incentives, general programming or education. 115.378 (e) – The LATFH GH Policy No. 14 M, Page 3, Section (g) states, "Clients may be subject to disciplinary sanctions for sexual contact with staff only upon findings that the staff member did not consent to such contact." No records of resident disciplinary sanctions for sexual contact with staff was provided and evidence to the contrary was not discovered during the on-site audit. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. 115.378 (f) – The LATFH GH Policy No. 14 M, Page 3, Section (g) states, "Disciplinary action(s) for making false allegations. 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. Clients may be subject to disciplinary sanctions only pursuant to positive findings that the youth engaged in youth-on-youth sexual abuse."

115.378 (g) – The facility provided the Youth and Family Orientation Manual, Page 10, General Guidelines Section to substantiate compliance with this provision. This highlighted section of the Youth and Family Orientation Manual states, "10. Refrain from physical contact with other youth and respect others' personal space and boundaries." This information does not present a resident with an affirmative instruction, as it is listed under "General Guidelines", and it does not specify the facility prohibits sexual contact. The facility's Youth Safety Guide, Page 6, "Sexual and Romantic Activity states, "All sexual or romantic activity between staff members, volunteers, contractors, and youth is prohibited and may be against the law. Also, sexual activity between youth and other youth is prohibited and in some cases is against the law." The facility indicated on the Pre-Audit Questionnaire the provision requirements of 115.378 (g)(2) were not applicable. As indicated in 115.378 (a), residents are subject to disciplinary sanctions if it was found the resident engaged in resident-on-resident sexual abuse, as opposed to consensual sexual activity.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.378 (e) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9, 2021 to substantiate corrective actions taken for this standard.

115.378 (e) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

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: *Medical/Mental Health Staff *Staff Responsible for Risk Screening *Residents who Disclose Sexual Victimization at Risk Screening Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Teaching Family Homes of Upper Michigan PREA Intake Screenings *Site Review 115.381 (a) – The LATFH GH Policy No. 14 M, Page 4, Section 5 states, "Residents that disclose any prior sexual victimization or perpetration during a screening must be offered a follow-up meeting with a medical or mental health practitioner within 14 days. All residents that disclose during screening that they previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days. These referrals must be documented." This auditor reviewed all of the PREA Intake Screenings for the past 12 months and noted none of the PREA Intake Screenings captured that a follow-up appointment with a medical or mental health practitioner was offered and whether the meeting was accepted or declined. The facility indicated Medical/Mental Health Staff does not keep secondary records. However, Medical/Mental Health Staff advised they keep resident records in off-site locations. As a result, there is no evidence the facility offers follow-up appointments with a medical or mental health practitioner to residents who report prior sexual abuse during risk screening. 115.381 (b) – As indicated above, the facility is not compliant with this provision. 115.381 (c) – During the site review, this auditor observed the resident binders, which were located in the staff office. The staff office is reportedly locked when not occupied by staff. According to administration, all staff has access to the PREA Intake Screenings, as all staff members are involved in security and management decisions, treatment plans, housing, bed and educational decisions for residents. The PREA Intake Screenings were not viewed in the common areas of the facility during the site review. 115.381 (d) – According to Medical/Mental Health Staff, they do not obtain informed consent from residents before reporting about prior sexual victimization that did not occur in an institutional setting because they are mandated reporters. They indicated they try to work within the therapeutic relationship, but ultimately, they would have to report prior sexual victimization. Medical/Mental Health Staff indicated the facility does not house residents past the age of 18.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.381 (a)(b) - The facility will need to update its PREA Intake Screenings to include a section to document that residents who reported prior sexual abuse victimization or perpetration are offered a follow-up appointment with a medical or mental health practitioner, and whether the offer was accepted or declined. The facility's contracted psychologist, or any other staff members who are responsible for risk screening, will need to be trained on the new requirement. Medical/Mental Health Staff will also need to record a general summary of any follow-up appointments and that documentation will need to be available in the resident's file.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9, 2021 to substantiate corrective actions taken for this standard.

115.381 (a)(b) - The facility provided two MDHHS Prison Rape Elimination Act (PREA) Screening Tools for the two residents placed post on-site audit. One of the screening tools indicated the resident reported prior sexual victimization. That resident's screening tool reflects a follow-up appointment date within 14 days of the resident's intake, as well as a clinical note summarizing the follow-up appointment. The facility provided a PREA Screening Tool training acknowledgment dated March 22, 2021 for the facility PREA Compliance Manager. In addition, the facility provided two training acknowledgments dated March 9, 2021 for the facility's contracted Medical and Mental Health staff. The PREA Compliance Manager confirmed the updated risk screening tool and the LATFH GH Policy No. 60.O were included in the PREA training for the contracted Medical and Mental Health staff on March 9, 2021.

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 *Resident Who Reported Sexual Abuse Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Teaching Family Homes, Lakes Area PREA Coordinated Response Plan 115.382 (a) – The LATFH GH Policy No. 14 M, Page 9, Section 4 states, "Following emergency response and completion of the rape kit (if applicable) a youth believed or determined to have been the victim of a sexual assault/rape must also be examined by medical staff for possible injuries, regardless of when the alleged sexual assault occurred..." Page 9, Section 6 states, "The victim of sexual assault/rape or attempted sexual assault/rape must be provided mental health assistance and counseling as determined necessary and appropriate." It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. Interviews with Medical/Mental Health Staff revealed resident victims of sexual abuse would receive timely and unimpeded access to emergency medical treatment and crisis intervention services as soon as possible, once safety is assured. They indicated the nature and scope of these services are determined according to their professional judgment. According to the resident who reported sexual abuse, they were not offered or taken to see a medical or mental health doctor/nurse after they reported the incident to staff. Facility administration advised Medical/Mental Health Staff does not keep secondary records for residents. Medical/Mental Health Staff advised they keep resident records in off-site locations. 115.382 (b) – The interview protocols for Security Staff and Non-Security Staff First Responders were not completed due to the fact the facility did not have staff meeting that criteria at the time of the on-site audit. The Teaching Family Homes, Lakes Area PREA Coordinated Response Plan lists First Responder duties and taking preliminary steps to immediately notify the appropriate medical and mental health practitioners is not listed in First Responder duties. 115.382 (c) – The LATFH GH Policy No. 14 M, Page 9, Section 4 states, "Resident victims of sexual abuse must 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." Medical/Mental Health Staff advised they would insist on a resident going to the Emergency Room so they could access those services in the event of a reported sexual abuse incident. The resident

who reported sexual abuse advised they were not offered those services.

115.382 (d) – The LATFH GH Policy No. 14 M, Page 9, Section 4 states, "All forensic medical examinations and follow up medical treatments are provided without charge to the resident." This section of policy speaks specifically to forensic examination treatment services, which does not address all other treatment services that may be required during a sexual abuse incident. According to the Superintendent/PREA Coordinator/PREA Compliance Manager, a resident would not have to pay for medical or mental health services related to an incident of sexual abuse.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.382(a) - It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information.

115.382 (b) - The facility will need to add taking preliminary steps to protect the victim to the LATFH PREA Coordinated Response Plan. Although policy indicates the facility will obtain medical treatment for residents of sexual abuse, the policy specifies that an examination for injuries must be conducted following emergency response and completion of the forensic medical exam/rape kit (if applicable). A medical examination for physical injuries should be the first priority and would likely be addressed if/when the resident is transported to the hospital. However, the appropriate medical personnel must still be notified to assess any injuries sustained by the resident. First responders are required to immediately notify the appropriate medical and mental health practitioners in this provision. This requirement must be added to both the LATFH GH Policy No. 14 M and the LATFH PREA Coordinated Response Plan. In addition, the updated LATFH GH Policy No. 14 M and the LATFH PREA Coordinated Response Plan must be distributed to all staff and all staff must be trained on the new policy language to address compliance with this standard.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on February 19, March 9 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.382 (a) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. This policy contains the required policy language and includes an effective date and signature of the Agency Head. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O was covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and adopted MDHHS policies.

115.382 (b) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 8, Section G of the policy now reflects all staff members, to include contractors, volunteers, medical and mental health providers must report immediately any knowledge, suspicion, or information that they receive

	in accordance with the program's Coordinated Response Plan (Appendix VI). The facility provided the updated Teaching Family Homes, Lakes Area PREA Coordinated Response Plan. The plan now reflects under the First Responder section that the victim and alleged perpetrator are to be separated and Medical and Mental Health staff are to be contacted. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O and Coordinated Response Plan were covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and the Coordinated Response Plan. 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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Teaching Family Homes, Lakes Area PREA Coordinated Response Plan 115.383 (a) – The LATFH GH Policy No. 14 M, Page 9, Section 4 states, "Following emergency response and completion of the rape kit (if applicable) a youth believed or determined to have been the victim of a sexual assault/rape must also be examined by medical staff for possible injuries, regardless of when the alleged sexual assault occurred..." Page 9, Section 6 states, "The victim of sexual assault/rape or attempted sexual assault/rape must be provided mental health assistance and counseling as determined necessary and appropriate." Neither of these sections of policy address mental health evaluation of a sexual abuse victim to determine what counseling or treatment services are needed. 115.383 (b) – According to Medical/Mental Health Staff, following up on bloodwork and samples, educating the victim on the sexual abuse investigation process and what to expect, making sure they have medication and follow up testing, and crisis level counseling are part of the evaluation and treatment of sexual abuse victims. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. As a result, medical records or secondary documentation that demonstrate victims receive follow-up services and appropriate treatment plans were not available for review. The resident who reported sexual abuse indicated they were not provided these services, nor did they request them. As indicated in 115.383 (a), mental health evaluation of resident victims of sexual abuse appears to lack a formal process. 115.383 (c) – According to Medical/Mental Health Staff, they would provide resident victims with medical and mental health services consistent with the community level of care. The facility reported no sexual abuse or sexual harassment investigations in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. As a result, medical records or secondary documentation that demonstrate victims receive follow-up services and appropriate treatment plans were not available for review. 115.383 (d) – This provision is not applicable, as the facility is an all-male population. 115.383 (e) – This provision is not applicable, as the facility is an all-male population.

115.383 (f) – The LATFH GH Policy No. 14 M, Page 9, Section 5 states, "Victims and perpetrators of sexual assault must be encouraged to complete tests for sexually transmitted diseases, including an HIV test. In the case of a substantiated incident of sexual assault, the perpetrator must be requested to complete an HIV test. If the perpetrator will not voluntarily take an HIV test, the Residential Director or designee may seek a court order compelling the test." Medical/Mental Health Staff advised they would insist on a resident going to the Emergency Room so they could access those services in the event of a reported sexual abuse incident. The resident who reported sexual abuse advised they were not offered those services, nor they were applicable for the incident they reported.

115.383 (g) – The resident who reported sexual abuse stated they were not really sure if they or their family would have to pay for any treatment related to what happened to them, but they indicated they thought insurance would pay for it. According to the Superintendent, Medicaid would pay for any treatment services for a victim of sexual abuse.

115.383 (h) – Medical/Mental Health Staff advised they would conduct a mental health evaluation of all known resident-on-resident abusers and offer treatment, if appropriate. They indicated they would conduct such an evaluation the next time they met with the resident who committed sexual abuse. The facility reported no sexual abuse or sexual harassment incidents in the past 12 months and, with the one exception that has since been addressed, no evidence was found to the contrary at the on-site audit. As a result, the facility provided no mental health records or secondary documentation that demonstrate evaluations of resident-on-resident abusers.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.383 (a)(b) - The facility is lacking a protocol for Medical/Mental Health staff to follow in the event a resident reports sexual abuse, and LATFH does not keep secondary medical/mental health records to document the services required under this standard have been offered/provided. The Teaching Family Homes, Lakes Area PREA Coordinated Response Plan lists only that Medical/Mental Health providers provide services as required, including forensic examination, post-incident medical exams, and counseling. It is noted the facility lists two agencies outside its scope of control; Helen Newberry Joy Hospital and Harbor House, as being responsible or potentially responsible to deliver those services to residents. It is also noted the facility does not conduct forensic examinations. The facility will need to create a detailed protocol for Medical/Mental Health staff to follow and record the actions that are required to be offered to residents who have been victimized by sexual abuse under this standard, which include: medical and mental health evaluations and, as appropriate, treatment; 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 and, tests for sexually transmitted infections as medically appropriate. These articulated Medical/Mental Health responsibilities also need to be added to the Teaching Family Homes, Lakes Area PREA Coordinated Response Plan. In conjunction with the Corrective Action for 115.365, Medical/Mental Health services can be documented on the facility's institutional plan to coordinate and track responsibilities in a sexual abuse incident. In the alternative, a separate tool to record Medical/Mental Health actions can be created. Staff must be informed of and trained on the changes to the Coordinated Response Plan and the mechanism used to record Medical/Mental Health protocol actions plan to address compliance with this standard.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 26 and April 12. 2021 to substantiate corrective actions taken for this standard.

115.383 (a)(b) - The facility provided the Lakes Area TFH Medical/Mental Health Provider Checklist For Sexual Abuse Incidents. The checklist includes verification of forensic examination completion, offer of follow-up medical/mental health evaluation and treatment to victim, applicable medical and mental health follow up appointments noted and scheduled, offer of outside supportive services to victims, offer and completion of HIV/STI testing for victim, HIV/STI testing for alleged perpetrators, education and provision of timely access to emergency contraceptive (when applicable) and STI prophylaxis as medically appropriate for victim of sexual abuse, provision of follow-up medical and mental health referrals for victim/perpetrator who is transferred to another placement or released from custody, and completion of follow up mental health evaluation of all known resident-on-resident abusers within 60 days of learning of abuse history, and offer treatment when deemed appropriate by mental health practitioners. The checklist requires the date and responsible party for each item be entered on the checklist. The facility also provided the updated PREA Coordinated Response Plan. The Medical/Mental Health Providers section of the Coordinated Response Plan now reflects responsibility to provide services as required, including verification of forensic examination, post-incident medical exams, and counseling through outside supportive services or by a qualified staff member. The Coordinated Response Plan requires Medical and Mental Health providers to utilize the Lakes Area TFH Medical/Mental Health Provider Checklist for Sexual Abuse Incidents, which is referenced and attached to the Coordinated Response Plan. The PREA Compliance Manager confirmed the Lakes Area TFH Medical/Mental Health Provider Checklist for Sexual Abuse Incidents, the updated PREA Coordinated Response Plan, and the LATFH GH Policy No. 60.O were included in the PREA training for the contracted Medical and Mental Health staff on March 9, 2021. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O and updated Coordinated Response Plan.

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 *PREA Compliance Manager *Incident Review Team Documents reviewed: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *LATFH Incident Reports *Luce County Sheriff's Office Report dated January 11, 2019 *MDHHS Form 5818, 30-Day Sexual Abuse Incident Review 115.386 (a) – The LATFH GH Policy No. 14 M, Page 10, Section H states, "A subsequent Incident Review form will be completed by the review team within 30 days of completion of the investigation (Appendix IX). The review team will consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse, whether incident or allegation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status, or gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility, examine the areas in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse, assess the adequacy of staffing levels in that area during different shifts, assess whether monitoring technology should be deployed or augmented to supplement supervision by staff and prepare a report of its findings, including but not necessarily limited to determinations made previously and any recommendations from improvement and submit such report to the facility head and PREA compliance manager." The facility reported no sexual abuse or sexual harassment investigations in the past 12 months; however, they disclosed a sexual abuse incident that occurred in January 2019. In the absence of other documentation, this auditor reviewed documentation for the 2019 incident. That documentation consisted of two LATFH Incident Reports and the investigative report from the Luce County Sheriff's Office. It appears a sexual abuse incident review was not completed in this matter. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M. It appears some language was recently added to address this audit's requirements, as the policy language does not appear in both versions. 115.386 (b) – As indicated above, facility policy indicates LATFH conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. However, evidence of the incident review was missing for the 2019 incident.

The facility attached a blank version of the MDHHS Form 5818, 30-Day Sexual Abuse Incident Review to substantiate compliance with this provision. However, there is no reference to this MDHHS form in the LATFH GH Policy No. 14 M or other LATFH policies provided to this auditor.

115.386 (c) – The Superintendent indicated management would likely conduct a sexual abuse incident review, and that the facility's contracted psychologist would likely participate in the review as well. The Superintendent appeared to be speculating, as opposed to referencing an existing practice, likely due to the apparent lack of sexual abuse incidents at the facility. Minutes of Incident Review Team Meetings or Reports were not provided for review.

115.386 (d) – As indicated in 115.386 (a), the LATFH GH Policy No. 14 M provides the requirements for the Incident Review Team to consider, as well as the requirement to make any recommendations for improvement and submit a report of the findings to the facility head and PREA Compliance Manager. As previously indicated, this review, analysis and documentation is lacking for the 2019 sexual abuse incident. The Superintendent/PREA Compliance Manager/Incident Review Team Member indicated they would use the information from the sexual abuse incident review to determine the best course of action for the youth and whatever they may need, and that the Incident Review Team would consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. It is noted the Superintendent/PREA Compliance Manager reported that in response to the 2019 incident, the facility changed its procedure to eliminate the possibility of two residents being outside of line-of-sight supervision while transitioning up or down the stairwell.

115.386 (e) – The LATFH GH Policy No. 14 M, Page 12, Section (I)(4) states, "Administrative staff will review each incident of sexual abuse for cause, staffing, and physical barriers, and make recommendations for prevention and implementation of remedy(s). This will take place through the agency Quality Assurance Committee." The policy does not address documenting reasons for not implementing recommendations from the review.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.386 (a)(b)(c)(d)(e) - The facility must conduct a sexual abuse incident review after each incident, in accordance with their policy. The facility will need to designate staff, consisting of upper-level management, line supervisors, investigators, and medical/mental health practitioners, to comprise the Incident Review Team. The facility will need to keep minutes for all Incident Review Team meetings, which must include the analyses for the factors outlined in 115.386 (c) and complete a written Incident Review Report. The facility can utilize the MDHHS Form 5818 or create its own documentation for incident review. It is noted this auditor was provided two different versions of the LATFH GH Policy No. 14 M, Prison Rape Elimination Act Standards and Compliance. In addition to the corrective actions discussed in each provision, the current version of the LATFH GH Policy No. 14 M should be reviewed for clarity and must be updated with an effective date and approval signature. The updated policy must be distributed to staff and staff must also be trained on the updated policy information. In reference to the MDHHS Form 5818, 30-Day Sexual Abuse Incident Review, this appears to have been submitted to address this audit's requirements. For the adoption of MDHHS forms or policies, LATFH will need to update the date the MDHHS policy was adopted in the LATFH GH Policy No. 14 M.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on March 9 and April 8, 2021 to substantiate corrective actions taken for this standard.

115.386 (a)(b)(c)(d)(e) - The facility provided the LATFH GH Policy No. 60.O (formerly LATFH GH Policy No.14 M) to substantiate compliance with this standard. Page 11, Section I indicates an Incident Review will occur, using the MDHHS-5818-PREA, 30-Day Sexual Abuse Incident Review Form by the review team within 30 days of completion of the investigation (Appendix IX). The same section of policy also indicates a written Incident Review Report is required. This policy includes an effective date and signature of the Agency Head. The facility also provided two training attestations for Incident Review Team training dated March 2, 2021 for the PREA Compliance Manager and facility supervisor. It is noted the facility reported no sexual abuse or sexual harassment incidents post on-site audit; as a result, the facility provided no Incident Review reports for review. The facility also provided training acknowledgments for 11 staff members dated March 26 and April 1, 2021. The training acknowledgments reflected the LATFH GH Policy No. 60.O and 30-Day Incident Review were covered in the training. Subsequent interviews with facility staff members were conducted by Microsoft Teams videoconference on April 13, 2021. Staff members verified their understanding of the LATFH GH Policy No. 60.O, adopted MDHHS policies, and the MDHHS-5818-PREA, 30-Day Sexual Abuse Incident Review Form.

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 *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *U.S. Department of Justice Survey of Sexual Victimization (SSV) *MDHHS Juvenile Justice Residential Facility Sexual Abuse and Sexual Harassment Data Collection, CY 2019 *Untitled Tracking Sheet *Agency Website 115.387 (a) – The facility provided a blank copy of the U.S. Department of Justice Survey of Sexual Victimization to substantiate compliance with this provision. The facility also provided a copy of the MDHHS Juvenile Justice Residential Facility Sexual Abuse and Sexual Harassment Data Collection, CY 2019. This document is sent by MDHHS to its residential juvenile facilities for the completion of the State of Michigan's SSV requirements. The facility also provided an untitled tracking sheet with the following categories: Date; Victim Name; Alleged Perpetrator Name; Description of Incident; Investigation Complete, and Determination (unfounded, unsubstantiated, substantiated). None of these documents constitute an instrument the facility would use to collect accurate, uniform data, using a standardized instrument and set of definitions. Although the untitled tracking sheet collects some information, it is lacking standardized definitions of offense categories (nonconsensual sexual acts, abusive sexual contact, sexual harassment, staff sexual misconduct or staff sexual harassment). The untitled tracking sheet is also lacking a breakdown by the type of incident, as its current format requires the reading of the incident description. The agency website has a PREA section, which contains the Juvenile Justice Residential Facility Sexual Abuse Data for 2019. This information is the same information that populates the MDHHS Juvenile Justice Residential Facility Sexual Abuse and Sexual Harassment Data Collection, CY 2019. However, in reading the data information it is noted part of the report reflects data from 2017. 115.387 (b) – The facility did not provide any documentation demonstrating their data collection or how they aggregate their incident-based sexual abuse data on an annual basis. 115.387 (c) – The facility provided the LATFH GH Policy No. 14 M, Page 13, Section 8 as evidence of compliance with this provision. This section of policy states, "The facility will 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. 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. (Note: Personal identifiers must be

removed.)" Although the facility has included this verbiage in its policy, policy does not serve as a standardized instrument to collect data used to complete the SSV.

115.387 (d) – The facility did not provide information on how it maintains, reviews, and collects data from all available incident-based documents, such as incident reports, investigation files, and sexual abuse incident reviews that would be utilized to complete and substantiate its sexual abuse/sexual harassment data.

115.387 (e) – The facility does not contract with other private facilities for the confinement of residents.

115.387 (f) – The Department of Justice did not request data from LATFH.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.387 (a) - The facility must update the untitled tracking sheet to include a title to clearly explain the purpose of the document. The tracking sheet must also be updated to include a standardized set of definitions for offense types and a clearly defined breakdown of what type of incident is being recorded, and a mechanism to collect year end totals.

115.387 (b) - The facility must aggregate its sexual abuse and sexual harassment data on at least an annual basis and be able to produce the aggregated data for review.

115.387 (c) - Once the facility creates a compliant standardized instrument, the recorded data must be clear enough to answer all questions from the most recent version of the SSV. Specifically, the data must be able to answer whether the allegations were for nonconsensual sex acts, abusive sexual contact or sexual harassment. In addition, specific categories to record whether the allegations were substantiated, unsubstantiated or unfounded and whether the perpetrator was a resident or staff are required to complete the SSV.

115.387 (d) - In addition to a comprehensive standardized instrument, the facility must have a centralized location to maintain incident reports, investigative reports, incident review reports and any other data related to incidents of sexual abuse or sexual harassment at LATFH.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 12 and 16, 2021 to substantiate corrective actions taken for this standard.

115.387 (a) - The facility provided the Lakes Area PREA Incident Tracking Log to substantiate compliance with this standard. The log now includes the facility name, a standardized set of definitions for offense types and a clearly defined breakdown of what type of incident is being recorded, and a mechanism to collect year end totals. The log includes the definitions to aid in accurate recording of data. The log records the date of the allegation, victim and perpetrator names, tracking for investigation completion, and whether the allegation was substantiated, unsubstantiated, or unfounded.

115.387 (b) - The MDHHS PREA Compliance Manager provided the updated contract between the State of Michigan and contractors for the placement of residents. Page 32, Section 2.12 of the contract requires contractors to report any substantiated PREA incidents. According to the MDHHS PREA Compliance Manager, facilities are now required to submit PREA incident data on a monthly basis, beginning May 1, 2021, and they provided a draft

	document that will be distributed to facilities on a monthly basis. That document requires facilities to report all incidents, not just substantiated incidents. The monthly submission of PREA incident data will exceed the standard requirement. 115.387 (c) - The facility provided the Lakes Area PREA Incident Tracking Log to substantiate compliance with this standard. The definitions listed on the log provide explanation for nonconsensual sex acts, abusive sexual contact, sexual harassment, staff sexual misconduct, and staff sexual harassment, consistent with the definitions required to complete the SSV. In addition, the log lists specific categories to record whether the allegations were substantiated, unsubstantiated or unfounded and whether the perpetrator was a resident or staff (staff sexual misconduct and staff sexual harassment by definition of offense type). 115.387 (d) - The facility provided confirmation of the creation of a SharePoint Folder to maintain all of its documents and data related to PREA. Access to the SharePoint Folder is limited to the PREA Compliance Manager and Agency Head/PREA/Coordinator/Investigative Staff, as verified by the Information Technology staff member's supervisor. The PREA Compliance Manager advised all PREA-related documents, including incident reports, investigative reports, incident review reports and any other data related to incidents of sexual abuse or sexual harassment 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: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance *Agency Website 115.388 (a) – The facility indicated on the Pre-Audit Questionnaire that there have been no corrective actions taken. However, this provision does not address corrective action, it addresses a review of the collected sexual abuse and sexual harassment data in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training. The facility did not provide any evidence of data review, such as meeting minutes, to substantiate compliance with this provision. It is noted the agency website has a PREA section, which contains the Juvenile Justice Residential Facility Sexual Abuse Data for 2019. This information is the same information that populates the MDHHS Juvenile Justice Residential Facility Sexual Abuse and Sexual Harassment Data Collection, CY 2019. However, in reading the data information it is noted part of the report reflects data from 2017. This report does not provide information on the agency's efforts to improve its PREA efforts or explain the effectiveness of current practices. The Agency Head/PREA Coordinator/PREA Compliance Manager advised the agency does not 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 and training. They indicated they only had one incident, that they focus on the "red flags sheet", and they make sure staff is aware of that information for prevention purposes. They advised from the January 2019 incident they added a camera to the stairwell and staff must now oversee group counseling and release youth upstairs. 115.388 (b) – As indicated above, the Juvenile Justice Residential Facility Sexual Abuse Data for 2019 that is found on the agency website is statistical data that populates the SSV and does not provide information on the agency's efforts to improve its PREA efforts, explain the effectiveness of current practices or compare the prior year's data. 115.388 (c) – As indicated above, the Juvenile Justice Residential Facility Sexual Abuse Data for 2019 is statistical data that populates the SSV and does not provide information on the agency's efforts to improve its PREA efforts, explain the effectiveness of current practices or compare the prior year's data. However, the facility has made this information to the public

through the agency website. The Agency Head advised they prepare this information for posting on the website.

115.388 (d) – According to the PREA Coordinator, they redact names or other identifiers from their annual report prior to publication.

CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING:

115.388 (a)(b) - The facility will need to document its data review on an annual basis to substantiate compliance with this provision. The facility administration will need to meet for the purpose of data review, keep minutes of the meeting, and include in the minutes what documentation was reviewed and what steps the facility takes to use the review to improve its effectiveness of its sexual abuse prevention, detection, response policies, and training. If the facility has no reported incidents of sexual abuse or sexual harassment, then that information should also be recorded to reflect the review was held. The facility should correct the data currently posted to the agency website to reflect accurate data collection years. The facility will also need to create annual reports to quantify incidents of sexual abuse and sexual harassment and provide analysis and response to such incidents, as well as an analysis of what is working well for the facility's PREA efforts and what improvements have been made to enhance sexual safety. LATFH 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 and sexual harassment in its annual report.

VERIFICATION OF CORRECTIVE ACTION:

This auditor was provided appropriate supplemental documentation on April 5 and 16, 2021 to substantiate corrective actions taken for this standard.

115.388 (a)(b) - The facility and MDHHS provided an alternate method of data review confirmation to demonstrate compliance with this standard. The MDHHS provided the Juvenile Justice Residential Facility Sexual Abuse and Sexual Harassment Data Collection (CY2020). This is the tool used by the MDHHS to collect sexual abuse/sexual harassment data from all facilities in the State of Michigan. The MDHHS also provided the spreadsheet utilized to record the sexual abuse/sexual harassment data required by the State of Michigan for Calendar Year 2020 for LATFH. As indicated in the Corrective Action Verification for 115.387, the updated contract between the State of Michigan and contractors for the placement of residents, Page 32, Section 2.12 requires contractors to report any substantiated PREA incidents. According to the MDHHS PREA Compliance Manager, facilities are now required to submit PREA incident data on a monthly basis, beginning May 1, 2021. The MDHHS PREA Compliance Manager provided a draft survey, which reflects the information will be requested on a monthly basis and requires facilities to report substantiated, unsubstantiated, and unfounded incidents of youth-on-youth nonconsensual sexual acts, youth-on-youth abusive sexual contact, youth-on-youth sexual harassment, staff sexual misconduct, and staff sexual harassment. Monthly submission of this data allows the facility to review its PREA-related data on a regular basis. The facility also provided the LATFH Annual Report for 2020, which this auditor located on the agency website. The facility did not include a narrative comparison to the prior year's data, however, the LATFH Annual Report for 2019 is posted to the website adjacent to the 2020 report.

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: *Pre-Audit Questionnaire *LATFH GH Policy No. 14 M, PREA-Prison Rape Elimination Act Standards and Compliance 115.389 (a) – The facility did not provide information on how it retains incident-based data. 115.389 (b) – The LATFH GH Policy No. 14 M, Page 13, Section (8)(b) states, "The facility will 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. 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. (Note: Personal identifiers must be removed.)" This auditor was able to access the 2019 sexual abuse data posted to the agency website. 115.389 (c) – This auditor reviewed the sexual abuse data posted to the agency website and noted there was no identifying information included in the report. 115.389 (d) – This auditor received no information regarding the length of time sexual abuse/sexual harassment data is maintained after its initial collection. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING**: 115.389 (a)(d) - The facility did not provide information on how it retains incident-based data, and the length of time sexual abuse/sexual harassment data is maintained after its initial collection. The facility will need to identify a secured means of maintaining sexual abuse/sexual harassment data with limited access and create a retention schedule to track how long that data has been maintained and when it is due for purging. **VERIFICATION OF CORRECTIVE ACTION**: This auditor was provided appropriate supplemental documentation on March 9, 2021 and April 12, 2021 to substantiate corrective actions taken for this standard. 115.389 (a)(d) - The facility submitted a Memorandum of Record dated March 4, 2021, outlining the facility's resident file retention schedule and procedure, which provides that resident files will remain in secured storage for a total of ten years. The facility advised the Memorandum of Record is stored in the PREA SharePoint Folder, with access limited to the PREA Compliance Manager and Agency Head/PREA Coordinator/Investigative Staff. The facility also submitted a Memorandum of Record dated April 12, 2021, outlining the facility's

	policy to maintain PREA investigation data electronically for ten years in the PREA SharePoint Folder, with access limited to the PREA Compliance Manager and Agency Head/PREA Coordinator/Investigative Staff. 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
	Documents reviewed: *Site Review 115.401 (a) – The MDHHS has established a pattern of PREA audits for its facilities every two years. This auditor reviewed PREA audit reports for LATFH for 2016 and 2018. 115.401 (b) – The MDHHS has established a pattern of PREA audits for its facilities every two years. This auditor reviewed PREA audit reports for LATFH for 2016 and 2018. 115.401 (h) – This auditor had access to and the ability to observe all areas of the audited facility. 115.401 (i) – This auditor was permitted to request and receive copies of any relevant documents. 115.401 (m) – This auditor was permitted to conduct private interviews with residents. 115.401 (n) – Facility administration advised resident mail is screened, both incoming and outgoing. Therefore, residents are not permitted to send confidential information or correspondence to their legal counsel. Although this auditor received no written correspondence from residents pre- or post-audit, it appears any correspondence to this auditor would have been screened. **CORRECTIVE ACTION IS REQUIRED FOR THE FOLLOWING**: 115.401 (n) - The facility will need to create a system to allow for confidential mail correspondence with legal counsel, outside supportive services and future PREA auditors. This process must be explained to residents in resident educational material or postings. Verification that this process has been established and communicated to residents is required to demonstrate compliance with this provision. **VERIFICATION OF CORRECTIVE ACTION**: This auditor was provided appropriate supplemental documentation on April 8, 2021 to substantiate corrective actions taken for this standard. 115.401 (n) – Although facility administration indicated during on-site interviews that resident mail is screened, the Youth and Family Orientation Manual, Page 9, Communication Policy Section indicates resident mail is not opened. This information is provided to residents and parents/legal guardians at the time of intake at LATFH. This auditor confirmed with facility administration that incoming and outgoing resident mail is not screened, unless there is clear and convincing evidence to justify screening resident mail. The facility provided the "Did You Know" posting, which indicates residents are permitted to confidentially send and receive mail from family members, attorneys, and other approved parties. The facility provided photographic evidence of posting.

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

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.403 (f) – The facility's PREA Audits for 2016 and 2018 were located on the agency website.

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	na
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	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.)	na
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes

115.313 (d)	Supervision and monitoring	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational 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?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	na
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?	no
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	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?	no
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	no
	Does the agency ensure that written materials are provided in formats or	no

	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.)	yes
115.321 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes

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

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

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

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

115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	no
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).)	no
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.335 (a)	Specialized training: Medical and mental health care	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na
115.335 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.335 (d)	Specialized training: Medical and mental health care	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	yes
115.341 (a)	**Obtaining information from residents**	
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes

115.341 (c)	Obtaining information from residents	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does 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?	no

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?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	no
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?	yes
115.367 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes

115.367 (c)	Agency protection against retaliation	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report 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?	no
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?	no
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?	no
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	no
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	no
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	no
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	yes
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes

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

115.382 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.382 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial 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.)	na
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)	na
115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or 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?	yes
115.386 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes

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

115.387 (c)	Data collection	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for 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?	no

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